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A qualitative study to the effect of working according to evidence-based care approaches for quality of care at Dutch care farms

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Preface

Dear reader,

Right now, you are reading the preface of my Master Thesis which is about the role of evidence-based care approaches in care delivery for quality of care at care farms. In this study, I tried to find an answer to the following research question: ''*How do the most frequently implemented EB care approaches contribute to quality of care at care farms in the perception of care farmers?''*

I carried out this study to graduate for my Master's in Health and Society at the Wageningen University. This study is a qualitative study in which focus groups were organized to collect data for answering my research questions. Organising these focus groups have been a challenge to be honest: finding enough study participants who are able and willing to participate has not been easy so to say. But therefore, I am even more thankful and happy that I still managed to organize all four focus groups, and that I have had fun meeting the study participants and collecting the data for this study.

I was engaged in working on this study from September 2022 to July 2023, which is almost a year. I extended working on this study for a few months because of various personal reasons. Right now, I am thankful and happy to be finished with writing my thesis. By times it was hard to continue working on my thesis due to several disappointments in organizing the focus groups and personal circumstances. Therefore, I am proud that I managed to finish my study.

I want to thank my two supervisors, Lenneke and Jan, for helping me in formulating my research questions and helping me with writing my thesis by providing feedback and tips for practice. You helped me a lot when I had questions and made me even more enthusiastic for my study topic. Besides, I want to thank my boyfriend, friends and family who helped me during the writing process and by giving me company while writing on my thesis report.

After all these months, I am still very interested and intrigued by the power of care farms, what quality of care means and how care is delivered in practice. In the future, I hope to learn a lot more about these interesting topics! I hope by reading my Master Thesis, you will become interested and intrigued by the results of this study as well, and that you will learn something new 😊

I hope you enjoy reading my thesis!

Kind regards,

Renske Schoon

Wageningen, August 2023

Samenvatting

Introductie: Op dit moment zijn er steeds meer zorgboerderijen in Nederland. Verschillende studies tonen aan dat zorgverlening op zorgboerderijen gunstige effecten heeft voor deelnemers die werkzaam zijn op zorgboerderijen en hier zorg ontvangen. Sommige zorgboerderijen werken volgens bepaalde methodieken, maar het is nog onbekend hoe en waarom methodieken worden geïmplementeerd in de zorgverlening op zorgboerderijen. Bovendien is het nog onbekend hoe de implementatie van methodieken de kwaliteit van zorg op zorgboerderijen beïnvloedt. De vraag is dus hoe methodieken bijdragen aan de kwaliteit van zorg op zorgboerderijen of dat ze deze juist belemmeren. In dit onderzoek wordt kwaliteit van zorg op zorgboerderijen gedefinieerd aan de hand van het kwaliteitskader van de Federatie Landbouw en Zorg (2022). In dit kwaliteitskader wordt kwaliteit van zorg gedefinieerd door drie kernwaarden, namelijk "samen" (wat staat voor het samen zijn en samen activiteiten doen op zorgboerderijen), "buiten" (wat staat voor de natuurlijke omgeving met haar hulpbronnen op zorgboerderijen, waarin deelnemers actief kunnen zijn en kunnen rusten), en het ``'normale leven" (wat staat voor de mogelijkheid voor deelnemers om deel te nemen aan het normale leven (activiteiten) op zorgboerderijen). In dit onderzoek werd dit kwaliteitskader gebruikt als een theoretische lens voor hoe kwaliteit van zorg wordt gedefinieerd.

Doelstelling: Het doel van deze studie was om te onderzoeken hoe de implementatie van methodieken op Nederlandse zorgboerderijen bijdraagt aan en/of belemmerend werkt voor de verschillende drie kernwaarden van kwaliteit van zorg op zorgboerderijen zoals gedefinieerd in het kwaliteitskader van de Federatie Landbouw en Zorg (2022).

Methoden: In verband met de haalbaarheid van de dataverzameling is besloten om in dit onderzoek te focussen op de vier meest gebruikte methodieken in Nederland. Deze vier methodieken zijn Triple-C, Oplossingsgericht werken, Geef me de Vijf en de Böhm-methodiek. Triple-C is een methodiek waarbij cliënt en zorgverlener samen activiteiten ondernemen, waarbij de activiteit en de betrokkenheid van de cliënt bij de activiteit is afgestemd op zijn of haar mogelijkheden. De focus ligt op het aanleren van nieuwe competenties aan cliënten en hun persoonlijke groei. Oplossingsgericht werken is een methodiek die zich richt op de positieve kanten van de situatie en de sterke kanten van de deelnemers. Binnen oplossingsgericht werken heeft de deelnemer een grote rol in het bedenken van mogelijke oplossingen en volgende stappen om hun eigen doelen te bereiken. Geef me de Vijf is een methodiek speciaal ontwikkeld

voor mensen met autisme. Geef me de Vijf geeft inzicht in hoe mensen met autisme denken en het geeft handvatten om mensen met autisme duidelijkheid en structuur te bieden. De Böhm-methodiek is speciaal ontwikkeld voor mensen met dementie en geheugenproblemen. De Böhm-methodiek richt zich erop dat mensen zich veilig en gehoord voelen door de zorg aan te passen aan hun levensgeschiedenis en ervaring van het heden.

Data werd verzameld door het organiseren van vier focusgroepen met zorgboeren, waarbij tijdens elke focusgroep het werken volgens een van de eerder genoemde methodieken werd besproken. Drie focusgroepen werden online georganiseerd via Microsoft Teams en één focusgroep werd in het echt georganiseerd. De gegevens werden geanalyseerd door middel van een thematische analyse waarbinnen een inductieve codeerstrategie werd toegepast. Binnen de thematische analyse werden gegevens gecodeerd die antwoord gaven op één of beide deelvragen van dit onderzoek. Dit betekent dat data gecodeerd werden die meer informatie gaven over hoe de methodiek in de praktijk werd geïmplementeerd en dat data gecodeerd werden die lieten zien in hoeverre het implementeren van de methodiek aansluit bij de drie kernwaarden van kwaliteit van zorg op zorgboerderijen.

Resultaten: De onderzoeksresultaten laten zien dat methodieken vaak niet precies volgens de richtlijnen van de methodieken worden geïmplementeerd, maar worden aangepast aan een aantal verschillende factoren. De eerste is de context van de zorgboerderij, de tweede de talenten, wensen en behoeften van de deelnemer, en de derde de mogelijkheden van de zorgboeren, dit is bijvoorbeeld werkervaring en kennis die zorgboeren hebben en het zorgpersoneel dat op dat moment aanwezig is. Daarnaast laten de resultaten van dit onderzoek zien dat er vaak meerdere methodieken tegelijk worden geïmplementeerd in de zorgverlening op zorgboerderijen. Zorgboeren combineren meerdere methodieken in de zorgverlening omdat elke methodiek hen verschillende nuttige hulpmiddelen biedt voor de zorgverlening. Deze hulpmiddelen geven inzicht in hoe mensen met verschillende verstandelijke beperkingen denken en zich gedragen. Daarnaast geven ze een algemene visie op het leveren van zorg en soms bijbehorende richtlijnen voor het benaderen van deelnemers. Tenslotte voorzien methodieken zorgboeren van praktische instrumenten die de implementatie van de methodieken ondersteunen. Hoewel de methodieken op zorgboerderijen deels anders worden geïmplementeerd dan de richtlijnen adviseren, heeft de implementatie meerdere gunstige effecten op deelnemers. Deze gunstige effecten zijn dat deelnemers zich gelukkiger en rustiger

voelen en dat deelnemers nieuwe vaardigheden ontwikkelen, waardoor ze groeien in zelfredzaamheid en zelfstandigheid.

Conclusie: Dit onderzoek laat zien dat het werken aan de hand van methodieken bijdraagt aan de kwaliteit van zorg op zorgboerderijen. Methodieken zijn een nuttig hulpmiddel voor zorgboeren om (hogere) kwaliteit van zorg te leveren. Ze ondersteunen zorgboeren bij het leveren van zorg door het bieden van een bepaalde visie op zorgverlening, kennis, duidelijke richtlijnen en hulpmiddelen. Vooral het leveren van persoonsgerichte zorg en het bijdragen aan persoonlijke groei van deelnemers is effectiever bij het implementeren van de methodiek dan bij het werken zonder een methodiek. Zorgboeren implementeren methodieken vaak niet precies zoals de richtlijnen van de methodiek oorspronkelijk beschrijven, maar passen de implementatie van de methodiek aan aan de mogelijkheden in de praktijk op zorgboerderijen. Zorgboeren hebben de neiging om onderdelen van de methodiek te gebruiken in de zorgverlening. Ze kiezen en mixen (delen van) verschillende methodieken samen tot een manier van werken die bij hen, de behoeften van de deelnemer en de context in de praktijk past. Op deze manier bereiken ze de hoogst mogelijke kwaliteit van zorg met de gegeven middelen.

Aanbevelingen: Voor verder onderzoek zou het interessant zijn om de ervaringen te bestuderen van deelnemers die zorg ontvangen op basis van een of meerdere zorgmethodieken. Het zou interessant zijn om te onderzoeken of deze ervaringen overeenkomen met de percepties en ervaringen van zorgboeren die deze zorgbenaderingen implementeren. Daarnaast zou het interessant zijn om verder te onderzoeken waarom en hoe meerdere EB zorgbenaderingen tegelijkertijd worden toegepast op zorgboerderijen.

Summary

Background: Currently, care farms in the Netherlands are increasing in number. Studies show that care delivery at care farms has several beneficial effects for participants who work and receive care at care farms. Some care farms work according to certain evidence-based (EB) care approaches, however, it is yet unknown how and why EB care approaches are implemented in care delivery at care farms. Besides, how the implementation of EB care approaches influences quality of care at care farms is still unknown. Thus, the question is how EB care approaches contribute to or hamper quality of care at care farms. In this study, quality of care at care farms is defined by the quality framework of the Federation of Agriculture and Care (2022). In this quality framework, quality of care is defined by three core values, those are "together" (which stands for being together and doing activities together at care farms), "outside" (which stands for the natural environment with its resources at care farms, in which participants can be active and rest), and "normal life" (which stands for the possibility for participants to take part in normal life (activities) at care farms). In this study, this quality framework was used as a theoretical lens for how quality of care is defined.

Objective: The aim of this study was to investigate how the implementation of EB care approaches at Dutch care farms contributes to and/or hampers the various three core values of quality of care at care farms as defined in the quality framework of the Federation of Agriculture and Care (2022).

Methods: The four most often implemented EB care approaches were decided to focus on in this study for the feasibility of the data collection. These four EB care approaches are Triple-C, solution-oriented working ("Oplossingsgericht werken"), Give me the Five ("Geef me de Vijf"), and the Böhm approach ("Böhm-methodiek"). Triple-C is a care approach in which the client and health care worker do activities together, in which the activity and the client's involvement in the activity is adjusted to his or her possibilities. The focus is on learning clients new competencies and their personal growth. Solution-oriented working is a care approach that focuses on the positive side of the situation and strengths of the participants. Within solution-oriented working, the participant has a big role in thinking of possible solutions and next steps to reach their own goals. Give me the Five is a care approach especially designed for people with autism. Give me the Five gives insight in how people with autism think and it gives tools to provide clarity and structure to people with autism. This approach is a care approach especially designed for people with dementia. The Böhm approach focuses on making people feel safe and heard by adjusting care to their life history and experience of the present. Data was collected by organizing four focus groups with care farmers, during each focus group working according to one of the previously mentioned EB care approaches was discussed. Three focus groups were organized online via Microsoft Teams and one focus group was organized in real life. Data was analysed by conducting a thematic analysis with an inductive coding approach. Within the thematic analysis, data was coded that answered

one or both of the subquestions of this study. This means that data was coded for that gave more information about how the EB care approach was implemented in practice, and that data was coded for that showed to what extent implementing the EB care approach aligns with the three core values of quality of care at care farms.

Results: The study results show that EB care approaches are often not implemented exactly according to the guidelines of the EB care approaches, but are adapted to the following factors. The first is the context of the care farm, the second the participant's strengths, desires and needs, and third the possibilities of care farmers, in terms of the job experience and knowledge they have and the care personnel that is present at that moment. In addition, the results of this study show that multiple EB care approaches are often implemented at a time in care delivery at care farms. Care farmers combine multiple EB care approaches in care delivery because each EB care approach provides them with different helpful tools for care delivery practice. These tools give insight in of how people with various mental disabilities think and behave. In addition, they provide a general vision on how to deliver care and sometimes corresponding guidelines for how to approach and inform participants. Lastly, they provide care farmers with practical instruments that support the implementation of the EB care approach. Although that EB care approaches are implemented partially different at care farms than the guidelines advise, the implementation has multiple beneficial effects for participants. These beneficial effects are that participants feel happier and more at peace and that participants develop new skills, resulting in growth in self-reliance and independency.

Conclusion: This study shows that working according to EB care approaches contributes to quality of care at care farms. Care approaches are a useful resource for care farmers to deliver (higher) quality of care. They support care farmers in delivering care by providing a certain vision on care delivery, knowledge, clear guidelines and tools. Especially delivering person-centred care and contributing to personal growth of participants is more effective when implementing the EB care approach, rather than working without the EB care approach. Care farmers often implement EB care approaches not exactly as the guidelines of the EB care approach originally describe, but rather adjust the implementation of the EB care approach to the possibilities in practice at care farms. Care farmers tend to choose parts of EB care approaches to adhere to in care delivery practice. They choose and mix (parts of) different EB care approaches together to a way of working that fits them, the participant's needs and the context in practice. This way, they reach the highest quality of care possible with the resources given.

Recommendations: For further research, it would be recommended to study the experiences of participants that receive care inspired by EB care approaches, and if these experiences align with the perceptions and experiences of care farmers who implement these care approaches. In addition, it would be interesting to further investigate why and how multiple EB care approaches are applied at the same time at care farms.

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1. Introduction

In various European countries, agriculture has undergone impactful changes since the end of World War II (Hassink et al., 2020). To remain economically profitable, it was necessary for farmers to increase the sizes of their farm, to work more efficiently and to make more use of external inputs, as for example pesticides (Meerburg et al., 2009; Hassink et al., 2020). Simultaneously, labour use per hectare was decreased. This resulted in fewer available jobs in the agricultural sector (Meerburg et al., 2009).

In the Netherlands in 1970, it became clear that the Dutch agricultural sector contributed greatly to climate change, and that the sector should work in a more sustainable manner (Meerburg et al., 2009; Hassink et al., 2020). The agricultural sector was seen as being guilty of contributing to environmental problems, amongst others homogenisation of the landscape, outbreaks of animal diseases as for example swine fever, and poor animal welfare (Hassink et al., 2007a; Hassink et al., 2020). This resulted in a negative image of the agricultural sector among the Dutch population and a higher pressure on the agricultural sector (Meerburg et al., 2009; Hassink et al., 2020; Hassink et al., 2007a). Furthermore, there were increasing demands from society regarding housing and recreation facilities, because the proportion of the Dutch population that moved to the countryside grew (Hermans et al., 2010). This led to even more pressure on agrarian production, as the amount of land that farmers needed to cultivate, needed to be divided over more people and organisations (Hermans et al., 2010; Hassink et al., 2020). Lastly, Dutch farmers had to extend their income basis to remain economically profitable, and therefore started with the diversification of their services to earn more money (Hassink et al., 2015). Taking this altogether, farmers needed to change their way of farming in order to meet these various demands from society and to remain economically profitable.

At the same time, in the 1970's, the medical model was a dominant paradigm in the healthcare sector in the Netherlands (Hassink et al., 2007a). This entailed that there was a focus on measurable biological (somatic) variables of disease and illness, and left insufficient attention to the social, psychological and behavioural aspects of disease and illness (Farre & Rapley, 2017). Because of this focus, there was insufficient attention to the patient as a human being and his/her strengths and possibilities (Farre & Rapley, 2017; Hassink et al., 2007a). It was unpleasant for patients to be treated according to their impossibilities and diseases rather than their possibilities, while there was insufficient attention to other aspects of their lives. This was unpleasant for healthcare workers as well (Hassink et al., 2007a). This was unpleasant because sick people often lived separated from the rest of society, and because focusing on impossibilities leads to less person-centred care.

Hence, awareness emerged about the fact that it was important to focus on coping with disease and providing care and support to empower people in their possibilities (Farre & Rapley, 2017). This focus became complementary to the focus on treating the measurable biological variables of disease (Hassink et al., 2007a; Farre & Rapley. 2017). This was the start of deinstitutionalization of the

healthcare sector in the Netherlands (Hassink et al., 2007a). Patients were able to live at their own home for a longer period of time and receive care at home, which gave them more freedom to give interpretation to their own life (Hassink et al., 2007a). This was also the start of the concept 'community care', which entails that care is provided while as a patient living in society, and provided by society (Hassink et al., 2007a). However, the practical implications of this concept failed multiple times because integrating 'sick' people in society was difficult. Practice showed that often healthcare institutions themselves helped these sick people, instead of the community as a whole. So there was a need for a good alternative to help realize community care in society (Hassink et al., 2007a).

Thus, to resolve the existing problems in the agricultural sector and to create an alternative to realize community care in society, farmers started to integrate producing food with providing care-related services and organizing activities that stimulate social inclusion (Hassink et al., 2007a; Hassink et al., 2020). This is called 'care farming' or 'social farming' (Hassink et al., 2020; Hassink et al., 2007a; Hassink, Hulsink & Grin, 2012). Care farming or social farming do not only create opportunities for social inclusion and empowerment, but also focus on good quality of care for individual patients (Hassink et al., 2007a; Hassink, Grin & Hulsink, 2015). Because of its beneficial effects for healthcare, agriculture and social inclusion, the number of care farms has been increasing tremendously in the Netherlands since 1998. In 1998, a number of 75 care farms existed in the Netherlands, while in 2020 this number raised to 1300 care farms (Van der Meulen et al., 2022; Federation of Agriculture and Care, 2022). Additionally, more than 30.000 people are currently working at a care farm (Federation of Agriculture and Care, 2022).

In this study, care farms are defined as commercial and noncommercial farms and agricultural landscapes where care, residence, therapy or support is delivered to participants. A care farm is a base for promoting mental and physical health, through normal farming activity (Murray et al., 2019; Hassink & Kettelaars, 2003). People that work/help at a care farm and are dependent of the support/care delivered at the care farm, are called participants. These people are called participants instead of patients or clients, because care farms strive to accomplish an equal relationship between the care-giver (as for example the care farmer) and the care-receiver (the participant) (Federation of Agriculture and Care, 2022). In this study, the term participants will be used too.

Care farms differ greatly from each other: they differ amongst others what commercial farming activities they do (e.g. working with crops, livestock and/or woodland), in their offered services and care for participants and what target groups they serve (De Bruin et al., 2020; Federation of Agriculture and Care, 2022; De Bruin et al., 2021). Because care farms are diversificated to earn sufficient money and remain economically profitable as a farm, they offer different activities to the participants to assist in. These activities can be amongst others agricultural activities, horticultural activities and animal care (De Bruin et al., 2020; De Bruin et al., 2021). The care services that care farms offer are amongst others day care, supported workplaces where participants can work under guidance of others, educational services

and residential places for a longer period than one day (Hassink et al., 2012; Elings & Koffijberg, 2011). There are various target groups that find a place at a care farm, these are people with amongst others mental or psychical disabilities, mental illness, an addiction background and/or learning disfunctions (Hassink et al., 2012; Elings & Koffijberg, 2011). Care farms can specialize in delivering care to one specific target group, but there are also care farms that offer care to multiple different target groups. A lot of farms serve participants from multiple target groups (Hassink et al., 2012). Furthermore, the age category of the target group ranges from children and youth to elderly (Hassink et al., 2012; De Bruin et al., 2020). Additionally, care farms can be more focused on the agricultural side of the farm, or the care delivery side. Care farms are somewhere on the continuum between on one side being a regular farm mostly focused on agriculture and a bit on care delivery, and on the other side being a care institute with a small agricultural side (Hassink & Kettelaars, 2003). A maximum of six participants is offered a place at agriculture-focused care farms, while at care delivery-focused care farms this number is higher and care personnel works here to deliver care and support (Hassink & Kettelaars, 2003). The reason why these participants stay at the care farm, is mostly because they cannot fit in yet in the current labour market or education system, or they are in need of respite care (Elings & Koffijberg, 2011). Respite care is understood as a period of time in which participants can stay at the care farm to relief their caregivers from their care responsibilities and to help increase the independence of the participants (Elings & Koffijberg, 2011; Whitmore, 2017).

However, it is known nowadays that care farms can have a positive impact in the lives of participants as well as in the overall Dutch healthcare sector (Leck, Upton & Evans, 2015; Elings, 2011; Federation of Agriculture and Care, 2022). According to the quality framework of the Federation of Agriculture and Care (2022), that describes quality of care at care farms, there are three core values that form quality of care, these are translated in this study as 'being together' (samen), 'outside' (buiten) and 'normal life' ('gewoon'). These three core values and belonging nine core themes will be further explained in the theoretical framework. Various aspects of working at a care farm underpin these core values, and are valued as contributing to good quality of care at care farms by participants themselves and their relatives (Federation of Agriculture and Care, 2022).

The characterizing aspects of a care farm taken together, lead to an informal context which is close to normal life (Hassink et al., 2010). These aspects have several positive effects on participants. Working at a care farm can contribute to improved mental and physical health. First, the positive effects on mental health will be explained. The dynamic, calming and at the same time activity-stimulating care farm environment contributes to better mental health, by less experience of negative emotions by participants from different participant groups as a result of their illnesses (De Bruin et al., 2021; De Bruin et al., 2020). For example participants with dementia experience less agitation, and people with mental health issues experience less depression- and anxiety-related issues (De Bruin et al., 2021). Working at a care farm contributes to physical health, by being physically active, which reduces the risk

of developing chronic diseases as for example diabetes, obesity, various types of cancer, and cardiovascular diseases (Federation of Agriculture and Care, 2022; Rhodes et al., 2017). Besides, being physically active regularly is associated with improved cognition, a slower developing cognitive decline, has a calming effect on someone's mood and reduces stress levels (De Bruin et al., 2021; Jackson, 2013; Rhodes et al., 2017). Besides, an effect of being physically tired after a day of working at the care farm, is that it improves quality of sleep of the participants as well, according to the study of De Bruin et al. (2020) among elderly with dementia and according to the study of Leck et al. (2015).

Care farms also have several other beneficial effects. Care farms also contribute to the vision of the government to integrate care facilities more in society (this is called deinstitutionalisation) (Hassink et al., 2007a). At the care farm, everyone is welcome and the focus is on doing what you are capable of instead of a focus on your disabilities. In this way, care farms contribute to social inclusivity in society and normalisation of working with/having certain illnesses (Hassink et al., 2007a). Besides, care farms offer participants a place at the care farm to work and receive care there, this helps shortening the waiting lists in youth healthcare and the mental healthcare sector (Hassink et al., 2007a). This is important, because the waiting list for receiving mental healthcare are currently greatly expanding the allowed waiting time in the mental healthcare sector, and the waiting times for children/youth for receiving care are high as well (Dutch Care Authority, 2022; Inspection of Healthcare and Youth, 2021). Lastly, because of the positive effects of care farms on mental and physical health, care farms help to prevent participants from getting more ill. In this way, it prevents harm and more suffering for individuals, and it helps to lower the healthcare costs in the Netherlands, or prevents the costs from rising even higher (Hassink et al., 2007a).

To conclude, care farms have a lot to offer in terms of delivering good quality of care. In the last twenty years, more and more research is done to the health-promoting characteristics of care farms and how these replace or add value to traditional forms of healthcare (Federation of Agriculture and Care, 2022). An overview of these characteristics is summarized in the quality framework of the Federation of Agriculture and Care, which is published last June (Federation of Agriculture and Care, 2022). The quality framework is formed by the experiences and opinions of the participants themselves and their relatives (Federation of Agriculture and Care, 2022).

At various care farms, care delivery is delivered by working according to certain evidence-based (EB) care approaches. In this study, EB care approaches are defined as care approaches that vary from certain theories, functioning as a guideline in interacting with participants, to approaches that are defined in detail and provide a specific step-by-step plan. At the moment, little is known about how many care farms work according to EB care approaches. At various websites of care farms, it can be read that care farms point out to work according to certain EB approaches. However, none to very little studies have proven this. Besides, it is yet unknown what EB care approaches in care delivery are used by care farmers/healthcare personnel at care farms, and how these care approaches are applied in the context of

their care farm. Lastly, it is unknown if working according to EB care approaches in care delivery at care farms even fits in the normal life setting of a care farm, and if working according to EB care approaches contributes to quality of care at care farms.

Several studies showed though, that different groups of healthcare workers in the traditional healthcare context do not in all cases make EB decisions, which are decisions based upon scientific knowledge or literature. A multiple times called reason for this is lack of time in healthcare practice to read scientific literature before getting started and making decisions (Finne et al., 2022; Warren et al., 2016). Therefore, it could be that a certain percentage of care farmers also experiences several barriers in EB decision-making in healthcare practice, which can lead to less or even no EB approaches chosen, despite if they are willing to do so. But it is questionable if this also occurs in the context of a care farm, as the context of a care farm is very different from the traditional healthcare context (Federation of Agriculture and Care, 2022). Which can also be the case, is that care farmers make decisions in healthcare delivery by using their professional intuition, as in traditional healthcare practice intuition certainly plays a role (Gobet & Chassy, 2008; Hassani et al., 2016).

However, EB decision-making (basing decisions in healthcare practice on scientific evidence) can contribute to higher quality of care (Melnyk, Gallager-Ford & Fineout-Overholt, 2016; Spring et al., 2019), and therefore, using EBP in care delivery at care farms could be a contributor to an even higher quality of care at care farms, which the Federation of Agriculture and Care (2022a) strives for. This is for various reasons. First, using EBP in care delivery helps to better take into account the different individual needs and desires of participants (Ward et al., 2022). It is important to take these personal needs and desires into account, because this can help to deliver care that is 'patient-centred', that means that care is adjusted to the individual participant and helps the individual participant best (Ward et al., 2022; Federation of Agriculture and Care, 2022). Second, EB decision-making creates awareness among healthcare workers why is done what is done in healthcare, and stimulates evaluation of practices in healthcare (Ward et al., 2022). Third, by using an EB approach in contact with participants over a certain time period, it is possible to evaluate and reflect upon if the approach was suitable or constructive for the participant (Ward et al., 2022). By evaluating the approach, other approaches or plans can be determined when needed (Ward et al., 2022). EB decision-making can become even more important in the future for care delivery at care farms, as the intensity of care that participants need will increase in the coming years (Van der Meulen et al., 2022).

Concluding, it is clear that care farms deliver good quality of care in general. It is unclear if care farmers use certain EB care approaches in contact with participants at their care farms, and if that is the case, how these approaches are applied. Besides, knowledge lacks about the effects of working according to EB care approaches for quality of care at care farms. This knowledge can be useful, in order to give care farms a clear idea and advice on if and how EB care approaches are useful and eventually needed, to achieve good quality of care at their care farm.

Therefore, this study aims to answer the following main research question:

How do the most frequently implemented EB care approaches contribute to quality of care at Dutch care farms in the perception of care farmers?

An answer to this main research question will be found by answering the following subquestions:

1. *How are EB care approaches implemented in the context of a care farm?*
2. *How do EB care approaches contribute to or hamper quality of care at care farms, in the perception of care farmers?*

The aim of this study is to get to know what the eventually added value is of working according to EB care approaches for quality of care at care farms. This will be done by answering the two subquestions of this study. By answering these research questions, this study aims to contribute knowledge on what factors in care delivery at care farms play a role in achieving good quality of care and how working according to EB care approaches connects to that. It can be useful for care farmers to have knowledge of this EB care approaches. By this, care farmers can expand their knowledge on how care can be delivered at care farms and what EB care approaches can mean for quality of care at their care farm.

The results of this study will contribute to more awareness about implementing EB care approaches at care farms for quality of care. Besides, EB care approaches will possibly play a more important role in the future in professionalizing the care farm sector and in justifying quality of care at care farms to external parties. Furthermore, the results of this study will be used for educational purposes in creating a new online academy for (starting) care farmers by the Federation of Agriculture and Care.

2. Theoretical framework

In this study, a newly composed theoretical model by the researcher will be used as the theoretical lens (figure 4). This theory is a composed by combining three validated models, which are the quality framework of the Federation of Agriculture and Care (2022) (figure 1), the EBP decision-making model by Spring et al. (2019) and Ward et al. (2022) (figure 2), and the EBP process by Spring & Hitchcock (2010) (figure 3).

First, in the following paragraphs the three models that are part of this new theory will be explained, followed by the explanation of the new theory as a whole.

2.1 Defining quality of care at care farms

2.1.1. Different definitions of quality of care

Quality of care is defined in many different ways by many different institutions and authors. Besides, what is perceived as quality of healthcare differs between various groups of people who work in healthcare or are dependent of healthcare (Nylenna et al., 2015). Quality of healthcare is defined different by for example a client, a healthcare practitioner or a healthcare manager (Nylenna et al., 2015). So, this shows that what is seen as quality of healthcare depends on what an individual itself needs or wants regarding the delivery of healthcare (Nylenna et al., 2015). Therefore, it is important to decide from who's perspective health care quality is looked at in this study, in order to choose the best suitable definition for what quality of health care is. In this study, quality of care at care farms is defined by the experiences of participants and their relatives, by using the quality framework of the Federation of Agriculture and Care (2022) as part of the theoretical lens. This quality framework is formed by the experiences and corresponding opinions and preferences of participants who work at care farms and their relatives.

2.1.2. Three core values of quality of care at care farms

The Federation of Agriculture and Care (2022) recently published a quality framework for care farming, in which they explain what factors form quality of care at care farms and in what four ways this quality improvement process takes place (figure 1). The Federation of Agriculture and Care mentions in this framework that the experiences and opinions of those people are of importance in deciding what good quality of health care entails at care farms, as the care farms are set up especially to help and support those people (Federation of Agriculture and Care, 2022). With the input of the participants and their relatives, three core values are discovered to be the core values of good quality care farming, and are in this study translated as 'together', 'being outside' and 'normal life' (Federation of Agriculture and Care, 2022). Also care farmers and other people who relate in a way to care farms, experience these three core

values as the most important central values (Federation of Agriculture and Care, 2022). The first element 'together', entails that participants are part of the community that works and lives at care farms, by doing meaningful work there together with others. This community also brings participants in contact with people from outside their own network and so helps to bridge the gap between participants and the rest of society. Furthermore, participants experience a feeling of togetherness and solidarity at the care farm. By this, the participants experience support and appreciation at the care farm (Federation of Agriculture and Care, 2022). The second element 'being outside', entails the characteristic environment at care farms, consisting of nature, animals and other people working there. The environment offers many opportunities for participants, it is possible to carry out different activities, but it is also possible to find a quiet place to rest. So, the care farm is a dynamic place full of life and space, and offers structure by adjusting its activities to the seasons and daily rhythms (Federation of Agriculture and Care, 2022). The third element 'normal life', entails that the environment and way of working with others based on equality is a reflection of normal life. So, interaction with others is based on equality, in which the traditional roles of healthcare practitioner and client shift to the background. Instead, in this more equal relationship, suitable goals and care approaches are decided on together with the participant (Federation of Agriculture and Care, 2022).

Figure 1: Quality framework of the Federation of Agriculture and Care (2022)

2.1.3. Nine core themes of quality of care at care farms

Within the three core values of quality of care at care farms, nine core themes are created (Federation of Agriculture and Care, 2022). These nine themes are explained below.

Within the core element ''together'', three core themes are included. The first theme is ''Interpersonal connetions'' (in Dutch: ''Ik hoor erbij en ik doe mee''). This theme entails that participants at the care

farm are in contact and work together with other people (De Bruin et al., 2021). Participants can build new contacts and relationship with others, and have social contact at the care farm with others from outside their own network from for example the healthcare institution (De Bruin et al., 2021). By these contacts and carrying out meaningful activities for others, the participants can more easily be part of society, this is appreciated greatly by the participants (De Bruin et al., 2021).

The second theme is ''Doing meaningful work'' (in Dutch: ''Ik kan kiezen uit nuttig werk''). This theme entails that participants can carry out meaningful activities at a care farm, which enables them to use their skills and talents for a higher purpose (Hassink et al., 2007a; Leck et al., 2015; De Bruin et al., 2021). This is called empowerment of the participants. Because of this, the participants feel tired, but fulfilled and appreciated after a day of working at the care farm (Hassink et al., 2007a). The fact that the participants contribute something valuable to the care farm makes the participants feel more self-confident, makes them more independent and they can more easily learn new skills in this way (De Bruin et al., 2021; Hassink et al., 2007a).

The third theme is ''Eating healthy'' (in Dutch: ''We eten samen gezond''). This theme entails that everyone working at the care farm eats the same meal together on fixed times, these meals are often freshly made by the participants themselves with crops from their own land. This helps participants to eat healthy meals and learn what is healthy food and how to prepare health food.

Three other core themes are included in the core element ''Outside'''. The first theme is ''Physical activity'' (in Dutch: ''Ik beweeg veel op de boerderij''). This theme entails that participants are physically active in a natural way at the care farm by carrying out different activities that need to be done. There are various places where activities can be done that are outside, as for example the garden and the stable.

The second theme is ''Natural environment'' (in Dutch: ''Er is ruimte en ik kan veel buiten zijn''). This theme entails that the environment itself at the care farm stimulates to go outside and be active (De Bruin et al., 2021). The environment at the care farm is dynamic and has a lot of different activities to offer. But at the same time, the environment at the care farm is calm and low of stimuli, which gives participants space and rest to think and reflect (Federation of Agriculture and Care, 2022; De Bruin et al., 2021). The environment of care farms has a lot of health-promoting characteristics, as for example outdoor places, animals, plants and other daily life stimuli (De Bruin et al., 2020).

The third theme is ''Daily structure'' (in Dutch: ''Het ritme op de boerderij geeft mij houvast''). This theme entails that the daily structure of activities that a care farm offers is beneficial for participants, because it distracts them from their daily life and problems and gives them clearance about what will happen that day (Leck et al., 2015; De Bruin et al., 2021; Hassink et al., 2007a). This daily structure is formed by amongst other fixed times to eat lunch and have a coffee break together, but also by fixed

daily tasks that need to be done. Besides, the four seasons and its belonging activities lead to a certain annual structure.

The last three core themes belong to the third core element ‘’normal life’’. The first theme is ‘’Personal attention’’ (in Dutch: ‘’Ik word gezien en gehoord’’). This theme entails that at the care farm, there is attention for the personal desires, possibilities and interests of participants. In this way, care farms deliver person-centred care. Participants are able to carry out activities that align with their desires and possibilities. Besides, participants experience an equal relationship between the care farmer and themselves. The care farmer is engaged in how the participant is doing.

The second theme is ‘’Doing daily life activities’’ (in Dutch: ‘’Het is op de boerderij net als in het gewone leven’’). This theme entails that the care farm environment is comparable to a normal life setting. Therefore, participants feel like they can experience a normal life setting when working at the care farm. The fact that not every risk is taken away from their activities makes it a more natural way of working and living. Besides, a care farm has a domestic mood and interior, which makes participants feel at ease and at home.

The third theme is ‘’Personal development’’ (in Dutch: ‘’Ik krijg de kans om te leren’’). This theme entails that at the care farm participants can carry out activities they are good at, this helps to maintain their skills and stimulates the development of their skills and talents. The care farm is a place where they can learn and develop, this becomes clear by the fact that participants can learn from their mistakes and personal successes. This positive learning environment strengthens their feeling of self-worth and helps them to grow towards a more regular job outside the care farm.

2.1.4. Care quality process at care farms

According to the quality framework of the Federation of Agriculture and Care (2022), four steps are undertaken to maintain and improve quality of care at care farms in a methodical way. By going through these four steps, quality of care is accomplished and justified to other external parties. So, going through this care quality process and the three core values of quality of care from the quality framework, go hand in hand to together form and maintain quality of care at care farms.

The four steps can be translated as follows: step one is person-centred care, step two is sharing experiences, step three is reflecting and learning, and step four is evaluating quality (figure 1) (Federation of Agriculture and Care, 2022). These four steps help care farms to maintain and improve its quality of care, by frequently reflecting on the delivered care and adjusting care to these reflections. By going through these four steps, care farms have responsibility for what care they deliver and how they do that, by reporting their delivered quality of care in the fourth step and sharing that with external parties (Federation of Agriculture and Care, 2022).

The first step, is person-centred care. By person-centred care is meant that care is adjusted to the needs and desires of each individual participant. In this way, the participants can help to decide in open dialogue what goals and other measures should be taken to create a safe environment for the participant and good quality of care (Federation of Agriculture and Care, 2022). The second step, is sharing experiences. In this step, experiences are shared by the participants and other relatives regarding delivered care at care farms. Sharing these experiences helps care farms to measure its quality of care (Federation of Agriculture and Care, 2022). The third step, is reflecting and learning. In this step, care farmers and their personnel reflect on the quality of care at their care farm and translate these insights in concrete steps. Reflecting on quality of care takes place with regard to the health practitioners, the complete team at the care farms, the care farmer and the care farm as an organisation. This reflection step takes place with the higher goal to maintain quality of care and where possible, to improve it (Federation of Agriculture and Care, 2022). The fourth step, is quality reporting. In this step, care quality measures at care farms are reported to show what is going well and what is being improved regarding care delivery. The quality report shows a continuing process of evaluating and improving care at care farms. Besides, the quality report functions as a justification of what and how care is delivered at care farms, to for amongst others participants, municipalities and authorising officers (Federation of Agriculture and Care, 2022).

2.2 Decision-making regarding care delivery

2.2.1. Decision-making at care farms

By going through decision-making processes in healthcare, it is decided what care and how care is delivered for a client in a specific condition and environment (Ward et al., 2022). At care farms, decision-making processes are also gone through in order to decide on what and how care is delivered to a participant. By deciding on what care approach to apply in working with a participant at a care farm, a decision-making process is gone through as well. From the framework of the Federation of Agriculture and Care (2022), it becomes clear that client characteristics are involved in the decision-making. Client characteristics involve amongst others life history, personal goals, needs and preferences of the participant. Obtaining this information from the participant takes place in the first step of the four steps of maintaining and improving quality of care at care farms, as described in paragraph 2.3.2. It is unsure if and to what extent practice resources are involved in decision-making regarding care at care farms. Practice resources involve amongst others the practical knowledge and experience of healthcare personnel or the care farmer who work with the participant and deliver care.

2.2.2. Evidence-based decision-making

Evidence-based practice (EBP) in healthcare can be defined as “a lifelong problem-solving approach to

the delivery of healthcare that integrates the best evidence from a body of research (also called 'external evidence') with a clinician's expertise and a patient's preferences and values (eventually also family-values preferences), to make the best decisions about patient care" (Melnyk & Fineout-Overhold, 2022). It is proven that client characteristics and practice resources are used to base decision-making upon in more traditional healthcare settings, according to the EB decision-making model of Spring et al. (2019) and Ward et al. (2022) (figure 2). However, a factor that is also used in EB decision-making according to this model is the best available research evidence, this makes the decision-making EB (Spring et al., 2019; Ward et al., 2022) (figure 2). The best available research evidence can be defined as research findings obtained by a systematic data collection by the EBP decision-making process. What research evidence would be the best evidence to use in the EBP decision-making, depends on what care interventions need to be carried out (Ward et al., 2022). The environment/organisational context in which the EB decision-making takes place is the fourth influencing factor in the decision-making process. This factor moderates or constraints the interventions that would be suitable considering the other three factors (Ward et al., 2022). When applying this to the care farm context, this means that environmental and/or contextual factors at the care farm can moderate or constrain the care approach that would be chosen, considering the best available research evidence, the client characteristics and the practice resources.

In decision-making in care delivery at care farms, the best available research evidence as a factor to involve lacks at at least a proportion of Dutch care farms. Basing decision-making upon the best available research evidence is not mentioned in the quality framework as being one of the steps in decision-making upon individual care (Federation of Agriculture and Care, 2022). This shows that decision-making regarding care delivery at care farms is not naturally based on research evidence. EB decision-making in more traditional healthcare settings can help healthcare workers to accomplish higher quality of care by being a guideline for involving the three previously mentioned factors (Ward et al., 2022). Thus, EB decision-making could possibly contribute to higher quality of care at care farms as well. Therefore, in this study, this theory will be used as part of the newly created theory. EB decision-making will be used as a perspective to investigate how EB care approaches can contribute to higher quality of care at care farms.

In the middle of the figure in the grey decision-making box, all three factors overlap: this is where the information of all three factors comes together and where EBP decision-making takes place (Ward et al., 2022). EB decision-making leads to a shared decision-making process, in which the scientific evidence, the practitioner and the client as well are considered and involved in the decision-making (Ward et al., 2022).

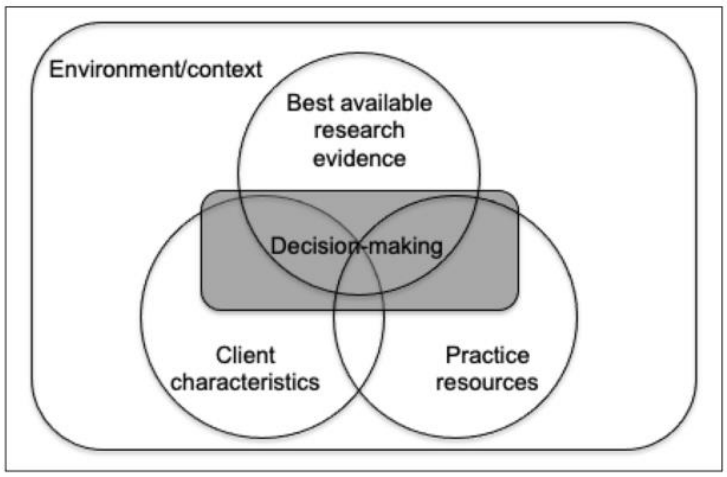

Figure 2: EBP decision-making model (Spring et al., 2019; Ward et al., 2022)

2.2.3. EBP decision-making by the EBP process

The EBP process is a five step process, by which the EBP decision-making is guided. The EBP process by Spring & Hitchcock (2010) follows the following five steps: ask a question; acquire the evidence; appraise the evidence; apply the evidence; analyse; and adjust practice (figure 3). The first step of the model by Spring & Hitchcock (2010) is ask a question. After assessing the situation or condition at hand, the health practitioner poses a relevant question or more questions about the health condition and context of the client in order to obtain a complete picture of the client's health situation and the client's characteristics. In the second step, the health practitioner tries to search for the best research evidence to answer this question (Spring & Hitchcock, 2010). Thereafter, in the third step, the health practitioner critically appraises the found evidence on its quality and applicability in the client's condition, context, and resources in the environment at hand. Fourth, the evidence will be applied in the decision-making together with the client (Spring & Hitchcock, 2010). Lastly, the outcomes of the application of the evidence will be evaluated and if better, adjusted to the practical situation accordingly (Spring & Hitchcock, 2010). The EBP process is a dynamic, cyclical and ongoing process, and throughout the process, relevant information can be acquired or the intervention plan can be adjusted if practical situations ask for that (Spring & Hitchcock, 2010; Ward et al., 2022). By following this decision-making process, healthcare workers are able to base their decisions regarding care on the three factors in the EBP-model, which enhances safety in healthcare and quality of care (Melnyk et al., 2016; Spring et al., 2019). The EBP process has a lot of similarities with the four steps of the care quality process from the quality framework. However, one important difference is that in the EBP process, the best available research evidence is searched for and that the research evidence is an important resource to build upon further in the rest of the EBP process. In this way, the best EB approach can be chosen to apply in the

situation of each individual client. The EBP process is the driver of involving research evidence in decision-making regarding care, that is why the EBP process is part of the new created model as well.

Figure 3: The EBP process model by Spring & Hitchcock (2010)

2.3. Evidence-based decision-making at care farms

The above explained models, are integrated in a new created model that is shown beneath (figure 4). This model shows the possible effect of EBP decision-making during the EBP process, on the three core values of quality of care at care farms.

The theory in figure 4 shows the possible effects of EB decision-making on quality of care of care delivery at care farms. More specifically: the theory shows whether EB decision-making contributes to or hampers the manifestation of the three core values of quality of care at care farms. Besides, the model shows how the EB decision-making process could be integrated in the quality process at care farms, while still carrying out the four steps of the care quality process. As previously mentioned, figure 4 shows possible relationships between the EB decision-making and the core values of quality of care at care farms. These relationships are made clear by using an '+' or '-' sign, to show that is yet unclear if this is a contributing ('+') or hampering ('-') effect. Lastly, the EB decision-making takes place in the care farm environment, this is the rectangular black form around the whole model. The care farm environment can either moderate or constrain decision-making on a certain care approach.

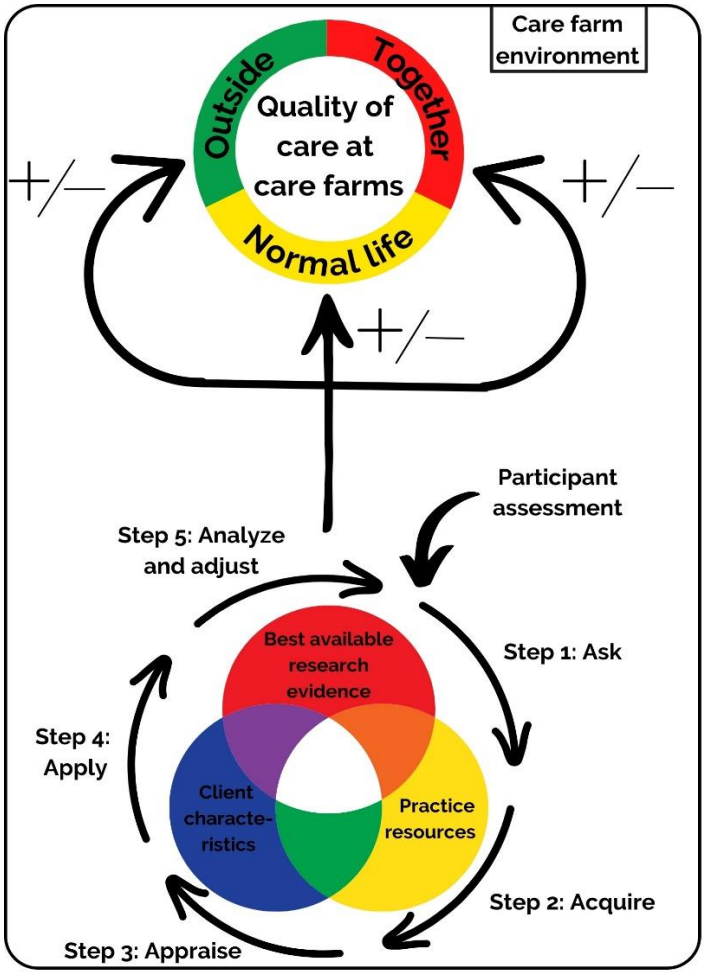

Figure 4: Possible effects of evidence-based decision-making on quality of care at care farms

3. Methods

In order to answer the research question, an answer to the two subquestions has been found. The main research question is as follows: '*How do existing EB approaches of care farmers contribute to good quality of care at care farms?',* which will be answered by the following two subquestions:

1. *How are EB care approaches implemented in the context of a care farm?*
2. *How do care farmers think that working according to EB care approaches in care delivery contributes to or hampers quality of care at care farms?*

How these research questions have been answered, will be explained in the following paragraphs.

3.1 Study design

3.1.1. Explanation on study design

In this study, a qualitative study design is adopted. In this study design it is possible to explore a certain topic by for example having conversations with study participants. This study design fits this study, because the goal of this study is to investigate the topic 'EB care approaches', and especially the use of those by care farmers and how care farmers reflect on that.

3.1.2. Decision-making on included care approaches

In this study, working according to four frequently used EB care approaches have been investigated. The first step in deciding how many and which EB care approaches are suitable to be investigated, was to investigate which EB care approaches are mainly worked with in care delivery at care farms. Therefore, six regional foundations for agriculture and care in the Netherlands were contacted to ask those which EB care approaches are mainly worked with by care farmers within their foundation. A few foundations had an overview of which care approaches are mainly worked with, these overviews were shared with the researcher. Also few foundations did not have an idea and/or overview of this. Therefore, to obtain a more complete picture of which care approaches are mainly worked with at care farms in the Netherlands, the Quality agency for Agriculture and Care in the Netherlands is contacted and asked if they had an overview of the mainly used care approaches. The Quality agency provided an overview of the most frequently used care approaches in the Netherlands as well. The overview of the Quality agency overlapped with four approaches that were mentioned to be frequently used within the regional foundations for agriculture and care in the Netherlands. Therefore, these four overlapping care approaches were chosen to investigate in this study. These four approaches are 'Give me the Five', 'Solution-oriented working', 'Triple C' and the 'Böhm approach'. The contact details of the regional foundations and the quality agency were provided by a researcher from Wageningen University and

Research [WUR]. He functioned as a gatekeeper for this study by providing contact details of employees of these foundations and of the quality agency.

3.1.3. The four evidence-based care approaches

Beneath in table X, short descriptions of the four EB care approaches that will be focused on in this study are described by a few main features.

Table 1: Descriptions of the four EB care approaches

	Triple-C *(ASVZ, 2023)*	**Solution-oriented working** *(De Vries & Prüst, 2017; Nederlands Jeugd Instituut [NJI], 2013)*	**Give me the Five** *(Geef me de Vijf, 2023; Kennisplein Gehandicaptensector, 2023)*	**Böhm approach** *(De Mensch, 2018)*
Vision on care delivery	Triple-C is short for three C's, which are Client (which is the patient or participant at the care farm), Coach (the healthcare professional) and Competency (of the client). Within Triple-C, the focus is on the client's needs instead of focus on the sometimes difficult behaviour of the client. Within Triple-C, difficult behaviour of the client is seen as a result of the unmet needs of the client. This focus is reached by working on a strong	The focus of solution-oriented working is helping to solve the perceived problems of the client together with the client. Thus, the focus in working with this care approach is on the problem's solution instead of its cause. The idea behind this care approach is that the client is in charge of what he or she wants (to change), and that the health care worker has a supportive and helpful role in the delivered care. The role of the health care worker is more of a supportive background role. The client and health care worker think together about possible solutions and steps towards the desired change of the situation. Therefore, working with this care approach means team work between the	Give me the Five is a care approach which is specially made for working with people with autism spectrum disorder. People with autism have a unique way of thinking and have a higher need of clarity than people without autism. Give me the Five helps health care workers, parents and teachers to give this clarity to people with autism.	The Böhm approach is a care approach which is especially created for people who suffer from dementia or memory problems. By working according to the care approach, care delivery is adjusted as best as possible to the life history and personal needs and desires of the individual client. This is called person-centred care. Person-centred care is delivered on the basis of an individual care plan for each client. This individual care plan is created by the health care professional together with the client and possibly family members and/or the partners of the client.

	relationship between the client and coach, in which the coach gives unconditional support to the client. Besides, the client and coach work together on new competencies of the client by doing meaningful activities.	health care worker and the client. When thinking about these steps and solutions, the strengths and resources in the environment of the client are used as much as possible. In working with solution-oriented working, the health care worker asks certain questions to the client in a methodical and structured manner to reach the goals of the client. This are questions that help the client see how their own behaviour can make a difference in the situation, and help them to dream about how the situation could look like in the future.		Within the Böhm approach, symptoms of dementia as for example memory problems, aggression and confusion, are seen as changeable, so how health care professionals are delivering care can influence the mood and behaviour of the client.
Goal of the EB care approach	The goal of Triple-C is experiencing normal life as best as possible. This means amongst others for the client that he or she has a place where he or she feels safe and at home. Besides, the client knows people that they trust and with whom they can do meaningful activities.	The main goal of solution-oriented working is strengthening the problem-solving capacity of the client to such an extent that the client can solve the problem(s) from the start of the care delivery by him- or herself and with the help of people from their social context.	There are five main goals of Give me the Five: 1. Understanding how people with autism think and behave, in order to have positive and constructive contact with someone with autism. 2. Having contact with the client in a positive and constructive way. 3. Giving clarity and rest to the client. For example by making a timetable for the whole day with a daily structure in it.	The goal of the Böhm approach is adjusting care to the experience of the presence by the clients, and fostering the mental and physical independency and autonomy of clients.

			4. Reducing arguments or fights by understanding the reason behind the behaviour of the client. 5. Stimulating the development of the client, in order to let he or she be as independent as possible.	
Effects of EB care approach	As an effect of applying Triple-C in practice, clients develop more self-confidence, and their trust in others and their environment increases. By this, the stress that clients experience and their problematic behaviour start to shift to the background.	As an effect of applying solution-oriented working in practice, clients become more optimistic about their (problem) situation and their autonomy over their own life grows. This can result in reduction in psychological complaints, such as depression- and anxiety-related complaints.	The application of Give me the Five in practice, gives clarity about daily activities, situations and everything else in the life of a client. This gives a feeling of rest to the client. In the long run, clients learn who they are as a person and can become more independent when Give me the Five is applied over a longer period of time.	Working according to the Böhm approach has several positive effects on the clients. It is proven that clients enjoy their days more when the Böhm approach is applied. Also, the clients experience more rest, and feel at home and understood.
Target groups	Triple-C is mostly used in working with people with a mental disability, who often experience psychological problems and/or have behavioural problems.	Solution-oriented working is applied when working with different target groups, what people of these target groups have in common is that they all experience one or more problems which they are not able to solve by themselves. When specifying this group of people, solution-oriented working is mostly applied in working with youth with behavioural problems or youth that experience problems in their family situation or at home.	Give me the Five is mostly applied when working with people with autism spectrum disorder, who sometimes also have a mild to severe intellectual disability.	The Böhm approach is mostly applied in working with people with dementia and memory problems, but can also be applied to a broader target group.

Helpful tools	-	A tool of solution-oriented working is asking the *''miracle question''*. This is a question that the health care worker can ask the client in order to help them imagine a future situation in which the problem is (partially) solved, and so the situation has improved. The question can be : *''If problem X would not have existed, what would your situation look like?''*	In working with Give me the Five, two tools are used. One of those are the five puzzle pieces of Give me the Five. This is a tool that gives health care workers and other people, a guideline for what information the client needs to have enough clarity. These five puzzle pieces are ''What'' (what needs to be done?), ''Who'' (who is going to do that?''), ''When'' (''When will this be done?''), ''Where'' (''Where will this be done?'', and lastly ''How'' (''How should this be done?''). Another tool, are the pictograms (or ''visuals'"") that are used in working with Give me the Five. These are visuals with pictures or photos of the activity or materials on it, to give clarity to the client by just seeing the picture instead of written text or heard information.	A tool that the Böhm approach uses, if the psycho-biography of a client. This is an overview of the life history and within that the important life happenings of a client that has formed the client to the person that he or she is now. On the basis of this, the individual care plan for the client is created.

3.2 Study population

3.2.1. Inclusion and exclusion criteria

In this study, various inclusion and exclusion criteria had been determined for the study population. There are three inclusion criteria for study participants, the first is that the study participants need to be care farmers based in the Netherlands, and the second is that these care farmers need to work according to one of the determined EB approaches that have been investigated in this study. The third is that the study participants should be able to talk fluently Dutch. Exclusion criteria are care farmers who do not meet the inclusion criteria. There are no inclusion or exclusion criteria related to personal characteristics (e.g. gender, age and ethnicity) and/or social stratifications (e.g. SES).

For organizing the focus groups, it was the goal to find 24 study participants in total, to have six study participants per focus group. This was the goal because a focus group should consist between four and eight study participants to achieve a focus group-effect (Carey & Asbury, 2012). Finding six study participants per focus group is above the minimum amount of study participants for organizing a focus group, but when one or two study participants drop out, there are still enough participants to organize the focus group. In the end, for each focus group six study participants or more were found. Finally, due to drop-out of participant for various reasons, three focus groups were organized with 5 participants, and one with three participants. Within these four groups, there were no specific inclusion or exclusion criteria except for the previously mentioned inclusion and exclusion criteria that have been applied to all study participants.

3.2.2. Participant recruitment

A convenience sampling method has been used to obtain the study participants Study participants had been obtained by contacting six regional foundations of agriculture and care in the Netherlands. These are BEZINN (in the Northern region of the Netherlands), Landzijde in North Holland, Farmer and Care ('Boer en Zorg') in the middle region of the Netherlands, SZZ in North Brabant, Care farmers ('Zorgboeren') in South Holland and Care farmers in Limburg. Via contact persons of these foundations, suggestions for care farmers that possibly wanted to participate in this study have been obtained. These care farmers were reached by telephone or email to ask them if they were willing to participate in this study. The idea was to organize offline focus groups, it was therefore important that participants from the same focus group live somewhat near each other or that they are eventually willing to travel to the location of the focus group. In practice, it became clear that it was quite difficult to find enough study participants for the focus groups, and the care farmers that were willing to participate in the focus groups often lived far away from each other and all across the Netherlands. This made organizing offline focus groups impractical for the researcher and often unfeasible for the study participants as well. Therefore, three focus groups have been taken place online via Teams. One focus groups was feasible to organize in real life, this focus group has taken place at the Windesheim, university of applied sciences in Zwolle.

3.3 Data collection

3.3.1. Focus groups

To obtain rich and detailed data, focus groups were organised with care farmers who use at least one of the four EB care approaches (Carey & Asbury, 2012). Organizing focus groups stimulates generating ideas about the EB care approach, and helps to form a complete picture and opinion about the care approach together (Carey & Asbury, 2012). Focus groups were also chosen as data collection method to stimulate care farmers to participate in this study, because care farmers can benefit from participating

in this study by learning from each other, instead of only investing their own time and effort when participating in this study without getting something in return for that. Thus, the focus group is beneficial for this study and for the care farmers themselves as well. Each focus group in this study was about one of the four EB care approaches.

3.3.2. Content of the focus groups

The content of the focus groups was guided by a previous determined topic guide by the researcher. This format includes different headings:

- Welcome and explanation on the topic of this focus group
- Explanation on ethical considerations, regarding privacy and informed consent
- Explanation on how the focus group will be conducted: e.g. format of the meeting and time schedule
- The content of the meeting; questions that will be asked, activities that will be carried out, etc.
- Giving thanks to the participants for participating, and ending the meeting.

In advance of the focus group meetings, the researcher prepared the program lead by thinking of what questions are suitable to ask in order to find answers to the research questions. Also the usage of additional tools or programs to support the data collection was considered by the researcher. This led to the following set-up of the focus group. The focus groups endured for 1.5 hour. After introducing everyone and explaining the practicalities of the focus group, the group of study participants was split up in two groups, of which one group was led by the researcher and one was led by the cofacilitator of the focus group. In these two groups, multiple practical cases of the study participants were shared that were about the application of the EB care approach. Each study participant shared two cases: one case was a case in which the EB care approach was applied and had a beneficial effect on the participant at the care farm, and one case was a case in which the EB care approach was applied and this had a negative effect on the participant, or at least not a positive effect. By sharing these practical cases, the goal was to find out how the EB care approach is applied in practice and how care farmers think about that. Thereafter there was a short break.

After the break, the two groups were merged again and during the rest of the focus group the Whiteboard function in Microsoft Teams was used to collect a lot of data in a fast and easy way. The Whiteboard function was used to inventory the possible advantages and disadvantages about working according to the EB care approach. The study participants could fill in sticky notes with all advantages and disadvantages that came to mind. After filling in these sticky notes, there was space for some discussion and additional questions about the sticky notes or about working according to the EB care approach. Thereafter the focus group was closed by thanking everyone for participating and ending the meeting. A complete overview of the content of the focus groups and the program lead has been added in Appendix I.

The focus group sessions were semi-structured, in which the determined questions were used to guide the conversation. Two meeting facilitators were present during the focus group, being the researcher and one co-facilitator. The researcher has led and moderated the focus groups by following the focus group format and time schedule. This included asking questions, leading the group discussions and guiding the conversation to the topics of interest. Besides, the researcher paid attention to the group dynamics of the study participants, and if needed actively stimulated more silent study participants to share their input, by asking questions and creating attention for those participants by the whole group. The cofacilitator helped to set up the meeting place. Besides, the cofacilitator made notes of the focus group by writing down impressions on the overall content of the discussion, the mood during the discussion and other remarks. The notes were structured by using a note-making format (see Appendix III).

3.3.3. Research setting

The location of the focus group that took place in Zwolle in real life, was adjusted to the region where the study participants of the focus group came from. This was done in order to make travelling to the focus group feasible and to make participating in the focus group more attractive. The other three focus groups have taken place by making use of Microsoft Teams.

3.3.4. Planning of focus groups

To accomplish participant groups that vary in study participants that participate, different study participants will be tried to find to participate in each focus group. Therefore, the goal is that no study participants will participate in two focus groups but that different study participants participate in each focus group. In this way, as much as possible different views of study participants will be included in this study. Data collection have taken place in March 2023, when all four focus group were held. The focus group about Triple-C was at the 9th of March, the focus group about Solution-oriented working was at 10th of March, the focus group about Give me the Five was at the 13th of March, and the focus group about the Böhm approach was at the 20th of March. The topic list and time schedule of the focus groups are shown in Appendix I. The length of all four focus group was 1.5 hour. In table I beneath, the time planning for the data collection and the whole research is shown.

Table 2: Planning of research activities

Research activity	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
Discussing and defining research topic	X	X										
Writing thesis proposal	X	X	X									

Handing in draft proposal				X								
Handing in final proposal				X								
Recruiting study participants					X	X	X					
Organizing focus groups: date, time, location, signing informed consent forms by study participants					X	X	X					
Data collection							X					
Transcription of data							X	X				
Data analysis								X	X			
Writing thesis report									X	X	X	
Handing in draft thesis report											X	
Handing in final thesis report											X	X

3.3.5. Capturing and storing data

The data was collected by recording the focus group meetings. To be able to analyse the data thereafter, the recordings were transcribed and stored in word documents at the laptop of the researcher in the online laptop cloud. A verbatim transcription method will be used for transcribing the focus groups. Notes of the focus group were taken by the cofacilitator, these notes contributed to making clear the perspectives, experiences and attitudes of the study participants. Besides, the notes helped to remember the mood and dominance of certain participants in the focus group session. The transcriptions and notes of the focus groups taken together, contributed to the veracity and validity of the data collection (Halcomb & Davidson, 2006). Right after each focus group were finished, the focus group meeting and written notes were discussed between the researcher and the cofacilitator to form an opinion on it together and to prevent researcher bias.

3.4 Data analysis

3.4.1. Data analysis method

To analyse the data obtained in this study, a thematic analysis approach was used and within this, an inductive coding approach. This analysis approach was chosen, because using this analysis approach leaves as much space as possible for new patterns, ideas and relations to arise and be remarked within the data during the data analysis (Carey & Asbury, 2012). This stimulates an exploratory and open attitude towards the data obtained. At the end of the coding process, a thematic network had been created that shows the emerged themes and associated codes during the coding process. The created lists of codes are shown in Appendix IV.

3.4.2. The coding process

The coding process was carried out by using the transcripts of all the focus groups in Microsoft Word. Coding was done by going through the coding process, in which applying codes to certain text fragments will be done by marking these text fragments in different colours. Thereafter, the structuring of the codes and creating the thematic network was done via Microsoft Word as well and by using different colours to mark different text fragments with different codes. As previously told, an inductive coding approach was used in this coding process. However, to search and select for the right data to code, the inductive coding approach was carried out by having the main research question and the two subquestions of this study in mind. So, data was coded that give information upon the two subquestions of this study. Therefore, data was coded by looking out for data that shows insights upon how the EB care approaches are implemented in practice, and by looking out for opinions/ideas of care farmers about how working according to the EB care approach would contribute to or hamper aspects of quality of care at their care farm. Besides, data was coded that made clear two other useful general aspects of the focus groups: firstly, to what extent participants (dis)agreed with each other, to say something about the general opinions of the study participants, and secondly, how they experienced working with the EB care approach, if this did not really belonged to one of the subquestions of the study. This information taken together completed the picture of the application and effects of working with the EB care approach.

3.4.3. Role of theoretical framework in data analysis

As previously explained, the data was analysed from an explorative perspective by a using a thematic coding approach with an inductive coding approach. Thus, no codes were determined previously to the data analysis that are based on the theoretical framework. Nonetheless, the created thematic network will be studied by comparing it with how quality of care at care farms is defined in the theoretical framework. This will be done to draw conclusions on whether and eventually how working according

to the four EB care approaches can contribute to or hamper quality of care at care farms, as defined in the theoretical framework.

3.5 Socio-ethical considerations

3.5.1. Risks and benefits of participation

Various socio-ethical considerations are important to think about before and during carrying out this study. One of those considerations is reflecting on the potential risks and benefits of participating in this study for the study participants. In this study, there are no potential risks of participating for the safety, health or other personal circumstances of the study participants. However, a potential benefit from this study might be that the study participants will be inspired by the other study participants and that they learn something new. To be sure of the consideration of potential risks and benefits for study participants that participate in this study, the thesis proposal was read and provided with feedback by the thesis supervisor.

3.5.2. Confidentiality and secure data storage

The personal data and input that study participants share during the focus groups, is kept private by the researcher and will not be shared with any third party or external person. This will be done to provide confidential handling of the shared data. Thus, the shared data will be stored in personal documents of the researcher and will not be stored in the laptop cloud to prevent unintended sharing of data with others. Besides, the obtained (personal) data of this study will only be used for study purposes. Personal data of the study participants will be kept anonymously by not mentioning any names or personal data in the study report. Additionally, when the thesis report is finished, the personal data that are provided by the study participants will be deleted by the researcher. However, the results of this study will be shared with the study participants if they are willing to read it, to show them what is done with their input from the data collection.

3.5.3. Voluntary participation

The study participants were able to participate in this study on a voluntary basis. This means that the study participants were not forced to participate and that they were able to withdraw from participation in this study at any phase during this study, for any reason that can be kept anonymously.

3.5.4. Transparency

To inform the study participants about this study before participating, an informed consent was provided for the study participants. In this informed consent, several important notes about (participating in) this study were mentioned and explained. The content of this informed consent entails who is conducting the study and the purpose of the study, voluntary participation in this study, consequences for the study participant of enrolling in this study, the right to withdraw from the study, the confidentiality and secure

storage of data, the risks and benefits of participating in this study and lastly how the gathered data will be used. The informed consent is added in Appendix II.

The informed consent was provided at least a few days prior to the onset of the focus group, to inform the participant in time before participating in the focus group. The study participant needed to sign this informed consent, prior to the onset of the focus group. By this, the study participants all agreed with the effects and consequences of participating in this study.

4. Results

In this section, the results of this study will be described. The results are classified in four subgroups, which are the four EB care approaches that the focus groups were about. Within these four categories, the results are categorized in three subheadings, the first one is about amongst others the general mood of the focus group and the group dynamics, the second subheading shows the results for subquestion one and the third subheading shows the results for subquestion two.

Within this results section, the study participants that were present during the focus groups are called ‘‘study participants’’, and the people that work at the care farms and receive care there are called ‘‘participants’’ in this section.

4.1 Evidence-based care approach: Triple-C

4.1.1. General impressions and facts of the focus group

The focus group about Triple-C endured for 1.5 hours, was held online and three study participants showed up in the meeting. In the first place, five participants were expected to be present, but due to various reasons they were last minute not able to come.

The mood during the focus group was pleasant. The study participants were all mentally present and focused on the topic of interest during the meeting. The study participants told a lot of information and asked quite a lot to other study participants from own initiative as well, which let the researcher and cofacilitator be a bit more on the background of the conversation. This made the conversation feel quite natural and led to interesting new information.

Overall, the study participants were very enthusiastic about working according to Triple-C. The study participants had difficulty with thinking of possible negative sides of working according to Triple-C, and also had difficulty with thinking of cases in which working according to Triple-C did not have a good effect on the participant. The positive sides of working according to Triple-C far exceeded the negative sides during the discussions about the positive and negative sides of working according to Triple-C. There was a lot of consensus about each other’s opinions.

4.1.2. How is Triple-C applied in practice at care farms?

During the focus group, several themes emerged in the discussions about working according to Triple-C. Beneath, these themes will be listed and further elaborated on.

Building a confidential relationship with the participant

The first step in being possible to work according to Triple-C, is building a relationship with the

participant that is based on trust. It is important and needed that the participants trust the care farmer, in order for the care farmer to work with and support the participants.

''It was important to let go of the expectation that the participant must join the activity, in order to build a relationship with him. We were searching for the pleasant moments and the moments of success for the participant''

Building on this confidential relationship before working on certain goals/new steps for the participant, is especially important when participants deal with attachment problems and/or with complex personal problems.

Some participants can deal with aggressive behaviour. This is experienced as an obstacle for care farmers in winning their trust, because aggression makes care farmers more distant in how they approach and have contact the participant. The aggressive behaviour makes them feel threatened by times as well. Triple-C does not give sufficient guidelines on how to deal with aggressive behaviour, according to care farmers. Therefore, care farmers combine working with Triple-C with other care approaches that help them in dealing with aggressive behaviour when this is needed.

''We also work according to Non-violent resistance as a care approach, and we put that care approach above Triple-C in this case. By this, we still focus on keeping the relationship warm with the participant, but we give the child more control over the situation by letting the child decide how he or she wants to solve the problem''

Person-centred care

A big theme that emerged during the focus group, was person-centred care. Person-centred care entails that the care/support is adjusted to each individual participant. Care farmers describe person-centred care as care that is adjusted to the needs, strengths and interests of the participant. So, the whole picture of who the participant is as a person.

''It is not about the behaviour itself, but about looking at the needs underlying the behaviour''

''We thought about how can we help the participant to be able to participate in normal life situations again. We did that by discussing with him what makes him happy and what he is good at''

The delivered cate is adjusted to the needs of the participant at that certain moment and the needs/goals in the long run. These needs can be mental needs and physical needs. This can even include meaningfulness in life.

Looking at the positive sides of the participant

Triple-C helps care farmers to focus on the positive sides of the participants, being their qualities and possibilities, instead of focusing on the participant's problems and/or negative behaviour. Besides,

Triple-C helps care farmers to look at the talents and interests of the participant, as told in the previous paragraph. This altogether gives a positive view upon the person the participant is.

''I focus on what someone can do and how that person fits in the group of participants, instead of focusing on possible problems''

Doing 100% together

A slogan belonging to Triple-C, is ''doing 100% together'' (in Dutch: ''samen 100%''). This slogan was mentioned a lot during the focus group by all participants. Care farmers support participants to carry out certain activities and/or tasks at the care farm, by doing those together with the participant.

''It is pretty much doing it together, from the basic principle doing 100% together''

Together, the care farmer and particpant do what is needed to complete the task or do the activity. The participant can join the activity in his or her own way, depending on the possibilities of the participant:

''We played a ball game together. In this ball game, good responsiveness to the ball is needed. The participant did not have a very well responsiveness to the ball, so I played the game together with her. She smashed the ball and threw it to the other side, while I was doing the rest. Together, we did 100%''

However, two or more participants can work together to do 100% together as well to each individual's possibilities. This is a alternative way of applying the slogan ''Doing 100% together'' in practice:

''You can do it together, one person was for cutting the vegetables and the other one for the focus and having fun together while the other person was cutting. In this way, both participants could do something meaningful and they could help each other''

Time and space at care farms

At the care farm, participants can experience normal life by doing daily activities and having positive interactions with others based on equality. This is possible, because there is enough time and space for participants at care farms to develop themselves. In traditional healthcare settings, there is less space and time for participants to develop their positive side and grow as a person.

'The space we are having outside really makes the difference for the participant''

At care farms, there is a lot of space outside around the care farm for doing a wide range of activities and tasks to do within working according to Triple-C. Besides, this space gives participants also space to be alone for a while or cool down alone outside when they need that. There is also more time at care farms for participants to develop themselves with support from care farmers, as participants can stay for a longer period of time (months, or even years) at a care farm. This gives more time to build a confidential relationship between the care farmer and the participant, which an important basis when working according to Triple-C:

''*Building this confidential relationship can endure for even half a year. But that is no problem at all, because we have got time to do so.''*

Learning participants new competencies/skills

Participants can learn a wide variety of competencies by doing activities at care farms. Social skills are learnt by working together with others and being with others in a group at the care farm. Besides, social-emotional skills as for example dealing with emotions, are learnt by talking about emotions with participants. Furthermore, more general skills as learnt at primary school can be learned at care farms in a very practical and natural way of learning, examples of this are arithmetic and biology. Lastly, (personal) hygiene can be learned about at care farms as well.

''When the participants are working together in a group, they need to take into account what the other participant wants and they need to listen to the others''

''An example is learning arithmetic at school, this does not work for some children. At a care farm, we calculate while we are putting the fencing around the cow pasture''

Participants can learn new competencies because the activities are adjusted by the care farmers to the abilities of the participant. Over a period of time, these activities/tasks can be made bigger or more complex to carry out. In this way, the participant is challenged and stimulated to so something new and thus learns new skills and grows as a person. This happens by little steps at a time. This step-by-step approach, is possible to apply at care farms, as there more time to reach the goals of the participant than in regular healthcare settings, as told before in the previous paragraph.

Use of practical resources at care farms

Practical resources at care farms are used as well in working according to Triple-C. Triple-C can be applied in practice in very different ways because of the space and resources at care farms. Among others, the animals at care farms are used in working according to Triple-C. Some participants really like animals or like working with animals, and therefore do activities at the care farm with animals. Also daily tasks that are needed to be done at care farms are done by participants who like to do those.

'He is crazy about the horses and mucking out the stables, so he is doing that''

These tasks can be carried out either inside or outside. Examples of these tasks are: feeding the animals, mucking out the stables, or preparing the meals for everyone at the care farm with fresh vegetables from the garden. Also more creative ways of applying Triple-C are used that do not especially have something to do with the care-farm-specific environment, for example playing a ball game as care farmer and participant together.

Applying Triple-C as well as possible

During the focus group, various general themes about working according to Triple-C emerged. The first

theme, is that due to staff shortage, Triple-C cannot be applied in practice exactly as the manual about working according to Triple-C describes. This results in situations in which less staff is working with a bigger group of participants than the manual advises. One of the study participants described this in the following way:

''Ideal would be to have 3 supervisors on 6 clients, but it cannot be realized''

Thereafter, the study participant continues by saying that despite this shortness of staff, still a lot can be reached:

''Most of the time we have 3 supervisors on 10 clients, or 2 on 10. We manage that!''

The shortness of staff is caused by a shortness in money to pay for sufficient staff that works in the same work shift. How many staff members are deployed per participant at a care farm, depends on the remuneration a care farm receives for delivering care to that participant.

The guidelines of working according to Triple-C state that Triple-C must be applied exactly as it is written to do so in the manual to make it work and have a good effect in practice. However, at care farms Triple-C is not applied exactly as the manual describes, but it still has positive effects on participants:

''Some of our clients react positive when a little bit of Triple-C is applied. For them it is enough in their situation. The use of the complete method is not always necessary. However you must be able to justify why you opt for a particular coaching style.''

What becomes clear during the focus group, is that the vision/way of thinking behind Triple-C on its own helps care farmers to approach the participant differently and so deliver care in another way, irrespective of the exact guidelines and tools Triple-C has:

''I really like the way of thinking Triple-C has, irrespective of the exact guidelines of how to work with it''

Group size of Triple-C care

The study participants said that participants mostly receive care in a group context with varying group sizes. If a participant is in need of more support and care that can be given in a group context, care farms also deliver one-to-one care in which one staff member has individual and specific attention and time for one participant only during that work shift.

''Being and working in a group of participants is too intense for him. But now that he receives individual attention from one care farmer, it is going very well''

Working with Triple-C in a group context, gives participants room to withdraw from the group programme when he or she has strong emotions or wants/needs to be alone. When this happens, the care

farmer can positively approach the participant and stimulate him/her to join in the programme again. This approach emphasizes the positive side of the situation: the care farmer wants the participants to join the group again and be there, and the care farmers does not give any attention to the sometimes negative/destructive behaviour of the participant:

''When a participant has walked away because of angriness, I only give attention to the fact that he or she is not present in the group. I approached her and asked: ''Are you coming back soon?'' and the conversation about her angriness will follow later, when she returned to the group''

Lastly, the study participants mentioned that sometimes to help a participant further, it is needed to react to the participant in a bit of a creative or different way than the participants are used to from earlier care experiences. In the long run, this leads to positive behaviour change:

''When you react a bit differently to the behaviour of the participant than the participant is used to, another reaction will come in return''

Awareness of Triple C and other care approaches

Study participants all mentioned that they work according to various care approaches at the same time. The study participants combine pieces of care approaches or the whole care approaches all together, to a kind of mix that works for them in practice. Thus, Triple-C is also combined with other care approaches, as for example ''Solution-oriented working'', ''Give me the Five'' and ''Non-violent resistance'' (''Geweldloos verzet'').

The study participants all mentioned to often be unaware of when they apply Triple-C and how they do that:

''I am not aware at the moment of doing something if I am working according to Triple-C. Sometimes when I look back, I can see that I used it''

''I would not think by myself in practice: what care approach am I applying at the moment?''

Triple-C and various target groups

Triple-C is applied in working with various target groups. Examples of those are children: children with ADHD and/or children that deal with attachment problems, or children with mild/severe intellectual disabilities. Triple-C is also applied in working with youth and adults with mils/severe intellectual disabilities, and people who deal with addiction.

4.1.3. Does working according to Triple-C contributes to or hampers quality of care at care farms?

Within this paragraph, the effects of working according to Triple-C will be listed and further elaborated on.

Positive effects on participant

Working according to Triple-C has various positive effects on the individual participant. One of those effects is that doing activities together adjusted to the abilities of the participant, gives the participant a happy feeling and the participant can enjoy the activity:

''We saw she was enjoying herself, a happy face and a happy girl when she went home''

In the longer run, another study participant mentioned that the negative behaviour of the participant changed in more positive behaviour towards the care farmers and the other participants. The study participants called these kind of changes in behaviour and these moments of a positive effect ''moments of success'' (''succesmomenten''):

''The contact with the participant became more and more pleasant. In the group the participant was not seen as a nice person, but also in this contact moments of success were achieved''

''We can create a moment of success with a small assignment''

Besides, the study participants mentioned that the self-reliance of participants increases by working according to Triple C:

''The self-reliance of the client has grown enormously''

Lastly, the study participants described that the self-esteem and self-confidence of the participants increases by working according to Triple-C:

''He saw that his need to discuss everything has become one of his qualities''

''The participant starts growing and developing healthy behaviour and his self-esteem grows''

''Self-confidence and self-reliance are strengthened by moments of success''

Participant is taking part in normal life

By working according to Triple-C, participants can take part in normal life activities with others and so become part of normal life. These activities are valuable activities, because they contribute to a higher goal.

''Working together is powerful''

''Acting together is satisfying''

Also, the participants learn to work together and form a team, each person with its own talents and abilities:

''One mission one goal, working as a team''

''Everyone can contribute something, together for one goal''

By taking part in normal life activities with others, the participants feel like they are really part of the activity and/or the group of people that is doing the activity or working at the care farm.

''She felt that she was part of the game''

Increase in job satisfaction for care farmers

Because working according to Triple-C makes care farmers work together with the participant and think together about a goal and plan to reach that goal, care farmers enjoy their job more:

''Working together and building a relationship increases the job satisfaction''

Besides, doing their job according to Triple-C feels for care farmers as a relief in workload:

''It was a relief when the client did not have to fulfill the entire program''

Study participants even mentioned that working according to Solution-oriented working, gives them tools to deliver care in practice:

''The slogan 'Doing 100% together' gives me a clear tool in practice''

One of the negative sides of working according to Triple-C was that it leads to more administrative work:

''The administrative burden is increasing''

4.1.4. Summary and overall analysis

The data shows that the application and effects of Triple-C on care delivery fit with the strengths of care delivery at care farms, as described in the theoretical framework. A big theme that emerged in the focus group discussion that really aligns with what is defined as quality of care at care farms. is person-centred care. The positive features of care at care farms give a lot of possibilities to deliver person-centred care to each individual participants. Examples of these positive features are doing activities that the participants like and being able to learn new competencies by doing activities alone or with others. As also described in table 1 in section 3.1.3 about Triple-C, the basis of delivering person-centred care is building on a strong confidential bond with the participant. This fits well at care farms, because having good relationships with others is also an important feature of quality of care at care farms.

Although that not the whole set of Triple-C guidelines are applied and that Triple-C is applied in sometimes an alternative way, care farmers still see positive results of working according to Triple-C on the participants and on their own job satisfaction. Maybe applying Triple-C at care farms even has more positive results than applying Triple-C in a more traditional healthcare setting, because the guidelines of Triple-C align so well with the vision on care delivery at care farms and because there are so many useful resources at care farms for applying Triple-C.

Furthermore, it seems from the data that the application of multiple care approaches in practice is feasible for care farmers and that this even helps them to better adjust care to each individual participant and so to deliver person-centred care of higher quality.

The question is however, to what extent care farmers work methodically if they can combine various care approaches together and still apply them all sufficiently to say that they work according to all care approaches. This question arises even more because care farmers mentioned to not be aware of when and how they work according to Triple-C, although that a reason for this can also be that working according to Triple-C has become a normal or automatic response in care delivery practice.

4.2 Evidence-based care approach: ‘‘Solution-oriented working’’ (‘‘Oplossingsgericht werken’’)

4.2.1. General impressions and facts of the focus group

The focus group about Solution-oriented working endured for 1.5 hours, was held online and five study participants showed up in the meeting. In the first place, seven study participants were expected to be present, but due to various reasons they were last minute not able to come.

The mood in the meeting was overall pleasant and calm. The discussions have been fruitful and informative. The interpersonal contact between the researcher and the study participants was pleasant.

The study participants were quite enthusiastic about the care approach, despite that there are also pitfalls and difficulties in working according to Solution-oriented working. Overall, the participants mentioned to see more positive sides in working with the care approach, instead of negative sides. There was a lot of consensus between the study participants about their opinions.

4.2.2. How is Solution-oriented working applied in practice?

Various themes emerged during this focus group which will be all listed and explained below.

Shifting the focus to the possibilities of the participant and/or the situation

With Solution-oriented working, care farmers try to find a solution to the problem/situation that is at hand. This is done by analysing the problem, looking at the needs and/or desires of the participant, and thus thinking of a suitable and sufficient next step to take or solution to the problem.

‘’We use Solution-oriented working for our clients to explore how to make daytime activities satisfying for them’’

Thinking of a suitable next step or solution to the problem is done together with the participant by talking about it. In this way, working towards the solution becomes something that they do together and involves the participant in the decision-making:

‘’We make a plan together, so the client is the owner en takes responsibility’’

‘’ Asking questions like: what is going well? And what is it that you want? These questions will help the participant to take charge in his life. That gives the participant a positive outlook’’

‘’By working according to solution-oriented working, you call upon the strengths of the participant. You do not take over responsibility but you work together’’

By working according to Solution-oriented working, the focus of the participants themselves, the care farmers and the parents/caregivers of the participants shifts to the more positive features of the participant:

''We ask clients question such as: ''What are your strengths? What do you like to do, do you have a hobby?''

One study participant also mentioned to really try to approach a new incoming participant with an open mind, by not asking for information about earlier care experiences of the participant.

It was remarkable that multiple study participants mentioned that parents/caregivers of the participants often had difficulty with thinking of positive sides of the participant. Asking questions about the positive sides of the participant is part of Solution-oriented working as well:

''We ask parents if they know what their child likes to do, what is their child good at, what are qualities of their child?''

''A lot of things are not going well in life for our participants, that is why they come to us. It is the reason why we ask first what is going well with the participant''

Multiple study participants mentioned as well that they ask questions about the goals/desires/wishes of the participants and their parents/caregivers. These questions are based on Solution-oriented working as well. These questions help to shift their focus to the future, and makes them dream and wonder about what change they want to see and how this can be realised:

''Our way of taking an interview is an invitation for wishful thinking. What would you like to be different? What has to change? What change would you like to see for your family?''

''How would you like the future to be? What is in that case needed?''

Use of resources

When working with Solution-oriented working at care farms, various resources at care farms are used. One example of a resource is the animals that are present there:

''The animals are helpful. For some participants the animals make them feel comfortable. So they can speak and make contact easier.''

Another example is the outside space at care farms:

''Working outside is helpful for the participant. The participant has a goal, needs to work together and learns to ask questions''

''Working outside with participants offers more possibilities than inside a house''

Another study participant mentioned that the combination of resources at care farms, which are the outside space at care farms, the possibilities for doing various tasks, and doing tasks together, makes that Solution-oriented working has positive effects on participants:

''But I think it is the combination of those factors together that makes the difference''

Working according to Solution-oriented working and other care approaches

All study participants agreed on often being unaware of when and how they implement Solution-oriented working exactly:

''I find it hard to distinguish between when I am working according to this or that care approach. During work, I am not aware of what care approach I am applying''

''I can hardly imagine what it is like to work without Solution-oriented working. You do not think it over every time, but you act professional towards the client with the knowledge you have''

When asking the study participants how they would have reacted in their case about a certain participant when they would not have implemented Solution-oriented working, they were really struggling with thinking of what this would have looked like:

''Well, this is a very difficult question…''

''Yes…''

''Yes it definitely is.''

Study participants mentioned to work with different EB care approaches and that they combine (parts of) these care approaches to what works for them in practice:

''We use the care approach ''Give me the Five'' ("Geef me de Vijf") a lot in a combination with Solution-oriented working''

''It is like an umbrella with a lot of colours. We mix and work with it in our own way''

One study participant also explicitly mentioned to find it hard to distinguish between what way of working is based on which care approach:

''I find it very hard to distinguish between these care approaches in practice, because we combine various care approaches together''

Working according to Solution-oriented working is described as a certain way of thinking:

''The colleagues must change along with the new way of thinking''

Pitfalls/difficulties in working according to Solution-oriented working

Study participants also mentioned a few pitfalls that they encounter during working according to Solution-oriented working. One of those pitfalls, is that as being a care farmer, it can be difficult to really think together with the participant about a solution or the next step to take, especially when the participant can be very quiet or needs a lot of time and incentives to give input for the solution:

''When the situation of the participant is not getting better it is hard to go on with the care approach, it is easier to quit and take over the responsibility''

''It is hard to help a participant by doing nothing and letting them think by themselves''

Another pitfall is that there is a certain ''blind spot'' in working according to Solution-oriented working. Although that, a study participant mentioned that every care approach has its own blind spots:

''Every care approach has a blind spot. Something you do not see when you are supervising the participant''

A last pitfall that was mentioned, is overestimating the possibilities of participants and/or the people in their environment:

''There is a risk of overestimating the participant and the environment around the client. The family environment can be damaging for the participant''

A difficulty in working according to Solution-oriented working, is that sometimes the personal circumstances of the participants, such as his or her home situation, school situation or other environments in which the participant is in, are so difficult, that it can be very complicated to think of a solution for a positive change:

''As a supervisor the problems of the participant can feel heavy too. Are we overestimating the participant when we say he or she has to think about a solution? Is it fair to do that?''

Solution-oriented working with different target groups

Working according to Solution-oriented working can be easier or more difficult, dependent on amongst others the target group that is served by it. Study participants mentioned that they find it more easy to apply the way of having a conversation of Solution-oriented working when this is with adults or children with ADHD.

''Talking to a client with ADHD can be more easy. They say everything without even thinking''

On the other hand, the study participants find it more difficult to apply this way of working in situations where participants are overly tired or overstimulated:

''When a participant is overly stimulated, the participant is not able to think properly about what he or she wants. In that case, finding a solution together at that moment does not really work''

4.2.3. Does working according to Solution-oriented working contribute to or hampers quality of care at care farms?

Within this paragraph, the effects of working according to Solution-oriented working will be listed and further elaborated on.

Participant develops a more positive attitude

Study participants mention that participants are more motivated to come into action, because they were involved in thinking about the next step/the solution themselves:

''Their personal motivation grows by working according to Solution-oriented working''

''The participant is more motivated''

Personal growth of participant

Various positive effects on participants of working according to Solution-oriented working are seen by the study participants. One of those, is that participants learn new skills and/or competencies in various aspects of who they are. Examples of these are for example learning social-emotional skills such as asking for help when they need it and discussing problems with others and together finding a solution for them:

''We apply working outside a lot in working according to Solution-oriented working. By this, participants learn to ask for help when they need it, and they learn to think of a solution by themselves or together with others''

Furthermore, participants learn to see what possible problems can emerge and individually find solutions to those. In this example, the participant even takes initiative to solve these problems by himself:

''He has become more alert on the right things, like for example cleaning up his own stuff. At first he was quite chaotic, so his stuff was everywhere when he was busy doing tasks outside. But today he said to me: ''Oohh, shall I clean up that suitcase? Because otherwise maybe it will be lost in a minute?''

Additionally, participants learn to push their limits and as a result, they grow as a person:

''So that guy exceeded himself, just because he wanted to reach his own goal''

The following case is a case about a girl with a mild intellectual disability that said she had a painful foot and did not want to walk. By Solution-oriented working, she could push her own limit:

''At some point we said: ''Show your foot please'', we looked at her foot and decided to believe her. Then I proposed to not bring her by car, but to walk, because her foot looked like there was nothing going on. So my wife went walking with her, and showed her how to walk in the best way. In this way, the girl received some personal attention for ten minutes. The next day, she felt no pain in her foot

anymore. So, because the girl learned to look from another perspective to her own situation, like ''it is not as bad as you think it is'', she pushed her own limits and that had a positive outcome.''

Because participants push their limits and grow in different competencies, their self-worth grows:

''The self-worth of participants grows, as a result of successes in reaching certain results. The participant can hold on to those results.''

Another example of a participant whose self-worth has grown, is the following in which a boy built a pen:

''Every time he sees his own pen, he recalls his own success, that he did something very well. He also says that he did something well now, at first he could become really angry when someone gave him a compliment. But now, he really has an attitude as if he can receive any compliment!''

So, as a result of succeeding in a certain activity or task, the participant was able to accept that he can accomplish something and that he can do it.

''Today he stood next to me, looking at the pen, and he said: ''It is beautiful, right''. He can finally accept that he can do something right.''

Besides, participants develop more personal control about their own life:

''This gives them more personal control over their own life. Their personal control is often low, because of all the complex problems in their personal life.''

''Because self-worth of participants grows, participants dare to and are able to take more personal control in certain situations''

One study participant summarised the positive effects of working according to Solution-oriented working instead of not working according to this care approach, in a very clear way:

''By making him think of the solution himself, his self-worth has grown, because he could think of ideas and he could carry out his ideas. His communication skills also improved, because he dared to push his own limit by giving his own idea and listening to the reaction of others to it. He has learned in so many aspects. But if we would have said: ''We are going to build the pen in this and this way'', then maybe he learned some technical skills, but he would not have been changed in his way of thinking.''

Positive effect on intensity of care delivery

Study participants mentioned that because of thinking of a solution or next step together with the participant, the way of working really feels as being a team-effort:

''When working according to Solution-oriented working you are doing it together with the participant''

This way of working, doing it together, makes care delivery less intense for care farmers, according to the study participants:

''That makes doing your work as a care farmer less intense. You are not forcing something on the participant.''

''It is more pleasant for the participant and for the care farmer as well: together you are working in an effective and efficient manner.''

4.2.4. Summary and overall analysis

Working according to Solution-oriented working helps care farmers, but also participants and their family/caregivers, to have a positive view on the participant and the undesired situation at hand. Solution-oriented working focuses on the positive side of the participant and the situation, by only giving attention to possible solutions for situations and to the strengths and interests of participants. Care farmers, participants and their family/caregivers develop a more positive attitude towards the situation, and participants' behaviour often changes in a positive way. Because of this positive view on the situation and themselves, participants become motivated to do new activities and show other behaviour, which makes them grow as a person.

The implementation of solution-oriented working is adjusted to the participant's needs, interests and strengths. Interests and strengths of participants can vary, it is therefore beneficial that care farms have a lot of different resources present at care farms that can be used in doing various activities. Examples of these are the animals and the equipment to do tasks outside.

When implementing solution-oriented working, the well-being and personal growth of the participant is a project which is talks about and carried out together. In this, the participants plays the main role in deciding what he or she wants to change, reach and do as the first next step. The care farmer has more of a background role, by asking relevant questions to help the participant think of possible solutions and goals and by discussing the ideas of the participant. This approach in conversations, stimulates the autonomy of the participants and helps the participants to become more independent and confident about themselves. Giving this autonomy to participants can be difficult for care farmers, but mostly gives them more joy in their work and job satisfaction.

The implementation of Solution-oriented working is by some care farmers combined with working according to other care approaches. Combining the implementation of different care approaches help care farmers to adjust care delivery as good as possible to the needs of the participants and their own needs to be able to help participants in the best way possible.

Care farmers mentioned that the positive sides of working according to the approach surpass the pitfalls of it. An often mentioned pitfall is the difficulty of implementing the care approach when participants are dealing with multiple complex problems. Thinking of solutions can be hard when the personal situation of participants are complex. Solution-oriented working can be a step in the right direction in this, as it gives opportunity to think of a next small step in the big complex situation. Solution-oriented working has a step-by-step approach, in which the next step is decided on together and is adjusted to the possibilities of the participant. Especially in complex situation of participants, thinking of a solution or

next step can be difficult. The step-by-step approach of this care approach helps to stimulate positive change.

Lastly, implementing solution-oriented working requires a certain way of thinking: a positive way of thinking, in which the focus is on the possibilities of the situation instead of the obstacles. This way of thinking does not always come naturally; some situations that participants are in are very difficult or have a lot of negative sides. The positive way of thinking needs to be trained in practice. Simultaneously, care farmers who have made this way of thinking their own and work with this in practice, are often unaware of when and how they work with the care approach. So, the way of thinking belonging to solution-oriented working should be learned in practice and made your own.

4.3 Evidence-based care approach: ‘‘Give me the Five’’ (‘‘Geef me de Vijf’’)

4.3.1. General impressions and facts of the focus group

The focus group about Give me the Five endured for 1.5 hours, and was organized in a meeting room at the Windesheim in Zwolle, a university of applied sciences. Two meeting rooms with catering were reserved there for 1.5 hours. Nine study participants were expected to come, of which two study participants came together with a colleague from the same care farm. So in total, study participants from seven care farms were expected to come. At the day of the focus group, four participants were not able to come anymore. So in the end, five study participants showed up for the focus group which were from four different care farms.

The general mood during the focus group was very friendly, cosy and fun. Every study participant was really focused, interested in each other and in the topic of interest, and were all very enthusiastic too about Give me the Five, which made the conversation about it very positive and fun. The dynamics between the study participants felt more natural and people were also non-verbally communicating more than in an online setting.

It was remarkable that the study participants agreed a lot with each other. Lastly, the study participants were complementing each other often during discussions or explanations and then agreed with each other’s additions.

4.3.2. How is Give me the Five applied in practice?

Within this focus group, various themes emerged which will be listed and further explained beneath in the following paragraphs.

Concrete tools of Give me the Five

Give me the Five includes a few helpful tools, that can be applied in practice to reach the goals of the care approach. One of those tools, is the five puzzle pieces that stand for the five questions that need to be answered for the participant, to give the participant clarity and structure when participants do not understand what is happening or are too overstimulated. These puzzle pieces are explained in table 1 in subheading 3.1.3. Care farmers use these five questions to give clarity to the participant:

‘‘Some of our participants have too much information in mind to process this appropriately. Then you can sit down with them, and can ask in a calm way: ‘‘What are we going to do now? Who is going to do that? Where will that happen and for how long?’’, just the five questions of Give me the Five.

''If I see that a participant does not understand what I am saying, then I think by myself: ''Allright, I need to pay attention now to what I am saying, and make the five question of Give me the Five clear.''

A second tool of Give me the Five, is using pictograms to give clarity about what is going to happen or what needs to be done, by visual information instead of written text or speech:

''We work a lot with those pictograms''

''Pictograms, those are really the basics of Give me the Five''

These pictograms are made for the general daily structure and activities for the whole group of participants. But when a participant needs more individual clarity, pictograms can also be especially made for one participant:

''A board with pictograms, made for each participant specifically. The bigger board shows the more mainstream pictograms, but some participants can better understand pictures''

''For a few participants we show the whole day planning in pictograms, especially for the youth, even for each part of the day I believe. For the older participants that are already used to the daily planning, we do not need as much pictograms.''

How detailed the pictograms are for the participant, depends on how precise and detailed the participant is in need of information. So, this is adjusted to the needs of the participant:

''For a few participants, we need to show the activities on pictograms very detailed. We even have a picture of a vacuum cleaner then when they need to clean, but another participant only needs a picture of an animal to know that he or she needs to feed the chickens.''

''For some participants that need to shower at our care farm, we described step by step how to clean himself/herself when taking a shower.''

A third tool, is visualising the conversation that the care farmer is having with the participant. When the participant have their head full of thoughts and information and are lost in this, the care farmer will start a conversation with the participant and while they talk together, the participants draw themselves to visualise the situation about which they are talking. In most cases, these conversations are about what is going on with the participants and why they feel what they feel. Another goal of these conversations is creating clarity and structure in the thoughts of participants:

''What we do a lot, is just sitting down with the kids, and having a little conversation while the participant is drawing. So, visualizing a head full of information. Then I ask: ''What is going on inside

your head?'', then we put a cross through that information to empty their heads. I think that works very well in Give me the Five.''

''Then we just draw the participant and his or her full head as a little person. Then I ask: ''Is the person looking happy or not?'' the participant said ''he looks happy'', allright, then I ask about what things we have to talk about today. That is mostly about his job. So then we draw his thoughts about his job.''

By drawing themselves, participants can better let go of all his or her emotions and literally draw all the information inside their head out of their head:

''It is absolutely fantastic, by drawing their full heads and putting a cross through them, or by drawing a trash bin and putting the information outside their head in the trash bin, the participants can really let go of that information. They do not have to think about it anymore, then the thoughts are really gone.''

By working according to Give me the Five, animals at care farms are also often used by the study participants. Animals have a positive effect on the participants, the participants often go to the animals when their head is too full with information or when they feel very angry or overly stimulated. The animals have a calming effect on the participants:

''When a child is having a lot of emotions, we let them be with the horses''

''The participants come to rest when they are with the horses''

''Yes the animals really make a difference. All animals make a difference, not only horses, because we have pigs''

''That is their comfort zone, being with the horses''

Also, it is remarkable that participants are in at least some cases, better able to talk with the animals about what is going on in their head than with care farmers. Therefore, letting the participant be with animals is a great way to get to know what is going on inside their head:

''Then she starts brushing the horse, and she talks a bit to the horse, and then you just hear what is going on inside her head.''

Adjusting to the participants

The first step in working according to Give me the Five, is to inventory the interests and strengths of participants, in order to adjust the activities, daily structures and care to them:

''So we started by being very clear, by step by step making a list with all the activities that the participant likes to do.''

''So when a new participant comes in, they actually do not know themselves. Then we start Give me the Five by discovering who this child is, and what he or she likes.''

''So step by step, we are discovering the identity of the child, so that they get to know themselves.''

How Give me the Five is applied in practice, is adjusted to the needs of the participants. Therefore, it differs between participants how Give me the Five is applied. The first step in this, is observing the participants and what his or her needs are:

''You are doing that the whole day long, looking at what the child is doing, and adjusting to that.''

It is important, according to the study participants, to really observe and analyse the reasons for certain behaviour of the participant to discover the needs of the participant:

''By working according to Give me the Five, you are looking at the reasons for the behaviour of the participant, in order to give what the participant needs''

''Always looking at the reasons for their behaviour''

Structuring by working according to Give me the Five

Study participants often mentioned during the focus group that Give me the Five really helps to structure life and daily activities for the participants. This structuring is done by using two different tools, one of those is a daily structure/daily planning in which all activities are written down in time slots. This shows what the participant is going to do, and how long and between what times:

''Well, we started by making promises about things, for example when she comes back from her work, we are first going to shower, and then we drink tea together, and then we start cooking. So step by step, we structured the whole day.''

''For the weekends we have a specific weekend planning, a few components are standard in this, as for example waking up, having breakfast, caring for the animals, having lunch, that kind of things. And all the extra activities in between.''

The other tool, is the ''core-information'' (''basisfundament''). One study participant mentioned to work with this core-information, this core-information is a daily planning especially for one participant, and shows what the participant is going to do, where, when, how long and at what time and with who:

''All the participants that come in new at our care farm, receive a core-information. We make that core-information together with the participant, to give him or her structure and a safe feeling from the start.''

''So a kind of planning with everything of Give me the Five on it. So what, where, who? We make that very clear, even if it is a planning for only one hour.''

The other study participants structure activities and daily plannings for their participants as well, but rather have one general planning for the whole group of participants than individual detailed daily structures. These care farmers discuss with the participant at unplanned moments during the day what they want to do and for how long, using a list of activities that the participants like as inspiration.

Give me the Five for different target groups

Give me the Five is mostly applied in working with people with autism because Give me the Five is especially made for this target group. But besides that, the study participants mentioned during the focus group that they also apply Give me the Five when working with for example children with mild intellectual disability, children with ADHD, children/ or adults with multiple problems and children who are highly gifted. The study participants mentioned that the care approach is applicable for various target groups:

''Give me the Five has positive effects on almost all participants from different target groups, especially for people with autism''

Despite that, some study participants also mentioned that for some target groups Give me the Five has less positive effect than for other target groups. For people with autism, the care approach works perfectly, but for children with ADHD, Give me the Five had lesser impact because the children forget the clear information that is given:

''But if we are talking about people with ADHD, the information does not stick in their head, they just forget what you said''

In addition, working according to Give me the Five has less positive impact on people who are highly gifted. This target group is less in need of clarity and structure, but rather wants flexibility:

''Also for example people who are highly gifted, for those participants Give me the Five works less well, because they rather need flexibility instead of clear structures.''

Convenience in working according to Give me the Five

The study participants made clear when talking about the advantages of working according to Give me the Five, that Give me the Five is easy to understand and implement in practice. Besides, they said that Give me the Five is applicable in different settings where the participant comes to and lives. This means that Give me the Five is not only applicable in care delivery settings, but for example at school and at home as well:

''It is an easy care approach to work with''

''The care approach can also be applied by parents at home, at school and in other environments of the participant''

Preconditions to succeed in working according to Give me the Five

There are some circumstances or conditions that are needed for Give me the Five to have a positive effect on participants. At first, it is important that participants are not in a very emotional state, because when they are, they first need to calm down:

''When they are calmed down, I go to them and have a conversation with them. But when they are having a lot of emotions, I let them cool down first.''

Second, for care personnel it is important to be well informed about the content of the care approach, to all work in the same way. This gives clarity to the participants.

''Give me the Five has one way of working, by this, all care personnel works in the same way''

''It is important to know the content of the care approach very well, so all care personnel including for example trainees''

Third, it is important for care farmers to control their own emotions when working with Give me the Five, otherwise their emotions can negatively influence the emotions of the participant:

''I think Give me the Five works really well if you can control your own emotions''

''So when you see a child that has a lot of emotions, or a child that is behaving aggressively, we say to each other: ''Close your jacket!''

* With ''close your jacket!'' is meant: do not let the emotions of the participant take over how you feel and react to the situation.

4.3.3. Does Give me the Five contribute to or hampers quality of care at care farms?

Within this paragraph, the effects of working according to Give me de Five will be listed and further elaborated on.

Clarity and rest for participants
Working according to Give me the Five, gives clarity to participants:

''Clarity for all participants. What are the rules? How are we going to do that?''

''So: clarity in each step, that clearly gives results.. Positive results''

This clarity gives rest to participants and calms them down:

''Then you see them come to peace''

''When I apply the five questions of Give me the Five, the participants often come to rest, because it is clear how it goes''

''It brings his head full of information to rest''

Despite that working according to Give me the Five gives rest clarity and rest, this approach can come across as a bit childish:

'Sometimes the pictograms or made promises are experienced as childish by the participants''

Developing oneself from a state of rest
Participants experience their day from a state of rest and are able to do activities they like because of the given clarity:

''Then doing tasks outside, is going very well''

''And from that starting point, you can do what you wanted or had to do''

Participants are because of their relaxed state, able to learn something new. This is because in a relaxed state, participants have headspace to do or learn something:

''When the moment is right, you can start learning the participant something new, or make the task a bit more complicated''

''It is a good basic state from where you can learn the participant something new''

Awareness about how people with autism think
Having knowledge of Give me the Five gives care farmers awareness of how people with autism think, and helps them to adjust what they say and how they say something very well to the perception of people with autism:

''The course in Give me the Five explained how the brain of people with autism work, that helped me understand it much better''

''On a certain moment, I said: ''Allright we are going to the barn'', but there was one girl who was still sitting at the table. Everyone was already getting ready to go. So I said: ''Hey, are you not joining us?'', ''oohh, do I have to?'' ''I said we are going to the barn, right"?'', ''Yes, but that is not me right?''. In those kind of little things, how are you saying something.. I should have called her by her name, then it was clear. Before I knew how people with autism think, I was less aware of those things.''

4.3.4. Summary and analysis

Give me the Five seems to be an effective and efficient care approach in giving people (most of them having autism) the structure and clarity they need. The clarity brings rest to people with autism and makes them feel more at ease. From this state of rest, participants can learn new things and develop themselves as a person.

The implementation of Give me the Five is adjusted to the needs of the participants. They mostly need clarity and structure in their daily life and activities. Give me the Five can offer clarity to participants by giving them the information they need in a way that suits how they process information. The care approach uses different tools for transmitting this information. These tools are the pictograms, the daily planning/structure, the core-information and visualizing the thoughts of the participants by drawings. Drawing is a helpful tool for participants with autism to structure their thoughts and see the information clear again.

Beside the helpful tools of Give me the Five, Give me the Five provides knowledge of and insight in how people with autism think and behave. This makes care farmers aware of the participants' behaviour and the way they react to that behaviour themselves. The awareness helps care farmers to understand the participants better and feel more able to adjust care delivery to the participants' needs. This contributes to person-centred care and thus quality of care.

When participants with autism feel overwhelmed by emotions or other stimuli, the approach according to Give me the Five is first giving participants the time and space to cool down and come to rest. Participants can cool down or come to rest very well when being in the presence of farm animals without other people around. In this way, the resources that the care farm offers fit in the approach of Give me the Five.

When participants are in a state of rest, the next step in Give me the Five can be taken, which is discovering who the participant is, what he or she likes, and new things can be learned and tried to do in little steps at a time with help of the care farmer. From the moment that a new participant comes in at a care farm, the focus is on what the participants likes and is good at. So, the focus is on the positive sides of the participant instead of the possible problems.

Give me the Five is implemented in working with participants with autism, but also in working with participants from other target groups. The approach can have positive effects on people from these target groups as well, as long as this fits the needs of the participant. Participants that have ADHD or are highly gifted benefit less from the approach of Give me the Five, because this approach does not fit their needs well enough.

4.4 Evidence-based care approach: Böhm approach (''Böhm-methodiek'')

4.4.1. General impressions and facts of the focus group

The focus group about the Böhm approach endured for 1.5 hours, was held online via Microsoft Teams and five study participants showed up in the meeting. In the first place, seven study participants were expected to be present, but due to various reasons they were last minute not able to come.

The mood during the focus group was friendly and calm. The study participants agreed a lot about how they work according to the Böhm approach in practice and what effects they see by that. Additionally, they also complemented each other's stories and opinions and afterwards all agreed on those additions. The study participants were enthusiastic about the Böhm approach and found it easy to think of cases in which they worked according to the Böhm approach with a positive effect as a result. Thinking of cases with a negative result was more difficult for them.

Two of the study participants followed the course about the Böhm approach at the care farm of one of the study participants. Because three participants knew each other already from this course, this influenced the mood during the focus group in a positive way. The study participants were quite soon at ease and immediately started talking to each other. The study participants agreed a lot with each other's opinions and ideas.

4.4.2. How is the Böhm approach applied in practice?

Within this focus group, various themes emerged which will be listed and further explained beneath in the following paragraphs.

Person-centred care

One of the core themes in working according to the Böhm approach is adjusting care and how to approach someone to the life history of the participant:

''By the Böhm approach, you actually delve deeper into someone's background, their past. And because of their dementia, the past evokes a feeling of recognition for the participants."

Two examples of adjusting care to the life history of the participant are explained beneath:

"For example, there was a participant who used to be a bricklayer. He performed various tasks for us because as a construction worker, he knew how to saw and hammer. But at some point, his condition deteriorated further. Communication was already difficult from the beginning, but eventually, it became almost impossible. We were renovating an old stable, putting a new roof on it, and the walls needed

pointing. My husband was working on it, and at one point, Jan was watching. So, we gave Jan a jointing tool with a trowel and some cement. We encouraged him, and he started helping with the pointing."

"For example, a participant at our care farm used to have canaries in the past. And now he takes care of our canaries very well, even though he hasn't done it for a long time because he doesn't have canaries at home anymore. It's his job now."

When the life history of a participant is not clear to the care personnel, due to various reasons, then adjusting the Böhm approach to the participant is not really possible. As a result, the Böhm approach cannot be applied in a helpful way:

‘’Maybe it's not because of the Böhm approach, but it is because I cannot extract enough information from my own factor. He had a new partner who hadn't been with him for long, so she also didn't know things from his past, so I couldn't get anything out of it."

"At our care farm there is a participant who is a Moroccan man with severe aphasia, so he cannot communicate well in Dutch anymore. We cannot get a good understanding of his story. So, the man comes, but we can't get the right information because communication is hindered by language, aphasia, and also by us on this front... We lack the connection to truly understand him."

Adjusting care to needs of participants who are highly educated can be a bit more difficult in the care farm context. A lot of practical activities and tasks can be done at care farms, but not a lot of ‘’complicated’’ tasks which require a lot of thinking. Therefore, finding activities or tasks that a highly educated participant likes can be a bit more difficult:

"Sometimes, I find it difficult when highly educated participants expect to have equal partners to communicate with. And they are not always available. And then, they don't feel completely at the same level, so to speak, and I find that challenging because they don't like outdoor activities, but they really want an equal conversation with another participant to fulfill that."

But to solve this problem, there are creative way to adjust care and activities to highly educated people as well. Another study participant knew what to do:

‘’I have my office upstairs, but sometimes I go downstairs to certain clients... Then I put on my director's hat. We talk at their level, and I also make space for that. In all the buildings, we have three different desks. Clients can also sit behind a desk and work. We have two computers for the clients, and the other one is a living desk, and most of them just sit there and read the newspaper. A director or someone in a high position wants to sit at a desk where they can overlook the space."

The study participants mentioned to not only adjust care for the participant to his/her life history, but they really try to adjust care to the current experience of the presence by the participant as well. Study participants try to adjust care to the needs of the participant in that situation:

"When participants come new in at our care farm via the case manager, it is advised to start as a 'volunteer,' well, then we go along with that. You go along with the experience of the participant.''

''One participant truly believed he was a teacher and on a camp trip with his students. And he had to go to the dormitory because the bus was coming and the bags had to be collected. And he had such an influence on the whole group: 'I have to go to the bedroom, I have to go upstairs.' Well we were not allowed to be in that room, my parents happen to live upstairs.. That participant should not go upstairs because then he will find out there is no dormitory. What was really helpful was that it was lovely weather outside, at some point we placed a bench outside and I wrote on a chalkboard 'The bus arrives at half past three,' and he sat down and started talking to all the campers passing by, saying, 'Yes, my bus arrives at half past three,' and then we enjoyed some tea with him, and that solved the problem. Well, that is person-centred care."

"A participant, who used to be a farmer, becomes a bit restless during lunchtime because he had been used to having lunch with his wife. And now he's sitting in the group and sometimes you see a bit of restlessness, then we sit next to him and talk about his wife Geertje and the cow they have that just calved, you know, things like that.''

One difficulty in working according to the Böhm approach, is that trying to adjust care to the participant's current experience of the presence becomes more difficult when a participant moves further into the dementia process. The participant then has less and less idea of what is happening in the actual present situation at hand:

"At the beginning, participants start off really well and can do a lot of things, but at some point, you notice that as they progress further into dementia, then they have difficulty carrying out certain tasks. But then trying to them realize that they are doing some things wrong, that can create challenging situations for me because I want to respect people's dignity."

"A participant, a lady, that came to our care farm, supposedly as a volunteer, started off really well. But at some point, you could really tell that she began to mix up things. We have a compost heap outside where we can throw away vegetable scraps, but she walked straight to that compost bin with a whole tub of salad that we were supposed to eat. I was able to convince her to turn around. But she wasn't happy.''

Another difficulty in working according to the Böhm approach, is when a participant is in a bad mood or does not feel well (can be for a longer period of time), then applying this care approach does not always have a positive effect:

‘’He has always played the piano, also had a piano shop. And when he came in, I was thinking: well, a piano shop, then we will help him involve with music and he will calm down. But that did not work for him. He actually did not want to be part of the group at all; he found that difficult, and music made him restless, there were too many stimuli for him. So that did not work. For him, it was just peace."

Activating participants

By working according to the Böhm approach, participants are stimulated to do activities/tasks that they like and suit their life history. They can do these activities alone, together with other participants, the care farmer or both. Participants are motivated to do such activities or tasks:

"Very person-centred: what motivates one person may not motivate someone else."

"Care is person-centred: not everyone wants to participate in the same activities that are done in a group setting."

These activities or tasks are adjusted by care farmers to the physical and mental abilities of the participant. By this, the participant can still do the activity or task:

"There are some people who used to work in a garden but can no longer do it, because it's physically too demanding. And now we have everything at sufficient height. But if you let them plant plants, well, the participants recognize how they should do it, the automatism returns, everything is placed carefully in the pots."

"At our care farm is a man who wants to help with food preparation, like cutting vegetables. But when I ask him something, I can see him just looking like: I don't understand, I can just see it in his gaze that he doesn't understand, but he just needs that small gesture. If you show him then how to do it, he understands it and then he continues.’’

To activate the participants even more and keep going on, care farmers compliment and encourage the participants for what they do:

"At our care farm is a participant who has a dog at home and it's as if the farm dog is hers, and I think that giving compliments is very helpful: ‘’I can see that the dog also loves you" you know.’’

"I am giving him a lot of compliments, because he actually easily excludes himself of the group."

The activities are mostly activities that can be carried out in the context of a care farm. These are for example activities outside with the animals, such as mucking out the stables:

"She doesn't want to go outside when the weather is bad. But if you say, 'we're going to the cows, clean up some manure,' then yeah, she goes along."

But also other activities or tasks are carried out outside that have less to do with the specific care farm environment, such as spotting birds or doing little helpful tasks outside:

"We also have a lot of nature lovers at our care farm who used to go egg hunting. Well, it's that time of the year again now, and then my colleague takes the bus and goes with them to the countryside. Well, that's fantastic. He brought a few binoculars with him, and then the participants recognize the activity and they can tell beautiful stories, despite sometimes having aphasia."

"One participant had simple jobs earlier, he really likes to sit still and actually prefers to do nothing. But he has also been a parking attendant for some time, and so we give him a lot of those small tasks to involve him, like observing and accompanying a participant so that he doesn't wander off."

When this fits participants better, activities inside can be carried out as well. Examples of these are doing the dishes:

''She grew up on a farm and was the oldest of ten children, so you can really see the perseverance, you know, after eating, she's one of the first to get up to clean the table, doing the dishes...''

At care farms, there is a lot of space which is used for different rooms for participants to do various kinds of activities in that are adjusted to the participants. Different activities are possible:

"We have, for example, four rooms for doing different activities where participants can switch between. We have a workshop room, a garden greenhouse and an art studio, and with that we can truly provide person-centred care and support."

"Well, one person likes animals, another prefers to go for a walk, and another prefers working in the garden, and there is such a diversity of activities that there is something for everyone."

Böhm approach in group context

Study participants were very enthusiastic about working with the Böhm approach in a group context, the Böhm approach is often implemented this way. In this way, participants can do activities together, talk together and can help each other. They have social interaction and they are activated in a natural way. Because participants help each other, care personnel has less tasks to do:

"Once they are in the nursing home, they all call for the nurse, but here we actually try to match clients to each other so that they can help each other as much as possible.''

"At our care farm is a participant who excludes himself from the group, but he actually is very caring. By offering him activities, he gets in touch with the other participants again, by for example distributing drinks, pushing wheelchairs, or helping someone put on a coat, you know."

Working according to Böhm in a group context, also gives certain challenges. One of those, is adjusting individual care to the current experience of the presence for each participant:

"Then you adjust to such a high extent to the experience of the participant that the other participants can no longer participate because they don't understand that part, and then you have to provide one-on-one support, but you also have to include the other people, and then you sometimes encounter limitations."

Administrating how to approach participants

A tool of the Böhm approach is the psychobiography of each individual participant. For the time period that a participant works at the care farm, there is a plan for how to approach and care for the participant, based on his or her psychobiography. When the participant moves further into the dementia process, this plan need to be changed because the experience of the presence of participants changes with the development of the dementia process. When a participant moves further into the dementia process quite fast, this plan needs to be changed quite often:

"But you quickly move on to another phase, where you actually have to revise the report you wrote."

4.4.3. Does the Böhm approach contribute to or hampers quality of care at care farms?

Within this paragraph, the effects of working according to the Böhm approach will be listed and further elaborated on.

Positive effects on participants

Working according to the Böhm approach has a lot of different positive effects on the mood and well-being of participants. First, the care approach gives participants a feeling of recognition and thus they feel less restless and more at peace:

''Then I really see the restlessness disappear''

Second, participants really enjoy the activities that they are doing or are going to do:

''He just continued doing the task and was pointing a bit, it was beautiful, he was really enjoying it!''

Third participants become enthusiastic about the activity:

''They can barely tell you anything, but because they are so enthusiastic about it, they can''

Fourth, participants feel that they are doing meaningful work:

''The participant felt very appreciated because he was doing such meaningful work''

Fifth, participant are able to do what they still can, and thus stay active:

''Giving people space to do what they still can do''

''Contributing to self-reliance of participants''

Sixth, participants feel at home at care farms:

''People feel at home here''

Seventh, the self-worth of participants grows:

''That by giving them compliments, we let their self-esteem grow''

Participants are part of normal life

By working according to the Böhm approach, participant have more interaction with others and can do various activities. This gives the participants the possibility to be part of ''normal life''.

Positive effect on intensity of care delivery

Working according to the Böhm approach makes care delivery less intense. The provided background

information from the psychobiography of a participant makes the behaviour of participants more understandable and more easy to react to in a proper way:

"You just get so much additional background information, which allows you to understand and manage the more challenging behaviours better."

Study participants think that participants with dementia remain stable in their dementia process for a longer period of time, by the effects that working according to the Böhm approach has:

"He is just busy with it physically and mentally, and all these things, I think, try to slow down the process."

"People remain more stable in their dementia and their functioning declines less quickly."

Another benefit of a more stable dementia process of the participant, is that participants can still live at home for a longer period of time. This is often desired by the participant and his/her spouse.

Study participants also mention that working according to the Böhm approach makes them enjoy their work more:

"On the other hand, offering so much variety in activities brings so much more joy to your work''

Extra tasks/responsibilities

Implementing the Böhm approach also leads to some more administrative work and thus takes more time. Additional audits are also done. The ECD (electronic client dossier) is not adjusted very well to the Böhm approach, this takes more time and effort for care farmers to administrate personal information of participants.

4.4.4. Summary and analysis

The core of implementing the Böhm approach, is adjusting care delivery to the life history and current experience of the present of each individual participant. In this way, person-centred care and quality of care is delivered. Adjusting care to the participant is possible in various ways in the care farm context, by the various indoor and outdoor spaces that are available there. In these spaces, various activities can be done that are care farm specific, as for example caring for the animals, or other tasks, as for example doing the dishes after the meals. The variety in activities helps to deliver person-centred care. Besides, participants can do activities that they like, this stimulates them to become active and motivates them to join certain activities.

The Böhm approach is often implemented in a group context, in which various participants are interacting together and help each other. Doing certain activities together and being together, gives participants a normal life experience. Furthermore, participants are activated by the care farm environment which is rich in stimuli from other people, nature and activities that can be done.

As a result, participants stay active and enjoy what they are doing. Participants experience rest from the adjustment to their life history and their experience of the present. This evokes a feeling of recognition and makes them feel at home. By doing activities, participants feel that they are doing something meaningful. Study participants think that because of the implementation of the Böhm approach, the dementia process remains stable for a longer period of time.

By adjusting activities to the possibilities and life history of the participant, the autonomy and independence of participants is stimulated. When the dementia process develops, giving autonomy to participants can become a bit more difficult because of their confusion and memory problems. To still be able to stimulate this autonomy, a one-to-one care delivery is needed sometimes. Also other participants are asked to look out for each other. Delivering person-centred care is limited to some extent by the shortage in care personnel available at care farms.

There are a few prerequisites for being able to implement the Böhm approach. One of those is that the life history of the participant should be known, otherwise adjusting care to it is not possible. Another prerequisite is being able to communicate with the participants themselves or with family members and/or caregivers of the participants, to get to know the life history of the participants.

The psychobiography belonging to the Böhm approach is used as well in care delivery, this helps care farmers to have insight in the life history of the participants.

Overall, the Böhm approach has several positive effects on the participants, and the advantages of implementing the Böhm approach surpasses the disadvantages (e.g. the additional administrative work).

4.5 Similarities between working according to the four evidence-based care approaches

In this section, the results of all the four previously described subparagraphs of the results are taken together, to discover if there are any similarities or if there is overlap between the results of the analyses of the four focus groups.

4.5.1. General impressions of the focus groups

In general, all study participants were positive and enthusiastic about working according to the EB care approach. There was a lot of consensus among the study participants about how and why the EB care approach is applied, and the effects this has on quality of care. Almost all study participants found it difficult to think of negative sides/disadvantages of working according to the EB care approach. Furthermore, they found it difficult to think of cases in which working according to the EB care approach had a negative, or at least not positive effect, on the participant. All study participants agreed that there were more positive sides than negative sides on working according to the EB care approach, the sticky note sessions made this visually clear as well.

4.5.2. Application of the care approaches

Regarding how the EB care approaches are applied in practice, a few overlapping themes between the four focus groups were discovered.

Firstly, it was remarkable that the study participants of the focus groups of Triple-C, solution-oriented working and Give me de Five almost all worked according to multiple EB care approaches. Examples of EB care approaches that are combined in practice are Give me the Five, solution-oriented working, Triple-C and the non-aggressive resistance approach. Only a few study participants mentioned explicitly to only work with the EB care approach that the focus group was about. The study participants described that they combined the EB care approaches to guidelines to what works for them in practice.

Secondly, how EB care approaches are implemented in practice differs a lot. Care farmers tend to use parts of EB care approaches in practice, and not always follow the whole set of guidelines or implement the whole set of tools that belongs to the care approach. Instead, care farmers tend to follow the guidelines partly, or even only work according to the vision of the care approach and delivery care with this vision in mind. Combining parts of different EB care approaches in practice helps care farmers to adjust care as good as possible to each participant.

Thirdly, all study participants mentioned that the EB care approach enables them to adjust the activities to the participants at care farms. The EB care approach provides care farmers with personal information about the possibilities of the participant rather than the deficits.

Fourthly, at care farms, the activities and tasks are done collaboratively. Multiple participants, or the care farmer and one or more participant(s) do something together. Because of the focus on the participants' possibilities, participants contribute to the activity to their own possibilities. In this way, everyone does something meaningful and contributes to a collective output.

Fifthly, all study participants mentioned the use of farm resources in the implementation of the EB care approach. These care farm context offers many resources. Examples of these resources are animals, farm tasks as for example mucking out the stables, and doing domestic activities inside, as for example cooking the daily meals.

Sixthly, all study participants agreed on the big importance of the role of space and time that is available at care farms. There is more space and time available for care delivery in the care farm environment compared to more traditional healthcare settings. This is beneficial for implementing the EB care approaches, as this can be done more elaborately when there is more space and time.

Seventhly, almost all EB care approaches were applicable to different target groups, according to the study participants. Examples of target groups are children, people with a mental disability, people dealing with an addiction, or children who deal with other personal traumas. Only the Böhm approach is a very specific approach, which is specifically designed for people who deal with memory problems, these are often people who suffer from dementia.

Eightly, it was remarkable that the study participants of the focus groups of Triple-C, solution-oriented working and Give me de Five almost all worked according to multiple EB care approaches. Examples of EB care approaches that are combined in practice are Give me the Five, solution-oriented working, Triple-C and the non-aggressive resistance approach. Only a few study participants mentioned explicitly to only work with the EB care approach that the focus group was about. The study participants described that they combined the EB care approaches to guidelines to what works for them in practice.

4.5.3. Effects of working according to the care approaches

Between the four focus groups, some overlapping themes about the effects of working according to the EB care approaches were discovered as well.

Firstly, person-centred care was an often emerging and important theme during all our focus groups. The study participants of all four focus groups agreed on the fact that working according to the EB care approach, helps them to deliver more person-centred care, care in which the care delivered is adjusted to the needs and identity of the participant in the best possible way.

Secondly, all study participants agreed that working according to the EB care approach makes their job less intense and to do. This works in various ways. Study participants from the focus groups of Triple-C and solution-oriented mentioned that the care approach helps them to think of and do a suitable activity

together. The involvement of the participant motivates the participant to do the activity or work with the plan that is created. Besides, study participants from the focus group of Give me the Five mentioned that the care approach helps them to understand how people with autism think. This makes care farmers better able to adjust care delivery to the participant's needs. Study participants from the focus groups about the Böhm approach, solution-oriented working and Triple-C explicitly mentioned that working according to the care approach makes them enjoy their work more.

Thirdly, all study participants mentioned that working according to the EB care approach has positive effects on the participant in the short run and long. Examples of short run effects are that participants often feel happy after doing certain activities and feel at peace as well. In the long run, participants learn new skills on different levels. An example on a social-emotional level is interacting with others, an example on an intellectual or physical level is doing new and often challenging activities or tasks. Only the Böhm approach is not really focused on learning new skills, which is logical seen the target group of the EB care approach. For people with memory problems, focusing on what makes participants recognize and what feels known and comfortable is more helpful than learning them new skills. Another effect on participants in the long run, is that they grow in self-reliance and become more independent on different aspects of life. Doing meaningful work and being respected in doing what they can, really contributes to this according to the study participants.

Fourthly, some cases overlapped in the reasons why the application of the EB care approach did not have a positive effect in that case. Two reasons were mentioned for this, the first was that sometimes the care approach cannot be adjusted fully to the needs of the participant for various reasons. The second reason, is that sometimes personal problems of a participant are so complex and that there are so many sides to the problem, that it is difficult to have a positive impact when applying the EB care approach. According to the study participants, this was often not due to the care approach, but to the complexity of the participant's personal circumstances.

Fifthly, all study participants agreed that each EB care approach has some disadvantages as well. The negative sides of all care approaches differ, an example of a negative side is the bigger amount of administrative work that needs to be done.

5. Discussion

Following the results section, in this section, several themes regarding the implementation and results of this study are discussed and evaluated.

5.1 Study findings

5.1.1.Main findings

This study shows that EB care approaches contribute to quality of care at care farms. Implementing EB care approaches supports care farmers in delivering person-centred care and has beneficial effects on the participant's well-being and personal growth. EB care approaches are implemented in different ways, depending on the participants' needs, the care farmer's way of working and (the resources in) the care farm context. EB care approaches provide care farmers with grip, knowledge, clear guidelines and tools for care delivery. Care farmers often combine working according to multiple EB care approaches at the same time. Care farmers choose parts of different care approaches and combine those together to a mix of guidelines and tools that works for them in practice. These mix of care approaches is formed to have the suitable information and tools to fulfil the participant's needs. So, this combination of care approaches helps them to deliver the best possible person-centred care.

Care farmers do not work with the care approach as the care approach describes that should be done. So, care farmers are creative and flexible in how they apply the EB care approaches and in some cases apply the care approach otherwise than is described, often due to shortage in health care personnel at care farms and money. Some care farmers only work according to the vision/way of thinking behind the care approach, and do not work with the whole set of guidelines or tools that the EB care approach offers. However, the study participants that work with the EB care approach in this way, mentioned that only the vision of the EB care approach already helps them to deliver person-centred care in practice.

5.1.2. Implementation of EB care approaches in the local context

As previously described, the implementation of EB care approaches is adjusted to the care farm context with its belonging resources and possibilities. Adjusting the implementation of a care approach or other intervention to the local context is called co-production of the intervention (Kok et al., 2012). Results from the study of Kok et al. (2012) to the implementation of health promotion interventions show that implementing EB interventions exactly as described in the local context, is often not feasible. But instead, the implementation of EB interventions is adjusted to the local context and depends on various factors present there (Kok et al., 2012). The results of this study show the same phenomenon: that EB care approaches are not linearly implemented, but are adjusted to its local context and interplays with various factors.

5.1.3. Working evidence-based

The results of this study arise the question to what extent care farmers use a care approach that is evidence-based, if they do not follow all the guidelines or complete set of tools in practice as the EB care approach advises to do. The question when a care approach can even be called evidence-based is also an important to consider. A few of the four care approaches used in this study, are part of a databank that contains an overview of approaches and interventions to use in care delivery that are scientifically proven to work by multiple academic studies. The question is however, if a care approach needs to be proven to work by multiple scientific studies to be called ‘’evidence-based’’. For example, other care approaches used in this study are not part of this databank, but they are based on theories thought of by experts in the fields of the target groups for which the care approaches are developed. To respect the care farmers that work with these approaches as well as the creators of the four care approaches, in this study all four care approaches are called evidence-based.

The questions is however, whether care farmers follow the guidelines of the EB care approach to a sufficient extent to claim that they work according to this care approach. This is especially a question because some EB care approaches themselves claim that it is important to apply the whole set of guidelines and tools to make it work and have good effects, as one study participant mentioned about working according to Triple-C. Study participants seem to find the effects of what they do important, they think the effects should be beneficial for the participant. Care farmers are not really focused on to what extent they imply the exact guidelines of the EB care approach. They are focused on the results of the delivered care: if that is positive, than they continue what they are doing, if it is not, then they change their approach. To a certain extent, how care farmers implement EB care approaches is also an evidence-based way of working despite that they do not follow the guidelines of the EB care approach in detail. This is because care delivery effects seen in practice can be even more representative for discovering if an approach works or not. Besides, within working according to the EB care approach, care farmers reflect on the delivered care and improve or change the approach or care delivery to the outcomes of these reflections. Reflecting on the delivered care is an important factor in working evidence-based (Spring & Hitchcock, 2012; Federation of Agriculture and Care, 2022).

5.2. Study findings and theoretical framework

The theories used in this study, are used as a lens through which the data is analysed and interpreted. In this study, three theories are combined to a new model (figure 4) which is composed by the researcher. In this paragraph, the relationships, similarities and differences between the content of the new made model and the data of this study are further analysed.

The three core values of quality of care align really well with the results of this study. When looking at the general results of this study as explained in paragraph 4.5, almost all emerging themes in this

paragraph fit with the content of the three core values. Examples of these themes are person-centred care, adjusting the activities to participants, doing activities together, the use of farm resources and the importance of space and time at care farms. Furthermore, a few emerging themes regarding the effects of working according to EB care approaches fit really well with the three core values. These themes are the positive effects on participants, growth in self-reliance and self-worth and personal development.

Figure 5: The three core values of quality of care at care farms (Federation of Agriculture and Care, 2022)

A lot of the nine core themes belonging to the three core values of quality of care, emerged as being big topics of discussion within the focus groups. All nine core themes were discussed indirectly within the focus groups, but some of the core themes were more discussed or appeared as being more important than others regarding working with EB care approaches. These core themes that emerged multiple times, are shown in figure 6. Two core themes that belong to the nine themes are ‘’We eat healthy together’’ and ‘’I am moving a lot at the care farm’. These two core themes also aligned with the results of this study, but these themes were less prevalent in the focus group discussions and the importance of it was mentioned less frequently. Therefore, these two themes are not added to figure 6.

The implementation of EB care approaches help some strengths of care delivery at care farms to flourish. Because of the provisions that EB care approaches give to care farmers, care farmers are better able and are better supported to deliver quality of care that is in line with the nine core themes of the quality framework.

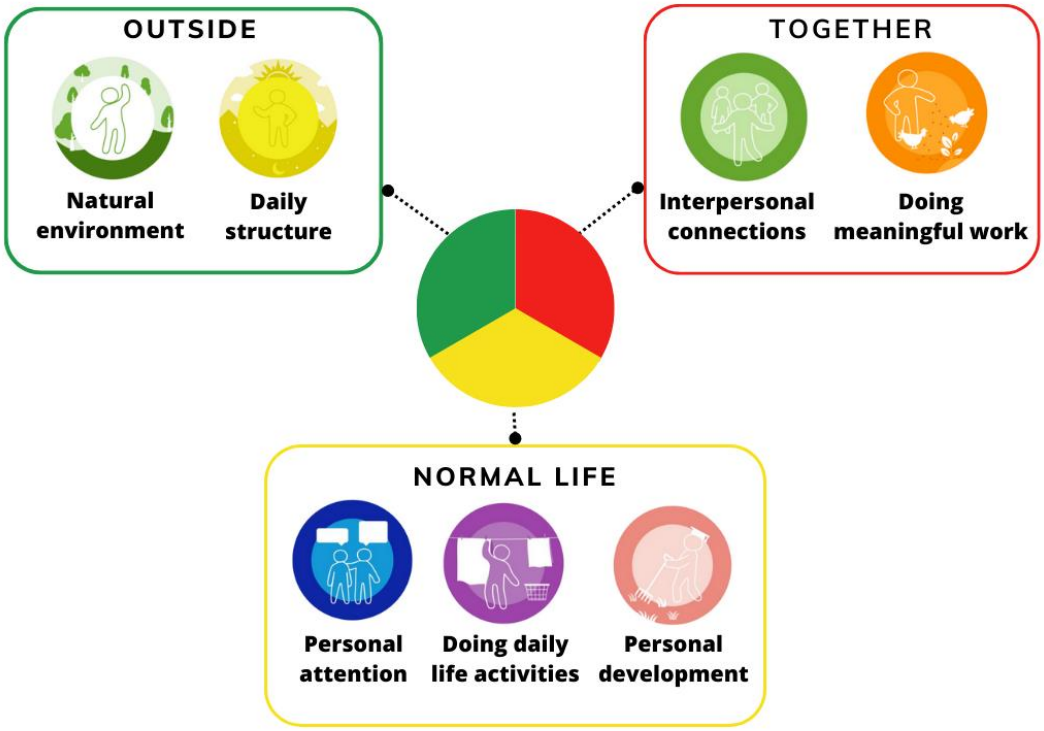

Figure 6: Often emerging core themes within the focus groups

5.3 Study validity and reliability

5.3.1. Internal validity

In this study, data was obtained by carrying out focus groups to find an answer to the research question. The data collection method, which were focus groups, helped in measuring what was intended to measure, because the study participants during the focus groups helped each other to stick to the topics of interest, next to the researcher en cofacilitator who were keeping an eye on the direction of the conversations and if needed, steered the conversations.

Focus groups were a suitable method to use in this study, because focus groups allow different views, ideas and information to arise during the conversation. The study participants all had a different perspective upon working according to the EB care approach, because of their different backgrounds. A lot of the study participants worked with other target groups, delivered different types of care and worked at different care farms. Although that, they all had in common that they work according to the EB care approach. Thus, the study participants were able to share their views and form a shared opinion upon working according to the care approach together (Carey & Asbury, 2012). So, the study participants all met the inclusion criteria of this study and besides had just enough experience and characteristics in common to have a meaningful conversation about the topics of interest.

The focus groups were transcribed verbatim and were complemented with notes taken during the focus group about general impressions and other remarkable aspects of the group dynamics. This contributed to the validity of the data analysis, because the notes gave some background context about the study participants themselves and their behaviour during the focus group.

5.3.2. External validity

With the external validity in this study is meant the extent to which the research findings of this study can be generalized to the whole target population of this study, to other research settings than this study and other time periods. A few factors regarding the external validity of this study will be mentioned and elaborated on. Firstly, the men/women ratio within the study participants group of every focus group were very disproportionate. In only one focus group, there was one male study participant and four female study participants, whereas in the other three focus group there were only female study participants. Despite this disproportionate group composition, all study participants met the inclusion criteria of this study which still led to a somewhat representative group of study participants for the target population. The disproportionate men/women ratio could have led to different answers and stories during the focus groups than with an equal ratio, because men and women are different and can think differently. Secondly, during participant recruitment, selection bias could have played a role. Participant recruitment was carried out by a convenience sampling method, to enlarge the chance that care farmers were willing to participate in this study. Within this sampling method, only care farmers who are member of regional agricultural care organizations or were known by contact persons from these regional agricultural care organizations were approached whether they were willing to participate in this study. By this, it could have been that only or mostly care farmers who are enthusiastic about working with the EB care approach were motivated to participate in this study. By this, study participants who are less positive about working according to the EB care approach were maybe underrepresented in the study participant groups. This may have influenced the data in such a way, that only the opinions of care farmers who are positive about working according to the care approach are represented in this study, while missing the opinions of care farmers who are not. Besides, there are also care farms who are not member of these regional agricultural organizations, these care farmers are not represented in this study. Maybe this led to sampling bias as well, for this group of care farmers is underrepresented in this study.

5.3.3. Reliability

Regarding the reliability of this study, some points can be mentioned. Firstly, the sample sizes of the four focus groups of study participants were somewhat small. In the first place, the sample sizes of each focus group were big enough for being an appropriate size for organizing a focus group, as this amount is four to eight study participants (Carey & Asbury, 2012). But due to drop-out of a few study participants, three focus groups consisted of five study participants, and one focus group of only 3 study participants. These sample sizes were the result of drop-out of a few study participants on the day of the

focus group, due to sickness and high work demand of their jobs. The sample size of one focus group was only three study participants, this is smaller than the minimum amount of study participants for a focus group. This could have influenced the data of this focus group, as the focus group effect, the degree to which study participants (dis)agree, complement and talk with each other and so immediately do a certain ‘‘quality check’’ on what the others say, could have been smaller during this focus group (Carey & Asbury, 2012; Boateng, 2012). Although that, the focus group with only three study participants was very informative as well and the discussions went a lot more natural and smoothly than during the focus groups with five study participants. So, the smaller amount of study participants could have had a positive effect on the data obtained as well, as the smaller group size naturally led to a more cosy and calmer conversation in which the study participants were less hesitant to tell things, ask questions and react on each other.

Besides, during the first part of the focus group in which the study participants were split up in two groups. The two groups consisted of two or three study participants, this amount of study participants was lower than the minimum of four for having a focus group discussion. In the second part of the focus group, all study participants came together again to fill in the sticky notes. Thereafter, there was little time to discuss the content of the sticky notes together, which makes that during the whole focus group there was relatively little time to have a discussion with the whole study participant group together to reach the ‘‘focus group effect’’ as earlier explained.

To look at the data obtained in the most objective way, the researcher discussed the focus groups and the data obtained with the cofacilitator. The general impressions of the focus group, remarkable things that were said, and patterns and/or relations that were observed were discussed together to prevent researcher bias as well as possible, because the researcher perceives and interprets the data in a certain way, with the underlying theories in mind (Halcomb & Davidson, 2006). The researcher discussed the data of one focus group with the thesis supervisor as well.

5.4 Study limitations

Regarding this study, a few possible study limitations need to be mentioned. Firstly, during the focus groups, group think could have played a role. This could be, because during focus groups group think is a known phenomenon that possibly influences input of the study participants during the focus group and thus the discussion and data (Boateng, 2012). Due to group think, study participants tend to ask less critical questions to the other study participants and easier assume that what other study participants say or argue is right or what they think themselves too (Boateng, 2012). There was a lot of consensus within the focus groups of this study, this is partially due to that the study participants agreed on a lot of topics and opinions, but maybe group think stimulated this high consensus as well to a certain extent. The influence of group think was tried to diminish during the focus groups by explicitly asking the study

participants if someone disagreed with a certain opinion or answer, or if someone had another opinion on a certain case or topic.

Secondly, as already mentioned, a few study participants knew each other already before the onset of the focus group, this made the start of the focus group and the general mood calm and pleasant. However, the fact that a few study participants already knew each other could have led to more socially desirable answers from the study participants as well (Boateng, 2012). Fortunately, during this focus group the study participants dared to disagree with each other and mentioned positive as well as negative aspects of working according to the EB care approach. Furthermore, to diminish the effect of group think and answering in a socially desirable way by the study participants, the study participants were asked to think of two cases to share during the focus group previously to the onset of the focus group. Additionally, individually filling in the sticky notes by the participants possibly diminished the effect of group think during the focus group.

Thirdly, another factor that possibly influenced the data of this study, is the setting of the focus groups. Three focus groups were organized online, during these focus groups became clear that study participants can be sometimes more hesitant in reacting to each other, in taking initiative to say something, and to intervene in the ongoing discussion. This possibly negatively influenced the data by being less rich in different reactions and opinions from the study participants.

5.5 Study implications

In the first place, the results of this study contribute to more awareness about working according to EB care approaches. This study discovered that care farmers work according to a lot of different care approaches, which was earlier not even known. The results of this study give new insights in how EB care approaches are applied in practice and about the role of EB care approaches in quality of care at care farms. These insights can be used by the Federation of Agriculture and Care, when thinking of and developing new courses and/or education material about various EB care approaches for care farmers. This new educational material or given courses provides care farmers with new knowledge, tools and ideas to apply in care delivery in practice. In the longer run, this will help care farmers in delivering high quality of care and hopefully will contribute to higher quality of care at care farms. Especially for starting care farmers, the knowledge of EB care approaches will help them to think of how and why they want to deliver certain care. The results of this study may have a stimulating effect on care farmers to think about how they deliver care and why they do so, and to discover whether working according to an EB care approach works for them in practice and would help them to deliver even higher quality of care.

This study is the first study that investigated how EB care approaches are applied in practice, and how this relates to quality of care at care farms. To the best of our knowledge, no such research was conducted previously as this study. Thus, comparing the results of this study with similar studies is not possible. However, there are studies done to what quality of care farms looks like from the perspective of participants who work at care farms and what EB working entails, as is described in the theoretical framework of this study. How these theories align with the results of this study, is described in paragraph 5.2. Besides, the results of this study can be compared to studies that explored how interventions in health-promoting contexts are implemented in the local context, this is described in paragraph 5.2 as well.

5.6 Recommendations

To achieve the most beneficial effect with implementing EB care approaches in practice, a few recommendations can be done on the basis of this study. First, it is recommended that care farmers have insight in the guidelines of the EB care approach, although that they do not follow all the guidelines exactly. These guidelines can still give insights and inspiration and can eventually be used in care delivery practice. Secondly, it is important for care farmers to combine working with the EB care approach with reflecting on how they implement it. In this way, they make sure that the delivered care has beneficial effects on quality of care. Thirdly, it is important for care farmers to keep on learning from others about how they implement the care approach.

For further research following this study, it would be interesting to investigate two different aspects of working according to EB care approaches at care farms. During the data collection in this study, it became clear that care farmers combine working according to different care approaches in practice, by

following for example the vision of one care approach and using the vision and tools of another care approach. It would be interesting to investigate how combining different care approaches in practice works. For example studying why care farmers combine care approaches in care delivery, how does the combining care approaches in care delivery works, and is it doable to follow (all) the guidelines of different care approaches when combining working with multiple ones, and if not, what guidelines of the care approaches are followed and which not, and why? These questions can be investigated by discussing this topic and questions with care farmers as well, for example by carrying out interviews or focus groups.

As second topic to investigate following this study, is how participants experience care that is delivered by a certain care approach, and if this differs from care that is not delivered according to a certain care approach. It would be interesting to see if these results would align with how participants describe quality of care in the quality framework of the Federation of Agriculture and Care (2022).

6. Conclusion

The aim of this study was to investigate how EB care approaches are related to quality of care at care farms. To reach this aim, the following main research question was answered: ''*How do the most frequently implemented EB care approaches contribute to quality of care at care farms in the perception of care farmers?''* An answer to this main research question was found by answering the following subquestions:

1. *How are EB care approaches implemented in the context of a care farm?*
2. *How do EB care approaches contribute to or hamper quality of care at care farms, in the perception of care farmers?*

In conclusion, the results of this study show that working according to EB care approaches contributes to the three core values of quality of care at care farms as defined by the Federation of Agriculture and Care. EB care approaches are a useful resource for care farmers when delivering care, because EB care approaches support care farmers in delivering quality of care by the vision on care delivery, knowledge, clear guidelines and tools that they provide. These altogether help care farmers to improve quality of care at care farms. Care farmers adjust working according to EB care approaches to what is possible in practice regarding the present resources at care farms. In practice, this means that often not the whole set of guidelines or tools that an EB care approach provides are applied in practice at care farms, because this is either not possible, or this is not seen as necessary or useful by care farmers to reach the desired effect on quality of care. Furthermore, EB care approaches are applied in different ways in care delivery for each individual participant, depending on the needs, strengths and interests of the participant. As a result of implementing EB care approaches in care delivery at care farms, the three core values and belonging nine core themes come to the fore even more and flourish even more than when not working according to EB care approaches.

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Appendix I: Focus group lead

Programmalead focusgroepen

Wat geel is: rol/taken van cofascilitator

Tijd: van 20:15-21:45

Inloop vanaf 20:00

In ruimte: Papiertje, pen en sticky notes voor ze klaarleggen
Koffie, thee, koekjes klaarzetten
Flipbord beschrijven met vraag + stiften klaarleggen
Zoek uit waar het toilet is
Verdeling maken van deelnemers in twee groepen (casusdeel) en opschrijven

Gehele meeting online: houd de chat bij of mensen hierin input geven of belangrijke dingen zeggen en sein dat naar mij.

20:00-2015
In real life: mensen welkom heten als ze binnenkomen, pak wat koffie/thee en een koekje en ga lekker zitten. Kletsen met de deelnemers.

Vragen of de deelnemers hun naam op naamkaartje willen zetten zodat ze elkaars naam kunnen zien.

20:15: **Van start!**
- Maak een tekeningetje van wie waar aan tafel zit met naam en geef ze een nummer (1 t/m …)
- Iedereen welkom heten
- Voorstellen van mijzelf en mijn rol in deze meeting
- Marjolein/Hannah stelt zichzelf voor en introduceren wat hun rol is in deze meeting
- Vertellen dat er een **opname** wordt gemaakt, zoals overlegd dmv toestemmingsformulier, **en deze aanzetten. Ook transcriptie aanzetten en die verbergen.**

20:20-20:30 Andere deelnemers voorstellen
Voorstellen van de andere aanwezigen: Vertel je naam, je zorgboerderij, doelgroepen met wie je werkt. Losse vraag: waar ben je trots op in je werk?

Vul tabel in over gegevens van deelnemers (namen en doelgroep)

Dan meteen dus kijken of iedereen goed hoorbaar en zichtbaar is (wanneer het online is). Zo niet, kunnen aanpassingen worden gedaan aan beeld of geluid.

20:30-20:35: Praktische zaken uitleggen

Dan over op hoe de focusgroep er praktisch uit gaat zien.
- We gaan een aantal casussen en vragen bespreken, bij één vraag ook met behulp van Whitebord functie in Teams of via de sticky notes die voor u liggen. Dit zal ik tzt uitleggen.
- Er zal halverwege de avond een korte pauze zijn waarin u even naar het toilet kan of wat drinken kan pakken. Mocht u ondertussen erg nodig naar het toilet moeten kan dat.
In real life: uitleggen waar het toilet is

Bij online:
- U mag uw microfoon de gehele meeting aan laten staan, zodat u makkelijk op elkaar kunt reageren en het gesprek wat makkelijker verloopt. Mocht dit erg afleiden of veel achtergrondgeluid geven, kunnen we dit aanpassen tijdens de meeting.
- U hoeft niet op uw beurt te wachten om iets te zeggen, maar u kunt gewoon reageren op elkaar. Zo nodig zal ik soms wel iemand actief de beurt geven.
- In principe als u wilt reageren, zeg dit dan hardop in de meeting, mocht u er niet tussenkomen mag u ook iets typen in de chat. Moet u tusssendoor erg nodig naar de wc/komt er iets tussendoor, zeg dat dan even in de chat, dan weten wij dat.
- Als er problemen zijn met uw internet of uw laptop en u gaat onverwacht uit de meeting, dan kunt u mij even sms'en of bellen zodat ik dat weet en u eventueel even kan helpen.

- De focusgroep duurt vanaf nu nog ongeveer een uur, dus om ongeveer 21:35 a 21:40 zullen we afronden zodat we om 21:45 klaar zijn.
- Zijn er nog vragen op dit moment of onduidelijkheden? Zo niet → beginnen aan de inhoud.

20:35-20:50: Casus 1

We gaan dit komende halfuur in twee groepen uiteen om casussen te bespreken over het toepassen van de methodiek. Via de mail heb ik u gevraagd om als voorbereiding één casus voor de geest te halen waarin u de methodiek toepaste in de praktijk en dit een gewenst effect had/goed werkte. Ook heb ik u gevraagd een casus voor de geest te halen waarin u de methodiek toepaste in de praktijk en dit geen gewenst effect had/niet goed werkte. Mocht u deze voorbereiding nog niet hebben kunnen doen, geen probleem, dan kunt u vanaf nu voor uzelf deze casussen bedenken.

Hiervoor gaan we in twee groepen uiteen, een groep zal worden geleid door Hannah/Marjolein, en een door mij. ***Dan de verdeling vertellen.**

De groepen gaan nu uiteen in verschillende ruimtes, of in break-outrooms en dan verdeel ik ze daarin. Eindtijd vertellen wanneer we weer plenair samenkomen (halfuur later is dat).

In groepjes deze vragen bespreken:
- Noem dat ook dit halfuur van de casussen wordt opgenomen, en zet de recording en transcriptie aan in Teams! De transcriptie kan je aanzetten en 'verbergen' (dan zie je de transcriptie niet maar dan loopt hij wel door). Zet voor de zekerheid ook je telefoon aan voor een extra opname mocht die van Teams verloren gaan. In real life alleen telefoonopname is voldoende.
- Noem dat je eventueel aantekeningen maakt over opvallende dingen. Als dit niet lukt tegelijk, is dat niet erg, maar onthoud dan wat opviel en schrijf dat achteraf op.
- Vraag of het voorbereiden van de casussen is gelukt
- Beginnen met de casus waarbij het toepassen van de methodiek wel werkte en ga zo iedere deelnemer af. Vraag wie er wil beginnen met delen of geef een beurt. Stel bij iedere casus een verdiepende vraag zo nodig en praat er kort over door mocht dat boeiend zijn.

1. Bedenk voor uzelf een casus/voorbeeld van uw eigen zorgboerderij waarbij u de methodiek *…* hebt toegepast en dat het het gewenste effect had.

Mocht het niet duidelijk worden uit de casus, dan deze vragen stellen ter verdieping:
- Hoe is de methodiek precies toegepast; is de methodiek hierin aangepast aan de zorgboerderij als context?
- Waarom werkte het toepassen van de methodiek goed in deze situatie?

- Maak wat aantekeningen zo nodig in tabel ''casus 1''

20:50-21:05: Casus 2

2. Bedenk voor uzelf een casus/voorbeeld van uw eigen boerderij waarbij u de methodiek *…* toepaste en dit niet het gewenste effect had.

Mocht het niet duidelijk worden uit de casus, dan deze vragen nog stellen:
- Hoe is de methodiek precies toegepast; is de methodiek hierin aangepast aan de zorgboerderij als context?
- Waarom werkte het toepassen van de methodiek niet goed in deze situatie?

- Maak wat aantekeningen in tabel ''casus 2'' zo nodig

21:05- 21:15: Samenkomen en korte pauze

Iedereen is weer in dezelfde meeting/hetzelfde lokaal. Dan 5 a 10 minuten pauze nemen, mensen wat te drinken en eten laten pakken en toilet-pauze.

* Drinken en eten klaarzetten

(je kan ook nu even korte aantekeningen van casus 1 en 2 opschrijven)

21:15-21:25: Voor- en nadelen van het werken met methodiek bespreken

Na de pauze weer verdergaan.

In het afgelopen halfuur heeft u ervaringen met het werken met de methodiek besproken en ontdekt hoe dit soms wel en misschien soms ook niet goed werkt. Om erachter te komen waarom je als zorgboer wel of niet zou willen werken aan de hand van *methodiek* wilde ik de volgende vraag samen bespreken, namelijk:

3. Wat zijn voor- en nadelen van het werken met deze methodiek?

Maak aantekeningen in tabel ‘’overige vragen 3 t/m 7’’

Online versie:

Deze vraag gaan we samen bespreken aan de hand van de Whiteboard-functie in Teams. Ik ga straks mijn scherm delen waarop het whiteboard komt te staan. Het idee van dit whiteboard is dat wij doordat ik het whiteboard deel, wij met zijn allen het whiteboard kunnen bewerken. Ik heb een wit vel gemaakt met sticky notes erop waarop de voor- en nadelen van het werken met de methodiek kunnen worden gezet.

*** Deel nu whiteboard-scherm**

Voor u links ziet u groene sticky notes waar u de voordelen van het werken met de methodiek op kunt zetten, en rechts rode sticky notes voor de nadelen. Door met uw muis op de sticky note te klikken kunt u er tekst op typen. Rechtsonderin kunt u uw scherm in en uitzoomen. U kunt zich verplaatsen op het whiteboard door uw muis ingedrukt te houden en heen en weer te bewegen met uw muis. Vragen of alles zo duidelijk is.

Als u uw input op een sticky note zet, zet dan uw naam even eronder, ***ik doe het even voor,** zodat we van elkaar zien wie wat heeft bedacht en we hier makkelijk over door kunnen praten.

Laten we beginnen met het invullen van de sticky notes, hierna bespreken we wat er staat even na met elkaar.

→ Evt. letterlijk hier vragen wat voor hun (kijkend naar de voor- en nadelen) dan de redenen zijn om wel te werken met deze methodiek.

Real life versie:

Hier voor u ziet u een flipbord staan met deze vraag, voor u liggen sticky notes en pennen. Op deze sticky notes kunt u voor- en nadelen schrijven om deze vraag te beantwoorden. Deze sticky notes mag u op het flipbord plakken. Hier geef ik jullie nu een paar minuten voor, denk even rustig na, hierna zullen we wat er op het bord staat even nabespreken samen.

Wat hier staat even bijlangs gaan en nader laten uitleggen

→ Evt. letterlijk hier vragen wat voor hun (kijkend naar de voor- en nadelen) dan de redenen zijn om wel te werken met deze methodiek.

21:25- 21:35 Vragen bespreken

4. Is er een verschil tussen het werken met en zonder de methodiek, en wat is dit verschil?

→ Evt. vervolgvraag: Wat betekent dit verschil voor de deelnemer en de kwaliteit van de zorg?

5. Is de toepassing van de methodiek over de loop van de tijd veranderd, of gebruik je het nog zoals in het begin?

6. Gebruik je de methodiek bij alle deelnemers op dezelfde manier, of zit hier verschil in tussen deelnemers?

Bij tijd over:

7. Wat merken de deelnemers van de zorg die verleend is aan de hand van de methodiek? Hoe ervaren zij dat? Heb je hier wel eens iets over teruggehoord/teruggekregen van de deelnemer?

Of andere nuttige vragen die verdiepend zijn.

21:35 – 21:45 Afronden

- Iedereen hartelijk bedanken voor zijn of haar komst.
- Kort momentje vragen naar hoe ze het vonden.
- Vragen of er nu nog vragen zijn/mensen iets willen opmerken of vragen?
- Aangeven dat de opname nu is stopgezet ***opname en transcriptie hier stopzetten**
- Online: ik laat de meeting nog even openstaan, voor als u het leuk vindt even na te praten of elkaar iets te vragen. Mocht u dit niet willen of kunnen, bent u nu vrij de meeting te verlaten. Ik blijf zelf nog maximaal 5 minuten hangen in de meeting voor als u vragen aan mij heeft en zodat de meeting niet

uitvalt.

- Voor real life: klein bedankje uitdelen aan iedereen
- In real life: praktisch hoelaat we uit het gebouw moeten zijn, napraten kan buiten/ergens anders. Zeggen dat deelnemers vanaf nu vrij zijn te gaan als ze dat willen.

- Maak laatste aantekeningen over algemene sfeer/groepsdynamiek. Evt. extra aantekeningen op laatste pagina van het format.

Na de focusgroep:
- Evt. nabespreken
- Later: opname van Teams in break-outroom of telefoonopname delen

Appendix II: Informed consent

Toestemmingsformulier voor deelname aan onderzoek over methodiekgebruik op zorgboerderijen

Voor u ligt het toestemmingsformulier over deelname aan het onderzoek over het effect van methodiekgebruik op de kwaliteit van zorg op zorgboerderijen. Dit toestemmingsformulier geeft onder andere informatie over waar het onderzoek over gaat, wat het meedoen aan het onderzoek inhoudt voor u en hoe de onderzoeker omgaat met uw (persoonlijke) informatie.

De onderzoeker is Renske Schoon, zij voert als enige dit onderzoek uit en zij is hierdoor ook de contactpersoon die u kunt bereiken als u vragen of opmerkingen heeft over het onderzoek of uw deelname. Bij vragen of opmerkingen kunt u de onderzoeker mailen of bellen, waarover u via de mail al bent ingelicht.

Dit toestemmingsformulier bestaat uit drie delen:

- Deel 1: Doel en inhoud van het onderzoek
- Deel 2: Deelname aan onderzoek
- Deel 3: Toestemming deelname

Deel 1: Doel en inhoud van het onderzoek

Doel van het onderzoek

Dit onderzoek heeft twee doelen. Het eerste doel van dit onderzoek is om erachter te komen hoe zorgboeren werken met de vier methodieken die in dit onderzoek verder worden uitgediept. Dit zijn de methodieken Give me the Five, Solution-oriented working, de Triple C-methodiek en de Böhm approach. Het tweede doel van dit onderzoek is om erachter te komen hoe het werken met deze methodieken invloed heeft op de kwaliteit van zorg op de betreffende zorgboerderijen.

Inhoud van het onderzoek: de focusgroep

Om bovenstaande doelen te bereiken, worden er focusgroepen georganiseerd. Deze focusgroepen zullen bestaan uit vier tot acht deelnemers. Iedere deelnemer werkt met de methodiek waar de focusgroep over gaat. Een focusgroep kunt u zien als een soort groepsgesprek waarin vragen worden besproken die de onderzoeker zelf heeft voorbereid. De focusgroep zal worden geleid door de onderzoeker. Er is daarnaast een extra persoon (docent of student van de Wageningen Universiteit) aanwezig die aantekeningen kan maken voor de onderzoeker, en die helpt bij het praktisch organiseren van de focusgroep.

Praktische informatie over de focusgroep

Als deelnemer van dit onderzoek zult u deelnemen aan één van deze vier focusgroepen. De focusgroep vindt eenmalig plaats en zal tussen de één en twee uur duren. De locatie en tijd van de focusgroep wordt vastgesteld in overleg met de deelnemers van de focusgroep. De focusgroep zal worden opgenomen en getranscribeerd (uitgeschreven). Als u voorafgaand aan de focusgroep vragen heeft over het onderzoek of over de inhoud van de focusgroep, dan mag u die stellen en zal de onderzoeker u daar antwoord op geven.
Voor informatie over hoe de onderzoeker omgaat met persoonlijke gegevens en de opname, zie deel 2 van dit formulier.

Deel 2: Deelname aan onderzoek

Vrijwillige deelname

Uw deelname aan dit onderzoek is volledig vrijwillig. Dit houdt in dat het uw keuze is of u mee wilt doen aan dit onderzoek of niet. Dit houdt ook in dat wanneer u om wat voor reden dan ook, toch niet meer mee wilt doen aan dit onderzoek, kunt u zich op elk gewenst moment terugtrekken van deelname.

U heeft het recht om de tijd te nemen om na te denken over uw deelname aan dit onderzoek. Daarnaast kunt u met iedereen die u wilt, delen dat u aan dit onderzoek meedoet.

Vertrouwelijke verwerking van verkregen data en gegevens

De gegevens die de onderzoeker van u verkrijgt, zijn uw naam en wat u vertelt tijdens de focusgroep.

Zoals eerder vermeld, wordt de focusgroep opgenomen en getranscribeerd. Uiteraard zal de opname niet met derden worden gedeeld, maar enkel de onderzoeker zal deze opname beluisteren om de opname te transcriberen (uittypen) via het gebruik van Word. Nadat de opname is getranscribeerd, zal de opname worden verwijderd. De opname en het transcript van de focusgroep zullen enkel worden gebruikt voor de data-analyse binnen het onderzoek en zullen dus niet voor andere doeleinden worden gebruikt. Als het transcript af is, zal het transcript worden geanalyseerd door de onderzoeker, en zullen de bevindingen hierover worden opgeschreven in het onderzoeksrapport. Dit rapport is het eindproduct van dit onderzoek. U heeft het recht om het onderzoeksrapport in te zien, bij interesse kan deze met u worden gedeeld per mail.

In het transcript van de opname, zal uw naam anoniem worden gemaakt door niet uw naam te noteren bij wat u gezegd heeft, maar een nummer. Ook in het onderzoeksrapport dat zal worden geschreven door de onderzoeker, zal uw naam niet worden genoemd maar zo nodig u worden aangeduid met een nummer. Zo blijft uzelf, en wat u gezegd heeft, anoniem.

Deel 3: Toestemming deelname

Toestemming van de deelnemer

De volgende paragraaf mag u lezen en als u hiermee akkoord gaat, zou u dan uw naam, handtekening en datum van ondertekening hieronder willen invullen?

'' Ik heb de voorgaande informatie gelezen, of het is aan mij voorgelezen zodat ik de inhoud van dit formulier ken. Ik ben gevraagd om deel te nemen aan dit onderzoek over methodiekgebruik op zorgboerderijen, en ik ga akkoord met de voorwaarden die zijn uitgelegd in dit toestemmingsformulier. Ik ga akkoord met de manier waarop er met mijn (persoonlijke) gegevens om zal worden gegaan door de onderzoeker. Ik ga ook akkoord met de manier waarop de verkregen data in dit onderzoek wordt bewaard en gepubliceerd. Ik heb de vrijheid

gehad om vragen te stellen over dit onderzoek, en deze vragen zijn naar tevredenheid beantwoord. Hierbij verklaar ik dat ik vrijwillig meedoe aan dit onderzoek.''

Naam deelnemer

Handtekening deelnemer

Datum

Belangrijk!

Nadat u het formulier heeft ondertekend, is het belangrijk dat u deze met de onderzoeker deelt via de mail. Een kopie van dit formulier kunt u zelf houden.

Het mailadres van de onderzoeker is renskeannaschoon.schoon@wur.nl

Toestemming van de onderzoeker

''Ik heb de informatie uit dit formulier verstrekt aan de deelnemer. Ik bevestig hierbij dat ik hem of haar de mogelijkheid heb gegeven om vragen te stellen, en dat ik deze heb beantwoord naar mijn kunnen. Ik verklaar hierbij dat de deelnemer vrijwillig deelneemt aan dit onderzoek. Een kopie van dit formulier zal ik verstrekken aan de deelnemer als deze ondertekend is.''

Naam onderzoeker

Renske Schoon

Handtekening van onderzoeker

Datum

07-02-2023

Appendix III: Format for making notes during focus groups

Format voor aantekeningen tijdens focusgroep

Datum: Aantal deelnemers van de focusgroep: Door:

Informatie over samenstelling van de focusgroep:

Vul onderstaande tabel in tijdens het voorstelrondje.

Als collega's van dezelfde zorgboerderij komen, dan dat even aangeven.

Naam deelnemer	**Naam zorgboerderij**	**Doelgroepen**
Nummer:		
Nummer:		

Nummer:		
Nummer:		
Nummer:		
Nummer:		

Algemene observaties over de hele meeting

Hoe was de groepsdynamiek: wat viel er op tijdens discussies/het bespreken van vragen?*	*Voorbeelden: waren bepaalde deelnemers dominant aanwezig, of hielden sommige deelnemers zich juist vrij stil? Werd er goed gereageerd op de vragen, of was een antwoord geven lastig? Etc. **Hoe was de algemene sfeer tijdens de focusgroep?**

Casus 1: Algemene observaties

Voorbeelden:
If applicable, facilitators and note takers are able to provide additional context to provide additional clarification/information to those conducting analysis of the information provided. Examples of comments may include the following:

- One or two participants dominated the discussion related to this question
- Staff who have been at the agency a shorter period of time didn't feel that they could respond to this question due to lack of involvement in these efforts
- There was consensus of all focus group participants related to this area of focus
- Participants mostly disagreed on a certain topic, namely …

The body language of participants did not align with what he/she/they said* (*this is of course quite subjective

Casus 2: Algemene observaties

Voorbeelden:
If applicable, facilitators and note takers are able to provide additional context to provide additional clarification/information to those conducting analysis of the information provided. Examples of comments may include the following:

- One or two participants dominated the discussion related to this question
- Staff who have been at the agency a shorter period of time didn't feel that they could respond to this question due to lack of involvement in these efforts
- There was consensus of all focus group participants related to this area of focus
- Participants mostly disagreed on a certain topic, namely …

The body language of participants did not align with what he/she/they said* (*this is of course quite subjective

Overige vragen 3 t/m 7: Algemene observaties

Ruimte voor overige opmerkingen/dingen die opvielen