SELF-REGULATION THROUGH QUALITY MANAGEMENT SYSTEMS

How Nurses in Dutch Elderly Homes Concretise the Goal of "Responsible Care"

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Abstract

This article describes the self-regulation of professionals in elderly homes based on the Dutch Act on the quality of health care institutions (Kwaliteitswet zorginstellingen). This goal oriented framework act demands that all care providers create a quality management system (QMS) to implement the goal of responsible care.[1] Care providers are thereby forced to co-regulate: in the QMS they formulate the rules on how they intend to achieve this goal. Although many different organisations, in different compositions co-decide what responsible care encompasses, the QMS of a care provider is central to the implementation of the Quality act. Through the QMS the nurses regulate their own activities, although within the framework of the goal of responsible care.

1 In Dutch: *verantwoorde zorg.* ´Responsible´ is used in a double meaning: as a description of the quality of health care (*sound care)*, and as holding the care provider accountable for the quality of health care (*accountable care).*

1 Introduction

"I do not experience the protocols as an obstacle: it is an improvement that we have them!" Lucy, nurse and coordinator of the health care in an elderly home in the Netherlands, is very positive about the regulation she is implementing in her daily job. As a 'health care coordinator' she is responsible for the health care activity and the wellbeing of the residents[1] in the elderly home. As the nurse highest in rank, Lucy is manager of the working place: she instructs the other care employees in their work, is responsible for a good working environment and takes part in drafting the policies of the elderly home. A large part of her activities are prescribed by rules, guidelines, protocols, and instructions, which is different from 30 years

1 Often, *residents* are also referred to as *clients*, to emphasise the contractual ("equal") relationship between the care provider and the resident and to mark that the wishes and needs of the resident are central to the care that is provided. Different care providers choose different terminology, but can still provide care in the same way. Therefore I will only use the more neutral word *resident*.

ago when she started her career. However, she feels she has enough room for adaption of rules and manoeuvre within these rules: "There is always room for interpretation."[2]

Lucy's view on the regulation she daily works with is quite surprising. Although the Dutch legislator in the last two decades has drafted legislation from a new point of view, which should grant professionals more freedom in deciding how to do their job, it has not been proved that these new acts have contributed to this goal. A spearhead of this new policy has been lowering the administrative burden of legislation for professionals. However, the Act on quality of health care institutions (Quality act) is concretised by a large amount of lower regulation, which demands a lot of administration at the working place. Therefore one would expect the nurses in elderly homes to be lost in the regulative chaos of lower (administrative) levels, instead of experiencing the new 'administrative burdens', such as the protocols, as an improvement.

This lower regulation is derived from the central article from the Quality act, which demands from care providers that they deliver *responsible care*. Which care can be described as *responsible care* is not specified. When the law was drafted in 1996, the purpose of the legislator was that care providers themselves would determine what *responsible care* is, thereby using the knowledge of the professionals, since they have better insight in what determines the quality of health care then the legislator will ever have.[3]

However, different organisations besides care providers have issued reports and documents on what *responsible care* is: the Health inspectorate (IGZ) in its reports and publishing of performance indicators, the HKZ organisation with norms on quality management systems, and the insurance companies through the Care offices[4]. At the same time the Steering committee for reliable care, in which several professional organisations take part, has issued the Quality framework for responsible care. From a traditional hierarchical perspective, it is not easy to describe how the goal of *responsible care* is concretised, since all these organisations contribute in a different way to the concretisation of the goal: any attempt to a description only depicts chaos. The amount of reports and regulation leads to the question: who regulates the main activities of professionals? What rules do the professionals in an institution have to implement and who has made these rules? Are they made by the professional organisations, as was the purpose of the Quality act, by the professionals themselves within the care provider, or by the administration through different organisations?

This article formulates an answer to these questions, explaining why Lucy can be so positive about the regulation, although based on the amount of organisations involved and the accompanying bureaucracy one would expect the opposite. The article focuses on the implementation of the goal of *responsible care* in elderly homes in the Netherlands[5]. The professionals in elderly homes, the nurses, form a rather homogenous group, which means there are not opposite interests within these care providers, which makes answering the questions less complex.

2 Interview with Lucie van Beek (nurse), 19-01-2009

3 Rapport algemene rekenkamer, *Implementatie kwaliteitswet*, p.8; Interview Heleen de Groot, lawyer who helped to draft the Quality act at the Ministry of Health, Welfare and Sports

4 In Dutch: *zorgkantoor*

5 There are two types of elderly homes in the Netherlands. When I refer to elderly homes in this article I refer to the nursing homes where people live who need care, but still are self-supporting in some respects (*verzorgingstehuizen)*.

Several interviews which I conducted as orientation interviews for my PhD research, such as the interview with Lucy, have inspired me to approach the question upside down. If we take the perspective of the legislator, we see endless proliferation in a kind of tree-like model. Seen however from the perspective from nurses in elderly homes, the concretisation of *responsible care* is not that divided, but centred in the quality management system (QMS) of each home. In a QMS all procedures and processes of the working place are documented, in order to reach good quality management, which is seen as the best way to improve client satisfaction while keeping the costs low, according to the latest development in ´the quality movement´. I will argue that Lucy and many other professionals influence how the goal of *responsible care* is implemented: through the protocols in the QMS, but also through several organisations which shape such a system by influencing its content and its implementation. Since the QMS is mainly used to guide the work of the professionals, and not to justify their actions, the extra administrative work load of the QMS is experienced as a positive improvement.

2 Concretisation of *responsible care*

2.1 Act on quality of health care institutions

The Quality act was drafted in 1996 after long deliberations on how to reform the health system in the Netherlands: increasing technological possibilities combined with the ageing of the population led to higher pressure on the health budget. When more people need care, and more care is technically available, it becomes important how the resources can be used as efficiently as possible. This need for change caused the legislator to use a new type of legislation.

Under the influence of New Public Management, which was very influential in the 1990s, the legislative preference in the Netherlands had changed from detailed national regulation to regulation which only set the framework: only setting a goal and not elaborating how and by which means to reach it.[6] This new type of legislation instead orders its norm-addressees to make the more detailed rules themselves. The Quality act is one of these framework acts, only containing so called goal prescriptions[7] accompanied by a rule which asks the norm-addressees, in this case the care providers, to make more detailed rules on how to reach the goal.

The goal prescription of the law, article 2, says “Care providers [should] provide responsible care. Responsible care is care of a good quality that is at a minimum effective, efficient, patient oriented and tuned to the realistic needs of the patient.”[8] As Mackor describes in her article on performance measurement, article 3 further instructs the care providers to organise the care “in such a manner that the result is, or at least reasonably must be, responsible care.” Article 4.1 specifies that the organisation of the care encompasses “systematic monitoring, controlling and improving the quality of the care.”

6 Osborne and Gaebler, see A.R. Mackor

7 See article P.C. Westerman in this book

8 Translated by A.R. Mackor, see article in this book

On purpose, the content of the term *responsible care* is not specified in the act. One of the main reasons to use this new type of legislation is efficiency: when health care has to become as efficient as possible, the latest information should be used to regulate it. Since the national legislator always will have difficulties acquiring all this knowledge, the field itself should make the rules on how to reach the goal of *responsible care*. At the same time, this new form of legislation seeks to solve a second problem; the perceived diminished room for manoeuvre for professionals. The new legislation such as the Quality act seems to provide more room of manoeuvre for professionals, by not specifying the content of the goal of *responsible care*. The purpose of the law was to use the knowledge available in the field in the best way possible, which means professionals should get enough freedom within the rules to act as they see fit under the specific circumstances of their working place. Do professionals have enough discretionary room within the Quality act and its accompanying lower regulation to fulfil their duties in accordance with their own knowledge?

3.2 Top-down perspective

In order to find out how much room for manoeuvre professionals have within the goal of *responsible care* I chose to focus on professionals in elderly homes: the nurses. An advantage of focussing on elderly homes, instead of for example on hospitals, is that the group of professionals within elderly homes can be easily defined and is more homogenous. In hospitals both medical specialists, general doctors and nurses need to cooperate, which would distract too much from my question.

I started to investigate how this goal of *responsible care* is concretised on lower levels, and in what form it finally reaches the working place of these nurses. What I encountered was a huge amount of reports and many different organisations, which all decide for a small part what *responsible care* encompasses:

The Ministry of health, public welfare and sports (*Volksgezondheid, Welzijn en Sport*) develops policy to motivate care providers to implement the Quality act. The minister of health, public welfare and sports is ultimately responsible for the quality of health care in the Netherlands. When in 2001 and 2005 evaluations of the Quality act showed that most care providers did not meet the requirements of the act, the ministry ordered the Health inspectorate to form a Steering group Responsible Care (see point 2). The ministry is also the initiator of the platform 'Care for better' *(Zorg voor beter)*, where all professional organisations, sector organisations and care providers meet, to exchange best practices in striving for the goal of *responsible care*.

The Steering Committee Responsible Care (*Stuurgroep Verantwoorde zorg)* has drafted the Quality framework Responsible Care for care for elderly people (*Kwaliteitskader Verantwoorde zorg*). The steering committee consists of representatives of the clients' organisation (residents) LOC, the professional organisations for nurses NVVA, V&VN , the professional organisation for care takers Sting, the organisation of care entrepreneurs ActiZ, the Health inspectorate (IGZ) - chair of the committee, the Dutch Care Insurers (ZN) and the Ministry of Health Welfare and Sports. The Quality framework contains the Standards for responsible care (*Normen verantwoorde zorg).* These standards are a type of performance indicators.

The Health inspectorate (*IGZ*) uses these performance indicators to monitor how the care providers perform: how many residents fall in the elderly home, how many residents unintentionally loose weight (which indicates they are undernourished), how many residents have decubitus[9], and 13 other indicators. The care providers need to report on these indicators to the inspectorate in their annual report. The data is then compared to the data of all the other providers, and then publishes on the website www.kiesbeter.nl (*choose better*). If a care provider performs well on these indicators compared to others, the inspectorate can assume a care provider provides *responsible care.*

The inspectorate can also supervise certain care providers, based on an indication in their annual report that some part of the health process does not function as is should. In that case, the inspectorate investigates more into detail how the care provider provides care, which results in an inspection report on the required improvements. The report therefore contains instructions for a specific provider on how to reach *responsible care.*

The care offices, each region has its own, are run by the joint health insurance companies. They are the actual health purchasers, who spend the national budget for elderly care. A care provider needs to sign a performance contract with a regional health office, which assures him of receiving funds for the amount of care he has contracted for. One of the entry requirements for these contracts is that care providers should have a certified quality management system, which guarantees that they provide *responsible care.*

A care office only pays for care provided to residents who were entitled to that type of care. The CIZ organisation approves the care-status[10] residents need to receive care in the elderly homes. Under the new *ZZP*-system[11], which January 2010 officially replaces the old system, a resident can obtain ten different care-statuses, on a level from one to ten, based on the level of care he or she needs. The more a resident can do by himself, the lower the care-status will be. On behalf of a (new) resident, a care provider applies for a certain care-status, of which it thinks it can provide the right level of (*responsible*) care to this resident. The CIZ organisation then decides whether it agrees with the assessment of the care provider. Every care-status comes with its own tariff, which can be charged at the health office. The care provider will only pay for the care that a resident is entitled to based on his care-status, and not for any extra care provided by the care provider.

The *HKZ* organisation designs certification documents for quality management systems of care providers. Although there are other certification documents, the *HKZ*-certificate is at the moment the biggest certificate. Therefore I focus in this text on the *HKZ*-certificate. The certification plan tells care providers what documents their quality management system needs in order to become certified. It does not say what action a care provider needs to take, but it does say which fields are so important that the provider needs to plan his activities. This means the certificate specifies themes of importance within the goal of *responsible care*: it makes the care providers all focus on the same issues, which according to the HKZ organisations are most important to guarantee the organisation provides care of good quality.

9 Decubitus refers here to bedsores, which are caused by lying in one position too long.

10 In Dutch: *indicatie van het CIZ*

11 *ZZP* is *zorgzwaarte pakket*, which means ‘care-weight package’

The Quality institute for health care *CBO* issues guidelines for quality in health care. The CBO is an independent institute, which helps professionals in health care to improve the quality of care. Three guidelines have been issued specifically for medical problems of elderly people: a guideline on dementia, one on Parkinson and a third on the prevention of fall incidents. These guidelines are derived from research done by other organisations and they contain no legal rules. However, the inspectorate does use the guidelines as field norms: care in accordance with the guidelines is assumed to be qualitative good care (part of *responsible care*). If necessary, a professional can deviate from the guideline when the situation of a patient so requires, but this deviation has to be documented and the professional will have to explain why he acted differently.[12]

The professional organisation for nurses and caretakers *V&VN* has issued the National Professional Code of Nurses and Caretakers, in which guidelines for professional behaviour are established. [13]

The care providers concretise the goal of *responsible care* in and through their quality management system, as ordered in article 4 of the Quality act.

Even when summarised as above, it is very difficult to understand the interaction between the organisations, let alone depict this in an organised way. It resembles to a large extent the dark picture which Westerman sketches in her articles on the risks of using goal regulation: a lot of different organisations trying to concretise the goal towards its implementation, which will all try to further their part of the goal, resulting in chaos for the person who is implementing the goals in the end, in this case the nurses in elderly homes.

This long list of different organisations, all concretising *responsible care* in their own way, suggests that the goal of *responsible care* is already fully concretised by all these organisations and that there is no room left for self-regulation by the professionals themselves. Moreover, it is difficult to understand how a small care provider with a limited amount of time would be able to live up to all the wishes of these organisations, which are not necessarily synchronised. This hierarchical perspective therefore gives the impression that goal regulation in a framework act leads to chaos in lower regulation, higher administrative burdens and therefore higher transaction costs. Since diminishing the transaction costs for norm-addressees is a major topic in current Dutch politics, this would be an alarming conclusion.

However, there are some uneasy parts in such a description from a top-down perspective. First of all, organising the points above in a hierarchical list is not that easy. At a closer look, several organisations turn out to be a fusion of other actors. The professional organisations are represented in the HKZ and the platform, the inspectorate asks these same professional organisations to take part in designing the performance indicators, and the inspectorate itself is chair of the platform. A care office in its turn is in a contractual, non-hierarchical, relation with the care provider, except that the contract is more important for the care provider than for the care office. The care provider needs the contract to be in business, whereas the care of-

12 CBO richtlijn preventie van valincidenten bij ouderen, p. 12

13 V&VN, *Nationale Beroepscode van Verpleegkundigen en Verzorgenden*

fice can also purchase its care from other providers. The fluent borders and non-hierarchical relations between the different actors make it impossible to describe these relations as a mere principal-agent relationship, as Westerman suggests.

A second problem for the hierarchical description was the reaction of my interviewees, whom I asked how they implemented the regulation of these higher levels. Where I expected to hear stories of bewildered managers, who could not manage to incorporate all these different demands in their organisation, managers unanimously reported to experience little problems with the regulation. And where I expected to find nurses who felt there was no time left to do their job properly, because of all the paperwork and organisation which comes with all the regulation and requirements of *responsible care,* I only found nurses who thought the current regulatory system was an improvement compared to earlier systems. How do these positive views of the nurses and managers of the working place match with the chaotic picture of different organisations all concretising a part of *responsible care* which should be implemented on that working place?

3.3 Working place central

In order to gain a better understanding of the actual work that is done in elderly homes, and to unravel the chaos I had run into, I decided to interview some managers and nurses in elderly homes. I wanted them to explain to me what their job is about and what kind of rules and regulation they work with in their day to day activities: what parts of this regulatory mess really reaches the professional in an elderly home? To my great surprise, the picture that I had described before as a hierarchy of organisations, rules and reports changed completely when I looked at it from the perspective of the managers and nurses I interviewed. From their perspective, one set of rules was clearly at the centre of all of the other documents: the quality management system.

Every care provider in the Netherlands has the obligation to have a quality management system. Article 4.1 of the Quality act states that care providers should systematically monitor, control and improve the quality of the care, which is interpreted as the obligation for care providers to draft and implement a quality management system.[14] The ISO 9000 norms, which are international standards for quality management systems, are widely used to determine what components a quality management system needs. Initially, the ISO norms were drafted to help improve the quality of manufactured goods, but now the norms are also applicable to the production of services, for example in the field of health care.

A quality management system should facilitate the improvement of the quality of care. In a quality management system, all the obligations of the care provider are documented: the care protocols, the fire safety protocol, the working environment protocol, the food hygiene protocol, protocol for incidents, and so on. When a care provider manages several elderly homes, all of these homes have the same quality management system. When a care provider only runs one home, this home has to have its own quality management system.
The nurses I interviewed were not confused or disoriented by the amount of rules and reports that origin from the Quality act. In their daily job, they were only confronted with rules ori-

14 Rapport Algemene Rekenkamer, p. 8

ginating from the quality management system, and not with any of the other documents made by the steering group, inspectorate or care office. As Lucy said, they expressed that writing down all the procedures in the QMS is an advantage, although they also expressed a concern about the risk that the QMS can become a 'paper tiger', with too much focus on the 'paper world' instead of the implementation in 'the real world'.[15]

Switching from a hierarchical perspective to a perspective where the working place is central, means that the QMS will be the starting point to describe how the goal of *responsible care* from the Quality act is concretised. I will show that within the QMS, the professionals regulate their own activities. The other organisations influence the QMS, which can affect the room for manoeuvre the professionals have. As I will argue, having a QMS has advantages and disadvantages, but still leaves the professionals enough freedom to do their job in accordance with their own knowledge.

4 Quality management system

4.1 The quality movement

At the moment, quality is a term which is used frequently in health care planning, of which the Quality act itself is the best example. All managers I interviewed talk about quality, plan according to quality and write about quality. However, this development is quite recent. Before the implementation of the Quality act, quality in health care was not a frequent topic in board meetings of care providers, their annual reports or their other documents. The origin of the quality movement lies in the industry of the 1900s, where the concept, language and methods developed.

Before the industrial revolution, the quality of a product was guaranteed by the craftsmen, who often were member of a guild. Delivering good products protected the reputation of the individual craftsmen (and of the guild), which assured them of customers. When the production of goods started to take place in factories, where no one was responsible for the complete process, quality issues arose. The lack of quality in certain products threatened the trust of customers in the produced goods. To guarantee the quality of a product, quality control of the finished products was introduced. However, disadvantages of quality control were that work had to be redone, and both time and materials were wasted, since only the selling of low quality goods is prevented, but not the manufacturing.

In the 1930s, the statistician William Edwards Deming did research in the United States on how to improve the quality of products in an earlier stage of the production process. Deming developed a theory on quality management, which today is widely known as the circle of Deming. His findings were put into practice in the Japanese industry in the 1950s and 60s, when the Japanese economy had to be rebuilt from scratch after the war. According to Deming, meeting the customer's expectations was central in competition, and if this was thoroughly implemented in the processes, any average company could become a market leader within

15 Interview with Jaqcueline Poortvliet, 22-01-2009 (location manager and nurse); Interview with Hendrik Hemminga, 23-04-2009 (region manager at *Oosterlengte* of amongst others the elderly home 'De Tjamme' in Beerta)

five years. Only in the 1980s, US producers became interested in quality management, after Japanese producers had taken a market lead in many former US dominated markets.[16]

In recent years, the quality movement also reached the health care sector, broadening its scope from only concerning manufactured goods to covering the production of services as well. Step by step competition is introduced in health care, which makes quality a central concept. The main difference between the private sector and the health care sector is that, in the Netherlands, the quality movement for the health care sector is mandated by the state, where in the private sector choosing to ´quality-manage´ a company is a free choice of the management.

The circle of Deming is still today used as the starting point for quality management in health care. It is also known as the circle of Plan – Do – Check – Act. In all elderly homes that I visited[17], managers explained to me they were working along this circle of Deming. Often they started working with it because it was one of the requirements of the HKZ-certificate. This circle of Deming is meant to help a care provider continuously improve the quality of its services. First the care provider has to plan his activities, he then has to implement them, measure whether the results were as he had planned them to be and finally act upon the findings of the measurement, which leads to a new planning cycle. In the meantime, while continuously improving the quality of the care, the managers need to make sure that the quality level that is reached is guaranteed by the processes that are already in place. The quality management system fulfils a role in the improvement and guaranteeing of the quality.

Quality management can be summarised as "managing a process to achieve maximum customer satisfaction at the lowest overall cost to the organisation while continuing to improve the process." A quality management system is then "a formalized system that documents the structure, responsibilities and procedures required to achieve effective quality management."[18] I will show that these quality management systems are central to the implementation of the Quality act, and the concretisation of the goal of *responsible care*.

4.2 Content of a quality management system

In this section I will use examples from the quality management system of elderly homes where I interviewed managers, nurses and 'quality employees'. Every quality management system is unique, but section 4.3 will clarify why most quality management systems consist of comparable components.

I will explain what a quality management system is, by following the path of two of the major health concerns in elderly homes: the complexity of medication distribution and the prevention of falling incidents of residents. Falling is the most important cause of death by accident for the elderly. A World Health Organisation report concludes that injury caused by a fall is the third cause of health problems for elderly people. Fall injuries often lead to diminished self-support and many medical complications, such as decubitus and pneumonia.

16 E. Sallis, *Total quality management in education*, third edition 2002, p. 5-9

17 I conducted interviews in 6 elderly homes in the Netherlands, owned by 5 different care providers.

18 ms.pbru.ac.th/qit3/dl/QIT_Method_DrJareuk/Quality%20Information%20Technology%20Terminology.doc

Every year, 3.300 residents of Dutch elderly homes need treatment in the emergency room because of a fall injury. [19] Therefore, it is very important to organise fall prevention within elderly homes, to ensure the goal of *responsible care*. Mistakes in the medication distribution are the most common incident caused by a mistake of an employee in elderly homes. For the patient safety, and therefore *responsible care,* it is very important that the amount of mistakes is minimised.

The basis for each quality management system is its planning in different documents. The quality management system is the start for each Plan-Do-Check-Act cycle. The documents form together the quality manual, which should guide all activity by the care provider. The documents (plan) need to be implemented (do), the results of the implementation will be monitored (check) and improvement if necessary will be made (act). For an elderly home, there is a planning on two different levels: the individual level, where the activities for the individual resident are laid down, and the institutional level, where all processes and procedures which take place in the organisation are planned, in mission and vision documents, and described in protocols.

The content of a QMS is different for each care provider: the type of documents that are used, what these documents describe or regulate and the content of the document itself. A care provider can choose to make procedures, protocols, internal guidelines, work instructions, forms, internal documents, external documents, or even other types of documents. If for instance a care provider wants to create a procedure on how to prevent residents from falling, he will have to decide: which measures the organisation should take to prevent falling; who is responsible for the implementation of the procedure and how the organisation will check whether the procedure really helps to prevent accidents.

Although care providers can name the documents in the QMS after their own wishes, based on the function of the document, every QMS is based on the following types of documents (every type is illustrated with the documentation on that level to prevent falling):

Abstract policy
The abstract policy, such as the mission and vision documents of the institution, state what the care provider wants to achieve.

Contracts
In the individual care plan, care provider and resident will decide together what care will be provided and how. When the resident has a risk of falling, because of a medical condition or a previous fall, the care plan will state how the individual situation is, and what measures will be taken to prevent falling. Under the section *fall prevention* it can for example say: “Madam walks with a walking aid, but is still scared of falling.” which shows that the topic of fall prevention is discussed with the resident, both external towards inspectorate, but also internal to other nurses. It describes what measures have been taken (the walking aid) and the current situation (she is still scared of falling, so it will be an item to follow up in the future).
The contract can specify decisions into great detail, for example on what time the resident want to get up in the morning, which day activities the resident takes part in, and how the re-

19 CBO richtlijn voor preventie vallen bij ouderen

sident wants to take a shower. If the nurse or care-taker feels that the decisions in the contract should be changed, they will need to discuss this with the resident. If the resident does not agree on changing the care plan, even though the nurse thinks continuing on the same basis does not meet the requirements of *responsible care*, the nurse has the responsibility to deviate from the contract, but she will have to explain and justify this deviation in the care plan.[20]

Rules (protocol)
All acts in the elderly home are described in protocols. Dependent on the formulation in the protocol, the nurses and care-takers have either discretion or no discretion in implementing the protocol. When the protocol leaves no possibility of acting differently, the protocol is a set of rules. An example of such a protocol containing rules is the medication distribution protocol of elderly home ´De Tjamme´ in Beerta. All acts and responsibilities are described in detail and there is absolutely no discretion in these rules: the nurses and care-takers will have to follow the rules under all circumstances.[21]

Guidelines (protocol)
When a protocol describes a process which needs to be individually customised, the protocol takes the form of a guideline. The fall protocol in `De Tjamme´ in Beerta is not at all as detailed as the medication distribution protocol. It only contains aspects which should be checked upon with new residents or when a resident has developed a risk of falling. The nurse should for example check what medication the resident uses, what shoes the resident wears and whether the resident experiences difficulties with walking. The protocol explains how these factors can increase the risk of falling and suggests which measures can be taken to lower the risk of falling. The nurse will have a lot of discretion in deciding, together with the resident, what measures have to be taken to lower the risk of falling. The decision will then be documented in the care plan.

Forms to register observations or acts
Reports of incidents (both on residents and employees), autograph lists, and complaint forms are all examples of the forms which are used to register both observations and acts. The format of the forms is part of a protocol, which tells the employee when to fill in the form and what to do with it after it has been filled in. In the case of a fall of a resident the protocol could say that the employee who is the first to discover this, should file a 'Report of incident – fall' and submit it to the highest ranking nurse. In this report the circumstances of the fall, as far as they are known, will be described. When all of the reports of incidents are gathered, it is possible for the management to start looking for possibilities to decrease the risks of falling, by looking for larger patterns.

Concrete policy
The concrete policy documents are the improvement plans, in which the points that need change in the protocols or in the home itself are decided, based on the results of the implementation of the protocols in the home. For example, in an elderly home where the monitoring of falling incidents showed that most fall incidents occurred with residents who suffered from dementia, within their own home, they could make an improvement plan based on this

20 Interview with Carla Sipkes, 15-01-2009 (care-taker)

21 Medicijnendistributieprotocol Verzorgingshuis De Tjamme, 2007

information. Research has shown that residents with dementia will fall more easily, since they cannot always distinguish between a white object and the white surroundings (white doorpost against white wall). Based on the information from their own monitoring and the available research, the care provider decided to paint the doorposts in red or blue and mount coloured toilet seats. This was written down in such an improvement plan, in order to show to the board and clients council that measures were taken to prevent falling in the future.

5 Self-regulation of nurses in elderly homes

5.1 Introduction

As I will discuss in this section, self-regulation of nurses takes place in two different ways: direct self-regulation through development of the quality management system in the care organisation, and indirect self-regulation through the professional organisations on higher levels. Other organisations do influence the concretisation of *responsible care*, but this has not such a large impact on the daily activities of the professionals (nurses), who are instead mainly confronted with the implementation of the rules which were ´self-drafted´.

5.2 Direct self-regulation

Development of a quality management system
Just as every quality management system is unique, so is the way a quality management system is made. Every care provider can decide who is involved in drafting the contracts, rules and guidelines, and how they can be adapted. However, based on the interviews I conducted, care providers draft their quality management system through very similar procedures, especially concerning the involvement of nurses in the drafting process.

The nurses I interviewed all stated that they had been involved in the drafting of the rules and guidelines, mainly through staff meetings and working groups. For example the medication distribution protocol of `De Tjamme´ had been drafted by a small working group, in which one nurse took part, and then re-drafted by the pharmacist, the family doctors of the residents, the health care coordinator and the nurses with ultimate responsibility for the care of the residents[22]. The care-takers lower in rank had the possibility to influence the content of the protocol through the monthly staff meetings. After the protocol had been used for half a year an evaluation was made, in which all care-takers and nurses could come up with alternative suggestions.

My interviewees all expressed that if they would disagree with a certain rule, it is always possible to bring this up, either in a staff meeting or through a special ‘staff initiative form’, which many care providers have. This does not necessarily mean the rule will be altered, but they felt that they had enough room to use their professional knowledge in their work.

Changes because of the quality management system

22 In Dutch: *EVVers* (eerst verantwoordelijke verpleegsters)

In the interviews two main changes were mentioned as a positive result of the self-regulation through a quality management system. The first change is the amount of influence the nurses and care-takers have on the way the health care is provided, because of the formalisation process of the internal rules. By the change from unwritten procedures to written protocols, especially nurses and care-takers lower in rank have gained influence on the content of the rules and guidelines. One of the care-takers in an interview explained this, when asked what the biggest difference was between her work now and when she started working 30 years ago:

> *"When I started working in a hospital, many things were done because they had always been done that way. All patients´ temperatures were taken at 6 o'clock, while the light was on all the time. Why couldn't we take their temperature at 7, when they got their breakfast? And why did we use the room light, which woke up everyone in the room, instead of the small bed-lights? I remember I was very surprised at the time, but it was impossible to do it differently, since the highest ranking nurse had decided that these were the procedures. There were many of these strange old habits, such as the bathroom rounds with fixed times to go to the bathroom. Luckily, a lot of this has changed now, and there is more attention for the wishes of the individual patient. It has become easier to come with suggestions of change for old rules."*

Because all the protocols are now in writing instead of remaining implicit, it is easier to talk about why the rules are as they are, change the content of the rules and to call colleagues to account for a deviation from the rules. This has increased the possibilities of self-regulation for care-takers and nurses in elderly homes. By making and adapting the documents of the quality management system, the staff of an elderly home are actively involved in the quality management.

The second change, which was mentioned in several interviews, is that residents now have a much larger say in how the health care is provided. Because of the focus on customer satisfaction, quality management also means adapting the protocols after the outcomes of customers´ inquiries and wishes. Several interviewees expressed that the most important change in health care in the past few years is that the health care is now organised after the requests of the resident, which are formalised in the care plan (contract), as a part of the quality management system.

> *"Now the elderly people have a much bigger influence on the care they receive. The focus has changed from care to living: when I started working as a nurse the residents moved in on our working place, now we work in the units which are their homes. On the lowest level it is decided how things should be done, together with the residents themselves who then have had a say in their own care."*[23]

5.3 Indirect self-regulation

However, the development of a quality management by the employees of a care provider does not happen in a vacuum. Where the previous section might suggest that a quality manage-

23 Ylva Larsson, 21-10-2008 (region manager of several elderly homes in Sweden, Uppsala)

ment system is made by complete self-regulation of an individual care provider, this is only half of the story. Professional organisations define in several ways, which topics will at least be part of a quality management system.
If we continue to follow the path of the fall prevention protocol, we have to trace who decided that fall prevention is a major topic in elderly health care. I interviewed managers and nurses in 6 elderly homes in the Netherlands, and visited as many Swedish homes in the same year. Both in Sweden and the Netherlands, fall prevention was an important topic in all elderly homes. Apparently, this is not decided by individual care providers and neither by national organisations. Fall prevention is internationally recognised as a very important health care topic, in the international debate of professionals, in the WHO and through international contact of the professional organisations. I will call this indirect self-regulation of professionals: the professionals working in the elderly home 'De Tjamme' in Beerta had no direct influence on choosing fall prevention as one of their major topics, but it is instead self-regulation by professionals through professional organisations on a national and international level, of which group the professionals in 'De Tjamme' are a part as well, by education and membership of these professional organisations.

In the Netherlands, the topic of fall prevention is then incorporated in the concretisation of *responsible care*, by the Steering group Responsible care, in their Standards for responsible care. One of the indicators that care providers have to monitor is the indicator *Fall incidents*: "The percentage of clients that has been involved in a fall incident over the last 30 days", which should be measured by dividing "the number of clients involved in falling incidents over the past 30 days" by "the number of clients with whom measurements were carried out on the day of measuring".[24]

These standards for responsible care take a very central role in the quality management systems of care providers. This is an example of what the Health inspectorate calls a field norm. It is drafted by the professional organisations together with patient organisations and care purchasers and is regarded by the field as a standard which brings health care a step forward:

> *"Now we do not need to discuss anymore whether providing regular day activities is an important component of responsible care or not. Previously, we had to agree on such issues in the staff meetings, now we can spend our time instead on deciding which day activities we really want to offer."*[25]

This means that the daily decisions of managers, nurses and care-takers on what care should be prioritised to reach *responsible care* are made easier by the standards for responsible care. The standards for responsible care decide which topics within the care for elderly people are most important, and therefore are a necessary part of *responsible care*.

When the professional organisations have decided that fall prevention should be a major topic in health care, elderly homes need to decide how they will prevent falling. This will be done through the documentation process of the quality management, but in this process they use the knowledge from other organisations, such as the CBO which draft detailed guidelines on

24 Quality framework Responsible care, p. 41 (indicator 4.3), document is already translated

25 Interview with Hendrik Hemminga, 23-04-2009

for example prevention of falling incidents for elderly people. This guideline of 80 pages contains the conclusions of the available research on fall prevention in the Netherlands, and from these 80 pages elderly homes have to destill which measures work best in their organisation. The guidelines work according to ´comply or explain´: it is possible to decide working differently from the way described in the guideline, but a care provider will then have to explain very thoroughly why he is deviating from the guideline.

The HKZ organisation is the third example of how professional organisations self-regulate. Within the HKZ organisation several professional organisations have contributed to draft the HKZ criteria for certification, based on the international ISO9000 standards, and applied to certain health care fields. The HKZ certificate is the largest certificate in elderly care in the Netherlands. In order for a system to become HKZ certified, its documents need to live up to the criteria in the HKZ scheme. This scheme, which is different for each health care field, describes which processes and procedures need to be part of the system.[26] All providers need to have a formulated mission, vision and annual plan. The annual plan formulates the goals of the care provider, which should be reached in order to work along the mission and vision of the care provider. These goals should be SMART: specific, measurable, attainable, realistic and timely. For example, the HKZ scheme indicates that all elderly homes need to have an incident protocol (how to report incidents such as falling), but it leaves it up to the care provider how the reports are done.

5.4 Other organisations which influence the quality management system

Next to professional organisations, which influence the quality management system through indirect self-regulation, the Health inspectorate and the care offices influence the quality management system by concretising *responsible care*. However, they mainly try to make sure all care providers do what most care providers are already doing.

The Health inspectorate uses the different documents drafted by the professional organisations, such as the CBO guidelines, as field norms: most care providers do comply with these documents, which means that the inspectorate can ask from the care providers who do not comply to change their behaviour or explain why they think it is more *responsible* in their case to act differently. The indicators from quality framework are a field norm as well. The Health inspectorate, for example, obliges care providers to send data listing how many residents fall (within the measure-week) in their annual report. These data are compared to the data of all other homes, and then the comparison is published on the website www.kiesbeter.nl. A care provider receives then a score of one to five stars: five stars means that the elderly home belongs to the 10% best performing homes, one star means that the elderly home belongs to 10% worst performing homes. Publication of the benchmark data is supposed to push care providers to perform better next year, since future residents can look up what the quality of the health care in a certain home is. In reports on individual elderly homes, the inspectorate can directly state which changes a home has to make, to live up to the field norms and thereby provide *responsible care*.

26 HKZ manual for QMS, p.49

The only direct influence the care offices at the moment have on the concretisation of *responsible care* is their demand that care providers are certified. The Quality act itself does not mandate certification, but the care offices do. By forcing the care providers to start a certification process, they force them to live up to the specific demands on a quality management system of these certification organisations.
The Health inspectorate and care offices influence the concretisation of *responsible care* by obliging care providers to comply with field norms, by publishing benchmark data and thereby trying to force the care providers to perform better next year (and focus on the specific health care topics of which the data is published), by obliging them to receive a certificate, and thereby determining which documents should be part of the quality as management system. However, these activities only force all care providers to live up to what most care providers already do. The content of the field norms and the certificates is decided by professionals within professional organisations, and then by several professional organisations together. The Health inspectorate and care office try to make sure all care providers live up to these field norms, preventing that some care providers do not deliver *responsible care*, since there is no internal professional system which guarantees that all care providers comply with the standards on responsible care and other guidelines.

If the managers of an elderly home do their job, the nurses and care-takers are never confronted directly with the legal requirements of the Health inspectorate or the care office. The changes that are necessary should be made in the quality management system, which is the outline for all activity of the professionals in the elderly homes. Developing the quality management system takes a lot of time, but for the nurses and care-takers it means there is no chaos of regulation: the quality management system provides the possibility to coordinate all the demands and requirements in one set of documents.

5.5 Guiding and justifying behaviour

We now know that nurses in elderly homes have both direct and indirect influence on the content of the rules they need to implement, both through changing the rules or because the rules leave room for interpretation. This gives nurses the possibility to work in accordance with their own professional standards. However, this does not explain by itself why the nurses I interviewed were unanimously content with the rules they had to implement. Besides the possibility to influence the content of rules, an important factor for contentment with rules is what function these rules fulfil within the organisation.

Two main functions of the rules in a quality management system can be distinguished. As stated above, a quality management system "documents the structure, responsibilities and procedures required to achieve effective quality management". [27] This means that the rules and guidelines documented in the system should guide the professionals in elderly homes in how to reach the goal of *responsible care*. At the same time the quality management systems are used to prove to a certification organisation, the care office or the Health inspectorate that the minimum requirements for providing *responsible care* are met.

27 ms.pbru.ac.th/qit3/dl/QIT_Method_DrJareuk/Quality%20Information%20Technology%20Terminology.doc

These two functions of the quality management system, guiding behaviour and justifying behaviour can support each other, but the justificatory function can also obstruct the guiding function. This can be explained by the ´bureaucracy paradox´.[28] One rule can have a double function, for example the rule on how to write down decisions on health care in the care plan of a resident. When a nurse has discussed the risk of falling with a resident, and they agree on that the resident from now on will use a walking aid, this should be clearly documented in the individual care plan. It serves both to inform her colleagues of the night shift that this resident will use a walking aid, which helps them to remind the resident of this. It also serves to show to the Health inspectorate and certification organisation that the topic was discussed. The two functions can co-exist without any problems, as long as the Health inspectorate and certification organisation do not require the nurse to write the care plan in a very time consuming way. A limited amount of bureaucracy supports the goal of *responsible care*, but too much bureaucracy will obstruct the care provider of reaching the goal, since the nurses will not be able to spend their time on other important topics in the care plan, such as decubitus or mental well-being.

At the moment many elderly homes are still developing their quality management system. The Health inspectorate is still inspecting elderly homes in the way they did before, by visiting the homes. In the new system, when all care providers have a functioning quality management system, the Health inspectorate will only visit a home when certain risk factors are found in the documentation: the annual report and the quality management system. This change from direct inspection to inspection at a distance, which focuses much more on the paperwork, could lead to a shift in the balance between the functions of the rules.

This shift is already visible in the focus on certification. Where the national legislator did not want to oblige a certificate for all care providers, the Care offices demand that care providers are certified. Certificates, such as the HKZ-certificate, demand a high level of documentation, which for the region manager of ´De Tjamme´ focuses too much on the justification and not on the guiding aspect, which results in more paperwork than necessary for delivering *responsible care*.

If the justifying function gains a larger role, because of a larger focus on inspection through documentation, this could lead to more restrictive rules regarding the procedures of documenting acts and procedures in a quality management system. It is therefore of importance to follow the change from direct inspection to inspection at a distance, which could decrease the freedom of professionals to organise their work in accordance with their professional knowledge.

6 Conclusion

Nurses in Dutch elderly homes influence the rules and guidelines they need to implement through different forms of self-regulation. These guidelines and rules are part of the quality

28 Elte. 2007. “Winst- en verliesrekening van bureaucratisering van het toezicht op onderwijs.” Pp. 179-193 in *Turven, tellen, toetsen : over toezicht, inspectie, handhaving en evaluatie en hun maatschappelijke betekings in Nederland*, edited by Leeuw, Kerseboom and Elte. Boom Juridische uitgevers. p. 183

management system of a care provider and ultimately stem from the Act on the quality of health care institutions. This Quality act prescribes that care providers should provide *responsible care*, by drafting a quality management system, which documents "the structure, responsibilities and procedures required to achieve effective quality management."[29] Quality management is "managing a process to achieve maximum customer satisfaction at the lowest overall cost to the organisation while continuing to improve the process."
Different organisations concretise the term *responsible care*, but from the perspective of the nurses on the working place it becomes clear that the implementation of the quality management system is central to the implementation of the Quality act. Through direct self-regulation they draft the rules and guidelines of the quality management system, which guide the actions in their daily work. Nurses have the possibility to influence the content of the rules and guidelines, when the quality system is drafted and they also have freedom of interpretation within the guidelines.

Through indirect self-regulation, nurses as a group of professionals influence the drafting of guidelines by their professional organisations. These professional organisations took part in the drafting of the Quality framework responsible care, which formulates the indicators for *responsible care*. Another example of indirect self-regulation is the drafting of guidelines on specific health topics by the Quality institute for health care *CBO*, such as the guideline on prevention of falling incidents for elderly people. These guidelines and frameworks, drafted by the national professional organisations, are also influenced by international organisations such as the WHO in which professionals are organised on an international level. This explains why the major health topics of quality management systems are similar in elderly homes in the Netherlands and Sweden, although all care providers individually draft these systems.

The Health inspectorate and care offices influence which parts of *responsible care*, as formulated in the Quality framework and in the certification schemes by the *HKZ*, need to receive more attention. Although these external organisations thereby decide which health topics should be prioritised by the care providers, they only strive to shift focus of the care providers from one topic to another, but they do not add new parts to the concretisation of *responsible care*, except for demands on the way a care provider should organise his administration process.

Based on the interviews that I have done so far, there seems to be a good balance between the guiding function of the rules and the justifying function of the rules. This explains why the professionals are so satisfied with the rules: they have a lot of possibilities to decide on the content of the rules, but receive also enough guidance from professional organisations and from the quality management system after it has been drafted. The Health inspectorate does not (yet) require the care providers to focus in their documentation on justifying their actions. This means that the quality management system to a large extent helps the professionals to organise their work, which makes that nurses do not experience the quality management system which is required by the Quality act as an "administrative burden", but rather as an "administrative improvement".

29 ms.pbru.ac.th/qit3/dl/QIT_Method_DrJareuk/Quality%20Information%20Technology%20Terminology.doc