

ORIGINAL ARTICLE OPEN ACCESS

Building a Community Among Multicultural Healthcare Teams in Nursing Homes: A Qualitative Study of the International Caregiver Development Programme (ICDP)

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Received: 9 April 2024 | **Revised:** 20 December 2024 | **Accepted:** 11 February 2025

Funding: This study was funded by VID Specialized University, Centre of Diaconia and Professional Practice in Oslo, Norway.

Keywords: community of practice | cultural diversity | empowerment | International Caregiver Development Programme | nursing homes | psychosocial intervention | qualitative research | staff development

ABSTRACT

Background: Healthcare workers in nursing homes are an educationally, experientially, culturally and linguistically diverse workforce who face increasing challenges in their working conditions. Studies indicate positive results with regard to cooperation and care from experiencing a sense of community in diverse healthcare teams.

Aim: This qualitative study aimed to explore healthcare workers' experiences of being part of a team in nursing homes before, during and after their participation in a psychosocial competence building intervention, the International Caregiver Development Programme (ICDP).

Methods: Fifteen focus group interviews of five ICDP group courses were conducted before, during and after participation in ICDP with 31 cross-cultural healthcare workers in nursing homes. The findings emerged through hermeneutic analysis. The results were compared with the open responses in an anonymous written evaluation. Consolidated Criteria for Reporting Qualitative Research (COREQ) served as a framework for reporting this study.

Results: Before ICDP, the participants reported a lack of communication regarding priorities, challenges in interactions with the residents and cultural and linguistic diversity among the healthcare workers. During participation in ICDP, they described increased knowledge and understanding of one another in addition to inspiring each other and acknowledging each other's diversity as healthcare workers. After completing ICDP, they experienced a sense of relational and practical community, a sense of pride in the team, increased self-confidence related to practice and increased job satisfaction.

Conclusion: This study indicated that ICDP has the potential to create a community of psychosocial practice in multicultural healthcare teams, which may be strengthened by experiences of mastery, confidence and pride. The participants in this study developed a common conceptual framework for understanding, prioritising and practising psychosocial care. The community seemed to facilitate cooperation between them and increase their job satisfaction.

Implications for Practice: Healthcare workers in nursing homes need time and space to share experiences to establish relationships that increase the quality of cooperation. While diversity among healthcare workers in nursing homes can pose challenges, participating in psychosocial competence building interventions like the ICDP can help it to be viewed as a valuable source of

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1 | Introduction

Healthcare workers (HCW) in nursing homes are an educationally, experientially, culturally and linguistically diverse workforce who face increasing challenges in their working conditions (Xiao et al. 2020). Studies reveal challenges in how nursing home care is structured, including poor or missing descriptions of tasks and scope of practice for all occupational groups, lack of sufficient competence, lack of HCWs and resources, diversity, discrimination and HCWs lack of competence in the native language as potential barriers to cooperation between HCWs in nursing homes (Chen et al. 2020; Ham 2021; Müller et al. 2018; Sellevold et al. 2019; Ødegård 2020). Development of knowledge that may contribute to preventing these challenges is important to limit the negative influence on the quality of care and on HCWs' relationships and cooperation, in addition to their experience of mastery and job satisfaction (Chen et al. 2020; Nichols et al. 2015; Sellevold et al. 2019; Ødegård 2020). Studies of interdisciplinary and multicultural teams of HCWs pinpoint several potential positive aspects of experiencing a sense of community (Squires et al. 2015; Vassbø et al. 2019; Xiao et al. 2020) and empowerment (Bing-Jonsson et al. 2016; Tashiro et al. 2013) to overcome potential challenges and barriers. This study examines HCWs' experiences of being a part of a nursing home healthcare team before, during and after participating in an interdisciplinary and cross-cultural competence building programme known as the International Caregiver Development Programme (ICDP). More descriptions of ICDP will follow.

1.1 | Diversity Among Nursing Home Healthcare Workers

The staff in Norwegian nursing homes consists of approximately 90% HCWs qualified with a degree from upper secondary school or without any formal healthcare training (Bing-Jonsson et al. 2016). Despite the professionalisation of healthcare services in Western countries (Theobald and Chon 2020), the daily tasks of all occupational groups and the competence needed in nursing homes are not clearly defined in Norway (Bing-Jonsson et al. 2016; Kiljunen et al. 2017). HCWs caring for older persons may experience a lack of guidance for how to provide quality care, as well as challenges in finding focus and that the descriptions of roles and responsibilities in practice are limited (Gautun and Syse 2017; Nolan et al. 2004). This may in turn contribute to a lack of confidence in their role (Coates and Fossey 2019) and challenges in interactions (Baker et al. 2011; Ogletree et al. 2020).

Nursing staff in nursing homes both in Norway and in other Western countries are increasingly ethnically and linguistically diverse (Chen et al. 2020; Statistics Norway 2018), posing both opportunities and challenges in healthcare services (Chen et al. 2020; Sellevold et al. 2019). Studies indicate that migrant

HCWs may inspire native HCWs to increase the quality of their care by making an extra effort for residents (Ham 2021), thereby increasing patient safety (Wagner et al. 2020). Migrant HCWs may experience discrimination, feelings of being an outsider and challenges in communication that can affect cooperation, interaction and relationships with residents, peers and other team members (Chen et al. 2020; Egede-Nissen et al. 2019; Sellevold et al. 2019).

Wenger (2004) defines communities of practice as 'groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly'. In line with Wenger (2004), Bing-Jonsson et al. (2016) describe the empowering potential in learning methods that develop a sense of community which is built on the diversity of the team members' skills, knowledge and experiences. Experiencing empowerment and respect and having confidence in their work seems to have a positive impact on HSWs' sense of responsibility towards residents, and on their job satisfaction and intent to quit (Berridge et al. 2020; Caspar et al. 2020; Kennedy and Mohr 2023; Squires et al. 2015). Vassbø et al. (2019) study indicates that a sense of a community, environmental support and the ability to prevent challenging situations, influence job satisfaction among HCWs in nursing homes. In addition, the sense of community among team HCWs is highlighted as essential for sustainable implementation of person-centred and psychosocial care in healthcare services for older persons (Carvajal et al. 2019; Moore et al. 2017; Oppert et al. 2018).

In a study of healthcare workers in multicultural teams, Sellevold et al. (2019) emphasise that time and space for open conversations about experiences and challenges are essential for mutual understanding and work-related bonding. Studies describe that sharing knowledge in healthcare teams may enable collaboration (Lillemoen and Pedersen 2015; Tashiro et al. 2013) in a way that allows the caregivers' various individual skills to complement each other in practice (Hartmann et al. 2019; Reeves et al. 2011). A summary of knowledge in municipal healthcare services points to a need for further studies on the development of competence that includes diverse teams and interactions (Rokstad and Øvereng 2017). Haywood et al. (2012) recommend healthcare development interventions and facilitating continuous engagement to build and adjust individual skills through various methods of active learning that are closely related to practice.

1.2 | The Intervention

ICDP in care for older persons is a multidisciplinary group-based intervention to increase caregivers' competence within psychosocial and person-centred care. Its content and key components are based on the original version of the programme, aimed at caregivers of children, which has been used in approximately 70 countries (ICDP 2024a). Different versions of ICDP in care for older persons have been in use in Sweden, Denmark, Germany,

Summary

- What does this research add to existing knowledge in gerontology?
 - Cultural diversity may be a source of improved knowledge of psychosocial practice.
 - Shedding light on diversity in nursing home practice may increase empowerment, prevent discrimination and challenges in cooperation within multicultural healthcare teams, and facilitate a community of psychosocial practice.
- What are the implications of this new knowledge for nursing care for and with older adults?
 - Shedding light on the value of diversity among healthcare workers and in psychosocial practice may increase the quality of care for older persons.
 - The International Caregiver Development Programme (ICDP) appears to have the potential to facilitate a sense of community among healthcare workers, which improves the quality of psychosocial practice.
- How could the findings be used to influence practice, education, research, and policy?
 - Healthcare workers in nursing homes need time and space to develop a community of psychosocial practice.
 - There is a need for more research on participation in ICDP with regard to discrimination among healthcare workers in nursing homes.
 - There is a need for more research on pride, acknowledgement, self-confidence and job satisfaction among healthcare workers.
 - Active sensitisation learning methods may facilitate a community of psychosocial practice that values diversity in culture, education, skills, attitudes, values and languages.

Japan and Colombia, yet there are, as far as we know, no published scientific evaluations.

ICDP is based on research within human psychosocial needs, humanistic psychology (Bråten 2004; Stern 2018), attachment theory and developmental, narrative and cultural psychology (Hundeide and Armstrong 2011). ICDP's platform of humanistic pedagogy (Rogers 2000) is based on mediated learning, activity in learning, humanistic counselling and contextual implementation (Hundeide and Armstrong 2011). Humanistic psychology emphasises that human beings are meaning-seeking and

interpretive and must be understood from their own unique interpretive position. ICDP seeks to support caregivers in understanding each person's unique needs.

One of the key characteristics of ICDP is that it intends to be *culturally sensitive* (BUFDIR 2016; Flakk and Waage Hanssen-Bauer 2023) and flexible, based on the idea that human beings must be understood in the socio-cultural context in which they live. Another key characteristic of ICDP is that the programme is *focused on shedding light on human resources*: the caregivers' as well as the older persons' skills and mastery in communication and interaction.

ICDP's active learning methods are designed to be easy to grasp. To make the ICDP relevant, understandable and enable acknowledgement of practice, the participants are encouraged to present films of themselves, role plays or describe typical examples of everyday situations in interaction with the residents. All ICDP participants, including group leaders, are invited to identify the eight guidelines (Table 1) in the video recordings, role play scenarios and verbal examples of practice and to reflect on how the various topics within psychosocial care can be understood in practice, in addition to trying out psychosocial care in practice. The programme is usually carried out with six to eight participants and conducted by two certified ICDP facilitators (preferably one Registered Nurse and one enrolled or assistant nurse employed in care facilities for older persons), over eight 2-h meetings held at 1 to 2-weeks intervals (for more information on the intervention in this study, see the section next). For more details about ICDP and ICDP in care for older persons, see Holmsen et al. (2023); Hundeide and Armstrong (2011); Hundeide et al. (2011); ICDP (2024b).

To our knowledge, this is the first study to focus on experiences participating in ICDP and the sense of community among HCWs in nursing homes. Qualitative methods are used to seek in-depth knowledge from a new field of research (Creswell 2013).

1.3 | Aim

This article aims to explore the following research question: 'What experiences do healthcare workers have being a part of a healthcare team in a nursing home before, during and after participation in the International Caregiver Development Programme (ICDP)?'

TABLE 1 | Eight guidelines for positive interaction in care for older persons.

The emotional expressive dialogue	The meaning oriented and expansive dialogue	The regulative and facilitative dialogue
1. Express loving feelings to the older person	5. Shared attention—mutual engagement	8. (a) Plan step by step together with the older person
2. Adjust to the older person's initiative	6. Provide meaning of experiences (here and now)	(b) Provide support adjusted to the older person's needs
3. Take part in the older person's emotions (including non-verbal expressions)	7. Provide continuation and connections	(c) Facilitate the older person's everyday life
4. Confirm and praise		(d) Provide positive and motivating supervision and limit setting

2 | Method

2.1 | Design

This study has a qualitative design, in which the experiences of professional caregivers in nursing homes participating in ICDP are investigated based on data from 15 multistage focus group interviews (three interviews of five different groups) and anonymous written evaluations.

2.2 | Participants and Setting

Participation in the ICDP intervention was a prerequisite for participation in the study, which took place in one of the largest cities in Norway. Both group participants and group leaders were recruited to ICDP by their unit leader, who selected participants based on the recommendation that ICDP participants should reflect the diversity of the healthcare team. The nursing homes paid their employees for participation in ICDP and chose to conduct the ICDP meetings in connection to the HCWs' shift change in the afternoon. They were encouraged to ensure additional staff and that the participants were available for emergency situations during the meetings.

All the HCWs who participated in the first five ICDP groups in the intervention were asked by the researchers to participate in this study. For details of the participants, see Table 2. The two leaders who conducted each ICDP group, one Registered Nurse and one enrolled nurse, were colleagues of the participants. For more information about the intervention, see Holmsen et al. (2023). The five focus groups were the same as the five ICDP groups. A typical focus group was composed of mostly enrolled nurses or nurse aides who had been working in nursing homes for an average of 14.5 years. The participants had different mother tongues and held a half-time to full-time positions. The focus groups remained consistent throughout

time points 1, 2 and 3, with an average of between six and seven participants.

The focus group interviews were planned by the unit leaders and conducted at the three nursing homes by the first author in collaboration with one of the other authors. All 31 participants from three different nursing homes that participated in the intervention consented to participate in three focus group interviews (31 participants) and provide an anonymous written evaluation (22 participants). The anonymous written evaluation was organised by the ICDP group leaders, who delivered the handwritten forms to the research team. The participants received written and oral information about the study, where it was stressed that participation was voluntary and that the participants could withdraw at any time without consequences.

2.3 | Data Collection

The data were collected in three different nursing homes in one of the largest cities in Norway from October 2018 to March 2019. The data consist of transcripts from 15 focus group interviews (5 groups $\times$ 3 interviews, 401 transcribed pages, 11-point font). In addition, the material includes anonymous evaluation forms with responses to open-ended questions from 22 of the 31 participants in the focus group interviews (8 pages, 11-point font).

To investigate the participants' progress in ICDP, the data were collected in parallel with the ICDP intervention (Figure 1). The first focus group interview was conducted before the intervention started, the second after four or five ICDP meetings and the third after ending the last (eighth) ICDP meeting, along with the written evaluation. Most HCWs participated in focus groups 1, 2 and 3, though absences (shift work, holiday, sick leave) could occur. The focus group interviews were

TABLE 2 | Characteristics of the 31 participants and the five focus groups.

Role	Registered nurse, 2; Enrolled nurse, 19; Nurse aide, 10
Years working in nursing home	2–40 years; mean: 14.5 years
Type of position	Half-time to full-time employment
Gender	Women, 26; men, 5
Age	24–64 years Mean: 47 years
Language	Norwegian mother tongue: 7; other mother tongue: 24
Languages	Norwegian (6), Tamil (4), Spanish (1), Serbian (1), Thai (1), Indian (2), Amharic (5), Tigrinya (1), Filipino (3), Portuguese (1), Asian (1), Chinese (1), Arabic (1), Akan (1), Italian (1) and Vietnamese (1).
Units	Somatic wards, open wards and screened units for persons with dementia diagnosis. Two groups were mixed from different units.
Number of participants in each focus group	A, 8; B, 6; C, 6; D, 6; E, 5 Mean: 6.6
Attendance in the eight ICDP meetings	All 8 meetings: 6 participants; 7 meetings: 16 participants; 5 meetings: 8 participants, 4 meetings: 1 participant; mean: 6.6 meetings

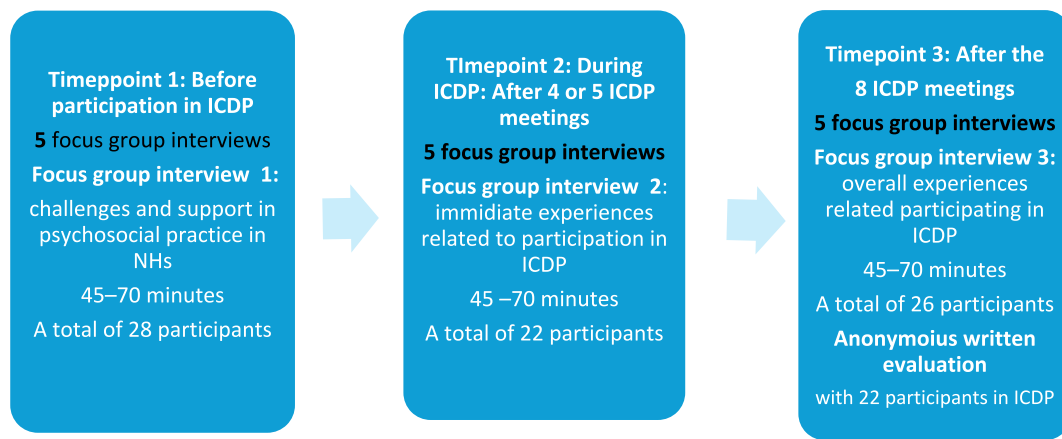


FIGURE 1 | Time points for the data collection from three focus group interviews of five different ICDP groups and anonymous written evaluations.

conducted by the first author in cooperation with all authors. The ICDP group leaders conducted the anonymous written evaluation after the last ICDP meeting. The focus group interviews and written evaluations were transcribed by the first author and stored on an encrypted flash drive. Pseudonyms will be used to preserve anonymity.

2.4 | Analysis

The qualitative analysis was conducted in 2022/2023 and involved going back and forth between the whole and different parts of the data material, inspired by Brinkmann and Kvale's (2015) descriptions of hermeneutic analysis.

Verbatim transcriptions were used to preserve the participants' way of expressing themselves (Oliver et al. 2005). We began our analysis by reading the material in different ways: structured by focus groups, all interviews 1–3, changing the order when reading while remaining open minded. We went back and forth between the data material as a whole and processed mind maps based on quotes from focus group interviews 1, 2, and 3. We then re-read the material in its entirety and developed the following analytic questions:

- How do the participants experience the workplace, themselves, colleagues and the team before starting the ICDP?
- How do the participants describe what happened during the ICDP exercises, and did it have an impact on how they experience themselves, colleagues, the team or the workplace?
- How do the participants describe being part of a healthcare team and their overall experience after participating in eight group meetings?

To reflect the entirety of the participants' dialogue and that the participants were talking about their experiences before and during participation in ICDP in both focus group interviews 1, 2 and 3, the material was re-structured to experiences that were related to time point 1: before ICDP, time point 2: during ICDP and time point 3: after the eight ICDP meetings. The material was coded and categorised before listening to focus group

interviews 2 and 3 to explore whether the recorded dialogue would add anything to the analysis.

To investigate whether the participants answered differently or were more critical to ICDP when the researchers were not present, we finally compared the results with the open responses in the written evaluations, which were anonymous. We prepared the written evaluations for comparison as independent data by categorising all quotations and extracting them.

The analysis was written as a text and supported with selected quotes that were adjusted into grammatically correct Norwegian, translated to English and finally back translated to ensure that the original meaning was preserved. Changes to original wording are indicated with square brackets [...].

Throughout the analysis process, which involved all authors, tentative results were presented in analysis seminars to the research team and other research teams at VID Specialized University, during which we discussed the validity of the findings and revised the themes and theme descriptions.

2.5 | Ethical Considerations

The project was approved by the Norwegian Data Services (NSD), project number 332083, in October 2018. Consent forms, code keys, contracts and other information, including information about participants, were stored in a locked cabinet at VID Specialized University.

The first author's dual roles as researcher and leader of the implementation of ICDP in the nursing homes raise specific ethical considerations. A list of presuppositions was made prior to the data collection (Malterud 2019). The research process seeks to be transparent to allow readers to consider whether and in what way preunderstandings may have affected this study (Brinkmann and Kvale 2015).

To safeguard the participants' and groups' anonymity, we have chosen not to provide group numbers for the quotes. Consolidated Criteria for Reporting Qualitative Research

(COREQ) served as a framework for reporting this study. For Supporting Information, see Holmsen et al. (2023).

3 | Results

The level of congruency between the written evaluations and the focus group interviews was surprisingly high. The written evaluations confirmed the analysis of the focus group interviews without elaborating anything new. However, a difference appeared in that a few more participants shared the criticisms that had already been voiced in the focus group interviews (e.g., the initial confusion regarding the guidelines). In addition, the written anonymous evaluations made it clear that all participants, except for one who had left the answer blank, recommended ICDP to other HCWs in nursing homes.

The presentation of the results follows the three sequences and reflects the movement in the participants' descriptions of their experiences before, during and after participation in ICDP (Table 3).

3.1 | Lack of Communication Regarding Practice

The participants described the situation before the ICDP intervention as characterised by problematic prioritisation, an absence of discussion within the team of HCWs and challenges related to cultural differences and language difficulties.

3.1.1 | Practical Tasks Are Prioritised Over Residents' Needs

The participants expressed that prioritising practical tasks and routines over caring for residents led them to experience a gap between the ideals of practice and reality.

Gerd: There is a... difference between how one [the HCWs] wishes it could have been here and the reality...
(Focus group interview, time point 1)

The participants reported that a common conception of prioritising care for residents in practice was often derived from various requirements through practical routines and/or work with structural quality improvements initiated by the management. They described that the challenges caused by prioritising differently could affect the quality of their daily work and be a potential source of misunderstanding that could hamper cooperation and lead to worsening the environment among the HCWs.

Mari: We [HCWs in general] are... more concerned about the practical tasks than [about] the residents... But, when I think that I have done a good job [prioritizing the residents]... and someone comes... and is irritated: 'Why haven't you done that?' It can affect... the environment. I get very stressed and go home with a very bad feeling...
(Focus group interview, time point 3)

TABLE 3 | The participants' experiences of being part of healthcare teams in nursing homes. Results shown in main categories and sub-categories for the three sequences: Before, during and after participation in ICDP.

Before participation in ICDP: Lack of communication regarding practice	During participation in ICDP: Opening up to each other	After participation in ICDP: Developing a sense of community
Practical tasks are prioritised over residents' needs	Transparency of practice	Being caring to their colleagues
Absence of discussion of challenges in interactions with the residents	Inspiring each other	Working side by side on the same 'track' in practice
	Acknowledging each other's work	Pride in the team's overall competence

Some participants described feeling stretched to the limit by the total burden of tasks and challenges. At the same time, the participants explained that they did not have time and space to talk with each other about priorities in practice before participating in ICDP.

3.1.2 | Absence of Discussion of Challenges in Interactions With the Residents

The participants described themselves as diverse practitioners. They expressed that they did not have time to talk with each other about practice and that they had limited knowledge of how their colleagues worked before the intervention.

Birgitte: It can be very difficult... something that I am never able to do with a resident... and I see that others have no problem, so... I wonder why...
(Focus group interview, time point 1)

The participants described many significant challenges before the ICDP intervention and shared that their practice was characterised by trying again and again in different ways.

Dina: We try our best... talk, give food, sing... medicine.... we try everything... it's hard.
(Focus group interview, time point 1)

The participants described that the challenges they faced in terms of communication and cooperation often were beyond their control. They felt stuck and eventually gave up. They did not talk to each other about challenges in their daily work and often did not document challenges in the residents' records.

Else: Some [caregivers]... do not want to admit challenges in care, and write that it has gone well... even though it really has not...

(Focus group interview, time point 1)

The participants explained that HCWs were worried about not being good enough as practitioners, feared being fired or not getting more shifts and/or struggled to express themselves in writing.

3.1.3 | Cultural Differences and Language Difficulties

The participants described themselves as diverse practitioners with regard to skills, knowledge, experiences, values, attitudes, culture and language. They expressed that it is not easy to talk about topics related to cultural diversity. They described linguistic challenges as a taboo topic and at the same time a familiar obstacle to teamwork and cooperation.

Sadie: ...For example, [there are] important messages that cannot be passed on because some say 'yes' and that they understand... Then it turns out that they don't understand. In acute situations... I mean... we are healthcare workers in the healthcare system... we work with life and death.

(Focus group interview, time point 3)

The participant highlighted this issue as important to psychosocial practice and described it as a sensitive topic and an example of what ICDP participants had in mind when they talked about taboo topics in nursing homes. Some participants described challenges with being patient with colleagues.

3.2 | Opening Up for Each Other

The participants experienced that the content and activities covered in ICDP made each other's practice more transparent and that inspiring and acknowledging each other led to the sense that everyone's contribution was equally important.

3.2.1 | Transparency of Practice

The participants expressed that seeing, analysing and reflecting on examples of their own practice on film contributed to transparency and awareness of each other's strengths in practice and a better understanding of themselves as diverse practitioners.

Linda: I watch... and the others watch the films... different ways of practicing. We can hear about the others' feelings... or their opinion.

(Focus group interview, time point 2)

The participants described that sharing insight into each other's thoughts and feelings, e.g., about own upbringing, contributed

to knowledge and understanding of each other's assessments of practice, language, values and attitudes. Some described that they experienced ICDP as a 'deeper way of learning' (FGI 3), which was achieved by participating in roleplay scenarios, sharing emotions and being transparent about interpersonal and intrapersonal skills relevant to psychosocial practice. Others expressed a desire for more conversations about emotional reactions in the programme.

At the beginning of ICDP, several participants expressed confusion about the purpose of the ICDP guidelines and questioned why they should talk with their colleagues about things they automatically did in practice every day.

Alvin: ...I asked myself: 'What are they talking about? We usually do this...' But when we use the guidelines to reflect.... 'ok, have I practiced in line with the [the guidelines]?' It makes me aware... It is a good tool.

(Focus group interview, time point 2)

During ICDP, several participants used the word 'refill' in reference to their participation in the programme in connection to aspects relevant to psychosocial practice. The participants expressed that they appreciated that ICDP reflected a need to adjust psychosocial practice to each situation and that the exercises in ICDP were 'weaving' theory into practice.

3.2.2 | Inspiring Each Other

According to the data, the participants experienced that sharing and reflecting on their colleagues' diverse skills and on ways to provide good care through the content of ICDP inspired them to try out their new knowledge in practice.

Felina: We have seen different movies... ways and techniques... and learned new and helpful things that I have tried [in practice].

(Focus group interview, time point 3)

In focus group interview 2, some participants reported their practice was unaffected by the programme and some were unsure. However, in focus group interview 3, the participants described specific changes in their practice as a result of being inspired by colleagues during ICDP.

Participants from the somatic and dementia units who were mixed together in ICDP appreciated gaining insight into diversity in practice. In addition, participants with a foreign mother tongue described that the dialogue with the other programme participants had inspired them to develop their Norwegian language skills.

Adele: I'm happy... to learn more Norwegian... in ICDP... because the others are Norwegians... I'm learning expressions...

(Focus group interview, time point 3)

3.2.3 | Acknowledging Each Other's Work

The participants expressed that recognising the guidelines in each other's practice when working on the ICDP exercises was a way of commenting on one another's mastery that they were not used to before participating in the programme. This entailed confirmation and acknowledgement of both themselves and others.

Darleen: ...we see that... our practice is right... the video recordings... are proving... 'Oh yes, that way'... yes, we do it right or... it is ok to do it that way.

(Focus group interview, time point 2)

Some commented that ICDP's one-sided focus on 'the positive' could be a weakness. Several used the word 'strengthening' when talking about their participation in the programme and connected this to recognising and becoming aware of both appropriate and inappropriate competence. Others expressed that participation in ICDP entailed a recognition and assurance of practice which was good enough and that their experience of acknowledgement included both current and past practice.

Moni: All the guidelines... Then you see 'oh, this I've done before' [and] you can see 'oh, I have empathy'. And then... 'I do all these things'.

(Focus group interview, time point 2)

Some also underlined the importance of support and acknowledgment from the ICDP group leaders.

3.3 | Developing a Sense of Community

After finishing ICDP, participants expressed that they had begun to share a sense of community, due to being caring towards each other and working side by side on the same 'track' in practice, in addition to developing pride in the team's overall competence.

3.3.1 | Being Caring to Their Colleagues

The participants explained that they had learned to see new sides of each other both as practitioners and as people.

Elin: We have gotten to know each other better... in a slightly different way... I think that... we have become more welded together...

(Focus group interview, time point 3)

The descriptions in the data material indicated that becoming more familiar with each other led to increased patience in cooperation with each other.

Gerd: You get to know more about the way the others work... how you and you and you work... (points to

her colleagues) You become more... patient and... it is easier when you know the people you work with...

(Focus group interview, time point 3)

Describing the changes in their experiences of collaboration and their relationships with each other, the participants spoke of being more 'patient', 'tolerant', 'listening' and 'caring' and 'less admonishing', in addition to describing a higher degree of 'mutual respect', a greater sense of safety and a more humorous tone between the participants (focus group interviews and written evaluations).

3.3.2 | Working Side by Side on the Same 'Track' in Practice

The participants explained that ICDP served as a 'reminder' to primarily focus on the residents and that it became increasingly clear to them that it was right to prioritise residents over practical or administrative tasks. In addition, several expressed that ICDP facilitated collaboration by promoting common assessments and conceptions and a shared language of practice.

Ivette: When we work together... things go... the same way... We understand each other and support each other... a closer connection... Instead of going separate ways, now we go more... in the same direction.

(Focus group interview, time point 3)

In focus group interview 3, several participants expressed that implementing the eight ICDP guidelines contributed to a more systematic common assessment of practice, which made them work more methodically and collaborate, which in turn led to increased job satisfaction.

Elly: In difficult situations.... we remember the guidelines and are able to cope. Therefore, there is more joy.... The feeling of mastery leads to more job satisfaction

(Focus group interview, time point 3)

Some participants shared that their new knowledge led them to notice more of their other (non-participating) colleagues' inappropriate interactions with residents, and potential collaboration challenges, and to recommend the programme to others working in nursing homes. One of the participants elaborated:

Ivette: I would recommend other nursing homes to have the same... thinking about what I have been through, how changed I am. There are probably many who do the same job who need [this].

(Focus group interview, time point 3)

The participants experienced that the process of change required participation in ICDPs learning activities and that the

knowledge could not simply be passed on. Some expressed a concern about the sustainability of the community and a desire for continuation after the eight ICDP meetings.

3.3.3 | Pride in the Team's Overall Competence

After finishing ICDP, several of the participants reported that they recognised all the ICDP guidelines in all situations of interaction both at work and in their private life and realised how theory, competences and experiences from different arenas and professions could be relevant in their work.

Sadie: ... it [ICDP] connects what I knew from before... my resources and what I know not only intellectually... I have [taken] many courses and have a lot of experience with music and theatre. I can use what I know as a person and... life experiences... my mother who died, everything.

(Focus group interview, time point 3)

She continued by saying that participating in ICDP allowed her to merge her competences with those of her colleagues, helping to make them a better team. In line with several participants' descriptions of increased pride, Dina (time point 3 after the eight ICDP meetings) expressed that participating in ICDP contributed to increased self-confidence. Nadia put it this way:

Nadia: I became proud... when I saw what we are doing every day....

(Focus group interview, time point 2)

4 | Discussion

This study aimed to explore healthcare workers' (HCWs) experiences of being part of healthcare teams in nursing homes before, during and after they participated in ICDP. Before ICDP, the participants reported that there was a lack of communication regarding priorities, challenges in interaction with the residents and cultural and linguistic diversity among HCWs. During participation in ICDP, they described opening up for each other in response to knowing more about one another, in addition to inspiring and acknowledging each other as practitioners. After finishing ICDP, the participants expressed that they had developed a sense of relational and practical community and a sense of pride in the team and reported increased self-confidence related to practice and increased job satisfaction.

4.1 | A Community of Psychosocial Practice

This study showed that developing a cooperative community within psychosocial practice requires HCWs to reflect on how theory can be translated into practice. It seems possible to accomplish this using the ICDP guidelines to reflect on video recordings, roleplays and other examples as close as possible to the HCWs' practice. This may contribute to decreasing the

gap that has been described between knowledge and practice in psychosocial care (Erickson 2017). Some participants initially found the ICDP guidelines to be confusing and did not see how they could be useful for them, which may have influenced their motivation to participate and commit to ICDP (Moore et al. 2017). However, the participants changed their views during their participation, recognising that practising psychosocial care in nursing homes requires systematic and reflective assessments of how to provide good quality care, which seemed to have facilitated the development of a shared platform of psychosocial practice and facilitated holistic, person-centred practice (Carvajal et al. 2019; Holmsen et al. 2023; Moore et al. 2017; Oppert et al. 2018; Tashiro et al. 2013). These findings might support the inclusion of psychosocial care as a part of the professionalisation of practice in nursing homes (Theobald and Chon 2020) and making mandates and responsibilities within psychosocial practice more explicit, which may in turn help improve empowerment and job satisfaction.

4.2 | A Community in Diverse Healthcare Teams

The participants in this study described cultural differences as a sensitive topic. In line with Sellevold et al. (2019) study of professionally and culturally diverse healthcare teams, this study indicated that ICDP created time and space for the participants to get to know each other better, including cultural differences, diversity in values, attitudes and assessments of practice, skills, experiences and language, which improved their relationships. Transparency regarding practice may lead to increased understanding of competences, roles and responsibilities, and in turn support team diversity (Baker et al. 2011) by enabling caregivers to complement each other in practice (Hartmann et al. 2019; Reeves et al. 2011) and in competence development (Bing-Jonsson et al. 2016). The content and learning methods used in ICDP seemed to facilitate patience and cooperation among the caregivers. A lack of resources in nursing homes will nevertheless continue to be a potential barrier to cooperation between HCWs in nursing homes (Baker et al. 2011; Ogletree et al. 2020).

The participants in this study described that sharing knowledge with each other through the exercises in ICDP was a source of mutual inspiration that enabled them to try out new things in practice, which in turn increased their experience of mastery. This may increase their sense of equality and prevent discrimination and underestimation of migrant caregivers' competences, as well as their fear of speaking to avoid negativity in the team (Chen et al. 2020; Munkejord and Tingvold 2019; Sellevold et al. 2019). This study showed a potential for ICDP participants to develop their Norwegian language skills, a sense of security and the self-confidence to take part in conversations at work. A previous study indicated that ICDP has the potential to support caregivers in developing a common language for psychosocial practice (Holmsen et al. 2023). This may strengthen the sense of community between the caregivers. In line with other studies' descriptions of HCW's experiences of empowerment, respect and confidence in their competence, this study indicates that the prevention of common barriers in cross-cultural healthcare teams may increase their job satisfaction (Berridge et al. 2020; Caspar et al. 2020; Kennedy and Mohr 2023; Squires et al. 2015).

4.3 | Methodological Considerations

Triangulation of different data collection methods and longitudinal data collection, in addition to a comprehensive dataset, could be considered strengths of this study (Creswell 2013, p. 251).

Nevertheless, the results should be interpreted considering several limitations. In line with a previous study conducted as a part of this research project, the participants' varying Norwegian language skills and the first author's role as an ICDP trainer might have affected the findings (Holmsen et al. 2023). The findings that seemed to stem from shedding light on the diversity in HCWs may have been strengthened by the dialogue in the diverse focus groups.

To address potential threats to the validity of the study, the research team comprised individuals with diverse methodological and academic backgrounds, and they closely monitored the entire study. To mitigate possible bias, we sought feedback by presenting the study in various forums, which included reflections on the first author's role and contributions. We included a written evaluation component to investigate whether different experiences or more critical opinions were described using an anonymous data collection method than in the focus group interviews. Nevertheless, additional quantitative research is necessary to confirm the effectiveness of ICDP in relation to teamwork and community in healthcare teams and to differentiate between Norwegians and immigrants and longitudinal experiences.

The results of this study seem to spring from, and be dependent on, the diversity in HCWs' values, attitudes and assessments of practice, skills, experiences, cultures and language. The study may therefore be most relevant to healthcare teams that are characterised by diversity. At the same time, the generalisability of this qualitative study must be considered as limited and dependent on the healthcare services' mandate, culture of care, structural frames, laws and leadership.

5 | Conclusion

The study indicated that ICDP has the potential to develop a community of psychosocial practice among multicultural HCWs that corresponds to Wenger's (2000) descriptions of 'communities of practice'. The multicultural healthcare teams in this study developed a common conceptual framework for understanding, prioritising and practicing psychosocial care. This facilitated a common platform of psychosocial care that included theory, practice and language. Their sense of community may have been strengthened by experiencing feelings of mastery, confidence and pride. In addition to relational qualities and a sense of pride, ICDP creates respect for the caregivers' differences, which can be seen as a strength for the team. This seemed to facilitate cooperation between them and increase their job satisfaction. Further studies should examine the sustainability and long-term experiences of the community of psychosocial practice. Studies of ICDP in care for older persons should focus on the effects of ICDP interventions in nursing homes and the

development of linguistic, multicultural and interdisciplinary aspects. More knowledge is needed regarding how ICDP can facilitate relationships, mutual inspiration and cooperation and prevent discrimination and underestimation of immigrant caregivers' contributions to multicultural healthcare teams.

Author Contributions

All authors made substantial contributions to the following: (1) planning and study design, data collection, analyses and interpretation; (2) drafting and critical revision of the article; (3) final approval of the submitted version. The first author had the main role in all the steps.

Acknowledgements

Our thanks go to the nursing homes and participants in this study and the ICDP trainers that assisted in the implementation of ICDP, namely: Eli Østberg and Astrid Kleppe Flackè. Open Access was funded by ICDP Norway and ICDP International.

Ethics Statement

The study was approved by the Norwegian Social Data Services (NSD) (ref. no. 332083).

Consent

Patient consent was not needed for this study.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data generated and analysed during this study are not publicly available because they are qualitative in nature and could potentially result in the identification of the participants. Anonymised transcripts of the focus group interviews and/or the written anonymous evaluations are available from the corresponding author on reasonable request.

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