Humanities & Social Sciences Communications

ARTICLE

https://doi.org/10.1057/s41599-023-02173-0 OPEN

Who cares? Tinkering with values in geriatric care by first-generation immigrant newcomers and established caregivers in a German residential home

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A German residential home invited recently arrived refugees who were interested in working in geriatric care. The purpose of this study was to gain insight into how established caregivers and first-generation immigrant newcomers tinkered with values to enact care for people with dementia. This ethnographic study included 200 h of participant observations, 24 in-depth interviews, two focus-group interviews with six first-generation immigrants and six established staff members. The established caregivers and first-generation immigrant newcomers demonstrated a willingness and ability to tinker in situations when different values came into play. However, when the workload becomes too heavy, staff from both groups may experience feelings of powerless, indifferent and demotivation. Institutional constraints exert a negative influence on the interaction between established caregivers and first-generation immigrant newcomers and impact their enactment of care for geriatric residents with dementia. In such situations, it becomes crucial for staff to have a supportive supervisor who can help them cope with the daily stressors of their practice.

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Introduction

The shortage of skilled caregivers is a significant problem in many countries (Horn et al. 2021). Germany, in particular, faces the challenge of having one of the largest aging populations in Europe, leading to a severe labor shortage within German residential homes. This shortage places a substantial burden on caregivers, resulting in a high level of absenteeism, which in turn, places additional strain on the remaining staff. To address these issues, many German residential homes have resorted to recruiting caregivers from East-European countries, including Poland, Slovakia, Bulgaria, and Russia (Menebröcker 2021). Furthermore, they have lowered their qualification requirements for caregivers (Horn et al. 2021). Despite these initiatives, the labor shortage persists, prompting some facilities to explore refugees and asylum seekers as potential groups for recruiting caring staff (Hussein et al. 2011).

In 2015, during the so-called "refugee crisis," Germany received nearly 500,000 asylum applications. Among the applicants were individuals with nursing degrees from their country and those interested in pursuing nursing careers in Germany. The German government actively encouraged first-generation immigrants to participate in the workforce, particularly in sectors facing labor shortage, such as geriatric care sector (Duell and Vetter 2020).

Employment is widely recognized as a successful strategy for the integration of refugees into their new host country (Hussein et al. 2011). However, previous research has shown that first-generation immigrants who start working in their new environment often encounter various barriers. Some scholars argue that caregivers trained in non-European countries may lack certain knowledge and skills. Consequently, they are typically required to undergo retraining programs and obtain specific qualifications to meet the standards of the host nation (Muller et al. 2017). Cultural differences, including variations in cultural values and communication styles, combined with limited language proficiency, pose significant challenges for these first-generation immigrants, as they may struggle to understand the demands of the new health care environment (Moyce et al. 2016; Xiao et al. 2014). Furthermore, first-generation immigrants from non-European countries often face racism and discrimination, not only from their colleagues, but also from their clients. Clients may resist their care, and colleagues may be reluctant to work alongside them (Kingma 2018; Ulusoy and Schablon, 2020; Zhou 2014).

To mitigate these difficulties, it becomes necessary to enhance cultural competency among all staff (Maltby et al. 2016) Cultural competence entails the ability to communicate effectively and behave appropriately in intercultural settings, based on one's intercultural knowledge, skills, and attitudes (Deardorff 2006: p 247–248). Consequently, some health care institutions that recruit international staff from outside Europe offer their staff cultural competence training. The objective of such training is to enable established staff and first-generation immigrants from various cultures to interact with and learn from one another, which can contribute to improved team collaboration. This aligns with the perspectives of nursing scholars who argue that robust team collaboration benefits clients and enhances the quality of care (Benner 2019; Eika et al. 2015; Schilgen et al. 2019).

In 2015, when a large group of refugees arrived in Germany, the management of a residential home in a small German town, recognized an opportunity to engage some of the first-generation immigrants in the field of geriatric care. They viewed this as a mutually beneficial arrangement. On one hand, the residential home could offer the first-generation immigrants a nursing orientation and job opportunities. On the other hand, the immigrants could alleviate the heavy workload borne by established caregivers. To prepare the entire staff for this diverse workforce, cultural competences training was provided. The recruitment of new staff and cultural competence training held the promise of fostering good team collaboration.

In every culture, care is central to daily practice. While nursing practices worldwide share commonalities, what counts as *good* care varies from one country to another. Good care is characterized as a cultural mode, a specific style, and a way of doing. Care practices reflect the values of caregivers and what matters most in a particular situation (Mol et al. 2010). Providing care is, therefore, a normative activity that involves daily tinkering (Mol et al. 2010; Moser 2008; Pols 2013). Tinkering is defined here as the activities through which caregivers adapt, attune, and calibrate their work to align with the goods or values that matter most in that particular time and context (Mol et al. 2010). Additionally, nursing care is influenced not only by societal, cultural, and political factors, but also by organizational standards, rules and regulations. Consequently, what qualifies as good care practice depends on how care is shaped by society and institutions, such as how older cognitively frail individuals are cared for in our society and how care workers tinker with the values that matter in geriatric residential homes. People working within the same country and similar circumstances, like caregivers in a residential home, are more likely to share certain habits, skills and dispositions that translate into similar practices and representations (Bourdieu 1990).

This paper centers on the day-to-day interactions between the established caregivers and first-generation immigrants, once the latter begin working in the residential home. Throughout this paper, I refer to first-generation immigrants as 'immigrant newcomers', signifying their new role in the German residential home. The central research question is: How do immigrant newcomers and established caregivers tinker with values to enact good care for geriatric residents with dementia in a German residential home? The aim of this study is to gain a deeper understanding of how established caregivers and immigrant newcomers enact care for older people with dementia.

Good care and tinkering in geriatric care: situational acting

The theoretical frameworks for this study drawn upon Pierre Bourdieu's concepts of 'habitus' and 'feel for the game,' as well as the concept of 'tinkering' introduced by the Dutch philosopher Annemarie Mol. According to Bourdieu (1990) individuals develop a habitus over their live times, i.e., a set of ingrained habits, skills, and dispositions shaped by their environment or social 'field.' Within fields, like elderly health care, individuals accumulate cultural, symbolic, and social capital through interaction with others (Bourdieu 1990; Mendoza et al. 2012). The field of elderly health care can be perceived as one such context. Continuous negotiation within this field cultivates a 'feel for the game,' where caregivers acquire practical knowledge and a sense of how to behave in various situations over time (Bourdieu, 1990; Mendoza et al. 2012). The daily routines of the residential home shape caregivers' habitus, and in turn, they shape the routines.

The field of health care for geriatric residents constitutes an ongoing dialectical interplay between the externalization and internalization of practices, skills, and dispositions. This study places central importance on how the values and practices of established caregivers and immigrant, referred to as their 'feel for the game', evolve, intersect and find resolution. To further elucidate this focus on the habitus of established caregivers and immigrant newcomers, we draw upon the insights presented by Mol et al. (2010). Mol argued that the manifestation of good care frequently emerges through a process she terms, 'tinkering'.

While the concept of tinkering, as defined by Mol, is not widely recognized, it underscores that the quality of care that takes form within close interpersonal relationships (Mol et al. 2010). Determining whether a practice qualifies as good care cannot be undertaken in isolation from these relationships (Moser 2008; Struhkamp 2004).

In each residential care facility, a distinct system of standards, rules, and protocols has been devised with the objective of enhancing the quality of care for its residents and safeguarding them against unacceptable and unnecessary interventions (Pols 2013). Both institutions and caregivers adhere to these protocols and standards. However, they are also guided by their own set of values and goods that inform their actions in the realm of nursing care. These values represent a myriad of goods that hold relevance for practice. When different goods find themselves in juxtaposition, caregivers frequently navigate their actions towards the good that matters most at that particular time and place, a concept often referred to as situational acting (Mol et al. 2010; Moser 2008).

Care plans, nursing goals, and protocols of evaluation are considered important professional instruments for operationalizing and measure the quality of care (Struhkamp 2004). However, processes such as goal setting are seldom straightforward endeavors. Moreover, while the concept of goal setting within nursing care plans may be theoretically good, its practical implementation does not invariably lead to optimal care outcomes (Struhkamp 2004). Consequently, a certain level of ambiguity persists between theory and practice. Furthermore, it is important to recognize that geriatric residents with dementia have wishes, needs and desires that they cannot always clearly articulate (The 2017). In the setting of a residence for older adults with dementia, these individuals frequently face challenges in setting their own care goals. Consequently, they rely on (social) support from the staff to address their needs and desires (Moser 2008; Struhkamp 2004).

In this study, therefore, good care is supposed to be the outcome of the tinkering of established caregivers and immigrant newcomers between different sets of care values, which, in specific situations, may either clash, align, or intersect with each other. Caregivers have the capacity to enact various forms of good care, and a single health worker may engage with different sets of values associated with good care in distinct situations (Pols 2013). Moreover, it is important to note that different values hold relevance within distinct contexts and different situations. In the realm of daily practice, the coexistence of conflicting values can give rise to tensions, but it is also plausible for these values to manifest concurrently. Thus, in one situation specific values may come to the fore, while in a similar situation an entirely different set of values may come into play. As mentioned earlier, this raises the question of how established caregivers and immigrant newcomers tinker with values in order to enact good care for geriatric residents with dementia in a German residential home?

Design

To gain a deeper understanding of how established caregivers and immigrant newcomers tinker between different values of care in the context of a German residential home, this study used an ethnographic approach with a primary focus on participant observation/shadowing (McDonald 2005). Ethnography was chosen to provide rich and detailed *thick descriptions* (Hammersley and Atkinson 2019). It enables not only insight into what people think, but also into what they actually say and do in a particular situation.

Data collection

This study is part of a broader ethnographic Ph.D. research project (Ham, 2020, 2021a, 2021b). The first part of this project focused on the workforce integration of first-generation immigrants with a refugee background in a Dutch residential home in 2016 and 2017. The current article presents findings from the second phase, which data was gathered in 2018 in a German residential home for geriatric residents with dementia. Online surveys or qualitative questionnaires do not yield satisfactory results in the search of meaning and value. Therefore data was collected through methodological triangulation (involving participant observation/shadowing, interviews, and focus group discussions). Methodological triangulation is utilized as a strategy to enhance depth and achieve a more comprehensive understanding of the data (Hammersley and Atkinson, 2019; Thorogood and Green 2013).

The German residential home provided first-generation immigrants with a three-month orientation course in geriatric nursing. Sixty-nine first generation immigrants were recruited for this course and divided into five different groups (Ham 2021b). This article focuses on one of these groups, which consisted of a total of seventeen people, all with a refugee background. They immigrated from non-European countries (Uganda; Togo; Syria; Afghanistan; Azerbaijan; Iraq), with German not being their first language. Among them were eight women and nine men, their ages ranged between 20 and 55 years. Their length of stay in Germany varied from three months and three years. They had different educational backgrounds, such as technology, pedagogy, or philosophy, with work experiences of 0–30 years. The residential home wanted to recruit immigrants with a nursing background, however, they were difficult to find. Three participants had previous nursing experience; two had obtained a nursing diploma in their home country and one had gained nursing experience during the war. However, their foreign caring diplomas were not recognized by German authorities.

The residential home residents were all white and native Germans. The established staff consisted of native Germans and immigrants, most of whom were born in other countries, such as Poland, Bulgaria, Congo, Russia, and Turkey, aged between 18 and 65 years. They worked in the department as nursing managers, nursing teachers, nurses, nurse assistants, or as helpers. Their length of service varied from 2 to 30 years. Most of the nurse assistants or vocational trained nurses worked in accordance with nursing level 2 or 3 of the German Qualification Framework (GQF) (see Table 1). The native Germans worked in accordance with nursing level 3 to 4 of the GQF.

The participants gave their informed consent before the start of the participant observation /shadowing, the interviews, and focus groups. Oral and written information was given by the researcher to the participants during the first meeting in the residential home. The aim and method were explained to the participants in German and English. Information was provided that they were free to withdraw from the study at any time and they were assigned pseudonyms. The researcher contacted three of the immigrant newcomers (who had experience in nursing in their home country) by text message to decide on days and time for shadowing.

Data collection was carried out by the author, a Dutch anthropologist with a nursing background, who closely followed the immigrant newcomers during the period of their three-month orientation course in the German residential home.

Participant observation was conducted between July to September 2018 for two to three days per week during classes, meetings, and internship hours (200 h). Seventeen recently arrived refugees were observed during the three-month training program. Two months were theory and one month was an internship. Three of the immigrant newcomers were observed after the training program during their internship in the department because theory might differ from practice and what

Table 1 Nursing care staff in Germany.

English title	German title	German qualification level[a]	Training length (in years)
Baccalaureate-educated registered nurse	Bachelor Pfleger/in	6	4
Occupation vocationally-trained nurse	Altenpfleger/in	4	3–5
Nurse assistant	Gesundheits-und Krankenpfleger/in	4	3–3.5 3– 3.5
	Krankenpflegerhelfer/in	3	2
Nurse assistant	Pflegerassistent/in	3	2
Nurse aide	Altenpflegerhelfer/in	2	2
	Alltagsbegleiter für Menschen mit Demenz		12 weeks

[a]According to the German Qualifications Framework (GQF) (OECD 2022).

Table 2 Overview of data analysis following thematic analysis.

Phases of data analysis (four stages)		
First	Reading the fieldnotes and transcripts (observational practices, meanings and experiences in transcripts) and rereading several times. Purpose: Familiarization with the field and tentative understanding of participants' experiences in workforce and transcripts as a whole. Transferring selected topics in chronological order to text documents using Atlas-ti. Emic codes were applied. Result: Simplifying the reading of selected fieldnotes and transcripts.	Emic codes
Second	Reviewing and quoting text documents on significant aspects. Each code compared to the others. Some codes were merged together. Purpose: identifying differences, similarities and patterns. Creating xx and quotations.	Codes merged together
Third	Delimiting the theory by comparing the segments. Thematic elements and etic codes were used. Comparison of codes and identification of themes in fieldnotes and transcripts followed by peer discussion. Purpose: translate these abstractions and theories as sensitizing concepts for guiding the data analysis.	Etic codes
Fourth	Describing thematic elements across fieldnotes and transcripts. Presenting the interpretation of the data analysis to participants to validate the understanding. Purpose: Strengthening of research findings through member reflections.	-

people express in the classroom may diverge from their actions in the department. The researcher participated in the training program and in caregiving activities within the department assuming the role of a participant observer. During this process, the researcher diligently recorded fieldnotes based on her observations, and obtained additional insights through informal conversations.

A total of twenty-four in-depth interviews were conducted with participants who had been enrolled in the three-month orientation course offered by the German residential home; six immigrant newcomers, with seven established caregivers (vocationally trained nurses and nurse assistants), six managers, and five teachers. The in-depth interviews were conducted because they allowed for the exploration of topics that had emerged from the data and were considered important by the participants. Thus, these interviews were guided by the data and provided room for individual participants to elaborate on their perspectives and experiences.

These interviews focused on 1) differences and similarities between the different values of immigrant newcomers and established staff members, 2) challenges and barriers encountered in the ward, and 3) notions of good care. The interviews were conducted in the residential home, with each session lasting between 45 and 60 min. All sessions were audio-recorded and transcribed verbatim in German.

Additionally, two focus group discussions were conduced to gain insight into the experiences, discursive repertoires, and ideas of each group (Silverman, 2013). One focus group consisted of six newcomers, the other of six established caregivers to explore their perspectives, values and norms and tinkering in practice. According to the theory of social psychology, individually constructed perspectives can be further explored through interactions with others (Ryan, Gandha et al., 2014). The topics that emerged from the data were, 1) the immigrant newcomer's project 2) the collaboration between established staff members and newcomers, and 3) notions/values of good care. These sessions were also held in the nursing home. They lasted between 90 and 120 min each, were audio-recorded and transcribed verbatim in German.

Data analysis

Ethnographic fieldnotes and transcripts were read and re-read by the researcher to develop familiarity with the data, and then analyzed using the constant comparative method (for specifications of the study's process, see Tables 2 and 3) (Brear 2019; Glaser 1965). The constant comparative methodology is a continuous comparison of theory and data and incorporates four stages (Glaser, 1965). In the first stage, an open inductive coding process was used to unravel the full range of observed practices, meanings, and experiences. During this stage, *emic* codes were applied (Hammersley and Atkinson 2019). These codes consisted of words and descriptions used by the participants, such as 'rules,' 'hard worker,' 'collaboration.' 'theory in class.' In the second stage, each code was compared to the others to identify differences, similarities, and patterns. Some codes, such as 'collaboration' and 'teamwork,' were merged. Stage three included delimiting the theory by comparing the segments. In this stage, *etic* codes, such as Bourdieu's notion of 'habitus' and Mol's notion of 'tinkering' were used as sensitizing concepts to get a certain kind of guidance to the data (Hammersley and Atkinson 2019). For example to distinguish routines or a 'feel for the game or to distinguish tinkering with colleagues, structures or values. Atlas.ti 10 software was used to generate *emic* and *etic* coding (Hammersley and Atkinson 2019). (4) to write the different situations about the enactment of care and (conflicting) values. With the combination of inductive and deductive analysis, a deeper understanding of care situations and the different and conflicting values emerged from the data. It appeared that caregivers had to

Table 3 Illustration of data analysis: Identifying meaning units (coding), clustering, and identifying themes.

Written language	codes	Code group	Theme
Birmasa, an established nurse, starts writing the nursing files.	Writing files	Norms (institutional)	Institutional accountability
Mohammed looks in the cupboard and comes across a German game: Man, don't get annoyed [*Mensch ärgere Dich nicht!*]. He puts the box on the table and calmly takes a seat opposite Mr. Feiliger: "Please, Mr. Böhmig, take a seat and play with us." While the three men play the game, Mr. Feiliger keeps repeating its rules. Mohammed and the men laugh, and no one gets annoyed.	Playing a game	Norms (habitus)	Personal well-being
Usually, there should be two skilled workers, but this frequently does not occur. Everything needs to be done quickly, quickly and quickly, she sighs.	Everything has to be done quickly	Norms (Tense time)	Efficiency
'When entering the residents' room, it is important to knock on the door and await a response, Approach the resident by addressing them by name and inquire if she would like a cup of coffee. Familiarize yourself with the resident's background and preferences. Ask about their ability to wash themselves and offer, assistance if required. Strive to empathize with, observe, listen to, comprehend, and ultimately acknowledge the resident as an individual with their distinct identity, values and preferences'.	It is important to ....be empathetic, observe and listen.....	Norms (institutional)	Carefulness
Mrs. Doldermann.....She stands completely naked, her arms in the air. Mrs. Doldermann pushes her clothes aside with her bare feet before sagging to the ground, her nude body lying on the carpet.	Completed naked.....nude body on the carpet	Integrity of the body	Dignity
Several residents are fixedly gazing at her. Mrs. Zierentz sighs and closes her eyes, Mrs. Mezel stands up and walks away. Mr. Vierbaum shouts: "No, no, not again! [*Nein, nein, nicht wieder!]* " as he looks to the ground with furrowed brow.	Sights and close eyes. No, no. not again.	Disturbing	Tranquility

tinker with three different sets of values of care, i.e., institutional accountability or personal well-being, efficiency or carefulness, tranquility or dignity. To improve the *credibility* and *validity* of the study, a *member reflection* was conducted through respondent validation, and the preliminary main findings were presented to the participants (Brear 2019). The participants affirmed that the findings reflected their views, feelings, and experiences.

Findings

The German residential home studied here provided care to psychogeriatric residents. From 2017 to 2019, the facility conducted a project called Asylum Seekers and Refugees as High Potentials in Germany, a Model Project in Social Affairs [*Asylbewerber und Flüchtlinge als Potenzialträger in Deutschland, ein Modellprojekt im Sozialwesen*, from now on referred to as AFP]. Sixty-nine first-generation immigrants from different countries, all from outside Europe, were recruited. Five different groups were admitted to five successive AFP projects, each one holding between 12 and 18 participants. Additionally, each project included an educational program, trainee for dementia assistants [*Auszubildende zur Dementzbegleiter/in]*. The residential home wanted to provide opportunities for first-generation immigrants to explore whether they would like to be trained as an occupational nurse, assistant, or helper/nurse aide in a nursing home (Table 1). The two-month 'Care for the Elderly' course covered basic knowledge and skills in psychogeriatric care. The third month involved an internship in a psychogeriatric ward.

The nursing home management supported the established staff by offering them a cultural awareness and sensitivity course called 'Care in a Cultural Context.' In order to ensure good collaboration, the established employees completed a short training program (12 h) with the aim of stimulating dialogue and looking for similarities, without judging the differences. The content of the training "care in a cultural context" was: multiple identity and factors influence human identities, biography, diversity in health care, explanatory models, (illness, disease, sickness), medical pluralism, caleidoscopia game, intercultural communication, Tongue, Order, Person, Organisation and Intentions [TOPOI] model, prejudices and stereotypes, and geography, and citizens in town. Some established staff members thought it was a good training and learned to ask questions to their new colleagues, others were more skeptical, saying that the new staff would not relieve them of their work. They were angry that, in addition to the heavy workload in the department, they were now also required to participate in this training, which was mandatory.

For this study, we chose the third AFP project group, when the residential home had already gained experience with two other groups of refugees. The results in this paper do not show the different *perspectives* of good care of the participants, but rather the specific situations in which established staff and immigrant newcomers *enact* care (Mol et al. 2010; Moser 2008; Pols 2013; Struhkamp 2004).

Institutional accountability or personal well-being

During the in-class theoretical course and also during the focus group, the immigrant newcomers shared their views regarding geriatric care. They all wished to enact good care by living up to the principles of equality and dignity, by placing themselves in the position of the geriatric residents with dementia, by listening to them, showing respect, and attending to residents' needs. These views were in line with the vision of the institution. However, in health care, shared values of care are never specific enough for a caregiver to know how to act in each situation. One of the newcomers said in the in-depth interview that he found it hard to know what was expected from him. During their internship, the immigrant newcomers realized that they were not familiar with the daily routines in the department. How caregivers tinkered with different values of care was influenced by the rules, regulations, and institutional protocols of the residential home. All immigrant newcomers agreed that the formal standards of the home were of high quality. They appreciated how those standards structured the daily practice—the punctuality of their established

colleagues, their ability to organize and plan, and their professionalism. However, if different values were involved at the same time, protocols provided insufficient guidance, and choices had to be made. The following situation illustrates that different values of care can work next to each other:

> Birmasa, an established nurse, starts writing the nursing files. Mohammed looks in the cupboard and comes across a German game: Man, don't get annoyed [*Mensch ärgere Dich nicht!*]. He puts the box on the table and calmly takes a seat opposite Mr. Feiliger: "Please, Mr. Böhmig, take a seat and play with us." While the three men play the game, Mr. Feiliger keeps repeating its rules. Mohammed and the men laugh, and no one gets annoyed. (Fieldnote dd. 01.07.2018)

In this situation, Birmasa and Mohammed engaged in different practices of care. By filling in the nursing reports in the office, Birmasa acted in accordance with the value of institutional accountability. The daily team meetings were structured around those reports for the purpose of continuity of care and information exchange. In turn, Mohammed, by playing a game of *Mensch Ärgere Dich nicht* with two elderly residents, attended to another value of care, i.e., the improvement of personal well-being. He told us afterwards that it was common in his home country for elderly men to play board games. Thus, playing a game with the two residents was part of his *habitus*. In this situation, the two values of care, did not exclude each other, but were enacted by different workers simultaneously.

Efficiency or carefulness

For the immigrant newcomers, it was not always clear what the established staff expected from them. During the interview, one of the immigrant newcomer said that they received conflicting messages; the established staff members issued strict orders while also expected them to demonstrated initiative. There were some established caregivers who appreciated the input of their new colleagues, but others were impatient. Some even refused to work with them. They accused their new colleagues of not showing initiative and not doing what they were told. Not knowing the German language was a main stressor. Some eventually decided to ignore the immigrant newcomers. They harbored feelings of resentment, some even feared to lose their job to them. The immigrant newcomers realized that due to the staff shortage they had to work hard and frequently on their own. One of the immigrant newcomers said that, although he had worked as a nurse for years, he knew he needed to adapt to a different way of caring. While in their home country nurses' work had mainly focused on aspects of medical care, how he was expected to attend more to the general well-being of residents. Washing residents, for instance, had not been part of a nurse's professional habitus: now it was.

In the focus group, the established employees said that they delegated responsibilities to their new colleagues, but that this did not really relieve them of their more demanding duties. During fieldwork it was seen that Asmat (immigrant newcomer) tried to live up to their expectations to work efficiently. How this worked out is shown below:

> It's 06.45 h; Vera sighs: "Two colleagues just called in sick, so today we are with three instead of five care workers; Asmat, you must go to the right wing of the ward and wash all 15 residents. I will go to the left." Hastily, Asmat takes a washing trolley and pushes it down the corridor. He opens the door of Ms. Schweigers' room. "Good morning," he greets, with a big smile on his face, "did you sleep well?" Ms. Schweigers, sitting on the bed in her white pajama, smiles when she sees us. With a laugh, Asmat approaches her and takes both her hands. "Come," he says, quickly lifting her up from the bed, "let's dance." Holding her hands, he moves her arms up and down. She grimaces with big eyes, not saying anything. Quickly, Asmat catches her when she almost falls, and with a little push he flops her onto the bed again. Ms. Schweigers grins. "Ha-ha!" Asmat laughs loudly, "don't fall!" Then he swiftly pushes her pajama trousers to her ankles. "Let's take a 'pipi' [urinate]," he says. He raises her up again and holds her hands. Ms. Schweigers sighs. They shuffle to the bathroom together. Ms. Schweigers walks barefoot, with small steps; her underwear and trousers are around her ankles. In the bathroom, Asmat quickly puts her on the toilet and says again: "Just make a 'pipi.'" As she sits on the toilet, he quickly washes her face with a washcloth. "We need to hurry up," he says. He removes her pajamas, washes her body, and helps her into her jogging trousers and a t-shirt. Then, Asmat holds her hand and opens the door to the corridor. "Oh," he says, "wait." He rapidly returns to the bathroom and comes back with a deodorant spray: "We forgot this." With a smile, he sprays the deo all over her clothes: "It's important that you smell clean." He grins, guides her to the breakfast table in the living room and then rushes to the room of the next resident. (Fieldnote, dd. 30.07.2018)

In this situation, Asmat efficiently completed his tasks within the allocated time, mirroring the approach of his regular colleagues. However, upon closer examination, it becomes evident that the manner in which Asmat provided care deviated significantly from what he had learned during his training. His training had emphasized the need for a specialized approach in caring for people with dementia:

> 'When entering the residents' room, it is important to knock on the door and await a response. Approach the resident by addressing them by name and inquire if they would like a cup of coffee. Familiarize yourself with the resident's background and preferences. Ask about their ability to wash themselves and offer assistance if required. Strive to empathize with, observe, listen to, comprehend, and ultimately acknowledge the resident as an individual with their own distinct identity, values and preferences'. (Respondent X, AFP Teacher)

When we compare these instructions with the actual choreography of the interaction between Asmat and Ms. Schweigers, it becomes evident that Asmat's care leaves a lot to be desired: he entered Ms. Schweigers room without knocking, nearly allowing her to fall, had her shuffling with her trousers hanging around her ankles, washed her face while she was using the toilet, and sprayed deodorant on her clothes. Although Asmat's maintained a cheerful and friendly demeanor, his eagerness to complete every task on his to-do list within the allotted time, led him to place Ms. Schweigers in undignified positions. We cannot ascertain whether Ms. Schweigers herself perceived this situation as such: she remained silent, merely grinning and sighing. Like many individuals with dementia, she may have been unable to express or even experience irritation, shame or fear (Moser, 2008). However, for the quality of care, this is immaterial: values such as carefulness, decorum and decency remain paramount, whether a resident is aware of the impropriety of her situation or whether others are present to witness it. Despite Asmat's colleagues appreciating his efficiency, their lack of supervision prevented them from recognizing that this came at the expense of his carefulness.

Tranquility or dignity

In accordance with the mission and vision of the nursing home, all caregivers were expected to uphold the dignity of geriatric residents. Dignity is intrinsically linked to the integrity of an individual body and mind, yet it also contingent upon the perceptions and experiences of others regarding what they consider dignified or undignified behavior and appearance (Nordenfelt 2014; Rejnö et al. 2020). Therefore, when someone's dignity is violated, it has repercussions not only for the individual involved but also for the overall tranquility and harmony of those who witness it, as illustrated in the following case:

> Mrs. Doldermann, a resident with curly gray hair, comes around the corner to the living room, screaming. Her face is red, her cheeks sunken, and her upper lip quivers before she starts yelling again. The shrill noise does not sound as if she is in pain. Suddenly she pulls off her joggers and t-shirt and throws them onto the floor. She now stands completely naked, her arms in the air. A few residents are staring at her. Mrs. Zierentz sighs and closes her eyes, Mrs. Mezel stands up and walks away. Mr. Vierbaum shouts: "No, no, not again! [*Nein, nein, nicht wieder!]* " as he looks to the ground with furrowed brow. Vera, one of the German careworkers, looks at Mrs. Doldermann and then walks past her to the corridor. Mrs. Doldermann pushes her clothes aside with her bare feet before sagging to the ground, her nude body now lying on the carpet. It seems as if she is in another world. After a while, Mr. Weiss, one of the residents, bends over her: "Dear, please come" [*Liebe, bitte komm doch mal*], he whispers. Slowly, she gets up. Mr. Weiss gently pats her shoulder. She turns her head toward him, her doll-like eyes distracted and confused. She slowly stands up and lets him guide her to the lounge. They then sit next to each other on the couch, she shivers, his hand gently takes her tiny one and soothes her, whispering: "shhhhh, shhhhh". (Fieldnote dd. 02.08.2018).

During the fieldwork, I observed several anxiety attacks experienced by Mrs. Doldermann. In these instances, staff often did not intervene. On one occasion, two staff members simply walked past her. In a subsequent conversation, Vera explained: "If we bring her to her room, she tends to cover herself with feces, so we'd rather keep an eye on her in the living room." Mrs. Doldermann's nakedness and agitated behavior conveyed a profound loss of control. The response of other residents clearly indicated their embarrassment and distress, witnessing her agitation and nudity in a public space, which compromised Mrs. Doldermann's dignity. However, when she covered herself with feces in her room, as Vera and Brev pointed out, her dignity might have been further compromised. Additionally, the caregivers would be tasked with cleaning the mess; a challenging and unpleasant duty. Therefore, they chose to allow her to remain nude on the floor for a while, even though it infringed upon her dignity and disrupted the tranquility of other residents.

At first glance, this case may appear to illustrate the so-called tragic dilemmas that employees sometimes face - situations where they must choose between, or tinker with two undesirable outcomes. In this instance, the dilemma was between accepting Mrs. Doldermann's public nudity, thus violating her dignity and disturbing other residents' tranquility, or confining her to her room where she would soil herself and her surroundings. The latter option would also infringe upon her dignity, albeit not in front of all residents, and burden the caregivers with the unpleasant task of cleaning up the mess. However, framing the dilemma in this manner, blinds us (as it did Vera and Brev) to the existence of other potential options. To enact good care, Mrs. Doldermann's agitated behavior could have been addressed by someone guiding her to her room and staying with her to prevent harm or soiling. This individual could have truly listened to Mrs. Doldermann's narrative, understood her past, and acknowledged her various identities. They would have approached her as an individual with needs and desires, rather than solely as a patient with an illness requiring sedation. The challenge, however, was that Vera and Brev were responsible for the care of 40 residents. Given the severe shortage of staff, the best option of care they could think of was simply to leave Mrs. Doldermann alone. The demanding circumstances not only impacted the established staff and their interactions with new employees but also influenced human dignity and the way care for geriatric patients was enacted.

Discussion

This paper offered insights in what constitutes good care practice in looking after older cognitively frail people in a geriatric residential home in Germany, and how ageing societies and their advanced economies manage the workforce demands arising from growing numbers elderly through recruiting new immigrants. In addition, this article examined the extent to which new dilemmas arise around the cohesion of an appropriate culture of care by integrating immigrant newcomers and established caregivers who enact care for geriatric residents with dementia in a German residential home. The results showed how they tinkered with different values when caring for the geriatric residents with dementia. For the immigrant newcomers, working in a German residential home required them to adjust to a new caring field, which meant that some aspects of their previous education and (work) experiences were no longer useful. They needed to get a 'feel for the game' of institutional geriatric care. The analyses showed how they cared for residents with dementia in situations in which different values were at stake and sometimes conflicted. Three modes of tinkering merged from the data, i.e., tinkering between the values of institutional accountability or person well-being, efficiency or carefulness, and tranquility or dignity. The quality of care depends on the extent to which caregivers are able to compromise between, or tinker with, different values of care. This study indicated that the enactment of care must be discussed in the context of institutional work conditions, organizational structures, and workforce processes. This paper showed how the established caregivers and immigrant newcomers tinkered with values to find good solutions. Caregivers needed a feel for the game to enact good care. This is in line with the anthropologist The (2017) who argues that a social approach to individuals with dementia is needed; to approach an individual with multiple identities with wishes, desires, and needs. Geriatric residents with dementia are not empty debilitated patients. A social approach makes the interaction between caregivers and people with dementia more bearable and meaningful.

To gain a deeper understanding of the enactment of good care by the established caregivers and immigrant newcomers when caring for residents with dementia, Mol's concept of tinkering provided a useful lens through which to understand interaction in daily practice. The concept of tinkering as applied to care work makes clear that different views of 'good care' can reflect different values operating within different situations. According to (Mol et al. 2010), good care is uncertain and precarious. To enact good care requires a constant tinkering between the different goods in connection with those who attune the different goods that matter most at that particular time, context, and place (Mol 2008, p 85). Each element of tinkering reflects a framework in which certain activities can be thought of as good, in specific circumstances (Mol et al. 2010, p 14). However, the concept of tinkering has three limitations.

First, the concept of tinkering ignores the general lack of recognition given to the moral worth of care workers, and the sense of their valued professionalism within formal care. Engaging in emotional labor, wherein care staff must regulate or suppress their emotions in exchange for wages, can be a significant job stressor leading to burnout (Jeung et al. 2018 p 187). It is essential to increase appreciation for healthcare professionals and mitigate the adverse effects of emotional labor while developing coping strategies to unlock their full potential. Strengthening the appreciation of care staff's professionalism can also contribute to the enhancement of care in long-term care practices (Kadri et al. 2018).

Second, the microsocial approach of tinkering can easily lead to the oversight of the influence of the broader contextual factors, such as organization dynamics and societal political structures. During the period of this research, for example, the emerging anti-immigrant rhetoric in Germany resonated in the day-to-day interactions within the residential home workplace. Research has demonstrated that discrimination and racist practices are prevalent not only in German society at large but also within (healthcare) organizations like German residential homes (Ham 2021b; Ratfisch and Schwiertz 2016; Schilgen et al. 2019; Ulusoy and Schablon 2020).

The third limitation of the concept of tinkering is its failure to account for factors such as the influence of organizational power and institutional structures. A closed ward within a residential home for people with dementia represents a protected and isolated environment that prevents others from entering easily, while what happens inside does not easily become known to the outside world (Olakivi 2017; The 2008). In fact, the layers of protection surrounding the care of people with dementia, including the pain of caregivers that management does not really care for them, as I showed in other articles (Ham 2020; 2021a; 2021b) make it difficult to bring issues of deteriorating care to the attention of higher political authorities. While an aging population and a structural shortage of caring staff in this German facility created a demanding workload, caregivers felt that their voices had little to no weight, further limiting their ability to enhance geriatric care. When no one assumes full responsibility for the overall quality of care, especially within institutional geriatric care, the risk of growing indifference toward geriatric care rises. Overemphasis on efficiency within an institution can lead to a system that erodes caregivers' moral considerations, resulting in routine and thoughtless work. Additionally, structural labor shortage and organizational constraints can hinder caregivers' ability to envision opportunities for enhancing care. As a result, caregivers in a residential home for geriatric residents with dementia who are not afforded the opportunity to reflect on the caregiving practice, may be reluctant to intervene in the ongoing process of dehumanization, even though they witness it daily (McHugh et al. 2011). At times, caregivers face dilemmas when they lack time to provide adequate attention to geriatric residents with dementia due to a structural shortage of staff or a shortage of personnel with the necessary skilled and experience. In the German residential home studied here, half of the staff consisted established caregivers, while the other half comprised immigrant newcomers who lacked the necessary qualifications. The latter group was less familiar with the increased complexity of the residents' conditions and their personal backgrounds, and this had implications for the quality of daily care. A heavy workload led to staff illnesses and high absenteeism rates. Employees who could no longer manage the demanding workload and felt that their voice were not valued became demotivated. Staff time was predominantly occupied by basic care tasks, and agitated residents were not afforded sufficient time or attention. Regardless of how diligently and efficiently caregivers worked, their tasks never seemed to be completed. Due to their lack of confidence in their ability to effect change in the situation, they became increasingly indifferent and less committed (Noordegraaf and Steijn 2013; The 2008). Thus, while both established caregivers and newcomers demonstrated a willingness to enact good care in their daily practices, their efforts were impeded by organization dynamics, structural limitations (including workload and high absenteeism), and the influence of broader societal developments (McHugh et al. 2011). To enable them to cope with the demanding workload, foster team collaboration, and promote the enactment of quality care for geriatric residents with dementia, it is essential to establish an appreciative support system for both immigrant newcomers and established caregivers.

Finally, one of the strengths of this study is that it not only involved interviews with established staff and immigrant newcomers to understand their perspectives on care but also included observations of their actual caregiving practices. While this research is part of a larger project, and a similar study was conducted in a Dutch residential home, it is important to note that these findings, centered on a single home for geriatric residents with dementia in Germany, may not be readily generalizable or transferable to other German care institutions. However, it is possible that other residential homes may recognize similar challenges faced by both established caregivers and immigrant newcomers.

Through this study, we explored the tinkering of values in understanding geriatric care and examined the various dilemmas that can arise among workers with different values. However, in making care into a laboring task that should be delivered with and through emotional and empathetic labor, various dilemmas (institutional constraints *and* emotional labor) must be recognized. Furthermore, we must contemplate how to establish a 'politics of care', aimed at creating optimal conditions for caring for our environment, our people and those who are vulnerable (Chatzidakis et al. 2020).

Conclusion

This study was conducted within the context of demographic change in an aging society and described how a German residential home coped with the increasing demand for labor resulting from a growing elderly population. In response to a severe shortage of staff, the facility recruited first-generation immigrants with refugee backgrounds. This study explored how first-generation immigrant newcomers and established caregivers in a German residential home tinkered between various values while providing good care for geriatric residents with dementia.

By examining the enactment of care, this study provided insights into how caregivers tinkered between market-driven values and the values of care that mattered most at that particular time and place. Some values took precedence while others receded into the background. This study showed that enactments of good care can be multifaceted, relational and context-dependent. For example, it illustrated how the value of institutional accountability can coexist with the value of personal well-being, but also how a focus on efficiency can potentially undermine carefulness.

Introducing market-based economics into service-driven systems like residential homes introduces market-oreinted valued such as productivity, efficience, and effectiveness. This can result in healthcare workers having to work faster and more efficiently, potentially overshadowing professional values like attentiveness and carefulness. This study highlighted how an excessive

workload can lead to the compromise of various values, violation of residents' dignity and disturbing the tranquility of geriatric residents. Additionally, it underscored how feelings of powerlessness can result in thoughtless behavior and hindered caregivers' ability to envision better ways to enact care at that specific moment.

Institutional constraints can exert significant influence on the interactions between established staff and immigrant newcomers, and thus their enactment of care for residents with dementia. We recommend that policymakers at both the national (macro) and institutional (meso) levels enhance working conditions, facilitate team collaboration, and establish a support network for both established workers and immigrant newcomers. This approach seeks to refine the diverse workforce, transitioning it into a more attentive workforce.

Data availability

Data generated or analyzed during this study are partly included in this published article. Other data cannot be shared openly to protect study participant privacy. The data for study were stored at the Hague University of Applied Sciences in accordance with Dutch General Data Protection Regulation (Alkemade & Toet, 2021).

Received: 20 August 2022; Accepted: 25 September 2023;
Published online: 09 October 2023

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Acknowledgements

I express my gratitude to the first-generation immigrant newcomers, the established staff members, and the geriatric residents for their willingness to participate in this research. I would like to thank Prof. Dr. Ria Reis and Dr. Baukje Prins for their support and guidance throughout this research. Additionally, I am grateful to Dr. Magdeline Aagard for her invaluable assistance in correcting my English. This study was supported by Netherlands Organisation for Scientific Research (Nederlandse Organisatie voor Wetenschappelijk Onderzoek: Grant number 023.008.044/1105).

Author contributions

The corresponding author is responsible for all aspects of this paper.

Competing interests

The author declares no competing interests.

Ethical approval

This study was approved by the Medical Ethical Review Committee of the Leiden University Medical Center in the Netherlands (code P16.087). The research was performed in accordance with relevant guidance/regulations applicable when human participants are involved and conducted according to the World Medical Association Declaration of Helsinki.

Informed consent

Informed consent was obtained from all participants and their legal guardians for participation in the study. All the participants received oral and written information about the study. Their informed consent was given prior to the start of this study. All names used in this paper are pseudonyms.

Additional information

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