Master Thesis

Nurses emPOWERed for professional practice
Perceived barriers and facilitators affecting the implementation of Professional Practice Model for nurses: A qualitative study.

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Abstract

Title: Nurses emPOWERed for professional practice, Perceived barriers and facilitators affecting the implementation of Professional Practice Model for nurses: A qualitative study.
Background: In response to the increasing complexity of care a professional work environment for nurses is required to maintain high-quality of care. Implementing a Professional Practice Model (PPM) can facilitate to establish a professional work environment and the positioning of nursing in the organisation. This study is focusing on implementation strategies of a PPM.
Aim: To explore the experienced barriers and facilitators affecting the implementation of a PPM for nurses in Dutch hospitals.
Method: This general qualitative study was conducted in 22 Dutch hospitals. Data were collected between February 2017 and April 2017. We used purposive reputation- and convenience sampling for 22 semi-structured interviews with 24 participants. The interviews were audiotaped, transcribed and subjected to qualitative content analysis.
Results: Three themes related to perceived facilitators and barriers were identified: creating the desired future at the strategic level, connecting services at the tactic level, and leadership for excellence in nursing care at the operational level, linked by one overall theme; 'leadership from bed to board'. The main themes are strongly related to each other and have a major impact on the professionalisation of the nursing profession.
Conclusion and implications: Taking responsibility and leadership at all levels in the organisation appear to be important in the nursing professionalisation. Decisions should be made about the governance structure facilitated by a clear vision. At the tactic level, a position, embedded in the organisation structure, where it connects all levels and disciplines in the organisation is recommended to ensure leadership of the nursing profession. Head nurses have roles crucial to the success, which urges for sufficient competencies.

Keywords: Professional Practice Model, implementation, barriers and facilitators, MeSH Clinical governance

Samenvatting

Titel: Verpleegkundigen empowered voor de professionele praktijk. Ervaren barrières en facilitators tijdens de implementatie van een professioneel praktijk model voor verpleegkundigen: Een kwalitatieve studie.

Achtergrond: Naar aanleiding van de toenemende complexiteit van zorg is een professionele werkomgeving aanbevolen. Het implementeren van een Professioneel PraktijkModel (PPM) kan helpen om een professionele werkomgeving op te zetten en verpleegkundigen te positioneren in de organisatie. Dit onderzoek richt zich op strategieën voor implementatie van een PPM.

Doel: Het onderzoeken van ervaren barrières en facilitators die invloed hebben op de implementatie van een PPM in Nederlandse ziekenhuizen.

Methode: Dit algemeen kwalitatief onderzoek werd uitgevoerd bij 22 Nederlandse ziekenhuizen. De gegevens werden verzameld van februari 2017 tot april 2017. In het totaal zijn 22 semigestructureerde interviews afgenomen bij 24 participanten, waarbij gebruik is gemaakt van een doelgerichte- en gelegenheidssteekproef. De interviews zijn opgenomen, getranscribeerd en onderworpen aan een kwalitatieve inhoudsanalyse.

Resultaten: Drie thema's die verband houden met ervaren facilitators en barrières zijn beschreven: het creëren van een gewenste toekomst op strategisch niveau, het aansluiten van diensten op tactisch niveau en leiderschap voor uitmuntendheid in verpleegkundige zorg op operationeel niveau, met als algemeen thema: Leiderschap van bed tot aan bestuur. De hoofdthema's hebben een sterk verband en een grote invloed op de professionalisering van het verpleegkundig beroep.

Conclusie en aanbevelingen: Het nemen van verantwoordelijkheid en leiderschap op elke laag in de organisatie lijkt belangrijk in het professionaliseren van de verpleegkundige beroepsgroep. Beslissingen, gefaciliteerd door een duidelijke visie, moeten worden gemaakt over de governance-structuur. Op tactisch niveau, is een positie, ingebed in de organisatie, welke verbinding maakt met alle lagen en disciplines aanbevolen om leiderschap van het verpleegkundig beroep te waarborgen. Teamleiders hebben een cruciale rol voor het succes, dit vraagt om voldoende competenties.

Sleutelwoorden: professioneel praktijk model, implementatie, barrières en facilitators, MeSH Cinical Governance

Introduction and rationale

Professional work environments for nurses are associated with improved outcomes like patient outcomes, e.g. decreased falls, infections, mortality, and increased patient satisfaction[1-6] and personnel outcomes, e.g. diminished nurse job dissatisfaction and job turnover.[7-11] Improved patient and personnel outcomes eventually lead to better organisation outcomes, e.g. cost savings because of the reduction in adverse outcomes.[12] Essential elements in a professional work environment, and therefore crucial in improving associated outcomes, are competent nurses, collaborative working nurse-physician relationships, autonomy for nurses, adequate staffing, control over nursing practice, managerial support and patient-centred culture.[13,14] Hospitals focussing on the presence of these elements, are the so-called high-performance hospitals, e.g. Magnet hospitals.[15] These hospitals are also characterised by the presence of a Professional Practice Model (PPM), which provides a representation of nursing practice throughout the hospital organisation.[2,9,16] PPMs include the concept of shared governance and facilitate nurses' control over the care delivery and its environment. Such a PPM supports registered nurses in their everyday practice to collaborate, communicate and develop professionally, i.e. relationships, personal growth, and systems maintenance and change,[17] in order to provide the highest quality of care.[16,18] Implementation of a PPM is associated with a significant improvement on professional work environments, and therefore on patient-, personnel-, and organisation outcomes.[2,3,10]

In addition, the increasing complexity of care and tight labour market of nurses worldwide require an effective and efficient hospital organisation and management, an inter-professional collaboration between physicians and nurses, and a professional nurses' work environment to maintain adequate and responsible care in the future.[19] The Dutch organisational model is a 'basic functional model', which lacks a supporting culture for nursing professionalisation and deals with inefficient processes.[20] Facilitated by a nation-wide quality incentive grant (Kwaliteits-Impuls personeelgelden: KiPz),[21] a growing number of Dutch hospitals is transforming their 'basic functional work environment' into a 'professional work environment' by designing and implementing a PPM or a supportive Dutch programme, i.e. 'Excellent care' of the Dutch association of nurses (V&VN).[22] Such a professional work environment is essential to implement the function differentiation between licensed vocational- and bachelor nurses to ensure quality of care, enhance personnel-outcomes and ultimately improve nurse retention.[19,23-25] There is limited empirical or theoretical guidance for an organisational redesign, hospitals often choose a PPM based on available resources and contextual requirements.[26] Therefore, most project managers involved in decision-making regarding the organisation of nursing care in Dutch hospitals shape their own PPM and have their own implementation journey.

To be able to formulate scientifically advice on essential ingredients for PPMs in the Netherlands[27] and strategies for implementation, the NPOWER research; “Nurses emPOWERed for professional practice’, was conducted. This study is part of the NPOWER research and is focusing on strategies for implementation of a PPM in Dutch hospitals. To ensure an effective and successful implementation of a PPM, it is important to explore which barriers and facilitators affect the implementation.[28-31] Although there are theories about essential elements for a successful implementation, e.g. vision, skills, motivation, resources, and actionplan,[32] there is no scientifically information available on the perceived barriers and facilitators while implementing a PPM in the Netherlands.

Aim

Therefore, the aim of this study was to explore the experienced barriers and facilitators of involved project managers of Dutch hospitals when implementing a PPM for nurses. Insight into these aspects would facilitate evidence-based information in order to: (1) support implementation strategies and develop activities for future successful implementation of PPMs, (2) improve the design of current PPMs, and (3) contribute to explaining the effectiveness and implementation outcomes of a PPM.

Methods

Design

A general qualitative approach with semi-structured interviews and content analysis was used to explore project managers experiences of the barriers and facilitators while implementing a Professional Practice Model (PPM) in Dutch hospitals.[33,34] Participants' experiences are subjective meanings, which cannot be measured statistical and require qualitative methods.[35] To conduct and describe the study the COnsolidated criteria for REporting Qualitative studies (COREQ) was used.[36]

Participants

A total of 22 semi-structured interviews were conducted with 24 participants from 22 Dutch hospitals. The participants had different positions in their organisations (table 1), e.g. member of the Nursing Advisory Board (*n*=5), project manager (*n*=6), nursing manager (*n*=4), education manager (*n*=7), innovation manager (*n*=1) and secretary of the board of directors (*n*=1). A purposive reputation sample was used to invite participants of teaching- (*n*=15) and general hospitals (*n*=2). The Dutch association for teaching- and general hospitals (NVZ) shared contact information of these hospitals. Furthermore, a convenience sample was used for the interviews with participants of University hospitals (*n*=5), as the participants identified themselves after contacting the Nursing Advisory Boards.[37] The participants were actively involved in the transition to a professional work environment. By gaining insight into their experiences, an overall view of the barriers and facilitators while implementing a PPM was obtained. A sample size of 20 was found appropriate to examine the in-depth explorations of concepts, processes and patterns from data.[38,39] All participants were informed about the aim of the study and invited to participate by email.

Data collection

Data were collected between February 2017 and April 2017 by KS and MV. Face-to-face in-depth semi-structured interviews (*n*=22) were conducted to maximize the opportunity to share their experience freely. However, in two hospitals participants preferred being interviewed in pairs.Ten interviews were conducted by two researchers (KS and MV) and twelve by one researcher, of which seven by MV and five by KS. All participants were interviewed once. Each interview was arranged at a convenient time and location for the participant, took 45 to 60 minutes, was conducted in Dutch, and voice recorded by the participant's permission. The questions, guided by a topic list (Table 2), were open-ended to encourage participants to tell stories in their own words to provide rich, detailed information.

Probes and prompts were used interview techniques.[37] Two researchers (KS and MV) composed the topic list, based on the literature and structured by the essential building blocks for successful implementation developed by Lippit.[32] CO and HV reviewed the topic list. The interview quality was judged during the first interview by an interview expert (CO) and found appropriate.

Data analysis

The researchers involved in the process of data analysis (MV, CO, KS, HV) used the systematic process of qualitative content analysis to identify prominent themes and patterns regarding the barriers and facilitators affecting the implementation of a PPM. Data analysis was conducted in Dutch, using MaxQDA version 12. Two researchers (KS and MV) independently analysed each transcript.

The iterative analysis process, which took place between February 2017 and May 2017, consisted of three main phases: preparation, organising and reporting[40], and started immediately after the first interview. The preparation phase started with transcription of the interview, whereby personal information was removed. To check the accuracy of the transcribed data, cross-checking took place while listening to the recorded interview. During this process, field notes were integrated.[37] The transcripts were read and re-read in order to immerse in the data and obtain the sense of the whole.[40] Text appearing to describe perceived barriers or facilitators was highlighted and a keyword was written in the margin, using participants' terminology.[40] In the next phase, data was organised by building a coding frame with the use of MaxQDA. This process included grouping codes into at least one main category and two subcategories, defining categories, and revising and expanding the frame to formulate a general description of the research topic.[40-42] The analytical process of coding and generating categories was reviewed and discussed by four researchers (MV, KS, CO, HV) until consensus was reached.

To increase the validity of the data a member-check was established, whereby participants attended a presentation and discussed the results. The participants recognised the results and no adjustments to the identified themes had to be made. Additionally, a researcher involved in Magnet recognition programme and a change agent involved in organisational change projects reflected on the researchers' interpretation of the results, which reduced the risk of biased decisions and interpretations.[37]

Ethical considerations

The local medical ethics review board (Radboud UMC) approved the study but waived the necessity of ethical approval because the study had no effect on the participants' wellbeing.

Participants gave written consent with the reply to the invitation mail. Before the interview and after giving a full explanation of this study participants gave oral informed consent and permission for voice recording. Assurances were given that all data remained confidential and anonymity of the participants and hospitals was guaranteed. Data were saved under identification numbers safeguarded by CO.

Results

The professionalisation of the nursing profession is an important contribution to the changing hospital care, according to the participants. Although the use of a Professional Practice Model (PPM) was not specifically mentioned, elements of a PPM were recognisable, and considered important for the professionalisation of the nursing profession. With regard to this professionalisation, the data-analysis comprised three main themes (table 3): creating the desired future at the strategic level, connecting services at the tactic level, and leadership for excellence in nursing care at the operational level, which were linked by one overall theme: *'leadership from bed to board'*. The main themes are strongly related to each other and have a major impact on the professionalisation of the nursing profession either as a barrier or facilitator.

Creating the desired future at the strategic level

Failing to make choices

Although only a few participants mentioned a PPM, most of them talked about the decisions necessity for the professionalisation of the nursing profession. To make decisions, a scientific foundation was considered a facilitator to convince the board of directors and other higher management (table 3-Q1).

Decisions should be made about components of the professionalisation programme, e.g. the positioning of nurses in the organisation, new roles and suitable remuneration structures, selective hiring and the nurses and head nurses' education, and the allocating of the nation-wide quality incentive grant. The professionalisation programme of nurses was primarily focussed on the function differentiation and upgrading the nurses' competencies. However, a repositioning of nurses in the organisation structure can also benefit the quality of care (table 3-Q2).

Participants were appreciative of the nation-wide quality incentive grants, because these facilitate the start of the professionalisation; without it, finance would be a barrier to start such a programme. Participants with authority to expend a budget experienced a better allocation of resources, without such authority the expend of this grant was unclear due to the scarce involvement in allocating the grant. The latter was experienced as a barrier (table 3-Q3).

Strong leadership on strategic level is essential to make decisions and crucial for a successful outcome (table 3-Q4). However, most hospitals are not decisive and wait for nation-wide recommendations concerning the Individual Health Care Professions Act (BIG Act), the new occupational profiles, and the experiences of other hospitals (table 3-Q5).

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Scarce intrinsic motivation

Extrinsic motivation appeared to be the driving force to initiate the professionalisation of the nursing profession, e.g. the function differentiation, the BIG Act, the increasing complexity of care, and the employees' attraction in a tight labour market (table 3-Q6). Nevertheless, participants declared a dearth of motivation and leadership at different levels in the organisation caused by ambiguities regarding the nationwide developments, finances, other large-scale projects, inadequate knowledge and sense of urgency, and not feeling responsible for taking leadership in this transition (table 3-Q7). The participants said, the professionalisation would be more facilitated by intrinsic motivation, enthusiasm, and recognition of the necessity by higher management, especially the board of directors. A shared vision on nursing and promotion of this vision in the organisation is recommended (table 3-Q8).

Vision ad hoc

The vision on nursing was mostly emerged by external factors, forcing organisations to think about the future of the nursing profession. A clear vision on nursing facilitate, because of the improved hospital-wide support and awareness of the nursing profession (table 3-Q9). Nevertheless, most organisations had no vision on nursing or developed it ad hoc. Some participants incorporated the thoughtfulness of 'excellent care' and 'Magnet®' as the basis of the vision because of the scientific substantiation. Others utilised a PPM, which facilitates to guide the desired future of the nursing profession. Some participants described this ability during the interview. Reasons for the absence of a PPM were finances, unfamiliarity with the concept PPM, and not enough priority of higher management through other major projects, e.g. fusion (table3-Q10,Q11). Noteworthy, if there was a vision or a PPM, this was developed by staff advisors, the project steering committee, or the nursing advisory board. Nurses' involvement seems minimal. Some participants argued that a shortage of knowledge, leadership, and decisiveness on mainly the operational level, but also on strategic- and tactic level was causal for this low level of involvement (table 3-Q12).

Connecting services at the tactic level

Lack of making links and collaborating

The professionalisation of the nursing profession affects every level and discipline in the hospital. Therefore, participants implied, a vertical connection is important at all levels of the organisation. Some even believed in the necessity of a full-time function which could act as a liaison between all levels and disciplines. Others believed that the hospital academy, human resource and the nursing advisory board were the effective triangle to connect (table 3-Q13).

Nevertheless, it is a challenge to connect, due to a ‘preaching to their own parish’ culture. People involved, have their own view on and task within the professionalisation (table 3-Q14).

Physicians also were barely involved despite the reported shift in the collaboration between nurses and physicians. According to the participants, this collaboration is limited to the operational level, and thence the head nurses’ responsibility (table 3-Q15).

Distributed leadership aka ‘throwing over the fence’

A substantive involvement of nurses would promote the control over their profession and practice. However, also declared was nurses’ minimal involvement in policies and the responsibility and ownership of the head nurses and nurses in the professionalisation. A dearth of responsibility and awareness of the nursing profession resulted in less progression in the professionalisation at the operational level (table 3-Q16,Q17).

According to the participants, the nursing profession is struggling with defining their profession and experiencing a lack of control (table 3-Q18,Q19). More control on the nursing profession and their work environment was experienced when the nursing profession was positioned in the organisation, e.g. a decision-making nursing advisory board. Therefore, a change in governance structure is needed (table 3-Q20).

Leadership for excellence in nursing care at the operational level

Gatekeepers for transition

The head nurses have a crucial role, they are the gatekeepers for the nurses’ professionalisation at the operational level. The work environment is important and therefore head nurses should translate policies at the operational level, empower nurses to frame these policies, mentor the nurses to show leadership, and provide opportunities for education. The head nurses must be a role model. Therefore, the head nurses’ role will change and their leadership and coaching competencies should be developed (table 3-Q21). Participants said head nurses should be sufficiently trained for this role. However, worries were expressed about head nurses’ current education level, they should at least have a bachelor degree to be a gatekeeper (table 3-Q22).

Developing strong clinical capability

Upgrading nursing competencies on knowledge to bridge the gap in competencies, e.g. evidence-based practice and clinical reasoning, was said by all participants. However, the inadequate attention in designing governance structures of nurses makes it difficult to translate these competencies. Therefore, awareness should be paid to communication,

leadership, coaching and attitude (table 3-Q23). Alongside the necessity of a governance structure, participants mentioned career opportunities for nurses, e.g. clinical pathways, which allow nurses to reach higher positions and more control over their profession (table 3-Q24).

Pleasing for collegiality

The nature of nursing is caring for each other and their team, so nurses do not address the behaviour of each other. By nature, nurses are obliging and do not appreciate if nurses stand out from the crowd. Participants said this 'culture' is maintained by the nurses and head nurses, but also by other disciplines (table 3-Q25). The caring proposition of head nurses is the reason why they feel uncomfortable by implementing choices that may be threatening to others, e.g. function differentiation. Head nurses act as real gatekeepers by protecting their staff and avoiding sensitive debate. Participants mentioned this uncomfortability was not only limited to the operational level, but also recognisable at the strategic- and tactic level (table 3-Q26).

Discussion

Experiences while implementing a Professional Practice Model (PPM) comprised three main themes: creating the desired future at the strategic level, connecting services at the tactic level, and leadership for excellence in nursing at the operational level, with one overarching theme: leadership from bed to board. Leadership appears to be important for the professionalisation of de nursing profession and eventually for the quality of patient care. Apparently, participants were not yet developing or implementing PPMs because they lacked knowledge about the meaning of the PPM and the advantages of the nursing reposition in the organisation. However, components of a PPM were implemented because these were included in their clinical competency upgrading programme.[27]

According to the participants, the lack of desired future of the nursing profession at the strategic level adversely affects the nurses' professionalisation. Generally, decisions on the repositioning of nurses and new roles and suitable remuneration structures were deferred by a wait-and-see policy. However, strong leadership and decisions on the strategic level facilitate an implementation.[43] To achieve these decisions, a clear direction is necessary to support and encourage implementation.[43] Strategic leaders have the ability to develop policies, which can be seen as a possibility for a strategic change, essential to develop a new vision and move in new directions such as the positioning of nurses.[44]

The repositioning of nurses by means of a governance structure is an essential element of a PPM. Through this repositioning, nurses will be able to influence organisational decisions which benefit nurses, quality management and the context of nursing practice at all levels in the organisation.[9,45-48] However, participants declared nurses and head nurses' minimal involvement on strategic- and tactic level despite the crucial role of this group. Also said was a dearth of responsibility and awareness of the nursing profession, where is wanted more leadership. But, is that possible for them without a governance structure? As indicated in the results, the nursing profession is struggling with defining their profession and experiencing a lack of control. This seems to indicate, that a governance structure facilitates, by giving the nursing profession the opportunity to show leadership, not only at the operational level but also at the strategic- and tactic level. Developing an organisational context and leadership capacity is necessary for an effective implementation climate and leadership.[49]

A governance structure also can facilitate connection and collaboration to address relationships among nurses, their colleagues, and leaders at all levels, for example introducing a Chief Nursing Officer (CNO).[50,51] Although making links and collaborating at all levels in the organisation is indicated crucial in the professionalisation of the nursing

profession, this function was often assigned to the project managers, and not incorporated in the organisation structure, which can cause a missing connection at the end of the project.

The role of the head nurses is crucial in this collaboration while it creates a professional and safe work environment. This result is confirmed by other studies whereby head nurses ensure empowering work conditions.[9,14,52] The head nurses' role will change and their leadership and coaching competencies should be sufficiently trained to support and guide nurses in this transition to enhance staff retention, reduce costs, and improve quality of care.[47,53,54] The participants stated that head nurses at least should have a bachelor degree to fulfil this role, other studies even stated a (post)graduate degree as a requirement.[55,56] Besides sufficiently trained head nurses, participants also mentioned the gap in nurses' competencies. To reduce this gap, there is an extensive attention in upgrading them, especially in evidence-based practice and clinical reasoning. However, some participants stated the awareness of communication and leadership also facilitate the professionalisation of the nursing profession, by learning how to show leadership for excellence in nursing care at operational level. Strong leaders can be developed by career opportunities, such as clinical academic career pathways.[57]

Besides the dearth of a governance structure and leadership at all levels in the organisation, also mentioned was the nature of nursing to care for each other hampered the professionalisation of the nursing profession. Nurses do not appreciate if other nurses stand out from the crowd, and head nurses feel uncomfortable by implementing choices that may be threatening to others. And again, the essence is a lack of leadership.

Limitations

Some limitations warrant consideration. The stages of the implementation process were limited to the participating hospitals of which most did not yet develop or implement a PPM. However, when PPMs had been implemented, the results would presumably be similar, given the results regarding the organisational structure and culture in hospitals. The study is generalisable to other Dutch hospitals, and not to hospitals in other countries. However, depending on their organisation structure and culture, hospitals could probably recognise the themes of this study. Furthermore, subjectivity in qualitative research could arise bias.[37] However, purposeful sampling, researcher triangulation, peer reviewing, and member checking was intended to enrich validity.[37]

Conclusion and implications for practice

This study on the barriers and facilitators affecting the implementation of a PPM implicates that leadership from bed to board is a crucial factor. Demonstrating leadership at all levels in

the organisation and taking responsibility seems to be an necessary facilitator in the professionalisation of the nursing profession. At the strategic level, decisions should be made and they must think about the positioning of the nursing profession in the organisation facilitated by a clear vision. At the tactic level, a position, embedded in the organisation structure, were it connects all levels and disciplines is recommended to ensure leadership of the nursing profession. Nurses appeal the opportunity to take control of their own profession. At the operational level, head nurses have positions and roles crucial to the success of the programme by supporting and guiding nurses through this transition, which urges for sufficient competencies. Advisable is they have at least a bachelor degree.

At all levels, a ‘culture’ change is needed, leadership from bed to board is crucial and decisions have to be made for a successful outcome. Nurses have to be involved in decisions on issues affecting them and the context of nursing practice at all levels. This will result in both improvements of the nursing profession and better patient – and organisation outcomes. To succeed the transition of the professionalisation of the nursing profession, a PPM can offer support to determine the direction of an organisation, as a spot on the horizon.

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Tables

Table 1. characteristics of the hospitals and participants

Categories	Range	*n*	%	*M (SD)*
Hospital Characteristics				
Type of hospital	Academic	5	22.7	
	Teaching	15	68.2	
	General	2	9.1	
Number of beds	412 - 1200			712(220.2)
Number of nurses	550 - 2300			1384(500.7)
Ratio Licensed Vocational	60 - 87			74(9.2)
Ratio Bachelor nurses	13 - 40			26(9.2)
Total of participated hospitals		22	100	
Participant characteristics				
Gender	Man	3	12.5	
	Female	21	87.5	
Age (years)	<25	-	-	
	25 to 35	3	12.5	
	35 to 45	13	54.2	
	45 to 55	6	25.0	
	>55	2	8.3	
Education level	Vocational	-	-	
	Bachelor	7	29.2	
	Academic	17	70.8	
Experience in years	1-26			7.2(6.9)
Total responses		24	100	

Note. n=population size; %=percentage; M=mean; sd=standard deviation

Table 2 interview guide structured by model for managing complex change[32]

Questions and Topics	
Main question	
Q	Can you tell which activities for the professionalisation of the nursing profession were performed in the hospital?
T	*Rationale (quality and patient safety, national developments, quality incentive grant)/function differentiation/nursing organisational structure/choice based on/phase of implementation*
Vision	
Q	Which vision is described of the nursing profession in the hospital?
T	*Key values/knowledge/multidisciplinary collaboration/autonomy of nurses/working environment/impact on nursing practice/culture/management support/professional practice model/current situation/development/involved in decision making/translation/motivation*
Q	What do you hope the outcome of the professionalisation will be?
T	*Knowledge/ multidisciplinary collaboration/autonomy of nurses/control/working environment/impact on nursing practice/EBP/culture change/management support/ personnel outcomes/patient outcomes/organisation outcomes/ organisational structure/changes or modifications*
Skills/resources	
Q	Which skills, knowledge and resources were necessary to achieving the professionalisation of the nursing profession?
T	*Education/collaboration/innovation culture/finance/barriers and facilitators/ positive- negative experiences/organisational and clinical representatives/ different phase of implementation/feasibility/working environment/control/ recommendations*
Motivations	
Q	Who were involved in the realisation of the professionalisation of the nursing profession? On which way, which interests and motivations?
T	*VAR/managers/nurses/different levels in organisation/patient/responses/ barriers and facilitators/positive- negative experiences/different phase of implementation/recommendations*
Action plan	
Q	How were activities of the professionalisation implemented? What went well? What could have been improved?
T	*Reality vs expectations/changes/organisational and clinical representatives/ communication/staging/orientation phase/perspectives/assuring/reporting/ barriers and facilitators*
Final question	*Is there anything we did not ask, but which you think it is important?*

Note. Q=question;T=topic;EBP=evidence based practice;VAR=nursing advisory board;vs=versus

Table 3 Overview of themes and supportive quotes.

Themes	Subthemes	Quotes
Creating the desired future at the strategic level	Failing to make choices	Q1. *Talking about the positioning of the nurses and related issues, we definitely have to validate the decisions. You cannot just say "we have ambitions". … The information to the board of directors, medical staff and stakeholders have to be scientifically substantiated to get their approval. - P21* Q2. *We prefer the function of a nursing director. … Nurses have direct contact with the patient, so together with the medical staff and board of directors, they surely can contribute to determine the course of our organization -P12* *Q3. Indeed, we benefit from grants. However, we have a relatively opaque view of underlying spending. The money has been slipped into the enlargement melting pot. We did not label the expenses for the project. If the finances should be labelled strictly to the professionalisation of the nursing profession, the outcomes would be more effective and efficient.-P18* *Q4. You had to use policy to manage the professionalisation of the nursing profession, otherwise this project will never be accomplished. … I do not believe in experimenting, you have to make clear decisions, otherwise it is pray and delay and you never make the transition, you were intended to make. -P22* *Q5. Adjustments are needed in de BIG Act. You can involve nurses and other disciplines in the transition of the nursing profession. However a change in the BIG Act determines nurses authorities. These need to be clarified before starting the project.-P13*
	Scarce intrinsic motivation	*Q6. Motivation is mainly referred to nation-wide developments, the new occupational profiles. These new occupational profiles are obliged by the increasing complexity of care as well as the fundamental flaw from the past, whether nurses were educated licensed vocational – or bachelor, they all had the same function-profile.-P6* *Q7. The board of directors said during the accreditation; 'all other projects, we put on hold'. ... Some head nurses took initiative to unroll 'excellent care', however, apparently, finances were running short, so it was not possible to unroll throughout the organisation.. Strategic mandate is necessary to unroll such a major project organisation-wide.-P11* *Q8. The director of care has firmly incorporated the development of the vision because of her intrinsic motivation. ... She has put much commitment and passion in it. She can promote this vision.–P9*
	Vision ad hoc	*Q9. The vision facilitates the start of this programme, it ascertains decisions and aims to*

		strengthen the nurses.-P22 *Q10. 'Excellent care' is a good starting point, because of the eight features. … Then you grow, you will take the spot you deserve. -P20* *Q11. we have a professional practice model, but we're still searching how to implement it. Currently, we consciously put it on a back burner because of the relocation and the introduction of the electronic patient file-P7* *Q12. The managerial quality of the nursing advisory board could be better. There are good intentions, but it's all very amateurish. They are very good nurses but that doesn't say anything about their policy-making and managerial competencies. There have a listener attendance at meetings, but they are not the right persons in decision-making.-P9*
Connecting service at the tactic level	Lack of making links and collaborating	*Q13. I'm the oil between all staff services, management, nurses, nursing advisory board, human resources, academy, from quality and safety to line management. I'm actually the link between all those people. We need everybody to make sure the lines are closed. When the lines are closed we are moving forward. -P4* *Q14. We have to discuss the organisation of care with each other. Now it's fragmented. Everybody advocates for his own 'piece of the pie' and 'preach for his own parish'. -P19* *Q15. I think, we have to take the next step with physicians, not me, but they need to be involved … All I can do, so to speak, is speak to the chairman of maybe give a presentation. … However, the relationship with the physicians occur especially at the operational level. –P3*
	Distributed leadership aka 'throwing over the fence'	*Q16. The nurse managers have to act. They are an essential factor in this project. -P14* *Q17. Nurses must take their profession seriously, so they have to take responsibility for their own learning. ... Now they wait patient until something happens, thinking "we've always do it this way, and when we have to change, the management have to tell me." But they themselves should want more for their profession.-P20* *Q18. I think it is about nursing care, …, eventually, we may participate, but how is it possible that a man in a suit is going to tell us how we should do it. -P11* *Q19 But you are becoming more and more aware, that policies are often forged high in the top. By the time it reaches the operational level, nurses or some doctors will say: Who invented that, we do not recognise this, how could we perform this? -P17* *Q20 The current systems demotivate nurses. Why should you professionalise at all if you don't have anything to say in decision-making and have to leave the bedside of the patient which is your first passion?-P1*

Leadership for excellence in nursing care at the operational level	Gatekeepers for transition	*Q21. The role of the nurse manager will change. They have to develop a more coaching style of leadership. … Now you see hierarchy and ordering. I don't think this is appropriate in the new role. -P2* *Q22. The head nurse has a crucial role in facilitating and motivating. They must have the knowledge to mentor and manage the nurses on the ward … We require, one of the criteria is at least a bachelor degree as they also had to lead the ongoing transition. (red. Function differentiation and upgrading programme). -P17*
	Developing strong clinical capability	*Q23. We need to upgrade the education level and skills of the nurses, as well as the positioning in the governance structure of the organisation. i.e. government, management, and decision-making. ... Another important component is leadership of nurses, which is related to attitude.-P22* *Q24. Nurses craved to certain positions. They want to care, but also want to do research, teaching or do management tasks to improve the quality of care. … Nowadays, the focus is mainly medical. We should offer more opportunities for the nursing profession. -P1*
	Pleasing for collegiality	*Q25. As a professional group, we are also hard against each other. If you do something extra as a nurse, if you stand out from the crowd, then we are hard against each other. … we also maintain a culture that ensures that we just do what we do and don't go 'the extra mile'. -P1* *Q26. Especially fear to indicate the difference in the education level of nurses. The organisation is afraid to say: there is a difference in function. This is a way of avoiding a sensitive debate. -P3*

Note. Q=quote; P=participant