

Thinking beyond numbers

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Valorization

In this chapter, the societal value of this dissertation's findings will be discussed. These findings contribute to recent political and societal discussions on quality of care (QoC) in Dutch nursing homes.

Also, outside the Netherlands, it is a persistent belief that 'more hands' are needed to improve QoC in nursing homes. An increase in the number of staff is presumed to positively affect the QoC and quality of life of nursing home residents. Despite the heterogeneity across countries, nursing homes worldwide have to ensure the delivery of high QoC, and adequately staffing the homes remains a major concern in most countries. Direct nursing care staff vary in their educational level, thus it is a significant challenge to determine the numbers and types of staff as well as staffs' competencies that are necessary to meet the complex needs of nursing home residents. The findings of this dissertation have demonstrated that an increase in the number of staff will not, per se, lead to better QoC in nursing homes and have deepened the understanding of the influence of direct nursing care staff on QoC. To improve QoC in nursing homes, it seems necessary to think *beyond numbers*.

Findings of the studies described in Chapters 2-5 are published in a literature review that we conducted for the Dutch Ministry of Health, Welfare and Sport (VWS). VWS provided this report to delegates of the Dutch House of Representatives ('*Tweede Kamer*' in Dutch). It received a lot of media attention in July 2016 and has contributed to the recent quality framework for nursing homes ('*Kwaliteitskader verpleeghuiszorg*' in Dutch) of the National Health Care Institute ('*Zorginstituut Nederland*' in Dutch). This quality framework was published in January 2017 and provides temporary norms for – among other quality aspects – nursing home staffing. Based on the results of our report, the National Health Care Institute concluded that the evidence base for a generic minimum staffing standard is lacking. Instead, more attention has to be paid to the quality of teams, which is in line with our findings.

The findings of this dissertation contribute to the further development of the quality framework's staffing norms, which are classified into three themes: (1) Attention, presence and surveillance, (2) Specific knowledge and skills, (3) Reflection, learning and developing. Based on our findings, we provide implications for each theme hereafter.

Attention, presence and surveillance

One norm related to 'attention, presence and surveillance' states that 'during intensive care moments (e.g., getting up, going to bed, intake and dying), at least two care providers are present to execute these tasks'. Basically, for direct nursing care staff, it is important to ask for and to get help in those moments that help is needed. Getting help if needed may increase the delivery of safe care. Therefore, it is important that care providers are able to critically reflect on what they do. Critical reflection allows them to estimate and indicate whether or not they need help.

It is questionable whether it is possible to determine ‘intensive care moments’ in which help is needed. For example, in small-scale living groups, often one staff member works alone during a great extent of the day. When a resident falls, it might be necessary to ask a colleague – who is working in another living group within the facility – for help. In addition, based on the formulation of the norm, it does not become clear if the two care providers both need to be present in the ward or whether the second care provider can be called in if needed.

To further concretize this norm, the physical environment of a nursing home should be considered, too. In a stand-alone, small-scale living group with six residents, it might be financially impossible to guarantee that at least two care providers are present in the ward. One consequence may be that such small-scaled living groups disappear. Based on our findings, there is no reason to assume that two care providers (instead of one), per se, increase the QoC provided.

Specific knowledge and skills

One norm related to ‘specific knowledge and skills’ says ‘24/7, a BIG-registered registered nurse (RN; ‘*verpleegkundige*’ in Dutch) is present within 30 minutes.’ We have to take care that this norm is not interpreted by nursing home organizations, as ‘It is not necessary to employ RNs within direct care teams, as long as an RN can be called in.’ The RN should not be seen as a professional who only executes the technical nursing tasks (e.g., placing a catheter). Due to the rising complexity, it is desirable to integrate (baccalaureate-educated) (B)RNs in direct resident care. Especially within a self-organizing team, it might be wise to employ (B)RNs who can support lower-educated staff members.

In the mentioned norm, no differentiation is made between vocationally trained RNs and BRNs. For nursing home organizations, it would be helpful to concretize desirable responsibilities of (B)RNs in nursing homes in the quality framework. Providing an overview of these responsibilities helps organizations to ensure that (B)RNs are employed to their full scope of practice and that the role of each staff member (e.g., BRN, RN, certified nurse assistant (CNA)) within an organization is differentiated. With regard to BRNs, we saw in one of our studies (Chapter 6) that competencies other than those traditionally associated with the nurse expert role are considered important, for example, competencies related to informal leadership and coaching. A BRN who is only present upon request may not be able to serve as informal leader and coach for a direct nursing care team.

Master-educated RNs are not mentioned in the quality framework’s staffing norms. In Dutch nursing homes, these RNs nowadays often work as physician extenders. In the quality framework, a consideration of which role master-educated RNs should play in Dutch nursing homes deserves further attention. For example, international experts in one of our studies (Chapter 6) stressed that a successful implementation of innovations

in care practice may finally depend on the collaboration between master-educated RNs and BRNs. They saw master-educated RNs as those professionals providing evidence on best practice and ensuring evidence-informed care delivery, while BRNs were expected to oversee the implementation of best-practice guidelines at an operational level. Therefore, it is wise to reconsider their mostly medically oriented positioning. Instead of taking over tasks from the nursing home medical specialist, they could, for example, play a role in the implementation and promotion of working methodologically. Since they have expertise in the fields of nursing and medicine, they might also be able to increase the interdisciplinary collaboration in nursing homes. Reconsidering the role of master-educated RNs can lead to a new career pathway for RNs in nursing homes, providing the opportunity to attract and employ more academically qualified staff in the future.

Reflection, learning and developing

In the future, working in nursing homes will become even more complex, not only due to an increase in residents' care needs but also due to the fact that nursing home residents and their informal network will have more influence on how their care is organized. Therefore, stimulating learning and development among the nursing home workforce (e.g., by training programs or coaching on the job) is considered desirable. One norm of the quality framework says 'For each care provider, there is enough time for learning and development via feedback, intervision, reflection and education. The amount and kind of [learning and development] are included in the quality plan.' Ideally, reflection, learning and developing should become a 'daily routine' integrated in the daily work of each direct nursing care team. To stimulate this, our results suggest that nursing home organizations should invest in positive team climates. When staff members have the feeling that the team climate is safe, they are more likely to openly address issues that should be improved. This may enable team learning, e.g., by asking for help, discussing problems or learning from errors. Besides team climate, we found that clinical leaders who act as coaches for the direct nursing care team might be an important aspect to consider. As they are present in the ward, they are considered to give feedback in real-time, to continuously monitor care delivery in a non-threatening way and to promote and sustain the uptake of evidence-based practices through role modeling.

Another norm related to 'reflection, learning and developing' says 'There is enough time available for primary responsible caregivers (*'eerst verantwoordelijk verzorgenden'* or *'contactverzorgenden'* in Dutch) to participate in the multidisciplinary meeting ('MDO' in Dutch).' Giving primary responsible caregivers the opportunity to participate in the multidisciplinary meeting is desirable, as these caregivers are those employees that are expected to know the clients best. Nowadays, often CNAs fulfill this role. In our qualitative study (Chapter 7), we saw that one nursing home organization chose to

position BRNs in a way that allowed them to closely collaborate with primary responsible caregivers and to coach them to fulfill their role. In another study (Chapter 6), international experts saw the BRN as the professional who is ‘able to coordinate the multidisciplinary team’ and is ‘the professional who sees the whole picture, [who] should organize regular team meetings in which all disciplines participate; [and who] should manage the overall care coordination’. Therefore, it is questionable whether CNAs are able to fulfill the primary responsible caregiver role individually. Maybe they should fulfill this role in a tandem with BRNs. Alternatively, like in home care, it should be considered whether a BRN should fulfill the primary responsible caregiver role. A careful evaluation of which (combination of) caregiver(s) is able to meet the needs of residents is desirable.

INNOVATIVE ASPECTS OF OUR STUDIES

Outside the United States, research on the relationship between direct nursing care staffing and QoC in nursing homes is scarce. The study presented in Chapter 3 is the first large-scale study that provides insight into the amount and responsibilities of BRNs working in Dutch nursing care wards. Although different Dutch stakeholders have made efforts to increase the amount of BRNs in elderly care, the study shows that the amount of BRNs in institutional elderly care is still low.

In many countries, the amount of BRNs working in nursing homes is low; obtaining more information on how to best allocate them in nursing homes was considered desirable. To allocate them optimally, it is important to obtain insight into their competencies first. When studying existing competency profiles, we felt that these profiles did not provide sufficient clarity on which competencies distinguish BRNs from other direct nursing care staff. In addition, as worldwide significant changes are occurring in the nursing home sector, we were asking ourselves how future-oriented and setting-specific the existing profiles were. Contrary to other studies on the competencies of direct nursing care staff in elderly care, we did not include BRNs that are currently working in a nursing home in our panel, since they would likely be influenced by their current working conditions and thus would have trouble envisioning alternative views of staff allocation.

To blaze a trail for BRNs in nursing homes, we conducted an exploratory, qualitative study (Chapter 7) to obtain insight into factors that can contribute to the development of BRN roles in nursing homes. In addition, we wanted to explore why some organizations succeed in employing BRNs in nursing homes, while other organizations do not. This study showed, for example, that organizations that have a clear vision on how to employ BRNs within the nursing homes do not experience great recruiting and retention problems. Therefore, ‘recruiting and retention problems’ might no longer be an important argument for not employing BRNs in nursing homes.

DISSEMINATION OF FINDINGS

Already early in the project, we started to disseminate our results. For the scientific audience, five out of the six studies presented in this dissertation are published in peer-reviewed, international journals. Two of the articles are published 'open access', meaning that they are freely accessible for everyone interested in these studies. Another way to share our findings with other researchers and professionals was by giving (scientific) presentations at several national and international conferences. As the project was embedded within the Living Lab in Ageing & Long-Term Care, findings have been spread early among the long-term care organizations that participate in the Living Lab, too, for example, by giving lay presentations for direct nursing care staff and managers of these organizations. During the whole project, findings were discussed with representatives from national stakeholder organizations (branche organization Actiz, client organization LOC, the Dutch Nurses Association (V&VN), the Health Care Inspectorate (IGZ) and VWS). The report of the literature study conducted for VWS is freely accessible at:

<https://www.rijksoverheid.nl/documenten/rapporten/2016/07/04/meer-is-niet-per-se-beter>.

To disseminate the main findings of this dissertation further, several steps will be undertaken. Through writing accessible summaries, we hope to reach a wider audience. A Dutch summary as well as an e-book of this dissertation will be made available on the website of the Living Lab (<http://www.academischewerkplaatsouderenzorg.nl>). The e-book will also be made available via the platform '*Proefschriften Verpleegkunde*' (<http://www.proefschriftenverpleegkunde.nl>). This platform aims to make scientific knowledge in the field of nursing more accessible for students, educators and nurses in the Netherlands and Flanders. As this dissertation revealed relevant insights into the role of baccalaureate-educated registered nurses (BRNs) in nursing homes, particular efforts will be taken to inform these nurses. To achieve this, we will be in contact with the network of Dutch BRNs specialized in gerontology and geriatrics (<http://www.hbo-vgg.net>) and the steering group of the Dutch campaign '*HBO-V in de ouderenzorg – daar zit meer achter*' (<http://www.daarzitmeerachter.nl>). To disseminate the findings internationally, an English and German summary will be made available, too.

Part of the results of this dissertation will be included in a handbook, which provides nursing home organizations with concrete guidance on how to reach a more optimal staff mix between BRNs and other staff members working in nursing homes. This handbook will be developed in 2017.