dr. Veerle Duprez
Diensthoofd Verpleegkundig Expertisecentrum

Gemengde zorgteams: een optie voor de toekomst?

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Zorgmodel

Geltmeyer K, Eeckloo K, Dehennin L, De Meester E, De Meyer S, Pape E, Vanmeenen M, Duprez V, Malfait S. (2024). How much do we know about nursing care delivery models in a hospital setting? A mapping review. Nursing Inquiry. doi: 10.1111/nin.12636.

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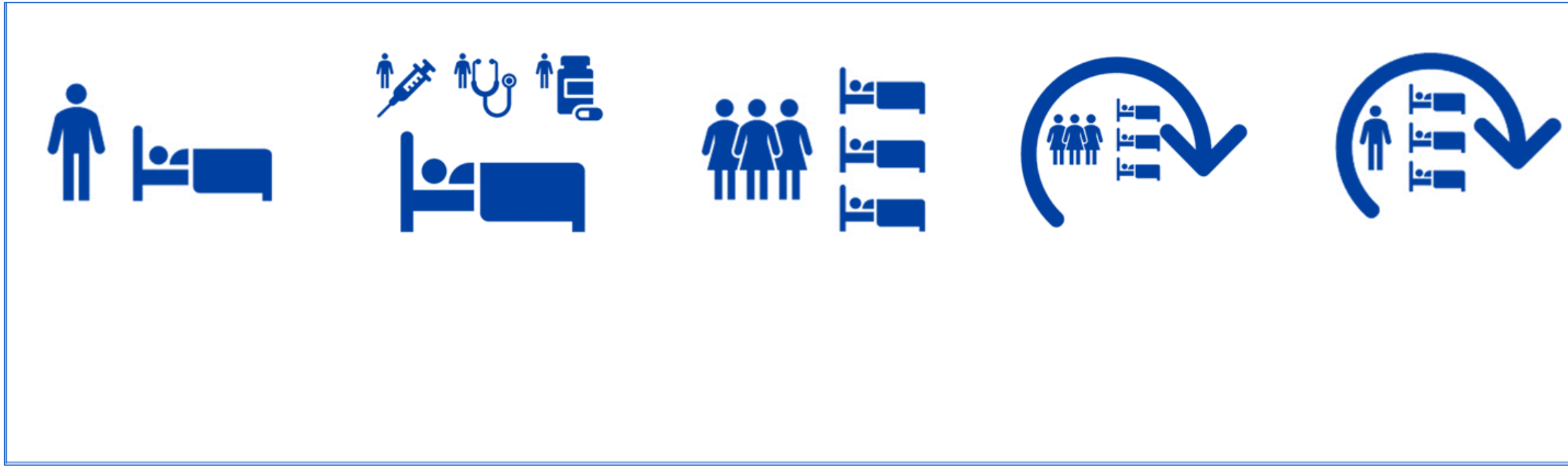
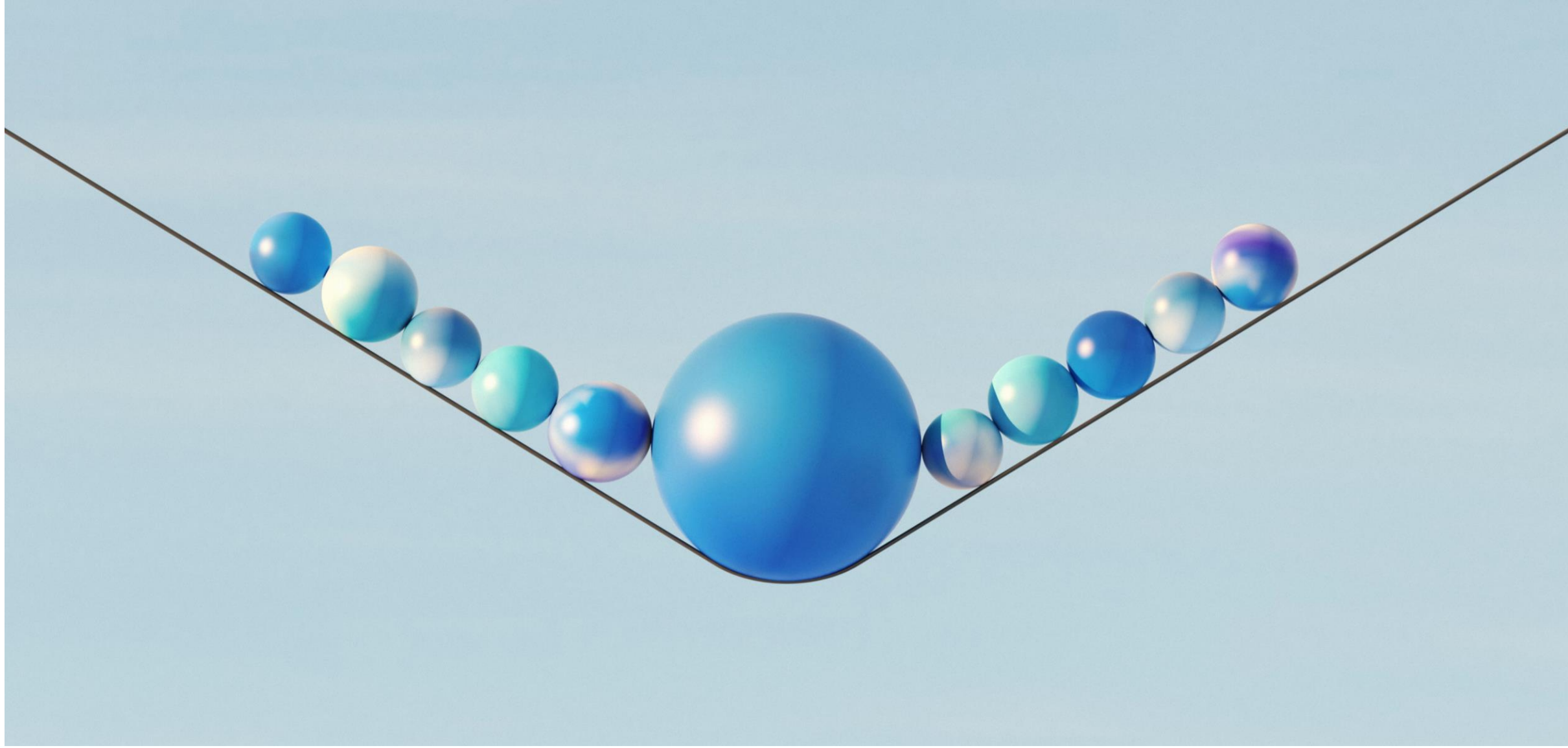


Geltmeyer, K, Duprez V, Blondeel M, Serraes B, Eeckloo K, & Malfait S (2024). The effect of different care delivery models in a hospital setting on patient- and nurse-related outcomes: A systematic review with narrative synthesis. Journal of Advanced Nursing. DOI: 10.1111/jan.16271



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Nieuwe zorgmodellen | wat leert de evidentie ons?

Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study

*Linda H Aiken, Douglas M Sloane, Luk Bruyneel, Koen Van den Heede, Peter Griffiths, Reinhard Busse, Marianna Diomidous, Juha Kinnunen, Maria Kózka, Emmanuel Lesaffre, Matthew D McHugh, M T Moreno-Casbas, Anne Marie Rafferty, Rene Schwendimann, P Anne Scott, Carol Tishelman, Theo van Achterberg, Walter Sermeus, for the RN4CAST consortium**

Lancet 2014; 383: 1824–30

Published Online February 26, 2014 http://dx.doi.org/10.1016/S0140-6736(13)62631-8

See Comment page 1789

*Members are listed at end of paper

Center for Health Outcomes and Policy Research, University of Pennsylvania School of Nursing, Philadelphia, PA, USA (Prof L H Aiken PhD, D M Sloane PhD, M D McHugh PhD); Centre for Health Services and Nursing Research, Catholic University Leuven, Leuven, Belgium (L Bruyneel MS, K Van den Heede PhD, Prof W Sermeus PhD); Faculty of Health Sciences, University of Southampton, Southampton, UK (Prof P Griffiths PhD); Department of Health Care Management, WHO Collaborating Centre for Health Systems, Research and Management, Berlin University

Summary

Background Austerity measures and health-system redesign to minimise hospital expenditures risk adversely affecting patient outcomes. The RN4CAST study was designed to inform decision making about nursing, one of the largest components of hospital operating expenses. We aimed to assess whether differences in patient to nurse ratios and nurses' educational qualifications in nine of the 12 RN4CAST countries with similar patient discharge data were associated with variation in hospital mortality after common surgical procedures.

Methods For this observational study, we obtained discharge data for 422 730 patients aged 50 years or older who underwent common surgeries in 300 hospitals in nine European countries. Administrative data were coded with a standard protocol (variants of the ninth or tenth versions of the International Classification of Diseases) to estimate 30 day in-hospital mortality by use of risk adjustment measures including age, sex, admission type, 43 dummy variables suggesting surgery type, and 17 dummy variables suggesting comorbidities present at admission. Surveys of 26 516 nurses practising in study hospitals were used to measure nurse staffing and nurse education. We used generalised estimating equations to assess the effects of nursing factors on the likelihood of surgical patients dying within 30 days of admission, before and after adjusting for other hospital and patient characteristics.

Findings An increase in a nurses' workload by one patient increased the likelihood of an inpatient dying within 30 days of admission by 7% (odds ratio 1·068, 95% CI 1·031–1·106), and every 10% increase in bachelor's degree nurses was associated with a decrease in this likelihood by 7% (0·929, 0·886–0·973). These associations imply that patients in hospitals in which 60% of nurses had bachelor's degrees and nurses cared for an average of six patients would have almost 30% lower mortality than patients in hospitals in which only 30% of nurses had bachelor's degrees and nurses cared for an average of eight patients.

Interpretation Nurse staffing cuts to save money might adversely affect patient outcomes. An increased emphasis on bachelor's education for nurses could reduce preventable hospital deaths.

Nieuwe zorgmodellen | wat leert de evidentie ons?

English National Health Service (NHS), the study focused on team size and composition, linking daily staffing rosters to patient outcomes. Adding an additional registered nurse to the average ward team on a shift reduced the odds of a patient death on that day by 9.6%. Adding more senior nurses (as measured by pay grade) had a larger effect than adding more junior registered nurses, whereas increases in assistant staff (healthcare support workers) and agency employed registered nurses were not associated with reduced mortality.

EDITORIAL

Nurse staffing and patient safety in acute hospitals: Cassandra calls again?

Peter Griffiths , Chiara Dall'Ora

BMJ Qual Saf: first published a

this research all supports the same conclusion. Support staff are important members of the team, but they are not effective substitutes for registered nurses when it comes to maintaining patient safety. Without sufficient registered nurses to supervise support staff, benefits are not realised and harm can

staff, benefits are not realised and harm can occur. Similarly, agency staff are not effective substitutes, with other studies indicating possible harms arising from heavy reliance on temporary staff.[9] Zaranko *et al* go beyond the existing research in showing the additional benefits of more senior registered nurses.

Gemengde zorgteams | wat leert de evidentie ons?

Received: 9 November 2021 | Revised: 15 April 2022 | Accepted: 15 May 2022
DOI: 10.1111/jan.15334

ORIGINAL RESEARCH: EMPIRICAL RESEARCH - QUALITATIVE

JAN WILEY

Implementing mixed nursing care teams in intensive care units during COVID-19: A rapid qualitative descriptive study

Klara Geltmeyer[1,2] | Dries Neyrinck[1] | Dominique Benoit[1,3] | Simon Malfait[2,4] | Hilde Goedertier[1] | Veerle Duprez[2]

[1]Critical Care Units, Ghent University Hospital, Ghent, Belgium
[2]Nursing Department, Ghent University Hospital, Ghent, Belgium
[3]Department of Medicine and Public Health, Ghent University, Ghent, Belgium
[4]Strategic Policy Unit, Ghent University Hospital, Ghent, Belgium

Correspondence
Klara Geltmeyer, Ghent University Hospital, Ghent, Belgium.
Email: klara.geltmeyer@uzgent.be

Abstract

Aims: The goal of this study was to gain insight into the views and experiences of an intensive care team working in a new nursing-care delivery model during the COVID-19 waves. A new model of care was implemented to augment nursing capacity and provide sufficient intensive care beds.

Design: A qualitative monocentric study using rapid qualitative descriptive methods was reported in line with the COREQ checklist.

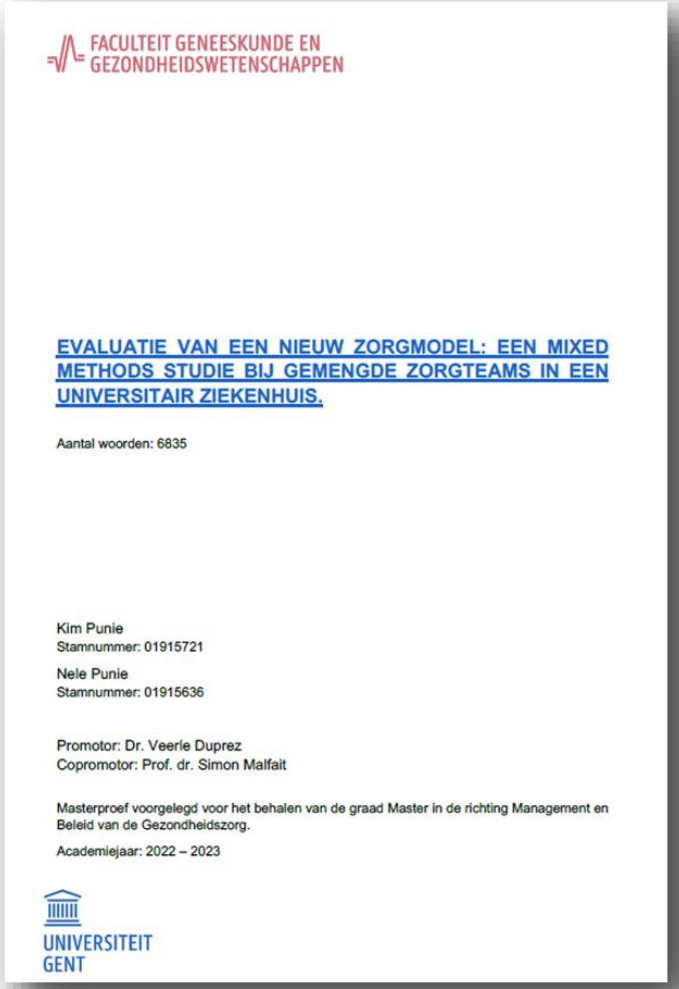
Methods: Nurse, ward manager and physician participants were purposively recruited between January and March 2021 in a tertiary university-affiliated hospital in the Flemish-speaking part of Belgium. Semistructured interviews were conducted and analysed using thematic analysis methods.

Results: The participants were seventeen expert nurses, twelve supporting nurses, seven ward managers and four physicians. A central theme of ensuring safe, high-quality care emerged from the findings. There was a sense of losing one's grip on clinical practice when working in the mixed nursing-care teams. Different underlying experiences played a part in this sense of losing control: dealing with unknown elements, experiencing role ambiguity, struggling with responsibility and the absence of trust. Several coping mechanisms were developed by the nursing-care team to deal with those experiences, including attempts to create stability, to strike a balance between delegating and educating, to build in control and to communicate openly.

Conclusion: In this rapid qualitative descriptive study, the implementation of a new nursing-care delivery model during a pandemic was seen to lead to several challenges for all members of the care team. Coping mechanisms were developed by the team to deal with these experienced challenges.

Impact: When rethinking nursing-care delivery models, the findings of this study may help guide the process of implementing mixed nursing-care teams. Special attention needs to be paid to clarifying roles, sharing responsibility and clinical leadership. Other significant influences (such as moral distress) should also be taken into account.

KEYWORDS
Covid-19, experiences, implementation, nurses, nursing, nursing-care delivery model, pandemic, qualitative study



FACULTEIT GENEESKUNDE EN GEZONDHEIDSWETENSCHAPPEN

EVALUATIE VAN EEN NIEUW ZORGMODEL: EEN MIXED METHODS STUDIE BIJ GEMENGDE ZORGTEAMS IN EEN UNIVERSITAIR ZIEKENHUIS.

Aantal woorden: 6835

Kim Punie
Stamnummer: 01915721

Nele Punie
Stamnummer: 01915636

Promotor: Dr. Veerle Duprez
Copromotor: Prof. dr. Simon Malfait

Masterproef voorgelegd voor het behalen van de graad Master in de richting Management en Beleid van de Gezondheidszorg.

Academiejaar: 2022 – 2023

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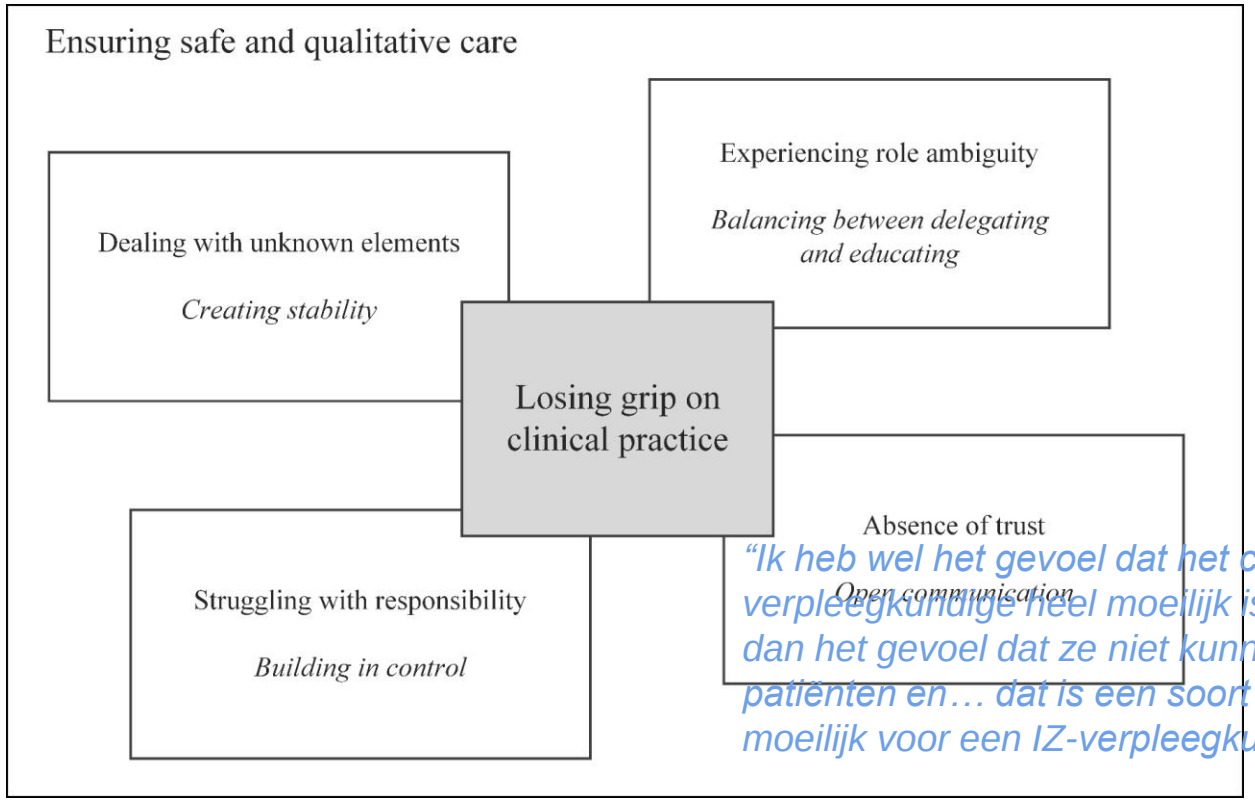
Gemengde zorgteams | wat leert de evidentie ons?



"Ik heb wel het gevoel dat het concept van 1 op 3 voor een verpleegkundige heel moeilijk is om te accepteren. Ze hebben dan het gevoel dat ze niet kunnen 100% controle hebben over patiënten en… dat is een soort loslaten en dat is soms heel moeilijk voor een IZ-verpleegkundige." (arts)

Geltmeyer, K., Neyrinck, D., Benoit, D., Malfait, S., Goedertier, H., & Duprez, V. (2022). Implementing mixed nursing care teams in intensive care units during COVID-19 : a rapid qualitative descriptive study. JOURNAL OF ADVANCED NURSING, 78(10), 3345–3357. https://doi.org/10.1111/jan.15334

Gemengde zorgteams | wat leert de evidentie ons?

- Belang van rolduidelijkheid
- Belang van standvastigheid
- Belang van vertrouwen
- Verantwoordelijkheid
- Klinisch leiderschap

Received: 9 November 2021 | Revised: 15 April 2022 | Accepted: 15 May 2022
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ORIGINAL RESEARCH: EMPIRICAL RESEARCH - QUALITATIVE

JAN WILEY

Implementing mixed nursing care teams in intensive care units during COVID-19: A rapid qualitative descriptive study

Klara Geltmeyer[1,2] | Dries Neyrinck[1] | Dominique Benoit[1,3] | Simon Malfait[2,4] | Hilde Goedertier[1] | Veerle Duprez[2]

[1]Critical Care Units, Ghent University Hospital, Ghent, Belgium
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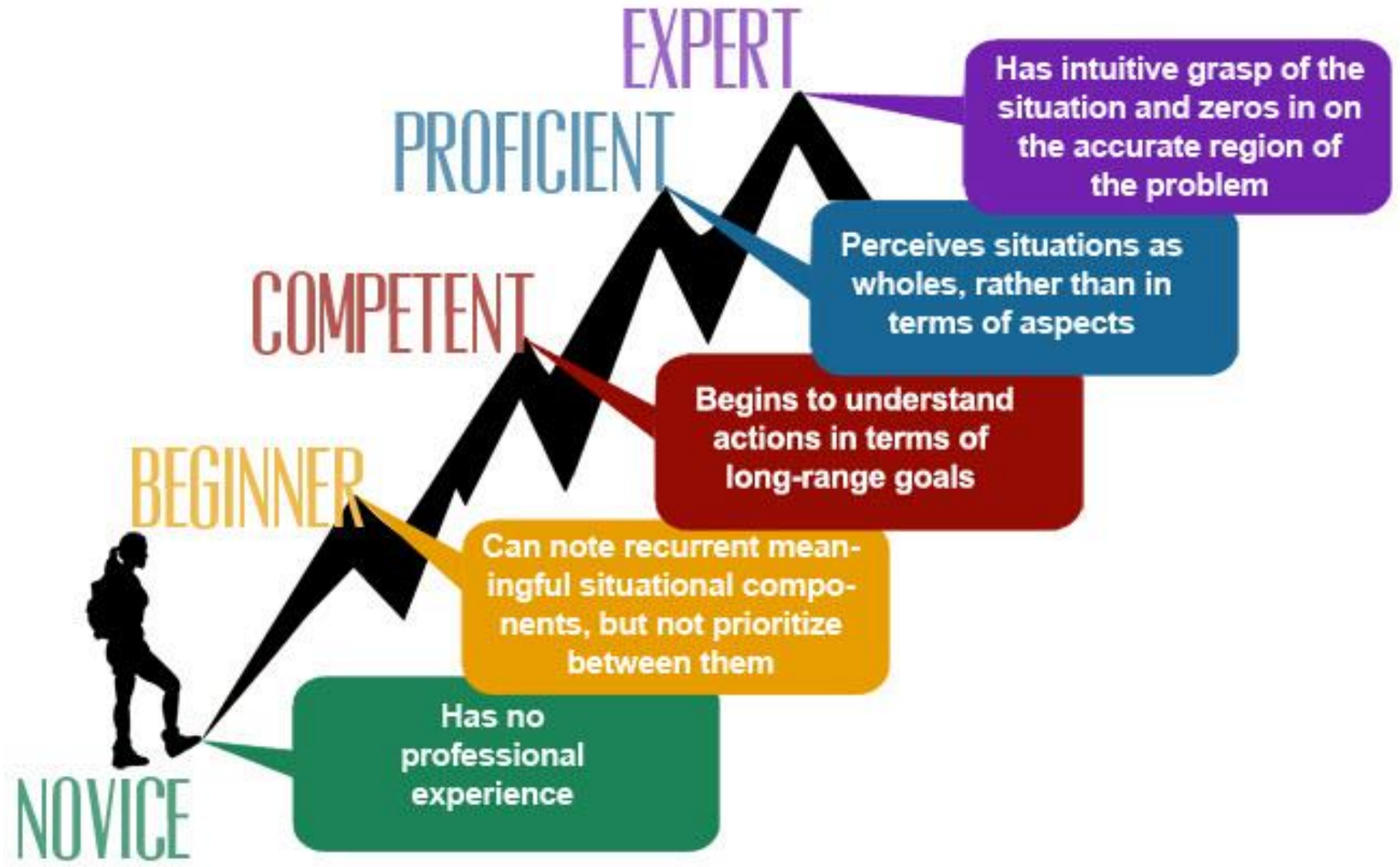
Impact: When rethinking nursing-care delivery models, the findings of this study may help guide the process of implementing mixed nursing-care teams. Special attention needs to be paid to clarifying roles, sharing responsibility and clinical leadership. Other significant influences (such as moral distress) should also be taken into account.

KEYWORDS
Covid-19, experiences, implementation, nurses, nursing, nursing-care delivery model, pandemic, qualitative study

Gemengde zorgteams | wat leert de evidentie ons?

In gesprek gaan met elkaar over zorg



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Benner's Novice to Expert Model (1982)

Gemengde zorgteams | wat leert de evidentie ons?

KLINISCH LEIDERSCHAP

- Deskundigheid en klinisch redeneren
- Effectieve communicatie
- Samenwerking, flexibiliteit
- Innovatief denken en handelen
- Visie op zorg & op de toekomst

- Leren door weten, doen, en observeren
- Rolmodellen

Check for updates

Received: 3 February 2023 | Revised: 23 August 2023 | Accepted: 2 October 2023
DOI: 10.1111/jan.15902

REVIEW

JAN WILEY

Understanding strategies that foster nurses to act as clinical leaders in hospitals: A realist review

Veerle Duprez[1] | Laure Dhont[1] | Margreet van der Cingel[2] | Thóra B. Hafsteinsdóttir[3] | Simon Malfait[1,4]

[1]Department of Nursing, Ghent University Hospital, Ghent, Belgium
[2]Professorship Nursing Leadership and Research, NHL-Stenden University of Applied Sciences and Medical Centre Leeuwarden, Leeuwarden, the Netherlands
[3]Nursing Science, Julius Center for Health Sciences and Primary Care, University Medical Center Utrecht, Utrecht University, Utrecht, the Netherlands
[4]Faculty of Medicine and health sciences, Ghent University, Ghent, Belgium

Correspondence
Veerle Duprez, Department of Nursing, Ghent University Hospital, Corneel Heymanslaan 10, Ingang 75, route 7520, B-9000 Gent, Belgium.
Email: veerle.duprez@uzgent.be

Abstract

Aim: To identify strategies that develop clinical nursing leadership competencies among staff nurses, and to explain the contextual elements and mechanisms that underpin the development of clinical nursing leadership competencies.

Design: Realist review according to the Realist and Meta-narrative Evidence Syntheses—Evolving Standards (RAMESES).

Data Sources: PubMed, Embase, CINAHL, Web of Science, Wiley Online Library, PsycInfo and ProQuest were searched from January 2000 until October 2022.

Review Methods: Three iterative phases: (1) development of initial programme theory, (2) structured searches for relevant published and grey literature and (3) data synthesis and interpretation by researchers and theory triangulation, and discussions within the research group.

Results: Multiple context-mechanism-outcome configurations were extracted from 10 reports that explain how, under what circumstances and why strategies can facilitate (or discourage) staff nurses to act as clinical leaders. Reports were both quantitative and qualitative in design, originating from English-speaking countries only.

Conclusions: A logic model was developed and suggests four contexts and five mechanisms underlying the development of clinical nursing leadership. Growth in clinical nursing leadership was mainly experienced through experiential learning, which was enhanced by a supportive relationship with a coach or mentor, the use of reflective practices and modelling from other leaders. Furthermore, a supportive work environment triggers ownership, confidence and motivation, and thereby growth in clinical nursing leadership competencies.

Impact: Fostering competencies for clinical leadership among staff nurses requires multifaceted strategies. Strategies are successful if, and only if, they combine learning by doing, by knowing and by observing, and establish a responsive work environment. Hospital policy should ensure that staff nurses have access to reciprocal relationships with role models or a coach. In order to grow as clinical nurse leader, ownership and self-reflection on own leadership behaviour need to be facilitated.

No Patient or Public Contribution: Prospero ID CRD42021292290.

“You don’t need to be in a position to be a leader”

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FLEMISH ACADEMY FOR CLINICAL LEADERSHIP

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VEERLE DUPREZ
Diensthoofd
Verpleegkundig Expertisecentrum

Universitair Ziekenhuis Gent
C. Heymanslaan 10 | B 9000 Gent
T +32 (0)9 332 21 11
E info@uzgent.be

www.uzgent.be

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