Exploring the needs and possible solutions to improve the formal assessment of district nurses in home care: A qualitative study

Master Thesis

Name student: Britt van de Bovenkamp
Student number: 6226817
Status: Definitive version
Date: 19-06-2020
Name docent: Dr. Jacqueline van Dijk
Name supervisor: Dr. Nienke Bleijenberg
Internship institution: HU University of Applied Sciences, Utrecht
Journal: International Journal of Nursing Studies
Number of words: 3744
Number of words English abstract: 299
Number of words Dutch abstract: 297
Criteria transparentize: COREQ
University of Utrecht Clinical Health Sciences, master program in Nursing Science, UMC Utrecht

RESEARCHERS STATEMENT

Britt van de Bovenkamp, RN; intern nursing researcher of the HU University of Applied Sciences, Utrecht, The Netherlands. Bachelor district nurse employed in home care, female.
Dr. Nienke Bleijenberg, RN, PhD; Professor Proactive Elderly Care, First Line Research Group for the Chronically Ill, Knowledge Centre for Healthy and Sustainable Living. HU University of Applied Sciences, Utrecht, The Netherlands.

ABSTRACT ENGLISH

Title: Exploring the needs and possible solutions to improve the formal assessments of district nurses in home care: a qualitative study.

Background: Home care differs widely across Europe in financing and care allocation. In the Netherlands, district nurses are authorised in care allocation, called formal assessment. In formal assessments, the district nurse determines the care demand based on the needs of the patient. However, practice variation occurs in formal assessments, meaning there are differences in care allocation for comparable patients. Practice variation reduces quality of care. Since district nurses perform formals assessments, it is important to gain insight into the needs and possible solutions of district nurses to improve the quality of formal assessments.

Aim: The aim was to explore the needs and possible solutions of district nurses to improve the quality of the formal assessment to determine the care needs of patients in home care.

Method: An explorative study was conducted. District nurses were purposefully sampled. Semi-structured interviews were conducted in March and April 2020. Data was thematically analysed according to Braun and Clarke.

Results: Two main themes emerged after interviewing district nurses (n=12): district nurses needs for quality and uniformity improvement, and district nurses' preconditions for quality and uniformity improvement. District nurses perceived learning from and with each other and education as important needs for district nurses to improve the quality and uniformity of formal assessments. District nurses defined preconditions to improve the quality of formal assessments by: retaining autonomy, more time, and structure and facilities.

Conclusion: This study provided insight regarding the needs and possible solutions of district nurses to improve the quality of formal assessments in home care. District nurses needs to reduce practice variation could be further explored considering that practice variation plays an important role in the quality of formal assessments.

Keywords: Home care [MeSH term], district nurse, formal assessments, needs, solutions.

ABSTRACT DUTCH

Titel: Een kwalitatief onderzoek naar behoeften en mogelijke oplossingen van wijkverpleegkundigen om indicatiestellingen in de wijkverpleging te verbeteren.

Achtergrond: De financiering en toewijzing van zorg bij wijkverpleging verschilt in heel Europa. In Nederland zijn wijkverpleegkundigen bevoegd om zorg toe te wijzen. Dat wordt indicatiestelling genoemd. In de indicatiestelling bepaalt de wijkverpleegkundige de zorgvraag of basis van de zorgbehoeften van de patiënt. Er treedt echter praktijkvariatie op in indicatiestellingen, wat betekent dat er een verschil is in de toewijzing van zorg in vergelijkbare patiëntsituaties. Praktijkvariatie vermindert de kwaliteit van zorg. Aangezien wijkverpleegkundigen indicatiestellingen uitvoeren, is het van belang om inzicht te krijgen in de behoeften en mogelijke oplossingen van wijkverpleegkundigen om de kwaliteit van indicatiestellingen te verbeteren.

Doel: Het doel van dit onderzoek was om de behoeften en mogelijke oplossingen van wijkverpleegkundigen te onderzoeken om de kwaliteit van de indicatiestellingen te verbeteren om zorgbehoeften van patiënten in de wijkverpleging te bepalen.

Methode: Een verkennende kwalitatieve studie is uitgevoerd. Wijkverpleegkundigen zijn doelbewust geselecteerd. Semigestructureerde interviews zijn in maart en april 2020 uitgevoerd. Een thematische analyse is uitgevoerd.

Resultaten: Er zijn twee hoofdthema's geïdentificeerd na het interviewen van wijkverpleegkundigen (n=12): behoeften van wijkverpleegkundigen ten aanzien van verbetering van kwaliteit en uniformiteit en randvoorwaarden van wijkverpleegkundigen voor kwaliteit en uniformiteit verbetering. Wijkverpleegkundigen vinden leren van en met elkaar en educatie van belang om de kwaliteit en uniformiteit van indicatiestellingen te verbeteren. Wijkverpleegkundigen hebben randvoorwaarden vastgesteld om de kwaliteit van indicatiestellingen te verbeteren: het behouden van autonomie, meer tijd en meer structuur en faciliteiten.

Conclusie: Deze studie geeft inzicht in behoeften en oplossingen van wijkverpleegkundigen om de kwaliteit van de indicatiestellingen in de wijkverpleging te verbeteren. De behoeften van wijkverpleegkundigen om praktijkvariatie te verminderen zou verder onderzocht kunnen worden, aangezien praktijkvariatie een belangrijke rol speelt in de kwaliteit van indicatiestellingen.

Kernwoorden: Wijkverpleging, wijkverpleegkundige, indicatiestellingen, behoeften, oplossingen.

INTRODUCTION AND RATIONALE

Europe is confronted with an increasing demand for home care due to the rising complexity of care and the aging population[1,2]. Meanwhile there are shortages of home care nursing staff. Home care differs widely across Europe in policy, financing, access of care, and in the allocation of care[1,3,4]. However, policy makers in Europe have similar goals: universal access and good quality and (cost) efficiency of care[1]. Governments try to manage healthcare costs and quality of care by controlling the allocation of care using strict eligible criteria, demanding partial payments from patients, and a needs analysis based on established criteria. In many countries, care allocation is based on a needs assessment by a general practitioner, municipality or an insurance company[1].

In the Netherlands, district nurses (DNs) were authorised to perform formal assessments until the 1990s[5]. Bachelor- or Master-level DNs have regained the authority to perform formal assessments since 2015[6,7]. In 2019, around 589.000 patients received home care with a formal assessment performed by a DN[6]. A formal assessment is a method for DNs to methodically determine the care demand based on care needs, while considering the self-reliance of the patient and the possible contribution of informal care[8]. This occurs in consultation with the patient[17]. This results in a description of the amount of hours for care per week and how and by whom the care will be provided[7,9].

Performing formal assessments is not a standardised process since formal assessments are based on each individual patient, and every patient has their own care needs[7]. This leads to variation between patients and home care organizations in formal assessments; differences exist in formal assessments off comparable patients. This phenomenon is called practice variation and is defined as ´the extent to which healthcare providers differ in the frequency with which and/or how care is provided to patients with comparable health issues´[10,p.17,11]. Practice variation occurs in different care settings, such as in hospital care settings (e.g. hospital admissions, surgical procedures and prescriptions drug use)[12]. Practice variation also occurs in home care within and between European countries[13]. Difference within countries are in the hours of allocated care. Difference between countries include care allocation, availability of care and the employability of informal care. This variation could not be explained by difference in patient characteristics[13]. Practice variation in healthcare raises critical concerns about quality and cost efficiency of care because it causes both underuse and overuse of care[12].

Dutch health insurance companies and the Dutch government discussed differences in formal assessments between DNs and home care organizations. Differences were found in the allocation of care and the amount of hours of care per week for comparable patients[10,14,15]. The

amount of allocated care hours can differ as much as 2.7 times and the average duration of home care provided between contracted and non-contracted home care organizations can differ up to one month[16]. This is undesirable given the cost of 3.5 billion euro in 2018[16]. It is important to reduce practice variation to diminish high costs and improve the quality of the formal assessments[17,18]. DNs have a great influence on the quality of formal assessments, given they are authorized to perform formal assessments[19].

It is unknown what DNs need to improve the quality of formal assessments. DNs might have possible solutions for optimizing the quality of formal assessments.

AIM

The aim of this study was to explore the needs and possible solutions of district nurses to improve the quality of the formal assessment to determine the care needs of patients in home care.

METHOD

Design

A qualitative explorative study was conducted. This design was chosen to gain insights into a relatively new phenomenon with limited present research[20,21].

Setting and population

This study was conducted with DNs employed in Dutch home care. Purposeful sampling was used to include DNs for this study[22,23]. Maximum variation was sought in gender; age; years of experience in performing formal assessments; employed organisation; and operation area. DNs were eligible for inclusion if they were a registered nurse employed within home care; had performed a formal assessment in the past six months; and spoke Dutch fluently. The Dutch professional nursing association was contacted and asked to send an invitation to a large group of DNs who are a member of the specific group called ‘society and health’. Members of this group distributed the invitation to participate in their employed organisation. The invitation was also placed in a newsletter send by the specific group. The invitation also was distributed within a national home care organization. Hereafter the snowball method was applied, DNs who participated in this study were asked if they knew a DN who was eligible to participate. DNs were asked to email or call the researcher if they agreed to participate. The researcher sends an information letter to each participant. Participants signed the informed consent prior to the interview.

Data collection

Semi-structured interviews were conducted guided by a topic list based on the literature and supporting tools and guides[6,7,9,24,25]. Interviews were conducted in March and April

2020 by the researcher (BB). Interviews were conducted face-to-face, through videocalls and by telephone. The face-to-face interview was conducted at the house of the DN. DNs were all at private settings during the telephone and videocall interviews. The opening question was 'How do you perform the formal assessment and what supportive tools do you use?' This question was intended to let the DNs talk about their application of the formal assessment and create an opening for follow-up with other topics. The topics were: current situation, quality, and needs and solutions. The topic list is shown in Table 1.

[Table 1]

Data analysis

Data was analysed using thematic analysis according to Braun and Clarke[26]. New codes and categories were compared with those that were already established. A continuous switch was made between data collection and data analysis. Data analysis was supported by NVivo12 software. Demographic data was descriptively analysed using SPSS24[27].

In the first phase, interviews were transcribed verbatim and re-read for familiarity with the data. Initial codes were made across the data in the second phase. The first three transcripts were re-read and coded by two researchers (BB, MK). Data was coded separately and then discussed afterwards until consensus was reached by the researchers. A summary of the discussion was reviewed by the principal researcher (NB). In the third phase, codes were assigned to potential themes, resulting in an initial thematic map. In the fourth phase, the themes were reviewed and merged, and initial patterns were examined. The themes were named and defined, resulting in a specified thematic map in the fifth phase. The thematical map was discussed by the research group (BB, MK, MT) until consensus was reached in defining the final themes. The final themes were reviewed by the principal researcher (NB). The final report was written in the sixth phase.

Trustworthiness

The trustworthiness of this study was taken in account by applying the qualitative criteria of credibility and dependability[28,29,30]. Credibility was strengthened through researcher triangulation during data analysis, which reduce bias and increased accuracy[20]. Member validation enhanced the credibility of the data collection through respondent verification of the researchers interpretations[20,31]. All participant received a summary of the interview to verify the researchers' interpretation. All participants agreed, although four respondents added certain statements to the summaries. The interpretations and analyse of their interviews were adjusted accordingly. To clarify the thinking process and self-awareness of the researcher, notes were made to reflect the interview skills of the researcher (BB)[32].

Observational notes identified relevant nonverbal responses to increase the dependability of this study[20]. Furthermore, the topic list was peer reviewed by DNs and an expert was consulted to ensure the feasibility and completeness, others might bring new insights and reduces bias[32]. The principal researcher (NB), an experienced interviewer reviewed the interview skills of the researcher (BB). This study was reported by the Consolidated Criteria for Reporting Qualitative research (COREQ)[33].

Ethical issues

This study was conducted according to the principles of the Declaration of Helsinki (2013 version)[34]. To ensure the privacy and anonymity of the participants, a data management plan was developed according to the Dutch 'General Data Protection Regulations' law and University of Applied Science HU protocols[35,36]. This study was no subject to the Medical Research Involving Human Subjects Act (WMO) because participants were not exposed to procedures, rules or behaviours[37].

RESULTS

In total, 12 DNs, employed by 10 different home care organizations participated in this study. Nine were female and the mean age was 35 years old (SD=10.62). One interview was conducted face-to-face, five were conducted by videocall and six by telephone. The duration of the interviews was on average 66 minutes (range: 45-86). One participant cancelled the interview because of personal circumstances. All baseline data is shown in Table 2.

[Table 2]

Themes

Two main themes emerged after analysis: DNs needs for quality and uniformity improvement, and preconditions of DNs for quality and uniformity improvement. The main themes contain sub-themes and are illustrated in Figure 1.

[Figure 1]

Theme 1: DNs needs for quality and uniformity improvement

This main theme contains two subthemes, referring to the needs of DNs to improve the quality and uniformity of the formal assessment. The sub-themes are learning from and with each other and the need for education.

Sub-theme 1.1: Learning from and with each other

Most DNs expressed a need for peer review of formal assessments. DNs stated they need to critically observe each other's formal assessments by reviewing the actions of other DNs and discussing them afterwards.

> 'So you need a peer review anyway. You simply cannot do without it'. Female, 38 years old, 5 years of experience.

DNs stated they prefer to gain insight into each other's formal assessments to see how other DNs handle certain cases and to copy positive assets from each other. Some DNs expressed the need to watch other DNs performing a formal assessment. They mentioned shadowing each other to give feedback on each other's performance of the formal assessment. By discussing the formal assessment afterwards and critically examine the patients' care needs, the care allocation and the amount of hours determined by the DN, DNs think they will learn from each other to improve the quality and uniformity of the formal assessment.

> 'But I would prefer to walk with colleagues, so they can give me feedback, also for me to see how she does things'. Female, 25 years old, 4 years of experience.

Most DNs expressed a need for meetings with other DNs to discuss formal assessments of specific cases. DNs perceived short lines of communication as essential because this enables them to find each other when necessary. They prefer to examine certain cases together to discuss, ask questions and give each other tips about formal assessments. DNs considered it important to learn from each other's knowledge and expertise to improve the quality and uniformity of the formal assessment.

> 'Well just to have a look, are we doing the same thing? How would you do this, learn from each other. This is a case, do you have the same outcome, why and why not. Have a look together, I think this will add value'. Female 39 years old, 5 years of experience.

Some DNs mentioned that junior DNs need guidance and coaching from experienced DNs regarding formal assessments. DNs acknowledged that they need or have needed coaching as a junior DN. DNs perceived coaching as important for improving the quality of the formal assessment.

‘Well to have a mentor or create a junior–senior construction. So, you can coach a junior in the performance of formal assessments’. Female, 38 years old, 5 years of experience.

Some DNs expressed the desire to explore how DNs from other home care organizations perform the formal assessment, to assume each other's knowledge and expertise without reinventing the wheel. DNs mentioned to brainstorming with DNs from other home care organizations, to learn from each other’s approaches and policies regarding the formal assessment. Home care organizations may also learn from each other by adopt positive assets into their own policies regarding formal assessments.

‘And maybe just look at how other organizations how the deal with this. And what you like or prefer or what you actually think is much better to do it that way’. Female, 28 years old, 1 year experience.

Sub-theme 1.2: Need for education

Most DNs expresses the need to be educated about formal assessments. DNs expressed the need for a collective base regarding formal assessments. DNs perceived it as helpful for improving the quality and uniformity of the formal assessments.

‘So there are less uncertainties, so if you give everyone an e-learning every year, but first a real training and then yearly an e-learning with new insights and guidelines and tools every year then everyone knows anything’. Male, 26 years old, 0.5 year experience.

Some DNs mentioned to test the professional competences according to formal assessments. Comparable to the reserved procedures such as injecting and catheterising, formal assessments should also be tested once every few years. DNs acknowledged that this may enhance professional competences and quality in formal assessments.

‘I would favor being allowed to perform formal assessments, if you can prove you did a course. I mean, I also have to be capable and competent to inject, why not in performing a formal assessment’? Female, 52 years old, 5 years of experience.

Theme 2: Preconditions of DNs for quality and uniformity improvement

This main theme consists of three sub-themes in which DNs identified certain preconditions for DNs to improve the quality and uniformity of the formal assessment. The sub-themes

are retaining autonomy, lack of time and structure and facilities to enhance quality and uniformity.

Sub-theme 2.1: Retaining autonomy

Most DNs perceived retaining their autonomy as important. DNs mentioned that autonomy is an essential aspect of performing formal assessments. According to DNs, they have the knowledge and expertise required to perform formal assessments and believe they are competent in doing so. DNs reported that they did not appreciate the influence of employers or health insurance on their formal assessments, because DNs are authorized to perform formal assessments.

> 'That's the fun thing about performing formal assessment, that you, as a DN can do it your way, based on your own knowledge and experience. You've to trust on that. Yes, i think so. And that's how I think a good formal assessment should be. Then it stays fun and if someone says: do it like this way or that way than it's very black and white. Who do you do this for? You are the one with the knowledge'. Male, 26 years old, 0.5 year experience.

Sub-theme 2.2: Lack of time

Most DNs mentioned a lack of time in performing quality formal assessments. Some DNs reported having many other activities aside from performing formal assessments, such as administration, accident care and consultation with other disciplines. DNs acknowledged that this may decrease the quality of formal assessments. DNs stated that if they receive more time, the quality of the formal assessment will improve. However, DNs also noted that they should take more time to perform formal assessments.

> 'More time, but more time is limited. But sometimes I think you just have to make time and just do it. So that's what I could do to improve it'. Female, 28 years old, 4 years of experience.

Sub-theme 2.3: Structure and facilities to enhance quality and uniformity

Most DNs expected accurate information from their employers but DNs think it is custom to be up to date with their knowledge on laws, regulations, and new guidelines of diseases. DNs perceived the provision of accurate information to be important. When they are aware

of new laws and regulations and thus up to date with their knowledge, DNs think they can perform high-quality formal assessments.

> ‘Information provision actually. Yes, you need that to be able to perform a formal assessment, so if something changes, it can always happen, you need to know’. Male, 25 years old, 2 years of experience.

About half of the DNs were familiar with the supporting tools and guides from the Dutch professional nursing association. Some of them reported having read through them once and are no longer actively using it. Other DNs believed that the supporting tools and guides, especially the framework of standards (in Dutch: normenkader) should receive wider attention within home care organizations in the Netherlands. In order to collectively improve the quality and uniformity of the formal assessment.

> ‘Actually, you would like to stamp the framework of standards between someone's ears. If you go through everything from the framework of standards, with every formal assessment, I’m sure that you’ll get very good formal assessments’. Female, 52 years old, 5 years of experience.

Some DNs expressed a need for up-to-date ICT-services which is in line with home care nursing. A few DNs acknowledged that ICT-services are unsuitable because they do not offer enough options for performing high-quality formal assessments.

> ’The ICT possibilities have to be good and fitting, that’s what you really need’. Male, 25 years old, 2 years of experience.

DISCUSSION

This study explored the needs and possible solutions perceived by DNs for improving formal assessment in home care. Two main themes emerged: DNs needs of quality and uniformity improvement, and preconditions of DNs for quality and uniformity improvement. DNs perceived learning from and with each other and education as important needs for DNs to improve the quality and uniformity of formal assessments. DNs defined preconditions to improve the quality of formal assessments by the ability for DNs to retain autonomy in their performance. DNs stress the importance of having and taking more time to perform formal assessments. Structure and facilities were important aspects for DNs to improve the quality and uniformity of formal assessments.

DNs in the current study expressed the need to learn from and with each other through peer reviewing, intervision meetings and to shadow each other. DNs in our study also announced they would prefer to follow a training about formal assessments and to have more time to perform formal assessments. This study results show similarities with De Veer's et al. (2019) quantitative study in the Netherlands[8]. De Veer et al. (2019) examined the experiences of DNs regarding formal assessments by an online survey with 125 DNs. About 62% of the DNs acknowledged they require quality improvement of the formal assessment[8]. The needs of DNs regarding the improvement of quality of the formal assessment found in the study by De Veer et al (2019)[8], confirm the current study findings. These similarities emphasize the importance of supporting DNs in learning from each other, education, and receiving more time to perform a formal assessment. DNs in the current study stress the importance of retaining autonomy in their formal assessments. The study of Maurits (2019) confirms the need for DNs to retain their autonomy[38]. This mixed-method study examines the relationship between autonomy and the attractiveness of working in home care[38]. This study showed that DNs add value to their autonomy and consider autonomy as essential in their professionalism[38]. This confirmation implicates the priority to support DNs in the ability to retain their autonomy in performing formal assessments to improve the quality. As mentioned before, home care in Europe is confronted with practice variation between and within countries[13]. Reducing practice variation and increasing the quality of care are two challenges of home care in Europe[1]. Some countries in Europe use performance-related rewards and control systems to reduce practice variation in care allocation and in allocation of hours of care to the patient[39]. Quality assurance in some European countries is not well developed. However, in most European countries quality improvement is executed by measuring patient outcomes and adhering to strict guidelines and are monitored by government and independent checks[39].

This study has some limitations. The transferability of the results of this study is diminished considering that laws and regulations of formal assessments in the Netherlands differ from other countries. It is imaginable that different needs exist for DNs in countries that have other laws and regulations regarding allocation of care. Moreover, maximum variation did not occur in operating area. DNs were employed by organizations that operated in only five of the twelve provinces of the Netherlands. Further research should include DNs operating in all provinces of the Netherlands, particularly in the north and south provinces, to improve the transferability. Additionally, it was intended to conduct all interviews face-to-face. Due to the COVID19 pandemic, only one interview was conducted face-to-face. Given the non-sensitive nature of the subject, it was not expected that non-verbal responses would change interpretation of data.

Furthermore, the richness of the data implies that the manner of data collection had no severe influence. Therefore videocall and telephone interviews were appropriate methods of data collection in this study[40,41].

This study was strengthened by researcher triangulation during data analysis. Researcher triangulation reduces potential bias and increases the accuracy of the data[20]. DNs in this study were employed within 10 different home care organizations in the Netherlands. These were national, regional, and local organizations. Two self-employed DNs participated in this study; they were employed by at least one, if not multiple home care organizations. This increases the transferability of this study. At last, data saturation occurred meaning there came no new information that would result in new themes[20]. However, to our knowledge, this is the first study exploring the needs and possible solutions of DNs regarding formal assessments in home care.

Future research regarding the improvement of quality of formal assessments is recommended. The needs of DNs to reduce practice variation in and between home care organizations could be further explored considering that practice variation plays an important role in the quality of formal assessments. The results of this study contribute to an enhanced understanding of the needs and solutions of DNs regarding the improvement of the formal assessment. Additionally, the results of this study can support policy makers of home care organizations in the Netherlands. Policy makers should take the needs and possible solutions of DNs into account to improve the quality of formal assessments.

In conclusion, this study provided insight into the needs and possible solutions of DNs to improve the quality of formal assessments in home care. DNs expressed the need to learn with and from each other and the need for education to improve the quality of the formal assessments. Retaining autonomy, more time to perform the formal assessment, and more structure and facilities are important aspects for DNs for improving the quality of the formal assessments.

REFFERENCES

1. Genet N, Boerma W, Kroneman M, Hutchinson A, Saltman RB. Home Care across Europe. European Observatory on Health Systems and policies; 2012.
2. De Groot K, Maurits EEM, Francke AL. Attractiveness of working in home care: An online focus group study among nurses. Heal Soc Care Community. 2018;
3. Kroneman M, Boerma W, van den Berg M, Groenewegen P, de Jong J, van Ginneken E. Netherlands: Health System Review. Health systems in transition; 2016.
4. van den Bulck AOE, de Korte MH, Elissen AMJ, Metzelthin SF, Mikkers MC, Ruwaard D. A systematic review of case-mix models for home health care payment: Making sense of variation. Health Policy. 2020.
5. Bloemendaal I, Essen van G, Kramer S, Windt van der W. Vraag en aanbod van wijkverpleegkundigen; 2015.
6. Putter ID de, Francke AL, Veer AJE de, Rademakers JJDJM. Kennissynthese de wijkverpleegkundige van vandaag en morgen: rollen, samenwerking en deskundigheid van wijkverpleegkundigen; 2014.
7. V&VN. Normen voor indiceren en organiseren van verpleging en verzorging in de eigen omgeving; 2014
8. Veer A, de Groot K, Francke A. Indicatiestellingen wijkverpleging: Ervaringen van verpleegkundigen en verzorgenden. NIVEL; 2020.
9. Bleijenberg N, de Bont M, Rosendal H, Zilverentant M. Expertisegebied wijkverpleegkundigen. V&VN; 2019.
10. Brabers AEM, de Groot K, Groenewegen PP. Practice variation among home care nurses. Primary Health Care Research & Development; 2019.
11. Kievit J, Bögels A, Polder J, Wagner C. Rapport. Begrippenkader Gepaste Zorg en Praktijkvariatie; 2015.
12. Corallo AN, Croxford R, Goodman DC, Bryan EL, Srivastava D, Stukel TA. A systematic review of medical practice variation in OECD countries. Health Policy (New York). 2014.
13. van Hout HPJ, van Lier L, Draisma S, Smit J, Finne-Soveri H, Garms-Homolová V, Bosmands JE, Declercq A, Jonsson P, Onder G, van der Roest HG. Signs of Inequality? Variations in Providing Home Health Care Across Care Organizations and Across European Countries in the IBenC Study. Health Service Insights. 2019.
14. ActiZ, Branchevereniging BTN, Patiëntenfederatie Nederland, Vereniging Nederlandse Gemeenten, Verpleegkundigen & Verzorgenden Nederland, Zorgverzekeraars Nederland, Minister van VWS. Hoofdlijnenakkoord wijkverpleging 2019 t/m 2022. Rijksoverheid; 2018.

15. Actiz, V&VN, Zorg thuis NL, Zorgverzekeraars Nederland. Samen op weg naar een toekomstbestendige wijkverpleging. Een gezamenlijk kader van ActiZ, V&VN, Zorgthuisnl en ZN; 2019.
16. Van Gerwen L, Huijsmans K, Luijk R. Ontwikkeling (niet) gecontracteerde wijkverpleging 2016-2018. Vektis; 2019.
17. Van Beek E, Lemmens K, van Schooten G, Vlieger EJ. Reduceren van praktijkvariatie: budgettaire effecten van scherpere indicatiestelling. Ministerie van Volksgezondheid, Welzijn en Sport; 2010.
18. Van Gerwen L, Huijsmans K, Luijk R. Ontwikkeling (niet) gecontracteerde wijkverpleging 2016-2018. Vektis; 2019.
19. Tussenrapportage Ontwikkeling nieuwe bekostiging wijkverpleging. Nederlandse Zorgautoriteit; 2020.
20. Boeije H. Analysis in Qualitative Research; 2010.
21. Percy WH, Kostere K, Kostere S. Generic qualitative research in psychology. Qual Rep; 2015.
22. Cresswel J. Qualitative, quantitative, and mixed methods approaches. Research design; 2013
23. Moser A, Korstjens I. Series: Practical guidance to qualitative research. Part 3: Sampling, data collection and analysis. European Journal of General Practice; 2018.
24. Harder C, Zilverentant M, Oonk M. Begrippenkader indicatie proces; 2019.
25. Toolbox indicatieproces: hulpmiddel indiceren zorgvraag. Verzorgenden & verpleegkundigen Nederland; 2018.
26. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006.
27. IBM. IBM SPSS Advanced Statistics 24.
28. Denise, F. Polit and Cheryl, Tatano B. Essentials of Nursing Research Seventh Edition Appraising Evidence for Nursing Practice. Journal of Chemical Information and Modeling; 2013.
29. Guba EG. Criteria for assessing the trustworthiness of naturalistic inquiries. Educational Communication and Technologie; 1981.
30. Korstjens I, Moser A. Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. European Journal of Genaral Practice; 2018.
31. Goldblatt H, Karnieli-Miller O, Neumann M. Sharing qualitative research findings with participants: Study experiences of methodological and ethical dilemmas. Patient Education and Counseling; 2011.

32. Holloway I, Wheeler S. Qualitative Research in Nursing and Healthcare. John Wiley & Sons; 2010.
33. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. Int J Qual Heal Care; 2007.
34. Declaration of Helsinki World Medical Association Declaration of Helsinki; 2013.
35. Schermer BW, Hagenauw D, Falot N. Handleiding Algemene verordening gegevensbescherming. Ministerie van Justitie en Veiligheid; 201
36. HU university of applied sciences. Data management - HU Bibliotheek.
37. Centrale Comissie Mensgebonden Onderzoek. Uw onderzoek: WMO-plichtig of niet?
38. Maurits E. Autonomy of nursing staff and the attractiveness of working in home care. 2019
39. Genet N, Boerma W, Kroneman M, Hutchinson A, Saltman RB. Home Care across Europe, Case studies. Eur Obs Heal Syst Policies, WHO. 2013
40. Vadi MG, Malkin MR, Lenart J, Stier GR, Gatling JW, Applegate RL. Comparison of web-based and face-to-face interviews for application to an anesthesiology training program: a pilot study. International Journal of Medical Education; 2016.
41. Sturges JE, Hanrahan KJ. Comparing Telephone and Face-to-Face Qualitative Interviewing: A Research Note. Qualitative Research Guidelines Project; 2004.

TABELS & FIGURES

Table 1. Topic list

Opening question: How do you perform the formal assessment and what supportive tools to you use?	
Topics	Questions
Current situation	•Are you familiar with the supportive tools of V&VN? And if so, which one can you name? •Which of these supportive tools do you use? •How do these supportive tools support you when performing a formal assessment? •What motivates you to use or not use these supportive tools? •Which classification system do you use when performing a formal assessment? •How does the current classification system support you? •Do you feel that the formal assessments are roughly the same between the district nurses and within your organization? •What contributes to this equality or differences between formal assessments? •How are you influenced in performing formal assessments?
Quality	•What do you think about the quality of your formal assessments? •What do you think about the quality of the formal assessments within your organization? •Which aspects contribute to a good formal assessment / what do you think a good formal assessment should look like?
Needs and solutions	•What do you and your colleagues do to maintain and improve the quality of the formal assessment? •What does your organization do to maintain and improve the quality of the formal assessment? •What do you need to improve the quality of the formal assessment? •What do you need from your organization to maintain and improve the quality of the formal assessment? •What solutions or interventions do you have to improve the quality of the formal assessment? •What do you and your colleagues do to perform a more equal/uniform formal assessment? •What does your organization do to have district nurses perform a more equal/uniform formal assessment?

•How do you think the formal assessments between district nurses could be more equal/ uniform?

•What needs do you have regarding to the available frameworks and supportive tools?

Figure 1. Thematic map

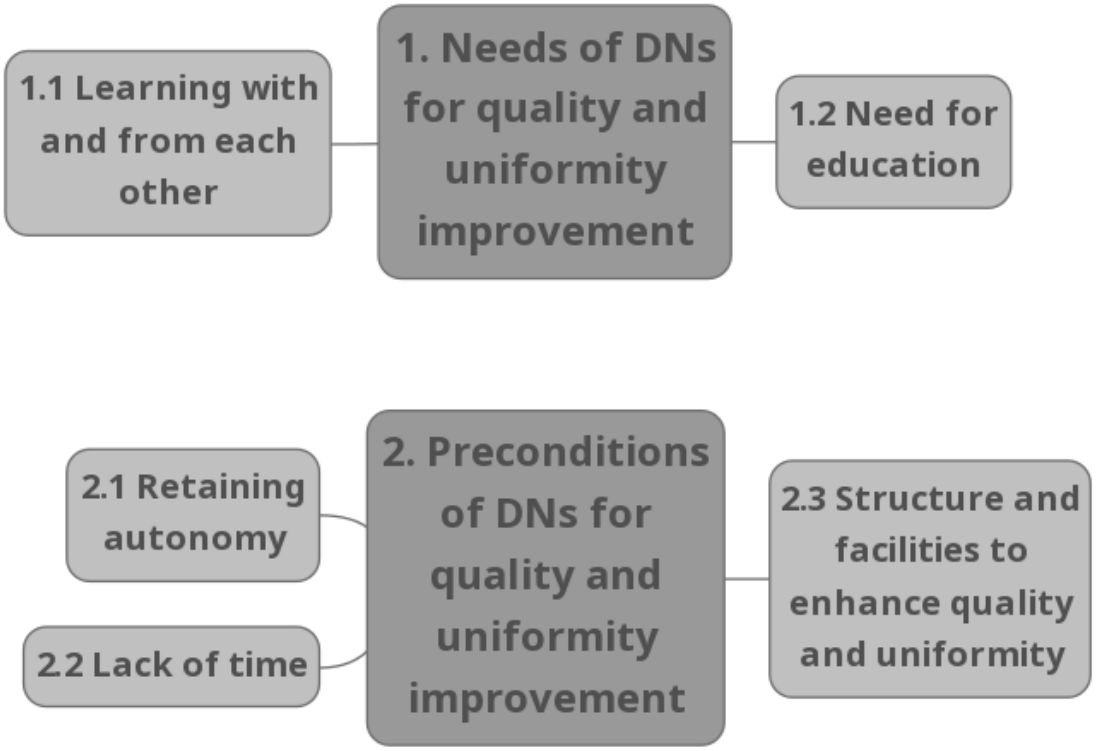

Table 2. Demographic characteristics

Participant characteristics N=12		
Gender	Female	9 (75%)
Age	Mean 35 year	SD (10.62)
	20-30 year	6
	31-40 year	3
	41-50 year	1
	51-60 year	2
Experience in performing formal assessments	Mean 3.7 year	Range (0.5-5)
	0 year	1
	1 year	1
	2 years	1
	3 years	1
	4 years	2
	5 years	6
Organisation type	Local	1 (8.3%)
	Regional	3 (25%)
	National	6 (50%)
	Freelance	2 (16.7%)
Operating area	NB	2 (16.7%)
	FLE	1 (8.3%)
	GLD	2 (16.7%)
	ZH	6 (50%)
	DRE	1 (8.3%)