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Attractiveness of people-centred and integrated Dutch Home Care: A nationwide survey among nurses

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ABSTRACT

The World Health Organization is calling for a fundamental change in healthcare services delivery, towards people-centred and integrated health services. This includes providing integrated care around people's needs that is effectively co-ordinated across providers and co-produced by professionals, the patient, the family and the community. At the same time, healthcare policies aim to scale back hospital and residential care in favour of home care. This is one reason for the home-care nursing staff shortages in Europe. Therefore, this study aimed to examine whether people-centred, integrated home care appeals to nurses with different levels of education in home care and hospitals. A questionnaire survey was held among registered nurses in Dutch home-care organisations and hospitals in 2015. The questionnaire addressed the perceived attractiveness of different aspects of people-centred, integrated home care. In total 328 nurses filled in the questionnaire (54% response rate). The findings showed that most home-care nurses (70% to 97%) and 36% to 76% of the hospital nurses regard the different aspects of people-centred, integrated home care as attractive. Specific aspects that home-care nurses find attractive are promoting the patient's self-reliance and having a network in the community. Hospital nurses are mainly attracted to health-related prevention and taking control in complex situations. No clear differences between the educational levels were found. It is concluded that most home-care nurses and a minority of hospital nurses feel attracted to people-centred, integrated home care, irrespective of their educational level. The findings are relevant to policy makers and home-care organisations who aim to expand the home-care nursing workforce.

1 INTRODUCTION

The World Health Organization (WHO) is calling for a fundamental shift in the way health services are delivered, towards people-centred and integrated health services (WHO, 2015). This plea for a change in health services delivery is driven by the need to meet the challenges of ageing populations, increasing prevalence of chronic diseases, the spread of unhealthy lifestyles and the fragmented nature of health systems. Some principles of people-centred and integrated health services as envisaged by the WHO (2015) are:

- Prioritising community care services;
- Providing integrated care around people's needs that is effectively co-ordinated across different providers and settings;
- Co-production of care by professionals, the patient, the family, informal carers and the community;
- Helping people to manage and take responsibility for their own health;
- Investing in health promotion and prevention strategies.

The WHO strategy on people-centred and integrated health services reflects current developments in home care. The proportion of older long-term care recipients receiving care at home has increased in many developed countries and the length of hospital stays has been reduced (OECD, 2015). High-quality care in communities is of great importance to the elderly people and to chronically ill patients. In order to improve home care, several European countries have set up initiatives focused on the integration and co-ordination of care services for home-dwelling patients (Genet, Boerma, Kroneman, Hutchinson, & Saltman, 2012). It is argued that integrated care needs to be people-centred, i.e. dealing with the whole person in their particular familial and community contexts, and that the informal domain and local community should be included as a resource and co-producer of care (De Maeseneer et al., 2012; Nies, 2014; WHO, 2008).

In the Netherlands, the work of home-care nurses reflects people-centred, integrated health services delivery as described by the WHO (WHO, 2015). Home-care nurses with a bachelor's degree in nursing (from a university of applied sciences) are appointed as central care professionals within communities. They are expected to co-ordinate and deliver people-centred, integrated home care in co-operation with nurses educated to associate degree level (who have completed senior secondary vocational education) and certified nursing assistants (see Box 1).

[BOX 1]

The WHO refers to a potential increase in the job satisfaction of health professionals resulting from the shift to people-centred and integrated health services (WHO, 2015). This is highly relevant to the home-care sector, given the current and expected future shortages of home-care nursing staff in many European countries (Eurofound, 2013; Genet et al., 2012), and thus the need to retain and recruit home-care nursing staff. Therefore, it is important to know whether people-centred, integrated home care actually appeals to home-care nurses. Furthermore, since the recommended shift in health services delivery entails a strengthening of community care at the expense of inpatient care, it is also of interest to know whether people-centred, integrated

home care appeals to hospital nurses. This may indicate the extent to which staff shortages in home care can be addressed by a shift of hospital nurses to home care. However, to date the research on factors that attract nurses to home care has tended to focus on general work characteristics. For instance, previous studies have shown that autonomy is important (Ellenbecker, Boylan, & Samia, 2006; Maurits, De Veer, & Francke, 2015; Tummers, Groeneveld, & Lankhaar, 2013). Little is known about the attractiveness of people-centred and integrated home care. Yet a literature review showed that elements of the management of care and the care process are associated with the job satisfaction of care professionals in the elderly home-care setting (Van Eenoo, van der Roest, van Hout, & Declercq, 2016).

People-centred, integrated home care can be expected to appeal to nurses as it is likely to enhance their professionalism. A recurrent notion in the large body of literature on professions is that members of an occupation control their own work and exercise discretion over areas of expertise, based upon a body of abstract, theoretical knowledge (see for instance Abbott, 1988; Freidson, 2001). According to Freidson (1999), professions are distinguished from occupations where the employer, manager or consumer controls the work, e.g. decides what tasks are to be performed, by whom, under which conditions and how. Being identified as a professional is an attractive prospect, in part because of the control over your work and the exclusive ownership of an area of expertise and knowledge (Evetts, 2003).

Although past literature has suggested a contrast between on the one hand organisational and managerial tasks and on the other hand the work of professionals (Noordegraaf, 2011), more recent work has argued that organising has become a normal part of professional work (Noordegraaf, 2015). This has been further substantiated by Postma, Oldenhof, and Putters (2015), who have shown that in the work of Dutch home-care nurses with a bachelor's degree, organisational tasks like co-ordinating and planning can be an inherent element of professional work. It is plausible that the organising and co-ordination tasks enhance home-care nurses' autonomy, a core characteristic of professionalism (Hall, 1968; Pavalko, 1971). Autonomy is frequently reported in the literature as an essential prerequisite for increased professionalism in nursing (Alidina, 2012; Varjus, Leino-Kilpi, & Suominen, 2011; Wade, 1999).

Independently assessing patients' home-care needs will most likely increase home-care nurses' professionalism by bringing this core aspect of professional work back into their jurisdiction (Abbott, 1988). Supporting self-management by patients and focussing on prevention gives nurses the opportunity to use a wider range of nursing knowledge and skills and increases the complexity of nurses' work. It also requires the application of abstract, theoretical knowledge to specific cases, which is associated with professionalism (Abbott, 1988).

It can be assumed that the attractiveness of people-centred, integrated home care differs between nursing staff depending on their level of education. In general, home-care nurses with a bachelor's degree experience more autonomy in their work than nurses with an associate degree (Maurits et al., 2015). Hence, these more highly educated nurses can be characterised by a greater degree of professionalism.

Therefore, it is likely that they will attach more value to having greater control over the content of their work by delivering people-centred, integrated home care than nurses with an associate degree. Furthermore, as can be seen in Box 1, home-care nurses with a bachelor's degree (rather than nursing staff educated to associate degree

level) have been given a central role in the community. This might also affect whether nurses with different levels of education perceive care integration and people-centredness as attractive. Moreover, competencies related to people-centred, integrated home care may also partially depend on the educational level, e.g. competencies regarding co-operation with other professionals within the community or the ability to take into account a patient's own opportunities for self-reliance or support from the social network.

1.1 Objective

The purpose of this article was to examine whether people-centred, integrated home care appeals to home-care nurses and hospital nurses educated to either bachelor's or associate degree level. This knowledge can help policy makers and home-care organisations in different countries in the retention and recruitment of nurses in home care, which is of crucial importance given the current and expected future shortages of home-care nursing staff in Europe. Hospital nurses are included in the study because a shift in which hospital nurses move to home care may be necessary given the desire to have more care delivered in the community rather than through inpatient facilities.

The main questions addressed in this study are:

1. To what extent do different aspects of people-centred, integrated home care appeal to nurses currently working in home care or in a hospital?
2. Is the perceived attractiveness of these different aspects associated with the educational level?

2 METHODS

2.1 Design and setting

The study employed a quantitative, explorative design. Data were gathered using a questionnaire survey among 609 registered nurses working in home care and hospitals. Data collection was carried out in the Netherlands in October 2015. In the Netherlands, home-care services traditionally include nursing care, support with daily living activities (i.e. personal care) and psychosocial care, and are mainly delivered by registered nurses and certified nursing assistants. Dutch registered nurses are educated to two different levels: associate degree level (equivalent to a UK foundation qualification) and bachelor's degree level (Maurits et al., 2015).

2.2 Participants

The sample was from a pre-existent nationwide research panel, the Nursing Staff Panel. This panel consists of a nationwide group of nursing staff members in various healthcare settings who deliver direct patient care and have expressed their willingness to complete questionnaires about topical issues in healthcare. Nursing Staff Panel participants are recruited via a random sample of Dutch healthcare employees provided by the Dutch Employee Insurance Agency. This procedure helps generate a representative group with respect to age, sex, region and employer (Maurits et al., 2015). In 2014, there was a supplementary recruitment drive in which participants working in home care were asked to invite up to four colleagues to join the Nursing Staff Panel.

For the survey presented in this paper, Nursing Staff Panel participants who worked as a nurse in home care or in a hospital were selected. A total of 328 nurses completed the questionnaire, providing a response rate of 53.9%.

2.3 Instrument

A self-developed online questionnaire in Dutch was used. The core part of the questionnaire addressed the perceived attractiveness of different aspects of working as a nurse in home care. These aspects were derived from the professional profile of home-care nurses developed by the Dutch professional association of nurses (De Bont, Van Haaren, Rosendal, & Wigboldus, 2012). As mentioned in the Section 2, the work of Dutch home-care nurses is in line with the people-centred and integrated delivery of health services as described by the WHO (WHO, 2015). The aspects addressed in the questionnaire that relate to people-centred, integrated home care were selected for the current study. Table 1 lists the aspects along with the corresponding WHO principles for people-centred and integrated health services.

[TABLE 1]

For each aspect, respondents were asked to indicate whether they considered this aspect attractive. The responses were originally on a three-point scale (“attractive”, “neither attractive nor unattractive” and “unattractive”). They were subsequently dichotomised: the responses “neither attractive nor unattractive” and “unattractive” were pooled since the response frequencies for “unattractive” were too low for the analysis of possible associations with healthcare sector and educational level.

The following respondent characteristics were measured in the questionnaire: healthcare sector, age, sex, educational level, work experience and number of working hours per week. Educational level was defined as the highest level of nursing education completed (either an associate degree or a bachelor's degree in nursing, possibly followed by a master's degree).

The content validity of the draft questionnaire was approved by the research project's advisory committee, which consisted of representatives of the Dutch professional association of nurses, associations of care organisations, organisations involved in nursing education and the Netherlands Organisation for Health Research and Development. Content validity and comprehensibility were tested further in a group of six nurses who completed a draft of the questionnaire. After this test, minor amendments were made, to take account of comments by the nurses and the advisory committee.

2.4 Data collection

Respondents were sent an e-mail with information about the survey and a link to the online questionnaire. To increase the response rate, up to two e-mail reminders were sent, after 7 and 18 days, to participants who had not responded thus far. When filling in the online questionnaire, respondents were not allowed to skip questions. As a result, there were no missing data for individual questions. Twenty-seven respondents quitted the questionnaire at an early stage. As these respondents did not answer the questions regarding the attractiveness of different aspects of working as a nurse in home care, they were excluded from the study. Since some of them quitted before answering the background questions, it was not possible to verify whether these respondents belonged to the research population and therefore no useful further analysis could be performed on these missing data.

2.5 Data analysis

Descriptive statistics were calculated for the perceived attractiveness of the different aspects of people-centred, integrated home care. Bivariate relationships between the perceived attractiveness of the different aspects and the respondent's healthcare sector or educational level were examined using Pearson's chi-square tests. The data were analysed using STATA 14.0 (StataCorp, 2015). A difference was deemed to be statistically significant if $p < .05$.

2.6 Ethics approval and consent to participate

This study was based on questionnaires completed by nursing staff; no patients were involved. As all the research participants were competent individuals and no participants were subjected to any interventions or actions, no ethics approval was needed under Dutch law on medical research (Medical Research Involving Human Subjects Act, <http://www.ccmo.nl>). Study participation was voluntary. Participant consent was assumed upon return of a completed questionnaire. The data were stored and analysed in accordance with the Dutch Personal Data Protection Act (http://www.privacy.nl/uploads/guide_for_controller_ministry_justice.pdf). Questionnaire data were kept separately from response information and personal details and the researchers did not have access to these background data. Hence, confidentiality and anonymity were assured. Privacy regulations have been drawn up and are in force for the Nursing Staff Panel.

3 RESULTS

3.1 Respondents' characteristics

Table 2 provides the individual characteristics of the respondents. Most were female (91%). The mean age of 46 (standard deviation or $SD = 11.8$) was slightly higher than the average age of employees working in the Dutch healthcare sector, which was 43 in 2015 (AZW, 2016). More than half of the respondents (55%) had an associate-level degree in nursing and 45% had a bachelor's degree. When compared with the population proportions in the Dutch home-care sector and in Dutch hospitals (Van der Windt & Bloemendaal, 2015a,b,c), it turns out that nurses with a bachelor's degree were overrepresented in this study, especially among hospital nurses. We have addressed this by performing subgroup analyses. The respondents had 19 years of experience in nursing on average ($SD = 11.9$) and an average working week of 27 hr ($SD = 6.0$). In this study, hospital nurses were more likely to be male and have a slightly higher average number of weekly working hours than home-care nurses (see footnotes to Table 2).

[TABLE 2]

3.2 Attractiveness of people-centred and integrated home care

As shown in Table 3, most home-care nurses regarded the different aspects of people-centred, integrated home care as attractive. Serving as a link between the domains of housing, social care and health care was least likely to be considered as attractive (70%). The other aspects were considered as attractive by 81% to 97% of the home-care nurses.

[TABLE 3]

Hospital nurses were less likely to view the different aspects of people-centred, integrated home care as attractive than home-care nurses (Table 3). However, all the different aspects were considered to be attractive by at least one-third of the hospital nurses. Taking control in complex situations was seen as attractive by three quarters of the hospital nurses. Furthermore, almost two-thirds of the hospital nurses considered the aspects “paying attention to health promotion and the timely identification of problems (prevention)” and “focusing on what a patient can still do and promoting self-reliance in a patient” to be attractive. The other aspects were regarded as attractive by 36% to 45% of the hospital nurses.

The biggest differences between home-care nurses’ and hospital nurses’ views concerned the aspects “having contact with family caregivers who are both users and partners in the delivery of care,” “having contact with everyone in the patient's network” and “working in the community.” These aspects were seen as attractive by 87%, 93% and 91% of the home-care nurses respectively, while 36%, 42% and 45% respectively of the hospital nurses regarded these aspects as attractive (Table 3).

3.3 Differences between educational levels

Home-care nurses with a bachelor's degree seem more likely to consider the different aspects of people-centred, integrated home care as attractive than home-care nurses educated to associate degree level (Table 4). However, a statistically significant difference between the two educational levels was found only for the aspect “having a network in the community and maintaining contacts with local residents, organisations, professionals and municipal officials.” Almost 9 of 10 nurses (88%) with a bachelor's degree regarded this aspect as attractive, whereas around three quarters (76%) of the nurses educated to associate degree level consider this aspect as attractive.

[TABLE 4]

No clear pattern of differences was found between the two educational levels among hospital nurses (Table 4), except for “taking control in complex situations.” Hospital nurses educated to bachelor's degree level are more likely (85%) to consider this aspect as attractive than nurses with an associate degree (69%).

4 DISCUSSION

4.1 Main findings

This study examined the attractiveness of different aspects of working in Dutch home care that correspond to people-centred and integrated home care. The results show that most home-care nurses regard these aspects as attractive. A focus group study by De Groot, Maurits, and Francke (2018) also showed that home-care nurses feel attracted to the fact that they can be a link between the patient and other professionals, and be responsible for the co-ordination of care. Reasoning from the study findings, being able to deliver and organise people-centred, integrated home care may increase home-care nurses’ job satisfaction and contribute to the retention of nurses in home care. These results are in line with the WHO's appeal for a shift towards people-centred and integrated health services in order to address current challenges in health care (WHO, 2015). In addition, the study findings support the

initiatives of several European countries to integrate and co-ordinate care services for home-dwelling patients (Genet et al., 2012).

Furthermore, at least one-third of the hospital nurses consider aspects of people-centred, integrated home care as attractive. This indicates a potential for a shift of hospital nurses to home care. The study findings also suggest that hospital nurses are more attracted to fostering a patient's self-reliance and health promotion than to people-centred care in the community. A possible explanation is that hospital nurses are more oriented towards the individual patient and have fewer contacts with the patient's family, community and professionals in the domains of housing and welfare.

That home-care nurses are more likely to consider aspects of integrated, people-centred home care as attractive than hospital nurses is likely to be related to their decision to work in this setting and their current work experiences in this regard. Choosing to work in home care indicates a preference for supporting patients in their personal living environment. This better reflects people-centred care than nursing care in hospitals, which is more focused on supporting physicians. If hospital nurses gain further experience with supporting patients in their home, they may feel more attracted to people-centred care. Furthermore, as suggested in the Section 2, enhanced professionalism may explain why delivering and organising people-centred, integrated home care appeals to home-care nurses. This mainly concerns the use of a wider range of knowledge and skills, more opportunities to apply abstract knowledge to specific cases, and greater autonomy. However, hospital nurses may prefer to specialise within their specific field of expertise, which is also a characteristic of professionalism (Freidson, 1999). Delivering and organising people-centred and integrated health services in home care may be at the expense of deepening specialist knowledge of the treatment of specific disease conditions. Contrary to expectations, the study showed no clear differences between educational levels. A possible explanation may be that, despite the differences in professional profiles and educational background, there are only a few differences between nurses with a bachelor's degree and nurses with an associate degree in nursing practice in the Netherlands (Van der Velden, Francke, & Batenburg, 2011). This may mean that experiences with the provision of people-centred and integrated care and the need for additional training are also largely the same.

4.2 Implications

The findings of this study indicate that strengthening people-centred, integrated home care is important for the attractiveness of working in home care and may help to retain current home-care nurses. In order to create a competent workforce for people-centred and integrated home-care delivery, nurses may have to develop new competencies. The WHO has described 42 competencies that are needed to deliver people-centred and integrated health services; these competencies are divided into the clusters of patient advocacy, effective communication, team work, people-centred care and continuous learning (Langins & Borgermans, 2015).

Furthermore, the study results seem to suggest some potential for the recruitment of home-care nurses among hospital nurses, although in general hospital nurses appear to be less attracted to people-centred and integrated home care than nurses who currently work in home care. Giving hospital nurses the opportunity to gain experience with delivering and organising people-centred, integrated home care may

help to encourage nurses to switch from inpatient care to home care. Such a shift appears necessary as signs of an imminent general shortage of nurses have diminished in recent years (OECD, 2016), while the demand for home-care nurses is likely to rise due to ageing populations and government plans for growth in home care, often seen as a replacement for residential and hospital care (Genet et al., 2012; OECD, 2015).

Suitable strategies for fostering people-centred, integrated home care are likely to vary between countries given the substantial differences in home-care contexts across countries, even within Europe (Carrera, Pavolini, Ranci, & Sabbatini, 2013; European Commission, 2013; Van Eenoo, Declercq, et al., 2016). It is plausible that providing people-centred and integrated home care by nurses is more difficult in countries where nurses mainly assist physicians, compared to countries where nurses operate more independently in supporting home-dwelling patients. The WHO has developed a framework for action on integrated health services delivery, which can assist countries in enhancing people-centred, integrated home care (WHO, 2016).

4.3 Strengths, limitations and suggestions for future research

Previous research on factors that attract nurses to home care has mainly been restricted to general working conditions, such as autonomy, rather than the way the home-care services delivered by nursing staff are organised, co-ordinated and provided. Therefore, this study provides valuable new insights. As the WHO is calling for people-centred and integrated health services while at the same time the home-care sector is struggling with nursing staff shortages, it is very important to know whether home-care nursing staff consider people-centred, integrated home care to be attractive. The findings of this study can be used for this purpose.

However, a few caveats need to be noted regarding the present study. Since there is variation in the provision and organisation of home-care services and in the overarching long-term care systems across countries (Carrera et al., 2013; Van Eenoo, Declercq, et al., 2016), the generalisability of the study findings may be limited to countries where the role of home-care nurses is well-developed and where a relatively high percentage of the population have access to nursing services and personal care at home provided by nursing staff. Furthermore, although this study indicated that hospital nurses feel some attraction to people-centred, integrated home care, it remains unclear whether they would actually consider switching to home care. In the view of calls to prioritise community care at the expense of inpatient care, hospital nurses' willingness to change to home care is an intriguing subject for future research.

5 CONCLUSIONS

People-centred, integrated home care appeals to most home-care nurses, irrespective of their educational level. The study findings also suggest that a minority of hospital nurses feel attracted to this characteristic of home care. These findings are relevant to policy makers and home-care organisations who aim to retain and expand the home-care nursing workforce.

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COMPETING INTERESTS

The authors declare that they have no competing interests.

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BOX AND TABLE

BOX 1. POLICY REGARDING HOME CARE IN THE NETHERLANDS

As part of a recent reform of long-term care, the Dutch government aims to give home-care nurses with a bachelor's degree a central position in the community, in which they are responsible for organising and co-ordinating home care and serve as a link between the domains of healthcare, social care and housing.

Since 1 January 2015, home-care nurses with a bachelor's degree have the legal authority to perform the formal needs assessment, where they determine what nursing-care and personal-care services are needed, taking into account the patient's care needs, opportunities for self-reliance, home environment and social network. Within home care, they collaborate closely with nurses with an associate degree and certified nursing assistants. In the care for individual patients, home-care nurses are required to promote self-management by the patient and co-operate with informal carers. In addition, they are responsible for healthcare-related prevention (Postma et al., 2015; VWS, 2014a,b, 2015).

Table 1. Aspects of working in Dutch home care that relate to people-centred and integrated health services

Aspects of the new position, tasks and responsibilities of Dutch home-care nurses	Corresponding principle of people-centred and integrated health services (WHO, 2015)
Having contact with family caregivers who are both users and partners in the delivery of care	Co-production of care by professionals, the patient, the family, carers and the community
Having contact with everyone in the patient's network (patient, informal caregivers, family, neighbours)	Co-production of care by professionals, the patient, the family, carers and the community
Working in the community, knowing the community	<ul style="list-style-type: none"> • Prioritising community care services • Co-production of care by professionals, the patient, the family, carers and the community
Having a network in the community and maintaining contacts with local residents, organisations, professionals and municipal officials	<ul style="list-style-type: none"> • Providing integrated care around people's needs that is effectively coordinated across different providers and settings • Co-production of care by professionals, the patient, the

Aspects of the new position, tasks and responsibilities of Dutch home-care nurses	Corresponding principle of people-centred and integrated health services (WHO, 2015)
	family, carers and the community
Paying attention to health promotion and the timely identification of problems (prevention)	Investing in health promotion and ill-health prevention strategies
Serving as a link between the domains of housing, social care and health care	Providing integrated care around people's needs that is effectively coordinated across different providers and settings
Focusing on what a patient can still do and promoting self-reliance in a patient	Helping people to manage and take responsibility for their own health
Taking control in complex situations	Providing integrated care around people's needs that is effectively coordinated across different providers and settings

Table 2. Descriptive statistics

	Total (<i>n</i> = 328)	Nurses in home care (<i>n</i> = 177)	Nurses in hospitals (<i>n</i> = 151)
	% or mean (<i>SD</i>)	% or mean (<i>SD</i>)	% or mean (<i>SD</i>)
Educational level			
Registered nurse, associate-level degree	54.9	53.1	57.0
Registered nurse, bachelor's degree	45.1	46.9	43.0
Age (years)	46.02 (11.78)	47.10 (11.68)	44.76 (11.80)
Sex*			
Male	8.8	5.7	12.6
Female	91.2	94.3	87.4
Work experience (years)	18.85 (11.90)	17.93 (11.94)	19.93 (11.80)
Working hours per week**	27.42 (6.01)	26.32 (5.76)	28.72 (6.06)

*Statistically significant difference between nurses in home care and nurses in hospitals, $p < .05$; **Statistically significant difference between nurses in home care and nurses in hospitals, $p < .01$.

Table 3. Percentage of nurses in home care and hospitals who consider different aspects of people-centred and integrated home care as attractive (versus unattractive or neither attractive nor unattractive) ($n = 328$)

	Nurses in home care ($n = 177$)	Nurses in hospitals ($n = 151$)	χ^2	p
Having contact with family caregivers who are both users and partners in the delivery of care	87.0	36.4	90.18	.000
Having contact with everyone in the patient's network (patient, informal caregivers, family, neighbours)	92.7	42.4	97.17	.000
Working in the community, knowing the community	91.0	45.0	81.56	.000
Having a network in the community and maintaining contacts with local residents, organisations, professionals and municipal officials	81.4	44.4	48.57	.000
Paying attention to health promotion and the timely identification of problems (prevention)	96.6	65.6	53.96	.000
Serving as a link between the domains of housing, social care and healthcare.	70.1	40.4	29.15	.000
Focusing on what a patient can still do and promoting self-reliance in a patient	96.1	61.6	60.88	.000
Taking control in complex situations	90.4	75.5	13.15	.000

Table 4. Percentage of nurses in home care and hospitals that consider different aspects of people-centred and integrated home care as attractive (versus unattractive or neither attractive nor unattractive); differences depending on educational level ($n = 328$)

	Nurses in home care				Nurses in hospitals			
	RN-aa ($n = 94$)	RN-bb ($n = 83$)	χ^2	p	RN-aa ($n = 86$)	RN-bb ($n = 65$)	χ^2	p
Having contact with family caregivers who are both users and partners in the delivery of care	84.0	90.4	1.56	.212	36.1	36.9	0.01	.912
Having contact with everyone in the patient's network (patient, informal caregivers, family, neighbours)	91.5	94.0	0.40	.527	38.4	47.7	1.32	.251
Working in the community, knowing the community	89.4	92.8	0.62	.430	46.5	43.1	0.18	.674
Having a network in the community and maintaining contacts with local residents, organisations, professionals and municipal officials.	75.5	88.0	4.48	.034	40.7	49.2	1.09	.296
Paying attention to health promotion and the timely identification of problems (prevention)	97.9	95.2	0.98	.323	66.3	64.6	0.05	.831
Serving as a link between the domains of housing, social care and healthcare.	66.0	74.7	1.61	.205	41.9	38.5	0.18	.673
Focusing on what a patient can still do and promoting self-reliance in a patient	95.7	96.4	0.05	.827	61.6	61.5	0.00	.991
Taking control in complex situations	87.2	94.0	2.31	.129	68.6	84.6	5.13	.024

- a Registered nurse educated to associate degree level.
- b Registered nurse educated to bachelor's degree level.