Perspectives on the delegation of hygienic care in the context of home nursing: a qualitative study

Irina Dumitrescu, Kristel De Vliegher, Audrey Maigre, Edgard Peters, Dominique Putzeys, Sam Cordyn

Irina Dumitrescu, Kristel De Vliegher, Sam Cordyn, Nursing Department, Wit-Gele Kruis van Vlaanderen, Brussels.

Audrey Maigre, Edgard Peters, Nursing Department, Fédération de l'Aide et des Soins à Domicile, Bruxelles

Dominique Putzeys, Collaboration Internationale des Praticiens et Intervenants en Qualité (dans le domaine de la) Santé

All authors are part of the Independent research group 'Collaboration Internationale des Praticiens et Intervenants en Qualité (dans le domaine de la) Santé. *Irina.dumitrescu@vlaanderen.wgk.be*

Today's health care is characterised by a shift from acute, supply-driven care to a need-driven and integrated care model, as a means to reduce health care costs, improve patient health and strengthen patient empowerment. All health governments are focusing on the crucial role of primary healthcare to create a stable healthcare system (World Health Organization, 2013). With an increased demand for home care and home hospitalisation, there is a growing demand for patient care at home. This requires nursing assessments (assessing a patient's medical, psychological, sociological and spiritual status as a first step in the nursing process) to continuously provide answers to these care demands (Verbeek-Oudijk et al, 2014).

The Belgian health care system is being reconsidered to improve its performance (European Observatory on Health Systems and Policies, 2012). Belgian home care services are provided by either home nurses, or health care assistants (HCAs). Belgian home nurses are trained as generalist registered nurses.

An HCA can be employed as a community aid by community services or as an HCA in organisations for home nursing. HCAs carry out personal and comfort care as community aids, whereas HCAs working in organisations for home nursing assist home nurses caring for patients. For example, they can identify problems associated with urinary catheters, help patients with oral medication (after this has been prepared by the nurse) or apply preventive measures for pressure ulcers.

HCAs perform 18 nursing activities, which are delegated and supervised by a home nurse, such as mouth care, care for a healed ostomy and preventing pressure ulcers (De Vliegher et al, 2016). In light of this, HCAs have greater responsibilities than community aids; who focus on domestic help, patient support and basic hygiene.

The Belgian Government provided the legal foundation for the integration of HCAs in home nursing in December 2006 (Federal Public Service Health Food Chain Safety and Environment, 2016). The organisations for nursing care are financed on a national level by the National Institute for Health and Disability Insurance, whereas community services are organised and financed by regional entities.

The reinforcement of collaboration between all health professionals on a primary level is being promoted by the Belgian Government, as is seen in the growing number of initiatives (European Observatory on Health Systems and Policies, 2010;

ABSTRACT

Background: In light of current trends and healthcare evolutions, delegation of patient care from home nurses to health care assistants (HCAs) is increasingly important. Hygienic care is an essential component of nursing education and practice, yet it has rarely been the subject of scientific literature. Aim: To understand the opinions and experiences of home nurses and policy makers with regard to the meaning of hygienic care and the delegation of these acts in the context of home nursing. Methods: A descriptive qualitative study (six focus groups with home nurses and two with policy makers from the Belgian home nursing sector). Content analysis of the data and the use of NVivo 11.0 software.

Findings: Hygienic care is a cyclical care process of continuously investing in a trusting relationship with a patient, assessing their care needs and ability for self-care and taking action and evaluating care as situations change. All of this must be mutally agreed with the patient and should consider their environment and lifestyle. The decision to delegate hygienic care is based on patient assessments and the patient's specific care needs using nursing diagnoses and indicators. Finally, barriers and facilitating factors for both delegating and providing hygienic care were addressed.

Conclusion: Hygienic care is a crucial component of nursing care, that can be delegated to HCAs with the necessary supervision.

KEY WORDS

• Professional delegation • Focus groups • Nurses • Community health • Nursing assessment • Skin care

Federal Public Service Health FCS and E, 2016).

The need to collaborate with and delegate care to other caregivers is emphasised by the Belgian government. Care should be delegated between first line and specialised settings, and can even be delegated to informal caregivers (Lane et al, 2003; McKenna et al, 2004; Paulus et al, 2012). Community nurses delegate tasks such as washing and observing the patient, but as these tasks are often undefined the extent to which they can be delegated is often discussed.

During recent years, specific technical nursing care has been thoroughly discussed in the context of efficient and cost-effective care. There is a body of evidence on the more technical aspects of skin care and personal care, such as wound care, incontinence and care for pressure ulcers. Personal care has rarely been the subject of scientific literature, although it is considered an essential and basic component of both nursing education and practice (Cowdell and Steventon, 2015; Kottner et al, 2015). This could be because hygienic care is not often defined for nurses, as it is a combination of what was taught at nursing school and what is best for the patient, which makes it difficult for a researcher to specify exactly what constitutes hygienic and personal care.

Nevertheless, De Vliegher et al (2015) explored the experiences of home nurses, medical specialists in hospitals and general practitioners in relation to the shift of technical, complex care from the hospital to home care. One of the discussion points was whether or not personal care can be considered a 'technical' act. Proponents argued that personal care is technical care due to the nurses' observations and the fact that this care is taught as a basis care act in nursing education. However, opponents did not consider personal care to be a technical act because of the lack of clear guidelines and procedures, which implies that anyone could carry out personal care. The scarce research available on personal care highlights the need for evidence and guidelines to clarify good hygienic practice(Cowdell and Steventon, 2015; Kottner et al, 2015).

The importance of nurses carrying out personal care has been supported in recent evidence (Elliott et al, 2016). Hygienic care is not only considered an essential part of nursing practice, but it is also the basis for the professionalisation of nursing (Cowdell, 2010; Pols, 2013; Kottner et al, 2015). For some patients, daily personal care is essential for day-to-day living, and some nurses consider it a requirement and a key element of good care (Cowdell and Steventon, 2015; Pols, 2013; Kottner et al, 2015). Personal care is also an important moment of contact between patient and nurse, and is the basis for building a trusting relationship with patient, family and other caregivers involved in the patient care. The home nurse is in a privileged position to pick up signals from the care context about the patient's wellbeing, health status and environment (Corbin, 2008; Kottner et al, 2015; De Vliegher et al, 2015).

Considering the important role of home care, in light of current trends as well as personal care, the authors explored how home nurses perceive personal care and its delegation. The aim of this study was to describe:

- The meaning of personal care to home nurses and policy makers in the home care setting
- The experiences of home nurses regarding delegation of personal care
- The criteria used by home nurses when delegating and monitoring delegated personal care.

Materials and methods

Study design

A descriptive phenomenological qualitative study was performed, using focus groups.

Sample and setting

This study was performed in the Dutch (Flanders) and the French (Wallonia) speaking part of Belgium. Respondents were purposively sampled by e-mailing home nursing services and organisations for independent home nurses. Six focus groups were organised with home nurses and two with policy makers. The six focus groups with home nurses took place in Ghent, Brussels, Genk, Liège and Namur.

Home nurses had to meet the following inclusion criteria:

- A varied age range across focus groups
- A variety of education levels (graduate, bachelor, master, additional education)
- Practical experience in personal care and its delegation
- Knowledge of nursing assessment (assessing what personal care a patient needs and who is best suited to provide this care)

The two focus groups with policy makers were performed in Brussels and Namur. Policy makers were eligible for participation if they were active in a policy function, and had experience/knowledge regarding home nursing and nursing care acts (if possible, any nursing background and experience or knowledge about collaboration with other professionals).

Data collection

Data was collected between November 2016 and March 2017. The focus groups were moderated by three researchers (ID, AM and EP). The three researchers are registered nurses with a background of nursing research. In four focus group, an observer with previous experience in nursing research (KDV or EP) was present in focus groups.

No relationship was established before the study started. At the beginning of each focus group, the researcher indicated the scope of the research and reported having no interests in the research topic. The focus group interviews took place in one of the organisations for home nursing and lasted for approximately 2 hours. All interviews were audio-recorded. Semi-structured interview guides were used, similar in both languages (*Appendix A*) and each conversation ended with an open question for additional information. The moderator asked clarifying questions when deeper discussion was needed and used prompts to encourage the participants. No pilot study or repeat interviews were carried out. When present, observers made field notes during the entire focus groups. The following topics were discussed:

- Experiences, definition and meaning of personal care
- Variation and frequency of personal care
- The choice to delegate and the importance of this care

Table 1. Temographic information

	Nurse	Policy worker
Number of participants (n=52)	39 (75%)	13 (25%)
Gender (n)		
Male	8 (15%)	8 (15%)
Female	31 (60%)	5 (10%)
Age (mean)	41.9	52.1
Civil state (n)		
Married	28 (54%)	10 (20%)
Not married	8 (15%)	1 (2%)
Divorced	2 (4%)	1 (2%)
Other	1 (2%)	1 (2%)
Education (n)		
Caregiver	1 (2%)	0 (0%)
Graduate	14 (27%)	0 (0%)
Bachelor's	14 (27%)	5 (10%)
Higher	10 (20%)	8 (15%)
Working for an organisation (n)	26 (50%)	9 (17%)
Working as an independent home nurse (n)	13 (25%)	4 (8%)
Regime (n)		
Full time	28 (54%)	13 (25%)
Part time	11 (21%)	0 (0%)
Average working years in home nursing (mean)	14.1	24.8

- Impeding and facilitating factors
- Nursing assessment
- Context of delegation of care.

Informed consent was obtained and self-reported demographic data were collected from each participant. The sociodemographic data were: gender, age, civil state, region and province where they lived and worked, education, working in an organisation or as an independent home nurse, occupational role, regime, potential secondary occupations and experience as a home nurse.

Participation was on a voluntary basis and each participant had the possibility to withdraw from the study at any given moment.

Data analysis

The focus groups were transcribed, anonymised and read thoroughly by all research team members. Afterwards, the focus groups were manually coded by three researchers (ID, KDV, and SC).

After the first focus group, data was transcribed and analysed in three phases:

- Transcript extracts which related to the research questions were isolated
- They were then categorised into free and tree nodes, which is a method of organising data. A tree is a way of representing the hierarchical nature of a structure in a graphical form, such as a family tree or biological evolutionary tree. The tree elements are called nodes. Free nodes are newly created nodes in a list, whereas tree nodes have been organised into a hierarchy.
- The free and tree nodes were discussed by the research team. The ideas and insights from the earlier focus groups informed subsequent focus groups questions.

This procedure was repeated for each focus group. Finally, the research team categorised the data into themes and agreed that data saturation was reached. Participants were not asked to review the transcripts.

Results

Sample

Table 1 provides information on participants' demographic information. In total, 52 respondents participated, with a mean number of 7 participants per focus group. Eight nurses were enrolled but did not attend the focus groups. Most of the participants were female (70%), married (74%) and had at least a bachelor's degree in nursing (37%). The participants' mean age was 44.3 years. Most of the participants (79%) worked full time and had an average of 14.41 years working experience in home nursing.

Three main themes emerged from the research. First of all, the main concern in this study was that personal care is inherent to nursing care and can be seen a cyclical care process. Second, concerning the delegation of personal care, several criteria and conditions were discussed. Finally, several impeding and facilitating factors for both delegating and providing personal care were noted.

Hygienic care as a cyclical care process, inherent to nursing care

The most important result of this study is that personal care is without doubt a nursing act. It is part of the holistic care that can be provided by home nurses. Equally, it can serve as a 'gateway' for patients, allowing them to be comfortable involving a health professional in intimate areas of their life, and provides an opportunity for the home nurse to assess patients' care needs and self-care ability.

Hygienic care is considered a 'container concept', which incorporates several care aspects that transcend merely washing the patient. Personal care can be initiated on different levels: through an actual care need, the need for patient supervision, because of the home nurse's instinctive feeling 'that something isn't right' or as supervision of the patient's self-care.

'Personal care is not only about care duties performed, it is a trust relationship. I'm a social nurse,

so I've had visits where you try to gain information to have an impact. It's easier when you're with your patient in the bathroom every day and in that intimacy sphere. That's another model, you have more input and the chance to do something. Don't take it away from that nurse, because it'll be more difficult to do what has to be done.' (FG4–Nl)

The participants emphasised the nurse's role in personal care. Home nurses have the knowledge, ability and opportunity to assess and evaluate the total care situation, take necessary preventive actions and refer the patient in the appropriate time frame to other health professionals. Based on the unique trust relationship with their patient and the ability to perform and interpret observations, home nurses are also an important link between patient and general practitioner and other involved health professionals.

'So we have those observations, we have the nurse consultation, the care plan, the patient's needs, the medical background, patient empowerment. Yes, especially the full guidance. We really are an addition to the doctor and that those observations support, change or refine the diagnosis, that is personal care with nursing assessments according to me. We do it automatically, but don't say it enough. We say we 'wash a patient', but we do so much more.' (FG1–Nl)

Hygienic care is a cyclical care process of continuously investing in a trust relationship, assessing the patients' care needs and the ability for self-care, taking action and evaluating, and this in constant agreement with the patient and their environment. Participants defined flexibility as one of the most important features of home nurses. After all, a home nurse adapts to the patient and their environment and not the other way around. This explains the importance of an introductory visit to get acquainted and build a foundation for mutual respect, prior to a home nurse starting care. During these visits, the home nurse creates a holistic impression of the patient and their self-care ability, based on observations of (in)visible care needs and the care context; and the patient clarifies their care wishes and goals. Alongside this, the nurse should make clear arrangements with the patient about what times they should visit the patient and how often, and how the patient would like the care to be carried out. For instance, would they prefer care to be carried out in the bathroom or bedroom.

When carrying out personal care in the period following this first conversation, the care needs, trust relationship and agreements are refined and complemented with elements of advice and education, if necessary, resulting in a continuous care cycle.

'This personal care should be our intellectual act. We go there to assess a situation and it's impossible to do so if you don't have a trust relationship, if you've never touched your patient. It's impossible. (FG4–Fr)

But it's also possible that this lady has diabetes, for example. And that she'll need a whole lot more care in time. You probably won't see this during a first visit. […] And yes, then it's our job to try to monitor these parts.' (FG3–Nl)

Finally, the lack of clear criteria or specific guidelines indicating how and when a patient should be washed, results in a variation of personal care. Some participants indicate washing the patient's feet every day, while others work out a schedule. It is quite common for complete bathing to take place in the morning and an intimate toilet in the evening. This variation in personal care is subject to structural agreements in organisations, strongly depending on the nurse carrying out the care, or is determined by the pathology or patient's wish.

'We often look at the patient's needs. And we notice that certain patients love having their feet washed every day. So we do that. We also have patients where we wash their feet on Monday, Wednesday and Friday, but we have about 5 patients whose feet are washed daily and afterwards rubbed with body lotion. It's very person-related.' (FG3–Nl

The delegation of personal care

A. Nursing diagnostics as the basis for delegating personal care

It is unclear when and to what extent personal care can be delegated to an HCA by a nurse. The most common method mentioned by the participants in the study is an assessment of the patient's situation and the specific care needs based on nursing diagnostics and nursing indicators.

A nursing assessment is very important. The BelRAI screener is a tool to assess a patient's care need by mapping the patient's care situation and wellbeing (eHealth, n.d.). Some participants in the study indicated that BelRAI could potentially indicate when personal care could be delegated, by determining the line between care and wellbeing. For instance, there is no indication for a nurse to be present for simple care in stable situations, like washing the patient's back. For patients without an actual nursing care need, but where daily visits are necessary, other caregivers can be involved.

'By definition, I will never send a healthcare assistant to a situation as long as it's unstable. (FG4–Fr)

The boundary lies between wellbeing and healthcare, that's where the line is. I mean, as soon as there is an indication from your nursing diagnostics or the BelRAI screener, whatever, that you're in a nurse domain, a nurse or healthcare assistant should carry out the act. If not, then it's not really our business.' (FG4–Nl)

B. Delegation as a function of the person carrying out the care

Delegation of personal care by a nurse strongly depends on the person receiving the delegated task and acting under the nurse's responsibility:

'When a task is delegated, doesn't matter if it's a personal care or signing a money transfer, the person delegating remains accountable. It also depends on the person to whom you delegate. It depends on the delegated care. And it depends on the context in which you're delegating.' (FG4-Fr)

Four possible directions were mentioned in this study: delegation to a patient, informal caregiver, community aid or HCA. Delegating personal care to a patient is the equivalent to reducing nursing care. It is 'temporary' personal care with the starting objective of regaining a patient's full self-care, for example help when washing after surgery. The care is reduced gradually, allowing the nurse time to continuously observe and assess the increasing self-care.

The participants agree that informal caregivers should not carry out personal care, as they have a different relationship to the patient than a health professional (e.g. parent, child, partner) and lack the necessary skills and qualifications. Carrying out this kind of care could undermine the patient-caregiver relationship since informal caregivers are not likely to indicate when the care has become a burden. This leads to nurses often 'appearing on the scene' in crisis situations when caregivers have already crossed their limits. Nurses find it difficult to build a trust relationship and provide customised care to the patient in these situations. However, caregivers sometimes prefer being involved in their loved ones' care, and participants agree that in these situations nurses should discuss and assess on a realistic basis what is still feasible.

'They [informal caregivers] have other tasks. We're there for half an hour, and they are for 23.5 hours, the rest of the day, which is a lot. And they can help us in other ways.' (FG1-Nl)

All participants agree that community aids should take on complementary detailed and comfort care, according to their professional profile:. This can include washing and curling hair, nail care, washing feet, domestic help and keeping the patient company. They can also support nurses, for instance helping patients with a fear of falling when taking a shower or by taking over personal care while the nurse provides other care. Home nurses should remain in contact with their patient and keep visiting and monitoring them to assess and monitor their situation and observe visible or invisible care needs. There are regional differences in the study, as Dutch-speaking home nurses would not delegate total personal care to a community aid, whereas the French- speaking nurses that were included in this study said that they would.

'A community aid can carry out care while the nurse carries out wound care or gives an injection. But if there aren't any other care needs, we trust them to care for the patient without supervision. We're all on the same team.' (FG2-Fr)

The criteria for delegating personal care to HCAs are similar to those indicated for community aids. A HCA can also carry out preparatory work in urgent situations until a home nurse is present. Home nurses expect HCAs to have a certain level of observational skills in order to identify when a nurse needs to visit. Home nurses' supervise HCAs in control visits and delegate tasks. A Belgian home nurse is required to visit the patient once a month to check if delegated care is being carried out appropriately.

C. Criteria for delegation of personal care

The most important criteria reported by the study respondents for the delegation of personal care are close collaboration between professionals, constant exchange of information during delegation of care and timely indication of changes in the patients' care situation It is imperative that delegated care returns to the home nurse where necessary, since the patient's care situation can change over time. Setting up a care plan, defining alarm signals or regularly visiting and assessing the patient's situation can facilitate this timely return of care to the home nurse. The participants in the study expect HCAs to contact a nurse when a patient's situation changes.

'We also have the agreement that healthcare assistants should observe procedures within their competency to improve their skills.' (FG2-Nl)

The patient's consent is another crucial aspect for delegating care. The intimate aspect of personal care and the established trust relationship with the nurse can lead to patients refusing or not accepting care from another professional.

'You have a relationship. There's this patient, she didn't want a community aid washing her during the week, because we always carried out the care. And, as time went by, she got to know the aid and the aid kept carrying out the care.' (FG1-Fr)

Finally, delegating care to HCAs should always be organised within the current legal framework.

Facilitating and impeding factors

A range of facilitating and impeding factors were reported for providing and delegating personal care.

A. Facilitating and impeding factors for providing personal care

First of all, when providing personal care, several factors related to the reimbursement system were noted. In Belgium, patient dependency is assessed by the Katz-scale (National Institute for Health and Disability Allowance, 2017), which determines the reimbursement rate. Participants in this study indicated that the score on the Katz-scale often does not indicate a patient's personal care need, leading to insufficient reimbursement of care. This is due to the fact that the care situation is not always clear cut and is also subject to change, and that patients can be ashamed to admit their real care situation.

Participants also pointed out that the general practitioners' (GPs) lack of knowledge about the home nursing legislation was another impediment to personal care provision. Home nursing legislation allows a patient to receive personal care without a prescription. (Federal Public Services Health Act,

2016). GPs that prescribe personal care are often not aware of the patient's personal care frequency, depending on his or her Katz-score, which means that patients can be misinformed about their care need. According to the participants of this study, they also underestimate the importance of their role referring patients who need personal care to home nurses.

Other factors that impact the provision of care are time constraints faced by home nurses and a breakdown of relations between a patient and health professionals. While home nurses are aware of the importance of keeping records of observations and care provided, keeping up with administation also takes time away for direct patient care. Finally, personal care provision can be improved by using an electronic nursing file to exchange information with colleagues.

B. Facilitating and impeding factors for delegating personal care

Current financial and legal healthcare issues were reported as important impeding factors to delegating personal care. As nursing care at home is covered by the national insurance system, whereas care from a community service is a direct cost for the patient, patients tend to refuse the latter. Due to the separate jurisdiction of community aid services (regional) and home nursing (national), community aids are not integrated in the home nurse team, resulting in the lack of supervision or control from the home nurse. This impedes communication with these services, leading to home nurses being unaware which patient is cared for by a community aid and which patient should be referred back to a home nurse.

On an organisational level, the negative elements in the collaboration with community aids have also led to home nurses being less likely to delegate certain care to community aids. The participants reported that some community aids do not respect their boundaries, fail to refer patients to home nurses in the appropriate time frame, and do not comply with agreements. Due to the community aids' busy work schedules, their presence cannot be aligned with that of a home nurse, and therefore the aids cannot help with nursing care. In addition, a high turnover and sick leave of community aids is reported, which leads to nurses and patients often adjusting to a modified schedule. On the otherhand, while HCAs are part of the home nursing team and can be supervised by the home nurse, their limited, legally established activities can impede the organisation of delegated care. A variation in the number and type of health professionals visiting patients at various times during the day, is a concern for both patients and home nurses indicating a lack of continuity of care.

On an educational level, some participants noted that HCAs and community aids lack nursing education and therefore lack patient observation and assessment skills while carrying out personal care. In this way, several signals can be missed, such as a small wounds or swelling, that are linked to the patient's health status. Some French-speaking participants also reported that nurses were not taught to delegate and could benefit from further training.

It can be concluded that a balanced collaboration with competent HCAs and community aids, around the patient and informal caregiver is needed to delegate personal care. There should be a clear indication of each person's role, responsibilities and delimited tasks. By ocassionally still carrying out the personal care themselves during control visits, home nurses can regularly evaluate the delegated care and observe the patient. Continuously consulting other professional caregivers and exchanging observations and information through an electronically shared file, allows the nurse to retain an overview and form a total picture of the patient, the informal caregivers and the context. A sensitive point here is that a collaboration with HCAs seems to be preferred rather than a collaboration with community aids, as nurses and HCAs work in the same integrated team:

> *'A central file, that's what's needed. If only for personal care. Someone has dry skin, or takes certain medication that causes itchiness, or someone has renal failure. These are areas of concern where information is needed.' (FG4-Nl)*

> *'I think the current system works, with healthcare assistants under supervion of nurses. It strengthens a team. The healthcare assistants carry out detailed tasks and patients like that. We have observations to supplement this, because you can't do one without the other.' (FG1-Nl)*

Discussion

Home nurses and policy makers in the home nursing domain consider personal care a crucial component of nursing care. It is often a gateway through which nurses can aquire a full impression of the patient and build up a relationship of trust. Home nurses have an added value when carrying out personal care, because they can observe, assess, evaluate and act upon the situation from a nursing perspective. To ensure monitoring and observation of the patient, home nurses believe that personal care should only be delegated under strict conditions. Remarkably, there are no clearly defined criteria for the delegation of personal care. A patient's care dependency and nursing diagnostics seem to be the most important criteria when assessing a patient's situation and care needs. It is possible that the absence of protocols or guidelines regarding personal care plays an important role in this (Pols, 2013). Another fact is that Belgian nursing education does not include supervision of delegated acts. In a recent small-scale study with home nurses in the USA, community aids supported patients with their medication use, after following training, and home nurses received training on how to assess, delegate and supervise. The nurses reported positive experiences and a high confidence rate in the community care aids (Lee et al, 2015). Although education and training opportunities in the USA are not completely comparable with Belgium, one can carefully deduct that offering training on delegation and supervision to Belgian home nurses, or systematically embedding this in nursing education, could facilitate the delegation process.

This study has shown that home nurses' supervision is an important condition for delegating personal care to community aids and HCAs. Home nurses were made responsible for delegating personal care to HCAs when this became part of

KEY POINTS

- The findings presented confirm that personal care is primarily a nursing act that can be delegated under specific conditions to healthcare assistants, community aids and informal caregivers
- The patient's care dependency and nursing diagnostics are an important tool when assessing how to carry out or delegate personal care
- Home nurses consider a close collaboration, constant exchange of information and supervision by the home nurse intergral to effectively delegating personal care
- General practitioners have a crucial role when assessing the informal caregivers' capacity for taking on care

Belgian health law.

Since then, nurses have gained valuable experience in supervising delegated care, demonstrating the value of collaboration and consultation with other health professionals. The Belgian government is also feeling the pressure to approach the patient and their environment from a view of networked care, making it a logical step for HCAs to carry out personal care under supervision of home nurses. However, this is not reality yet: currently, when HCAs carry out care, the care is taken from the nurse. In this view, it is important to build the possibility of a follow-up visit in the financing system.

Finance system

The current finance system was identified as one of the most impeding factors in both carrying out and delegating personal care duties. The current Belgian regulation has set a certain reimbursement for home nurses carrying out simple personal care duties. Other care aspects are not covered by the terms of this payment, even though their importance has been cited several times in this study. Future finance systems should account for the fact that personal care is more than merely washing the patient; it also consists of observing and monitoring the patient, stimulating self-care and prevention of further ill health. Moreover, patient empowerment, psychosocial support and care need evaluation are also part of personal care. This finance system should support a patient's ability to care for themselves and manage their health.

Today, only nursing care is reimbursed, which does not encourage patients to carry out the care themselves and thus gain autonomy. Patients prefer being cared for by nurses, since they believe that nursing care is 'free of charge', while nurses believe that they carry out care tasks for the patient faster than a HCA. In addition, the principle of subsidiarity is undermined as patients do not have to directly pay for nursing care, but directly pay for community aid care.

Health care systems need to be reformed and reinterpreted to ensure access to health care. The Belgian government aims to guarantee the continuity of care by supporting and emphasising the informal caregiver's role in an early care stage, after which professional care can be organised when this is needed. On average, over 30% of the European population carries out informal care. However, a recent study based on data from the European Social Survey, indicated that informal caregivers report lower levels of mental well-being (more depressive symptoms) than non-informal caregivers (Verbakel et al, 2017). The qualitative study of Lane et al (2003) described higher levels of stress, social isolation, loneliness and sadness in informal caregivers and emphasised the importance of supervision of informal caregivers.

This study confirms these statements, indicating that informal caregivers often cross their own limits. Moreover, the respondents expressed their concern about the informal caregiver's capacity to carry the burden of care and identify the need for professional help in the appropriate timeframe This is in line with international literature, indicating that informal caregivers often cross their own limits. This research has recognised the crucial role that general practitioners will have to take on by assessing the informal caregivers' capacity, something that still does not happen sufficiently today.

Recommendations

The following recommendations are derived from this study:

- From the vision of 'networked care', the collaboration between 'health care' and 'wellbeing' needs to be strengthened. As a result of shifting care from hospital to home care, the subsidiarity principle will gain importance and the right tasks will need to be carried out by the right person. This will only be possible if all health professionals use a shared electronic patient file
- A new financing system is needed that takes account of the 'container concept' of personal care. Education, prevention, consultation and follow-up also need financing, in order for patients to be encouraged to care for themseleves and manage their own healthcare needs
- A shared electronic patient file needs to be worked on, for the involved care professionals to work effectively and efficiently together on networked care.

Methodological strengths and limitations

Despite the fact that only home nurses and policy workers in home nursing were included, one HCA also joined a focus group, possibly influencing the discussion in the focus group. During its analysis, the researchers took this into account by coding certain statements with accompanying notes.

The average number of participants in each groups was 7. There were two people in the smallest group and the group moderator adapted questions to create an informative discussion.

The intention of this research was to have a representation of the different regions of the country and the different professional statutes (independent and employees). Nevertheless, the province of Luxembourg was not represented in the study. Because this province covers areas that are sometimes difficult to access, it is possible that relevant data were unintentionally missed.

Trustworthiness, credibility and rigor

The qualitative study design implies methods and techniques that are variable and open to personal interpretation. To control bias and elements of dependability, credibility and

transferability, different techniques were used. Peer debriefing, where a researcher calls upon a peer not involved in the research project, was used. The peer independently validated and discussed the recorded data until a consensus was reached about the uncertainties. When discussing the French data, a French-speaking colleague was included in the peer-debriefing team. Furthermore, space triangulation (collecting data on the same phenomenon in a range of locations) was used, since the focus groups were spread throughout Belgium. Regarding dependability, the code-recode procedure was applied. With regard to transferability, the 'thick description' method was used, where the profile of the focus groups was described in detail.

Conclusion

This study indicates that personal care is primarily a nursing act, which can be delegated under specific conditions. Considering the further increase of patients being cared for at home, collaboration and providing appropriate care by the right professionals will be of great importance. This can be achieved through a new funding system, investing in electronic devices and a shared electronic patient file, as well as strengthening partnerships between home nurses and family care services. **BJCN**

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Appendix 1 available on request via BJCN@markallengroup.com

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CPD REFLECTIVE QUESTIONS

- Is support from a healthcare assistant available in your region or organisation? Would this benefit your patient care?
- Reflect on what your patients would like you to consider when delegating tasks to other health professionals
- General practitioners have a pivotal role as part of the multidisciplinary team around a patient. Are there other caregivers involved as well?

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