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PRESENCE AS AN INNOVATION CONCEPT IN CARE: REFLECTIONS ON A PILOT STUDY

ABSTRACT

Presence as an innovation concept in care: reflections on a pilot study
The "Theory of Presence" (ToP) (Baart, 2001) is quite popular in different care sectors. Managers and professionals see possibilities for ToP as an innovation concept that can improve the quality of care. However, there are still several unresolved issues in the process of operationalization of the theoretical description of ToP to presence as a usable innovation concept. Our research question is therefore: to what extent can more clarity be found on: (a) the conceptualization of ToP from a change management perspective; (b) the impact of various learning contexts to teach ToP; (c) assessment of results of educational programmes; and (d) core elements of the individual learning processes involved in ToP? In this experimental pilot study, five educational programmes for caregivers were developed based on five different learning contexts (Ruijters, 2006) and

the caregivers' learning processes were followed. Baseline and repeated measures using the self-report presence questionnaire (PQ-C) (Kuis, Goossensen, Van Dijke & Baart, 2014) showed that participants progressed in four of the five educational programmes, demonstrating that the concept of presence can be taught in other ways than the traditional theoretical learning style. Based on the qualitative results we carefully conclude that three elements seem to characterize the individual learning processes that occurred in all five of the educational pilots: becoming aware of a relational dimension in care, evaluating one's own "being attuned" and using (one's own) practical examples. In an attempt to assess whether caregivers adopted ToP, the PQ-C, reflection diaries and in-depth interviews were used, of which none are without limitations for assessment of results of educational programmes in ToP. It became evident that a clearer concept, with precise criteria about when ToP is successfully adopted, plus a concrete operationalization are necessary to evaluate educational programmes in ToP and achieve a successful innovation of care practices.

Keywords

Theory of presence, educational programmes, assessment, adoption, innovation

SAMENVATTING

Presentie als innovatie concept in de zorg; reflectie op basis van een pilot studie
De presentietheorie (ToP) (Baart, 2001) is vrij populair in verschillende zorgsectoren. Zowel managers als professionals zien mogelijkheden om ToP te gebruiken als innovatieconcept voor de verbetering van de kwaliteit van zorg. Er zijn echter nog een aantal onopgeloste vraagstukken in het proces van operationalisatie van de theoretische beschrijving van ToP tot presentie als bruikbaar innovatieconcept. Daarom is onze onderzoeksvraag in hoeverre meer duidelijkheid gevonden kan worden over (a) de conceptualisatie van ToP vanuit verandermangementperspectief, (b) de impact van verschillende leercontexten om ToP te onderwijzen, (c) de evaluatie van de resultaten van scholingsprogramma's en (d) de kernelementen van het individuele leerproces in ToP. In deze experimentele pilotstudie zijn vijf scholingsprogramma's ontwikkeld voor zorgverleners, gebaseerd op vijf verschillende leercontexten (Ruijters, 2006). De leerprocessen van de zorgverleners zijn gevolgd. Voor- en nametingen met de zelfrapportage presentie vragenlijst (PQ-C) (Kuis *et al.*, 2014) laten zien dat deelnemers vooruitgingen in vier van de vijf scholingsprogramma's. Dit toont aan dat het concept presentie onderwezen kan worden middels andere leervormen dan de traditionele theoretische leerstijl. Uit de kwalitatieve data valt voorzichtig te concluderen dat drie kernelementen kenmerkend lijken voor het individuele

leerproces van deelnemers in alle vijf de verschillende pilots, namelijk bewustwording van een relationele dimensie in de zorg, evaluatie van het eigen "aansluiten bij de ander" en het gebruik van (eigen) praktijkvoorbeelden. In een poging om de resultaten van de scholingsprogramma's in ToP te evalueren, zijn de PQ-C, reflectiedagboeken en diepte-interviews gebruikt. Geen van deze methoden blijkt zonder limitaties om vast te stellen of zorgverleners werken volgens ToP. Het is duidelijk dat voor het evalueren van scholingsprogramma's in ToP en om te komen tot succesvolle innovatie van zorgpraktijken, een scherper concept met precieze criteria om vast te stellen wanneer iemand succesvol werkt volgens ToP én een concrete operationalisatie nodig zijn.

Trefwoorden

Presentietheorie, scholingsaanbod, evaluatiemethode, adoptie, innovatie

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INTRODUCTION

The "Theory of Presence" (ToP) (Baart, 2001) received a lot of attention in the Netherlands. It has appeared frequently in the literature (Paes, 2009; Schilling, 2003; Steketee & Flikweert, 2003), was the topic of PhD theses (Kal, 2001; Keinemans, 2010; Timmermann, 2010) and has been an inspiration for many fields of care (Baart & Grypdonck, 2008; Brinkman, Baart, Van Doorn & Van der Laan, 2004; Olthuis *et al.*, 2013). Care professionals are taught how to practise ToP, and managers and professionals see potential for ToP as an innovation concept to improve care.

Baart (2001) developed ToP based on empirical qualitative research in the tradition of "the grounded theory". A short definition of ToP is: a practice in which the caregiver relates to the other with attention and dedication; develops an understanding of what is at stake for the other (desires or anxieties, for example); realizes how the other needs them to respond and provides care accordingly

(Stichting Presentie, 2011). According to ToP, what is needed in the context of the caring relationship will become evident or more clear in a certain situation for this specific person, as will the appropriate response to the others' needs and fears. ToP therefore addresses the ability of care workers to adjust to their patients by being open and receptive to them. This results in opportunities for patients to open up more and experience "being seen", an existential experience of acknowledgment (Van Heyst, 2011). Being present also includes the objective of not abandoning the other either emotionally or relationally, but rather remaining dedicated to the other, even if no cure is available. So-called relational-based programming, which attunes care to the need of the other, contributes to the avoidance of mismatch, which could be described as "the non-correspondence of (care) supply and (care) demand and failures to connect care and need correctly" (Vosman & Baart, 2011, p. 207). Mismatch could be caused by a lack of acknowledgement of the other, even while medical-technical care is excellent.

Background

Health care professionals are being inspired to work according to ToP in fields including elderly care, palliative care and hospital care. Professionals, managers, trainers and consultants have endeavoured to understand the main concept of ToP and to translate this into recommendations, training modules, and evaluation criteria. Several unresolved issues had to be addressed during this process of operationalization of the theoretical description of ToP to presence as a usable innovation concept.

Firstly, significant fluidity in the conceptualization and meaning of "presence" was observed. The theory of presence (ToP) as described by Baart (2001) was established, consisting of a complex set of theories about suffering, "lifeworlds", relational attunement and more. There is a short definition as described above1 focused on searching for who the caregiver could *be* for the care receiver and what the caregiver could *do* for the care receiver (Stichting Presentie, 2011). Furthermore, the presence *approach* is said to be broader than ToP including research on ToP and different groups of clients in different practices (Brinkman *et al.*, 2004; Keinemans, 2010; Timmermann, 2010). However, none of these can be considered a clear concept of presence that can be operationalized in a clear way for improvement initiatives. International publications about presence *do* describe it as a concept (Covington, 2005; Doona, Haggerty & Chase, 1997; Gilje, 1992), although different definitions are given and debates about its meaning continue in the literature (Godkin, 2001). Defining a clear concept is challenging because ToP is an ambiguous concept; it is extremely complex. Understanding ToP requires caregivers to change their mental frameworks to be able to see things with different eyes than before. Adopting[2] it requires triple-loop learning, and affects the way people behave and think. It goes beyond learning certain skills.

It requires awareness of hidden habits or routines, and adopters' attitudes, perception and thinking need to be questioned. Triple-loop learning requires someone to be aware, or to become aware, of how language, assumptions, tacit thoughts, emotional reactions and mental models affect one's interactions (Isaacs, 1993). All in all, the concept of presence does not yet seem tangible enough to facilitate adopters of different backgrounds to understand it easily, resulting in possible difficulties in the adoption process. Crucial questions include the extent to which the clarity of the concept enables or frustrates the learning processes, and identifying the possibilities for clarification, as well as the consequences for successful innovation of health care if this does not happen.

Secondly, the standard introduction course to teach ToP has a theoretical learning style. Different students seem to learn in different ways, for example by reflecting on their work experiences. Would rethinking educational programmes according to the learning contexts of Ruijters (2006) be useful? Five different learning contexts were described: 1) copying the art; 2) participation; 3) acquisition; 4) experimentation; 5) discovery. To what extent would differentiation in educational programmes produce learning benefits? Following Kolb (1984), it is believed that every individual will have a preference for one or a combination of multiple learning contexts (Ruijters, 2006). We decided to develop five pilot educational programmes for ToP based on different learning contexts.

And thirdly, questions were raised about the possibility of assessing whether professionals improve when adopting ToP. How can we evaluate the results of educational programmes? When can we say that caregivers have successfully learned about ToP? Can criteria for successful adoption be formulated? Are norms available? Is it possible to define what is clearly not sufficient for working according to ToP? Clarification of these issues will help to improve innovation processes from a change management perspective.

AIM

The aim of this article is to reflect on conditions for ToP-based innovation in care from a change management perspective.
Research question: to what extent can more clarity be found on: (a) the conceptualization of ToP from a change management perspective; (b) the impact of various learning contexts to teach ToP; (c) assessment of results of educational programmes; and (d) core elements of the individual learning processes involved in ToP?

The remaining article describes the development of the educational pilot programmes, followed by an evaluation of the learning process based on quantitative and qualitative data, respectively.

In the discussion we reflect on the results and conditions for improvement of innovation opportunities.

METHODS AND RESULTS

Reflection on the research issues happened along the way of developing alternative educational programmes, identifying likely assessment methods and gathering data.

Development of the educational programmes

Developing new educational programmes requires conceptual clarity and transfer of the concept to new educational contexts. Experienced trainers in ToP were involved in developing and teaching the educational programmes. The process of development challenged the trainers as it touched on their insecurities concerning the extent to which the essence of ToP could be nurtured in the new learning contexts based on Ruijters (2006). It was also unclear if the caregivers would enjoy these different educational styles, or if adoption of ToP would progress. These different learning contexts and the content of the corresponding educational programmes are described in Table 1.

Sample

A convenience sampling procedure was used. Several care institutions showed interest in ToP, and five institutions were recruited to take part in this study. The institutions signed up their caregivers, both professionals and volunteers, to take an educational programme. Table 2 gives a description of the institutions. The prominent learning context of caregivers for each care facility was examined using the situgram developed by Ruijters (2006) to establish learning preferences. Based on the group's preferences, a match with an educational programme was made (see Table 2). Each pilot lasted approximately 6 days, spread across 4 to 7 consecutive months. All participants were informed that their data would be used to monitor the learning process within the study and that all data would be processed anonymously. Their identity would not be disclosed to the institution at any stage and the research team would maintain confidentiality concerning the information.

Evaluation of learning ToP: quantitative data

In order to learn more about assessment possibilities, an attempt to determine a baseline was made prior to the start of the educational programmes using the PQ-C under construction (Kuis

Table 1: Five contexts with some key words

Learning context	Key words	Accent in ToP educational program
Copying the art: learning by example and good observation, analysing what works and using that in one's own work	Role models, imitation from best practice, real-life, pressure	ToP experts were invited for informal question & answer sessions to share their work experiences. Participants asked questions based on experiences in their own work.
Participation: learning by discussion with others; this helps to sharpen and clarify their ideas	Dialogue with others, collaboration, discourse, trust	With a little (theoretical) input, group discussions were enabled in which conceptual knowledge, questions, tacit insights, cases and examples were shared and reflected on.
Acquisition: learning based on the transfer of knowledge, e.g. learning by lectures or reading books	Objective facts, transfer of knowledge from experts	Standard introduction course with a strong accent on reading the ToP book and plenary lectures, although different methods are also used such as video material and experiential exercises.
Experimentation: learning by applying what is learned in practice in forms like on-the-job training, work experience and role-play	Critical reflection, safe, experimentation, explicit learning	Sessions were developed with a strong accent on role-plays with an actor/ experienced (ex-)patient. Exercises and rehearsal, practice in one's daily work and reflection were key.
Discovery: learning by discovering things for oneself.	Meaning, deep understanding, inspiration, self-reflection	Participants were encouraged to search for information and develop creative solutions from ToP perspective for experienced problems and insufficiencies in their organization.

Note. Retrieved and adapted from Ruijters, Noorman, Rockwell, & Simons (2004).

et al., 2014). Participants filled out the questionnaire as a part of the educational programme. It was emphasized, however, that if people did not want to participate they could say so. The questionnaire was repeated within six months after course completion. The scale measures the extent to which professionals think they have adopted ToP. The PQ-C contained a total of

Table 2: Care facilities

Description of care facility	Pilot	Participants (N)	Data available
1. Addiction care centre. Division: supervised living/lodging.	Participation	7	PQ-C, RDT, RDP, IDI
2. Addiction care centre. Division: Day care and activity centre.	Copying the art	10	PQ-C, RDT, RDP, IDI
3. Christian centre for addiction care and psychosocial care. Division: Motivation centre.	Discovery	8	PQ-C, RDT, IDI
4. Organization that aims to contribute worldwide to improving the health and quality of life of substance users by providing information on AIDS and other health issues. Outreach and prevention.	Acquisition	5	PQ-C, RDT, RDP
5. Day care for homeless people, not addicted to hard drugs.	Experimentation	7	PQ-C, RDT, RDP, IDI

Note. PQ-C = presence questionnaire, RDT = reflection diaries trainers, RDP = reflection diaries participants, IDI = in-depth interviews.

64 items, e.g. "I find it important to understand the way in which my client views the world" and "Clients may test, move and entangle me". More information on the operationalization of the items is presented in Kuis *et al*. (2014). Items are rated from "1" (strongly agree) to "5" (strongly disagree). After an initial study into the factor structure of the PQ-C, 31 items were retained. These 31 items were used to calculate a sum score. Internal consistency of the 31-item questionnaire is good (α = .82) (Kuis *et al.*, 2014).

Baseline questionnaires were fully completed by 58 participants (92.1% of attendees). Follow-up questionnaires were fully completed by 45 participants (71.4% of attendees) resulting in 39 sets of complete data (61.9%). Because of the pre-post comparison design, any questionnaires that could not be paired with the companion instrument (pre and post) were excluded. Reasons for drop-out were job termination, transfer of occupants or illness. Two outliers were identified and excluded from

the sample because of extreme difference scores on the sum score (more than 3 SD from mean). The final sample included 37 participants. Participants had a mean age of 41.1 years (*SD* = 12.2, range 20 to 62 years). Their professional experience was 6.6 years on average (*SD* = 4.8) and the average time spent working for the care facility at the start of the pilot was 3.6 years (*SD* = 3.2). With regard to education, almost half of the participants had finished vocational school (44.4%), 33.3% had a Bachelor's degree and 8.3% a Master's degree. Participants held different positions, including nurse, case manager, social worker, manager and volunteer. People were asked about their knowledge of ToP. Most people answered that they had heard about ToP before (37.1%), were more or less skilled in ToP (20%) or did not know about it before (20%), others had not heard about ToP, but already believed that they practised it (11.4%), or were already very familiar with ToP (11.4%).

Quantitative analyses on the PQ-C were conducted using SPSS, Version 22.0. The total sum score reflects how professionals score themselves in terms of adoption of ToP. Pre-test and post-test sum scores of the total group on the PQ-C were compared using paired sample *t*-tests. Participant scores on the post-test were significantly higher than pre-test scores [t (36) = -2.97, $p < .01$]. On average, workers in all facilities improved in working according to ToP. Figure 1 shows pre- and post-test scores for the total group and for the different care facilities. The maximum total score is 31. Scaled scores are shown in the table, however. No cut-off point for "sufficient" adoption of ToP is available. Mean scores of the different institutions were compared. At the start of the educational programme, Team 2, where "copying the art" was taught, had the lowest score (66.5%) on the questionnaire compared to the other teams, followed by 66.8% (Team 5 – "experimentation"), 67.7% (Team 3 – "discovery") and 69.1% (Team 1 – "participation"). Team 4 ("acquisition") had the highest score on the pre-test (73.5%). Team 2 showed an improvement of 8.3%. This is the best improvement in pre-test and post-test scores compared to the other teams. The other teams showed improvements of 7.8% (Team 4), 3.7% (Team 5) and 3.3% (Team 1). However, Team 3 showed a decrease in mean sum score of 2%.

Understanding learning of ToP: qualitative data

A variety of qualitative data was collected. Reflection diaries of both trainers and participants were available. After completion of the educational programme, twelve of the participants took part in in-depth interviews to evaluate the educational programmes. To learn about ToP from a change management perspective, the qualitative data was analysed using a phenomenological tradition. We searched for the experience of learning ToP and tried to find common elements in it. We

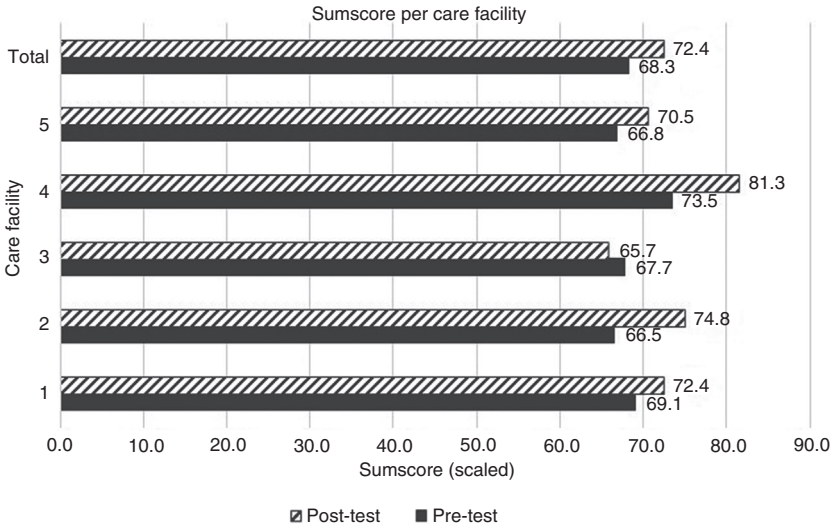

Figure 1. Mean sum scores on the PQ-C.

examined the elements that were described by many respondents and compared material in order to find a potential essence of the learning process that could account for the experience of every caregiver in attempting to learn ToP (Patton, 2002). Three important themes became apparent in the shared experience of learning ToP.

1. Becoming aware of a relational dimension in care

The first theme was "becoming aware of a relational dimension in care". Both trainers and participants mentioned this frequently in their stories, "awareness is the magic word" (T-2:3). ToP provides the language to address the relational dimension in care. As one participant put it: "I became aware, partly through the educational programme (…) there is a name for what I am doing" (I-2-5:119:122). This might indicate that some people may already be unconsciously capable of good relational attunement. Being able to put this into words is experienced as a great step forward. However, awareness does not come easily for all. One of the trainers said that "Awareness of [restricting] natural habits and lack of relational programming sets in" only after the third day of the educational programme (T-3:3). An illustration:

> It really enriched my work. I am more aware that, although we are an institution and have certain rules and protocols, we work with PEOPLE. Of course I knew and experienced that already, but theory of presence made me even more aware of that. Also, how can I attune myself as a person to the other person? What does this person need from me? And how can this person help me? You learn to appreciate each other a lot more. (I-3-3:402:406)

2. Evaluating one's own "being attuned"

The second theme is evaluating one's own relational capabilities. In the educational programmes this type of evaluation is stimulated by exercises, asking questions, deliberation and other methods. The material highlights the impact of this type of triple-loop learning. Questioning one's own (hidden) thought processes and acting on these appears complicated. We understand this as (self-) reflection, taken to mean the careful examination of personal thoughts and actions (Somerville & Keeling, 2004). It appeared to be quite confrontational to evaluate situations taken from one's own" past from an attunement perspective.

> I think it [learning process including self-reflection, EK] is nice, exciting and sometimes confrontational. But I do not mind being confronted, because it is safe enough, there is enough mutual respect for learning. So I feel a healthy tension: hey, I am onto something… I am not an expert in theory of presence yet, but I am on my way to becoming one. I like that and I think it is exciting. (I-3-2:304:316)

Apart from the difficulties experienced, participants report that they enhanced their evaluation of their own experiences following completion of the educational programme. They are more critical of themselves and the way they acknowledge the other's perspective, and they are eager to find avenues for improvement. A participant:

> I reflect more now (…) what do or don't I hold on to, what is important to me, from which rule do I deviate and to which do I adhere? (…) One day a client came to me: "I have to go to the dentist, but I lost the key to my bike. Can I borrow your bike?" I said: "Actually, that is not allowed, but if you search a bit longer I will talk to my supervisor. I think it is fine, but let me discuss it first." Well, then she found her key and left on her own bike. I thought this is presence. She has to go to the dentist, what is at stake for her? (…) I wanted to consider it now. Whereas before I always thought: this is not allowed, so no. I have become more lenient. (I-1-2: 28:37; 63:76)

What this respondent calls "reflection" might be the best predictor of future adoption, since ToP is about *searching* for how care can be best attuned to the client while remaining critical and focused on relational-based programming.

3. Using (one's own) practical examples

To understand and learn ToP, respondents lean heavily on practical examples. From the interviews it became apparent that participants experience reflection on specific cases as particularly helpful. Working with cases is experienced as "lively and informative" (T-3:3) and "through the use of practical examples the theory becomes more comprehensible" (T-4:1). Participants reflected on cases with other participants. This gave them the opportunity to talk about a specific example: who is this client? What perception or understanding do I have of him or her? What does he or she need? They could compare this to their own ways of working and explore their own habits. After the second day of the programme, one of the participants stated in her diary that working with cases had been truly useful. "Brainstorming and discussing colleagues' approaches made me think" (P-1:2). Furthermore, working with cases can help to link the theory not just to practice, but to people's *own practice as they experience it* and to tacit knowledge. It seems peculiar to ToP that the answer to what good care is can only be found in the specific situation by tuning. This explains why learning ToP is made significantly easier by working with one's own cases. People who looked back on working with specific practical examples reported that this method enhanced their learning. Others, who did not work with practical examples but with other learning formats, indicated that they would have preferred to work with cases as well. "I think that next time a similar course is offered, I would like to discuss cases and how we deal with them" (I-2-6, p.4).

DISCUSSION

The goal of this study was to learn more about effective ways to adopt ToP from a change management perspective. Our research question was: to what extent can more clarity be found on: (a) the conceptualization of ToP from a change management perspective; (b) the impact of various learning contexts to teach ToP; (c) assessment of results of educational programmes; and (d) core elements of the individual learning processes involved in ToP?

Quantitative data showed that participants did progress in four of the five educational programmes, demonstrating that the concept of presence can be taught in other learning styles and contexts than the traditional theoretical programme. Differences between participants from

the different institutions could be explained by the educational programme followed; however other factors such as organization, team or management might be of influence. Furthermore, individual differences could be accidental as the sample size was small (N=37).

We learned more about the essence of caregivers' experiences of the individual learning processes of ToP. Based on the qualitative results we can carefully conclude that three elements seem to appear in the learning processes that occurred in all five educational pilots. These were: becoming aware of a relational dimension in care, evaluating one's own being attuned and using (one's own) practical examples. This result will be useful for developing improvement strategies that fit different groups of professionals. Also, the results will be useful for the further development of effective forms of deliberation in care, as an implementation strategy for ToP.

The methodological search for relevant evaluation instruments had clear value with regard to improving innovative potential. Several instruments were used, namely the PQ-C, reflection diaries of both participants and trainers and in-depth interviews; all of these instruments have limitations. The PQ-C was used to measure whether caregivers adopted ToP. The quantitative results are useful for comparing groups and showed that participants improved on average in adoption of ToP (by self-report). It must be noted that there are no norms available yet to establish which questionnaire score bandwidths can be assigned to caregivers who "fully adopted" the concept, or who adopted it "reasonably" or "poorly". This is not due to neglect on the part of the researchers, but corresponds to a situation in practice in which it is difficult to understand who practises ToP well enough and who does not. Since no norms are available, nothing can be concluded about acceptable scores for successful adoption. These norms need to be developed to enable implementation of successful innovation projects. The question is whether this will be possible given the current conception of ToP. Similar difficulties seem to exist in international studies on presence. Presence is often described in publications (Covington, 2005; Doona *et al.*, 1997; Gilje, 1992), but ambiguity in concepts exists and clear operationalization suitable for measurement purposes is lacking. Only Hines (1991) has attempted to measure presence, and Kostovich (2012) developed the Presence of Nursing Scale (PONS) to measure nursing presence from a patient's perspective. In international studies on presence, psychological and spiritual or theological presence concepts are distinguished. Psychological concepts of presence indicate: full awareness, receptivity and attention for the other (Horner, in Covington, 2005) and non-judgmental listening and reciprocity (Finfgeld-Connett, 2005). Spiritual or theological concepts of presence are even more evocative: vertical or horizontal transcendence is the core of these types of presence concepts (Covington, 2005; Gilje, 1992). ToP seems to fit in the latter category. The PQ-C in its current

form seems interesting for the learning process in that it indicates elements of presence that can be improved. Of great importance in this respect is that the eight working principles of ToP on which the 64 items were based had not yet been validated by empirical research. In an initial validation study, three new elements appeared that can be described as: dedicated attitude, openness in perception, and reciprocal humaneness (Kuis *et al.*, 2014). Further research into the factor structure of the questionnaire is still needed. In our opinion these findings reflect the lack of clarity at the conceptual level of ToP, which results in a lack of clarity in learning directions.

A limitation of all data collection methods is that verbal information is gathered from caregivers themselves about their own professional behaviour. There is a risk that someone who might understand ToP intellectually but is not able to practice it, will not be recognized as understanding the theory either. We have no information to assess whether caregivers actually practise ToP. The scientific problem in this case is that we can only know whether ToP has been practised by asking patients, because researchers will then be able to identify whether caregivers did in fact address what was at stake for a patient and whether they responded appropriately. This means that if we want to know whether relational tuning actually took place (from which we derive that caregivers practised ToP), information from the care receiver will be essential. What should the care receiver then be asked? No specific measurements have been developed yet for this type of evaluation, and methodological difficulties are present, since patients cannot be asked if their caregiver adopted ToP. This also cannot be measured by an instrument with competence-based categories regarding what the caregiver did or said. Upon reflection we suspect that the only evaluation instruments that will work will be those that investigate what was at stake for the patient and to what extent this was addressed. This means that qualitative research needs to be conducted.

There are some further methodological limitations. The sample only consisted of a small group of professionals (N = 37), so nothing definitive can be concluded about the effects and principles that caused these effects. Moreover, the study took place in specific care settings (facilities for addiction care and homeless people). It is unclear if data can be generalized to cover other fields of care. No control group was used. If a control group had been used the two groups could have been compared to determine any differences. Another limitation is that quantitative measurements were taken prior to the start of the educational programme and within six months after the course completion; no other follow-up measures were taken afterwards. It is therefore not possible to determine any lasting effects from practising ToP. Learning ToP is not about knowledge transfer, but about third-order learning where the caregiver has to change. Changing oneself is not easy; there is always a risk that new ways of working will disappear and old habits and routines will return.

CONCLUSION

In this pilot study, five educational programmes for caregivers to teach them ToP were developed based on five different learning contexts. The caregivers' learning processes were followed. Baseline and repeated measures using the PQ-C showed that participants did progress in four of the five educational programmes, demonstrating that the concept of presence can be taught in other ways than the traditional theoretical learning style. Based on the qualitative results, we carefully conclude that three elements seem to appear in caregivers' individual learning processes that occurred in all five educational pilots: becoming aware of a relational dimension in care, evaluating one's own being attuned and using (one's own) practical examples. In an attempt to assess whether caregivers adopted ToP, the PQ-C, reflection diaries and in-depth interviews were used, all of which have their limitations. It became apparent that a clearer concept, with precise criteria stating when ToP is successfully adopted, plus a specific operationalization are necessary to evaluate educational programmes in ToP and to achieve successful innovation of care practices.

NOTES

1 "A practice in which the caregiver relates to the other with attention and dedication; develops an understanding of what is at stake for the other (desires or anxieties for example); realizes how the other needs them to respond and provides care accordingly. Sensitivity, expertise and practical insight on the side of the caregiver is needed" (Stichting Presentie, 2011).

2 The term "adoption" is used in this study in accordance with Greengalgh, Robert, Bate, MacFarlane & Kyriakidou (2005) and their theory on the diffusion of innovations. By adoption we mean that caregivers work according to ToP (they implement the 'innovation').

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