GRADUATION RESEARCH:

The development of the scope of practice in rehabilitation care: a learning history study

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ABSTRACT

Background: The number of people per year in the Netherlands requiring geriatric rehabilitation care is increasing. Despite the recognition of rehabilitation care as a nursing specialisation, there remains a lack of clarity regarding the scope of practice of rehabilitation nurses. Nurses' scope of practice is influenced by education, experience, field of work and personnel availability. Care organisations face a major challenge to organise care, with a focus on staff autonomy. Self-organising teams are used in this case study as an implementation of more autonomy and positive work environment. How this is experienced by different stakeholders in a long-term care setting is unclear.

Research question: How did the scope of practice in short-term rehabilitation care developed over time and how does this relate to nurse autonomy in a self-organising team in a long-term facility?

Method: A qualitative descriptive method called learning history was used to investigate the research question.

Results: Increased complexity of care and nurse autonomy have deepened the scope of practice. New tasks for the nurses through the introduction of self-organising teams have broadened the scope of practice. Nevertheless, varying degrees of autonomy, one-sided communication and lack of a supportive manager put pressure on the introduction of self-organising teams.

Conclusion: The scope of practice has become broader and deeper due to the increased complexity of care and development of the nurse autonomy. However, the introduction of self-organising teams is under pressure due to challenging change process regarding the autonomy of nurses.

Recommendations: A positive work environment consisting of autonomy, teamwork and a positive manager are the basis for self-organising teams. This basis is needed to provide a proper fulfilment of the changing nursing scope of practice.

Keywords: Scope of practice, nurse autonomy, short-term rehabilitation care, learning history

SAMENVATTING

Achtergrond: Het aantal mensen per jaar dat in Nederland geriatrische revalidatiezorg nodig heeft, neemt toe. Ondanks de erkenning van revalidatiezorg als verpleegkundig specialisme, blijft er onduidelijkheid bestaan over de scope of practice van revalidatieverpleegkundigen. De scope of practice van verpleegkundigen wordt beïnvloed door opleiding, ervaring, werkgebied en personeelsaanbod. Zorgorganisaties staan voor een grote uitdaging om de zorg te organiseren, waarbij de autonomie van het personeel centraal staat. Zelf-organiserende teams worden in deze casestudy gebruikt als een implementatie voor meer autonomie en een positieve werkomgeving. Hoe dit wordt ervaren door verschillende betrokkenen in een langdurige zorgsetting is onduidelijk.

Onderzoeksvraag: Hoe heeft de scope of practice in de kortdurende revalidatiezorg zich in de loop van de tijd ontwikkeld en hoe verhoudt zich dit tot de verpleegkundige autonomie in een zelf-organiserend team in een langdurende voorziening?

Methode: Een kwalitatieve beschrijvende methode genaamd leergeschiedenis werd gebruikt om de onderzoeksvraag te onderzoeken.

Resultaten: De toegenomen complexiteit van de zorg en autonomie van verpleegkundigen hebben de scope of practice verdiept. Nieuwe taken voor verpleegkundigen door de invoering van zelforganiserende teams hebben de scope of practice verbreed. Echter, wisselende mate van autonomie, eenzijdige communicatie en gebrek aan een ondersteunende manager zetten de invoering van zelforganiserende teams onder druk.

Conclusie: De scope of practice is breder en dieper geworden door de toegenomen complexiteit van de zorg en de ontwikkeling van de verpleegkundige autonomie. De invoering van zelf-organiserende teams staat echter onder druk als gevolg van veranderingsproces met betrekking tot de autonomie van verpleegkundigen.

Aanbevelingen: Een positieve werkomgeving bestaande uit autonomie, teamwork en een positieve manager zijn de basis voor zelf-organiserende teams. Deze basis is nodig om een juiste invulling te geven aan de veranderde scope of practice van verpleegkundigen.

Trefwoorden: Scope of practice, verpleegkundige autonomie, kortdurende revalidatiezorg, leergeschiedenis

INTRODUCTION AND RATIONALE

The number of patients requiring geriatric care in the Netherlands is increasing(1). There are two reasons for this increase, firstly the ageing of the Dutch population and secondly the positive developments in trauma care(2). These developments lead to a serious challenge in rehabilitation care and urge for a renewed view of the scope of practice within nursing rehabilitation care work and the organisation, management, and governance of rehabilitation care(3).

Nowadays, the demand for geriatric rehabilitation care is high. However, this has not always been the case. Geriatric rehabilitation care is a new concept, nor is rehabilitation care. It was not until the Second World War that the view on rehabilitation care changed. During this war, the focus of the nurses was to patch up soldiers to a state of fitness so they could either return to battle or be sent home(4–6). At this time, interventions focused mainly on disability and physical improvements(4). From those beginnings, the need for rehabilitation became increasingly obvious in the field of physical impairments, such that patient care was no longer centered on the disease itself but on the individual as a unique entity. In 1964 rehabilitation was organized as a nursing speciality(5). Rehabilitation nursing has been defined as 'the diagnosis and treatment of human responses of individuals and groups to actual or potential health problems stemming from altered functional ability and altered lifestyle'(5). Despite the recognition of rehabilitation care as a nursing specialisation, there remains a lack of clarity regarding the scope of practice of rehabilitation nurses(4).

According to the International Council of Nurses (ICN), the scope of practice of nurses is dynamic and responsive to the needs of health care(3). Nurses' scope of practice is influenced by the education, experience, and work area of each individual nurse(3). However, nurses find it difficult to define their own scope of practice(7). Nevertheless, the scope of practice is used as a guideline in policy around the deployment of skill mix and staffing(8,9). Nursing skill mix constitutes the proportions of different levels of nurse, including the level of qualifications, expertise, and experience, available for patient care during a nursing shift(8). In rehabilitation care, the nursing workforce comprises of two levels of regulated qualified nurses, Bachelor educated Nurses (BN), and Vocationally educated Nurses (VN)(10). Due to staff shortages and difficult retention of BNs, it is difficult to get the desired staff mix(10,11). As a result, the roles are blurred, and tasks are often allocated inappropriately(10). To optimally use the qualities of the nursing levels, new job descriptions need to be created within the care organisation. Long-term care organisations in the Netherlands provide different forms of care(10). This creates a challenge in designing attractive job descriptions and a positive work environment for nurses working in different

care settings(10,12). Especially, for a short-term rehabilitation setting within a long-term care facility.

According to Oosterveen et al. (2021), a positive work environment is important for good patient care and is strongly associated with attracting and retaining healthcare professionals(12). This study revealed the following top five of the most important aspects of a positive working environment: autonomy, multidisciplinary collaboration, supportive manager, teamwork, and workload(12). Nurse autonomy is even linked to better patient outcomes(12,13). More healthcare organisations are therefore making nurse autonomy a priority in their organisational policy. Self-organising teams at Buurtzorg, in which the nurses were given a central role in the management and design of care is a successful and well-known example(14,15). These organisational changes would, ideally, lead to a renewed scope of practice with so called hybrid professional characteristics in it(16). Hybrid professionalism is framed by Noordegraaf by coordinating cooperation with flexibility in authority and meaningful values(16). The new scope of practice consisting of more autonomy and a positive influence on the work environment, is the starting point of the self-organising teams in the long-term care organisation in this case study, *De Wever*.

To explore how the scope of practice has developed in short-term rehabilitation care in relation to nursing autonomy in a self-organising team, a learning history method is used to reflect on the past with the aim of providing advice for the future(17,18).

RESEARCH QUESTION

How did the scope of practice in short-term rehabilitation care developed over time and how does this relate to nurse autonomy in a self-organising team in a long-term facility?

METHOD

Study design

A qualitative descriptive method called learning history was used to investigate the research question(17–20). This method has, according to Lyman & Moore (2018), similarities with the grounded theory approach(17). This learning history method contains the following steps: define the research setting; form the research team; convene key stakeholders; collect data; analyse data; validate data(17).

Research setting

The research is conducted in a long-term care facility in the south of the Netherlands. For this study, only those involved in short-term geriatric rehabilitation departments were included.

Research team

The research team consisted, in line with the learning history approach, of an external research team and an internal researcher(17–20). The external research team was familiar with the research methodology and supported the principal investigator (S.S.) in the design and implementation of the research. The internal researcher is team manager of a number of short-term rehabilitation departments within the organisation. She served as a gatekeeper, kept the external researchers sharp and ensured that they kept the right question in mind(21).

Participants (Key stakeholders)

The participants of the study or stakeholders in learning history language, were selected by a purposive sampling method, in order to get a sample with varying degrees of interest in the organisation and familiarity with organisational processes(17,18,22). Participants were considered eligible to participate if they understand written and spoken Dutch, had at least a working experience of three months within the current department and a working experience of at least a year within the care organisation. Participants were excluded from participation if they were still in training for a function.

An information letter about the study prepared by the principal investigator (S.S.) was further distributed to potential participants by the internal researcher. If potential participants were willing to participate, they could pass this on to the internal researcher, and permission was asked to be contacted by the principal investigator (S.S.) to re-explain the study and arrange an interview.

The researcher received a list with fifteen potential nurses and five potential management/policy members to participate. Eight nurses were selected to be interviewed and all five management/policy members were asked to be interviewed. The potential nurses were divided according to their level of education so that a proportionate number of nurses would be selected for each level of education.

Data collection

Prior to the interviews, an interview with one of the cluster managers took place. Based on this interview and additional documentation from the organisation, a topic list was established, see Appendix 1.

All twelve semi-structured interviews were conducted by the principal investigator (S.S.) via video calls using Microsoft teams. Only the first interview was supervised by the coordinating investigator (P.L.) to provide feedback on the interview technique after the first interview. Before starting the interview, the study was re-explained, and verbal informed consent was asked. The verbal consent was audio-recorded as alternative for written consent. Before the interview questions started, demographic data as age, highest degree of education and years of deployment were asked.

Each interview began with an inviting question. To ensure that the tone of the interviews became more informal, and the participants had the opportunity to speak freely. Throughout the interview, participants were encouraged to talk about their own experiences and opinions, with the researcher asking more in-depth questions.

During the interview, the researcher summarised to check whether the researcher had interpreted the information correctly. At the end of each interview, a short summary of the interview was given. After which the participants were asked if they agreed and had anything to add.

Analysis of data

The data was analysed according to the steps of the distillation process common in a learning history approach(17,18,20). In the distillation process, the raw data are condensed into a coherent narrative of the changes that have taken place in the organisation(17–19). This process shares some similarities with a thematic grounded theory approach(17,19).

The analysis of the data started after the first interview was conducted. In step one, the interviews were transcribed verbatim and read and reread by the researcher (S.S.) to become familiar with the data(17). During this same process, the researcher examined other raw data such as annual reports of the organisation and documents referred to in the interviews. Through this process, new insights came to light which made it possible to sharpen the topic list for the next interview.

While the first process was still running, the coding of the data was started. During the coding process, fragments from the transcripts were given labels with the use of Atlas.ti software version nine. Thereby, concepts and events related to each other were grouped into categories by the researcher (S.S.). After the first coding process, the labels were refined by discussing them with members of the research group. Critical questions were asked by the research group so that the researcher (S.S.) could possibly rephrase the labels. As a result, adjustments were made in the assignment of labels. Then the first version of the learning history was written, in which the researcher (S.S.) looked for multi-voicing and highlighted any outliers.

Validation

After the distillation process was completed, the researcher validated her findings with the participants in the form of a member check. The member check consisted of two interviewed participants, the internal researcher, the principal investigator (S.S.) and the coordinating researcher (P.L.). Through the member check, the participants were asked to discuss additions or changes that would convey the learning history of the organisation more clearly and effectively.

Ethical considerations

Ethical approval was granted by the CCMO of the Radboud UMC for the overarching study. The committee reviewed the study and classified it as non-medical-scientific research (non-WMO)(23). Further approval was obtained from the scientific research committee of the care organisation De Wever, and permission for further performance was given by the manager of the short-term rehabilitation care.

To ensure that the research complies with the Helsinki Declaration and the Data Protection Act (AVG), a data management plan was used to guide the data collection process(24,25).

To ensure that data could not be traced back to the respondent, participant numbers were assigned to each respondent and data file. The personal data of participants with their study number are stored at a different network disk with password protection than the other documents such as records and transcripts. All data will be kept for 10 years on a personal network drive of Utrecht University of Applied Sciences with password protection. Only the principal investigator (S.S.) and the coordinating investigator (P.L.) have access to all documents including an overview of participant numbers.

Furthermore, participants were informed that all data are kept confidential, that participation was voluntary and that they could withdraw at any time without reason.

Trustworthiness

To enhance trustworthiness and quality of the research, the COREQ checklist for reporting is used(26). The checklist checks whether the items in the study design are written in sufficient detail to ensure transparency and reliability. A member check was used to check for new information and to find an appropriate form of information transfer for the organisation’s learning history. In addition, peer students and members of the research team were used to provide feedback on the research process(22,27).

To minimize researcher bias, the researcher reflects and discussed thoughts and feelings within the research group to re-evaluate impressions of respondents and challenge pre-existing assumptions and hypotheses(22,27).

RESULTS

Out of the 13 participants approached for recruitment, 12 participants agreed to participate. The mean age was 46 ranged from 33-55 years and most participants were female (n = 10). Eight participants worked as nurse and four participants had a management or human research role within the care-organisation. An overview of the characteristics of the 12 participants are presented in Table 1.

[Insert Table 1 here]

The following four themes describes the learning history: Becoming a responsible rehabilitation nurse in the lead; Exploring the scope of practice: Does education matter; the search for who's in charge; Self-organising asks for mutual engagement.

Becoming a responsible rehabilitation nurse in the lead

With the development of healthcare, the nursing profession has also changed. Nurses experience more responsibility in caring for the client. This new responsibility requires different qualities from nurses and a different way of working. The interviewed nurses indicate that they are taking more control in caring for the client. *"The difference is that you start the conversation more often and see what you can accomplish together. Whereas before, there was more of a manager who said this is what we are going to do,"* says a nurse. Taking more control and responsibility in day-to-day care is seen by nurses as important and as a new characteristic for the current role of the nurse. For example, a nurse mentioned, that taking more control in client care was one of the characteristics of nursing leadership.

Exploring the scope of practice: does education matter?

When nurses were asked to name qualities that they possess as individuals, they seem to have difficulty in giving a clear meaning to this. In the first instance, they often get lost in specialist terms or terms associated with the job description, such as transcending the scope of work, coordination, helicopter view, coaching. Only when asked to explain with a practical example, more concrete characteristics and actions emerge. A nurse mentions the example of coaching colleagues: *"I am the one who says, give the message back to the person and take action*". She said that she wants to be an example to her colleagues and refers to the expectations of her level of education, bachelor educated nurse.

In the education of nurses, a distinction is made between levels, to which certain qualities are linked. In the workplace, the difference in education levels appears to be fading. There is no difference in direct client care, such as washing and dressing, according to the nurses. But if you look at the way of thinking, nurses do notice a difference. A nurse said the following about this: *"It is easier for me to nuance, to reflect in a different way or to paint a different picture for other people*". Mainly the BN's recognise this difference. The BN's mentioned the following aspects corresponding to their level: reflective capacity, thinking outside the box and a coaching role. Not all VN's recognise this difference. *"We have a number of higher education nurses and a number of higher vocational education nurses, but the distinction is not really made. We do function as one team*." said a VN about the different education levels. She did see a difference between nurses but referred to it as the difference in years of experience and personality.

The search for who's in charge?

In terms of autonomy, the nurses themselves make decisions in direct client care, such as the use of nursing interventions, but also the possible scaling up or down of care. *"If the number of clients is low, we decide to give colleagues some time off. And we ask for more staff when the level of care is heavy".* There are differences between departments in how far this autonomy extends. Mutual resistance of nurses to new tasks causes differences in independence and responsibility of teams within the same organisation. One nurse said: *"then I would have to speak to you as a colleague, well I'm not going to do that".* Regarding the fact of addressing colleagues about sick leave. That's a task for the manager according to the nurses. This is one of the examples that nurses do not agree with in line of the new policy process.

Nurses indicate that communication with the management is often one-sided. "*It (new information) is not communicated in the right way, which gives way to different interpretations. This creates unnecessary unrest among colleagues*", according to a nurse. The question that arose was why the nurses do not demand more participation. They do show their direction and responsibility in terms of direct client care, but what about their position in the organisation?

Self-organising asks for mutual engagement

The differences between teams marks the organisational process of self-organising teams. With the new management philosophy around self-organising teams, the organisation wants to give the nursing teams more steering and independence. *"We want fewer rules together and you want to create more space for the professional to act more within his own professional framework,"* says the management. However, this freedom of choice is not yet experienced by the nurses*. "Instead of being an independent team, on the one hand they say you have to do everything yourself, and on the other hand they give you all kinds of tasks and assignments that you have to carry out from the top".* This statement illustrates the implementation of the new management philosophy is not yet flawless.

Nurses also stated a lack of involvement in the policymaking of self-organising teams. During an interview, a nurse looked at the information poster about the self-organising teams, and said the following about it: *'Just, the fact that it was suddenly there, in 2018 there came a form [...], it said what we had to do, and what the tasks of the team managers were. Because, at some point we would have indicated that we wanted to become more independent and do our own thing more."* The nurse cannot recall ever having indicated this. The management indicates that they are also faced with difficult choices, even when others are involved. *"Which, by the way, does not necessarily mean that subsequently everyone recognises themselves in the translation given by the board of directors and the management"*, says a management member. But at the end of the day, they do have a common goal - to provide good quality of care.

DISCUSSION

The purpose of this study was to investigate how the scope of practice has developed in short-term rehabilitation care in relation to nursing autonomy in a self-organising team. The main findings of this study were the different perceptions of the scope of practice of nurses by the participants and the interpretation of nurses' autonomy.

The scope of practice has become broader and deeper over time. The increasing complexity of the client has led to more knowledge about the client and their clinical profile, which has deepened the nursing scope of practice. As a result, nurses have taken more control in direct client care. This increased autonomy is ideally extended by management to include new organisational tasks, thereby broadening the scope of practice. However, this opinion is not shared by the nurses.

The degree of autonomy differs per department and is negatively influenced by the cooperation with management and positively influenced by the cooperation within the nursing team. This creates pressure on the positive work environment and the development of self-organising teams. The study by Oosterveen et al (2021) shows that multidisciplinary collaboration, autonomy, supportive manager, teamwork, and work pressure influence a positive work environment(12). This research reveals a lack of supportive manager. One-sided communication and lack of management involvement are mentioned by the nurses. However, autonomy and teamwork are perceived as positive by the nurses. Nurses are taking the lead in shaping autonomy and teamwork in their own self-organised team.

However, the new policy of self-organizing teams is under pressure due to the challenging change process regarding the autonomy of nurses. This creates a demand for a different professional, the hybrid professionals, who are characterised by coordinating cooperation with flexibility in authority and meaningful values(16). In practice, however, there are many pure professionals. They are characterised by their dedication to standards, expertise, professional ethics, and human values(16). The current method of introducing self-organising teams creates friction between these two types of professionals. While the hybrid professional wants to apply the new organisational policy, the pure professional holds on to recognisable values and therefore finds change difficult.

A strength of this research was the use of an internal researcher. This researcher served as a point of contact within the organisation, which facilitated the provision of information to potential respondents since the researcher herself was not allowed to visit the site due to covid restrictions. In addition, it was possible to discuss with the internal

researcher to what extent certain plans for the research were considered feasible within the organisation, which made it possible to work more efficiently. Secondly, the research group served as a peer group for the principal investigator. In this way, choices made by the researcher were critically examined and the research group served as a reflection for the researcher. In addition, to enhance trustworthiness, the COREQ checklist for reporting, peer feedback and member check were used(22,26).

A limitation of this research was the use of online interviews due to the covid restrictions. Face-to-face interviews are preferred because, firstly, they are more personal, secondly, as a researcher you enter the conversation more easily and, thirdly, the conversation often goes more smoothly because you see the respondent's reaction more quickly. To build up trust during the online interviews, the choice was made to give each respondent the opportunity to ask additional questions about the research prior to the interviews. A second limitation of the study is the method of approaching participants, this was done by the internal researcher. The internal researcher is team manager within the organisation and does not necessarily have much knowledge about conducting research. In addition, it is not clear to what extent the internal researcher knows the proposed participants and therefore may have selected participants who can form a clearer or more desirable opinion on the subject than others, which may lead to selection bias(22).

Due to the chosen method and small sample size, the results cannot be generalised. The results are only applicable to the described care organisation. However, transferability is often a problem in qualitative research, however it is also not the aim of the study.

CONCLUSION

The scope of practice has become broader and deeper due to the increased complexity of care and the development of the nurse autonomy. However, the development of the self-organising teams and a positive work environment is under pressure due to the different views on the scope of practice, the varying autonomy in the organisation and a lack of supportive manager within the organisation. Nevertheless, nurses are taking the lead in shaping their autonomy in their self-organising team.

Relevance to clinical practice

A positive work environment consisting of autonomy, teamwork and a positive manager are the basis for self-organising teams. Mutual involvement of nurses and management is needed to provide a proper fulfilment of the changed nursing scope of practice.

REFERENCES

1. De Staat van Volksgezondheid en Zorg. Geriatrische revalidatiezorg. [Internet]. Available from: https://www.staatvenz.nl/kerncijfers/geriatrische-revalidatiezorg [Accessed 4th February 2021].

2. Meyer C. Directions: The Changing Face of Rehabilitation Nursing. Am J Nurs. 1993; 93(2): 76–82.

3. Schluter J, Seaton P, Chaboyer W. Understanding nursing scope of practice: A qualitative study. IJNS. 2011; 48(10): 1211–22.

4. St-Germain D. The rehabilitation nurse then and now: From technical support to human potential catalyst by Caring-Disability Creation Process Model in an interprofessional team. J Nurs Educ Pract. 2014; 4(7). 54-61.

5. Spasser MA, Greenblatt RB. Mapping the literature of rehabilitation nursing Professor of Education and Information Services. JMLA. 2006; 94(2): 137-42.

6. van Bergen L, Bakker CTh. Dutch nurses and the Great War: on caregiving and gender. First World War studies. 2021; 11(2): 107-122.

7. Oelke ND, White D, Besner J, Doran D, McGillis Hall L, Giovannetti P. Nursing workforce utilization: an examination of facilitators and barriers on scope of practice. Nurs leadersh. 2008; 21(1): 58–71.

8. Jacob ER, Mckenna L, D'Amore A. The changing skill mix in nursing: Considerations for and against different levels of nurse. J Nurs Manag. 2015; 23(4): 421–6.

9. Dubois CA, Singh D. From staff-mix to skill-mix and beyond: Towards a systemic approach to health workforce management. Human Resour Health. 2009; 7:87: 1–19.

10. Backhaus R, Verbeek H, van Rossum E, Capezuti E, Hamers JPH. Baccalaureate-educated Registered Nurses in nursing homes: Experiences and opinions of administrators and nursing staff. J Adv Nurs. 2018; 74(1): 75-88

11. Griffiths P, Saville C, Ball J, Jones J, Pattison N, Monks T. Nursing workload, nurse staffing methodologies and tools: A systematic scoping review and discussion. Int J Nurs Stud. 2020 Mar; 103:103487.

12. Maassen SM, van Oostveen C, Vermeulen H, Weggelaar AM. Defining a positive work environment for hospital healthcare professionals: A Delphi study. PLoS One. 2021;16(2)

13. van Oostveen C, Vermeulen H. Greater nurse autonomy associated with lower mortality and failure to rescue rates. Evid Based Nurs. 2017; 20(2): 56.

14. Gray BH, Sarnak DO, Burgers JS. Home Care by Self-Governing Nursing Teams: The Netherlands' Buurtzorg Model. Commonwealth fund. 2015; 14(5): 1–10.

15. Kreitzer MJ, Monsen KA, Nandram S, de Blok J. Buurtzorg Nederland: A Global Model of Social Innovation, Change, and Whole-Systems Healing. Global Advances in Health and Medicine. 2015; 4(1): 40–4.

16. Noordegraaf M, Siderius K. Perspectieven op publieke professionaliteit: Van professionals (in organisaties) naar organiserende professionaliteit. M & O. 2016; 70(2): 4–19.

17. Lyman B, Moore C. The learning history: A research method to advance the science and practice of organizational learning in healthcare. JAN. 2019; 75(2): 472–81.

18. Roth G, Kleiner A. Learning about Organizational Learning - Creating a Learning History. Learning. Cambridge, MA: MIT-COL; 1995.

19. Lyman B, Cowan LA, Hoyt HC. Organizational learning in a college of nursing: A learning history. Nurse Educ Today. 2018; 61: 134–139.

20. Kleiner A, Roth G. Field Manual for a Learning Historian. Cambridge, MA: MIT-COL and Reflection Learning Associates; 1996.

21. Simmons M. Insider ethnography: tinker, tailor, researcher or spy? Nurse Res. 2007; 14(4): 7–17.

22. Polit DF, Beck CT. Nursing research: Generating and assessing evidence for nursing practice. 10th ed. Lippincott Williams And Wilkins; 2016.

23. Centrale Commissie Mensgebonden Onderzoek. Uw onderzoek: WMO-plichtig of niet? [Internet]. Available from: https://www.ccmo.nl/onderzoekers/wet-en-regelgeving-voor-medisch-wetenschappelijk-onderzoek/uw-onderzoek-wmo-plichtig-of-niet [Accessed 3rd Dec 2020].

24. Association WM. Declaration of Helsinki World Medical Association Declaration of Helsinki Ethical Principles for Medical Research Involving Human Subjects. JAMA. 2013; 310(20): 2191–4.

25. Autoriteit persoonsgegevens. Algemene informatie AVG. [Internet]. Available from: https://autoriteitpersoonsgegevens.nl/nl/onderwerpen/avg-europese-privacywetgeving [Accessed 1st Nov 2020].

26. 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 Health Care. 2007; 19(6): 349–57.

27. Holloway I, Galvin K. Qualitative research in nursing and healthcare. 4th ed. Chichester, West Sussex, UK: Wiley Blackwell; 2017.

Appendix 1 Topic List

Themes	Nurses	Management/policy staff
Inviting question	▪ Can you tell me about what has changed in your profession and work as a nurse in recent years?	▪ Can you tell me more about your role within the organisation?
Development of the professional group	▪ How has the role of the nurse changed? ▪ Which processes play a role in the changes of the nursing profession?	▪ Which developments have you experienced within the organisation? ▪ What changes in the work of the nursing staff do you experience over the years?
Scope of practice versus educational levels	▪ Do you see any distinction on the work floor between different levels of education? ▪ How is the care divided on the work floor? ▪ To what extent is the level of education more important than the individual qualities and experience of a nurse?	▪ How are different levels of education differentiated within the organisation? ▪ How do nurses respond to this? ▪ To what extent is the level of education more important than the individual qualities and experience of a nurse?
Current organisation policy: self-organising teams	▪ How do you experience the new organisational policies of independent teams? ▪ In what way are you as nurses involved in new policy processes?	▪ What was the reason for the new organisational policy on independent teams? ▪ In what way is this vision implemented within the organisation?
Nurse position	▪ How do you see your role currently within the organisation? ▪ In what way has the position of the nurse within healthcare changed?	▪ What role do nurses have in policy making? ▪ What are the expectations towards the nursing staff with the new organisational policies?

Table 1

Baseline characteristics of the participants

N	12
Male/female	2/10
Age in years, mean (range)	46 (33-55)
Highest degree of education*, n	
MBO	4
HBO	7
WO	1
Years of employment, mean (range)	13 (0.25 – 34)
*Highest degree of education according to the Dutch standards:	
MBO = Secondary vocational education; HBO = Higher professional education.	
WO = University education	