UHASSELT

KNOWLEDGE IN ACTION

Faculteit Geneeskunde en Levenswetenschappen

master in de verpleegkunde en de vroedkunde

Masterthesis

Implementing the basic nurse role within a structured care team on a Flemish hospital ward: a qualitative evaluation guided by normalisation process theory

Natalie Emanuel

Scriptie ingediend tot het behalen van de graad van master in de verpleegkunde en de vroedkunde, afstudeerrichting zorginnovatie

PROMOTOR :

Prof. dr. Jochen BERGS

2024
2025

UHASSELT

KNOWLEDGE IN ACTION

www.uhasselt.be
Universiteit Hasselt
Campus Hasselt:
Martelarenlaan 42 | 3500 Hasselt
Campus Diepenbeek:
Agoralaan Gebouw D | 3590 Diepenbeek

UHASSELT

KNOWLEDGE IN ACTION

Faculteit Geneeskunde en Levenswetenschappen

master in de verpleegkunde en de vroedkunde

Masterthesis

Implementing the basic nurse role within a structured care team on a Flemish hospital ward: a qualitative evaluation guided by normalisation process theory

Natalie Emanuel

Scriptie ingediend tot het behalen van de graad van master in de verpleegkunde en de vroedkunde, afstudeerrichting zorginnovatie

PROMOTOR :

Prof. dr. Jochen BERGS

Table of Contents

Abstract 1

1. Introduction 2

2. Methods 3

Research Team 3

Study Design 3

Data Collection 3

Analysis 4

3. Results 5

Participant demographics 5

NPT constructs and components 6

Relationships between NPT Constructs 10

4. Discussion 10

Challenges 10

Implications 10

Applicability of Findings 11

Strengths and Limitations 11

Recommendations 11

5. Conclusion 11

6. Ethical Considerations 12

7. Acknowledgements, Funding, and Conflict of Interest 12

8. Literature 13

9. Appendix 15

Interview guide 15

Table 2:Normalisation process Theory 18

Abstract

Background

Pressure on the Belgian healthcare system is increasing. The greater prevalence of chronically ill patients, staffing shortages, and increased care complexity negatively impact team efficiency and overall quality of care. [1] In response, the federal legislators introduced reforms through the law on healthcare professionals, including creating a new nursing role: The Basic Nurse. Legally established in 2023 and situated at level 5 of the Flemish Qualifications Framework, this new profile aims to bring greater structure and efficiency to inpatient care. This study explores how healthcare teams experience the introduction of the Basic Nurse role, focusing on its impact on care organization, task distribution, quality of care, and nurse job satisfaction. [7]

Methods

This qualitative study was part of a larger quality improvement project at the Belgian hospital "Ziekenhuis Oost-Limburg" (ZOL). It explored nurses' perspectives on implementing a new care model, including the "Basic Nurse" profile. The focus group approach was used to evaluate these experiences. The analysis was guided by the Normalization Process Theory (NPT).

The study involved two clinical hospital wards (surgical and geriatric) in an east Limburg, Belgium hospital. A pilot ran over three consecutive days, including all shifts per 24-hour period. Five participants from the surgical ward (two represented a Basic Nurse profile, and three represented Coordinating Nurses) were recruited using convenience sampling. A post-intervention focus group was conducted, audio-recorded, transcribed verbatim, and analyzed using an inductive method. NVivo software was utilized for coding purposes, followed by the mapping against NPT constructs.

Results

A qualitative analysis reveals existing relationships between the core Normalisation Process Theory (NPT) constructs. More concretely, a lack of coherence and an unclear understanding of the Basic Nurse's role and competencies contributed to poor cognitive participation. Therefore, team members found engaging with or trusting the new Basic Nurse challenging. This hesitancy, insufficient leadership, and vague role expectations caused hindrances to collective action, resulting in fragmented care and ineffective practice. Critical reflection appeared under reflexive monitoring, where participants critically reflected on the implementation's feasibility. The sentiments in this phase were often negative. The reflections looped back to the initial lack of coherence, suggesting a cyclical pattern in which insufficient preparation at the beginning of the intervention led to low levels of integration and dissatisfaction with outcomes. The Findings indicate that successful implementation of the Basic Nurse profile is hindered by role ambiguity, lack of trust, inadequate structure, coordination, and training.

Conclusion

Significant integration barriers were recognized when the Basic Nurse profile was introduced using the current approach. There is a need for structural clarity, training, and substantial support from leadership. Successful implementation will require effective communication of responsibilities, team instruction, and consistent coordination to avoid stress and ineffective care delivery.

1. Introduction

The Belgian healthcare system has been facing numerous challenges for quite some time. A rising number of chronically ill patients is leading to an increased strain on healthcare systems.[1] Overcrowded hospital wards and often insufficient (qualified) staffing, increased workload for healthcare teams, and longer waiting times for patients may adversely affect the quality of the provided care.[1] [2]
Proper coordination of healthcare systems is essential, and a lack of response to these organizational needs may result in unwanted consequences. Despite efforts to optimize healthcare systems, many institutions struggle to deliver consistent and efficient patient-centered services. [1]

Belgian governing bodies recognized the need for reform in response to the mounting pressure on the healthcare system. The federal law, which is an overarching regulator, namely the (coordinated) law of May 10, 2015, regarding the practice of healthcare professions or abbreviated: WUG (Wet Uitoefening Gezondheidszorgberoepen) "Law Practice of Healthcare Professions." WUG regulations were contained within the Royal Decree KB 78 until 2015 when an amendment was made. Multiple adjustments have been made, but despite previous reform efforts, the law remains rather complex.[3] [9] [10]

One such reformation attempt was geared toward creating a clear healthcare structure with various nursing levels and creating new nursing profiles, one of which was the "Basic Nurse" profile.[4] Concerns from the European Commission led to the introduction of this profile in 2023, resulting from modifications made to the former HBO5 nursing training per the EU directives. The Flemish Qualifications Framework has placed the new role of Basic Nurse at Level 5, between secondary (Level 4) and professional bachelor's level (Level 6) of education. (Fnbv – Vlaanderen.be) This profile was legally solidified within the WUG on Jun 28, 2023. A clarification on their nursing practice and specific conditions for execution were clarified in the royal decree of September 20, 2023, and Apr 14, 2024.[9] [10]
The basic nurse profile is projected to enter the workforce in 2026 and, in doing so, provide much-needed structure and improve efficiency on inpatient wards.[3] To better comprehend the impact of pending changes, this research's objective is to explore nurses' experiences concerning the introduction of the "Basic Nurse" profile into a structured care team.[16]

2. Methods

Research Team

The focus group was facilitated by an experienced female researcher from the THINK³ simulation and innovation lab, assisted by a Master of Healthcare Innovation student. Neither researcher held a clinical role at ZOL during data collection. Open dialogue was encouraged by creating a neutral and respectful atmosphere. The assistant researcher took notes, engaged in peer debriefing, and acknowledged her dual role as an observer during the pilot testing days and an assistant during the focus group. Data analysis was conducted in collaboration with experienced colleagues from ZOL and UHasselt's THINK³ lab to decrease the risk of bias.

Study Design

Theoretical Framework

As a part of a larger quality improvement project (QIP) lead by the Flemish hospital East Limburg (ZOL), a pilot study was conducted. The aim was to assess how effectively the new nursing profile, "Basic Nurse," could be integrated into a structured healthcare team.

A component of this mixed methods study, a qualitative assessment of the experiences of nurses involved in the pilot study was conducted using a focus group design to facilitate in-depth analysis based on Normalisation Process Theory.

Setting and Participant Selection

The pilot was initially intended to include three hospital wards, more specifically, an internal medicine, a geriatric, and a surgical department. Due to several concerns regarding testing the intervention and patient safety, the internal medicine department was excluded from the study, leaving two clinical departments. Eligible clinical departments were those located at ZOL campus Genk; prior participation in innovation projects was a prerequisite, as well as providing medium complexity care. High-complexity care units were excluded from the project.

Three consecutive days of testing were organised in the participating departments. The test ran for the entire duration of a 24-hour cycle including all shifts (early-, late- and night shifts). On the first day, testing on the surgical unit was postponed from the early shift to the late shift due to challenges resulting from insufficient staffing and a high occupancy rate.

Sampling method

Participants were included through convenience sampling and roles of "Basic Nurse" or "Coordinating Nurse" were ascribed based on team member preference. The geriatric ward was subjected to an informal inquiry post testing and therefore not included in this thesis.

The focus group took place in an office on the nursing unit G35 after the handover from the early to late shift. Occasional brief interruptions took place by non-participants to collect personal items from lockers.

Data Collection

A comprehensive interview guide was developed, a facilitator and assistant roles were assigned based on levels of experience. Audio recording was done and field notes were taken by the assistant. The session lasted 70 minutes, none of the participants requested a break.

Analysis

Procedure and qualitative data analysis

One focus group was organized post-testing for participants employed at the surgical ward. A total of 5 team members attended the focus group (n=5) less than four weeks post-testing. All participants were present for the testing on days 1,2 or 3. Three participants undertook the role of Basic Nurse (BN) during testing, and two assumed the responsibility of being the coordinating nurse (CN). An audio recording was made during the session after all participants had given their informed consent. Verbatim transcription was applied, and emergent themes were identified using an inductive coding approach. Once cleaned, the transcript was uploaded to NViVO software for coding. After the initial transcription, a collaborative analysis was performed. Besides the primary researcher, three other researchers, more specifically, two THINK³ researchers and one ZOL researcher, were present.

Normalisation Process Theory

The Normalisation Process Theory was then applied, which allowed for a streamlined theoretical mapping of the most commonly occurring codes. NPT has been described in the literature as a theory-driven and vigorous framework for evaluating the implementation of complex interventions in healthcare settings.[12] NPT provides a structured tool to gain insight into the efforts individuals and teams made to integrate new practices into routine care.[12] NPT manage to capture the nuances of implementing new interventions, most especially in understanding the relational and operational challenges experienced by healthcare professionals.[8] Applying NPT in this study facilitates a systematic exploration of how the "Basic Nurse" profile is comprehended, adopted, and sustained within a structured healthcare team in a Flemish hospital, offering valuable guidance for future implementation strategies.[12]

3. Results

Participant demographics

The study included five participants with varied roles and educational backgrounds relevant to the implementation of the Basic Nurse (BN) function. Four of the five participants were female, and one was male. Ages ranged from 26 to 60 years; one participant's age was not disclosed. Three participants (Participants 1, 2, and 4) held the role of coordinating nurse (CN/CN) during the testing phase, all of whom had obtained a bachelor's degree or an A2/HBO5 nursing qualification. Two participants (Participants 3 and 5) functioned as Basic (Associate) Nurses (BN). Participant 3 held an A2/HBO5 diploma, while Participant 5 had completed a master's degree, making him the most highly educated among the group. This diversity in professional roles and educational levels provided a broad range of perspectives on the integration and operationalization of the BN role within the care team. An overview is provided in Table 1.

Table 1 Participant demographics (N=5)

Participant	**Age in years**	**Sex**	**Education**	**Role during testing**
Participant 1	undisclosed	Female	Bachelor	Coordinating nurse/CN
Participant 2	48	Female	Bachelor	Coordinating nurse/CN
Participant 3	35	Female	A2/HBO5	Basic (Associate) nurse/BN
Participant 4	60	Female	A2/HBO5	Coordinating nurse/CN
Participant 5	26	Male	Master	Basic (Associate) nurse/BN

NPT constructs and components (Table 2 of the appendix)

Coherence: Shared Understanding and Planning in Implementation

-Differentiation

During the implementation of the role of the Basic Nurse (BN), it became evident that there was a fundamental lack of differentiation. Team members struggled to distinguish the BN's competencies from other roles (e.g., healthcare assistants), leading to widespread confusion and uncertainty about their clinical reasoning and responsibilities. While the roles and limitations of other healthcare providers, such as healthcare assistants, were well understood, there was no comparable clarity for the Basic Nurses. As a result, tasks were often assigned based on an ad hoc basis without clear agreements or structure. This contributed to disorganized work situations and frustration among staff.

> "*That was also the difficult part because, with healthcare assistants, we know what they can do, may do, and actually do. With Basic Nurses, with this test, I have no idea to what extent they can reason clinically. I don't know what their training involves. If they see a wound or a vital sign, do they know what to do with it? That was very difficult*."– *Participant 5, BN*

-Communal Specification

Well coordinated planning and alignment regarding the deployment of BNs in team briefings was missing. Mutual understanding of the BN role and how it fits into the broader team dynamic was limited. Morning briefings were perceived as missed opportunities to clarify roles and responsibilities, resulting in a lack of structure and mutual trust.

> "*Actually, in the morning briefing, someone should say: look, this Basic Nurse had this and that. They are easy patients, and there is nothing you shouldn't do. Those are your patients and also your responsibility.*" – *Participant 4, CN*

-Individual Specification

The absence of Individual Specification, more specifically, clarity about one's own tasks and scope, compounded this issue. Basic Nurses were unsure about what they were allowed to do, resulting in hesitation and inefficiency.

> *"She had to show it first to get approval before starting wound care."*
>
> *– Participant 5, BN.*

-Internalization

In terms of Internalization, trust, and alignment with personal and professional values were weak. Nurses questioned whether the new profile aligned with their commitment to patient-centered care.

"By dividing up tasks, the patient feels like just a number." Participant, CN

The selected quotes illustrate obstacles concerning *coherence*: there was a limited shared frame of reference to guide the implementation process effectively. This not only rendered the role unclear but also made it feel unsafe for both Basic Nurses and Coordinating Nurses.

Cognitive Participation: Building Collaborative Practices Through Joint Effort

-Initiation

Despite initial enthusiasm (Initiation) for testing the BN role, the process of actively engaging others was hampered by uncertain responsibilities and inconsistent overarching leadership.

"It wasn't clear who had which task." – Participant 2, CN

-Enrolment

While there was a willingness among team members to collaborate in implementing the Basic Nurse (BN) role, this intention was undermined by unclear responsibilities and a lack of structured task allocation. The absence of extensive guidance created uncertainty about accountability, particularly in relation to patient care. Although team members felt a shared sense of responsibility, it was often unclear who held the final authority, leading to hesitation and role confusion.

"Where does the responsibility go then? Who is it for?" – Participant 4, CN

-Legitimation

Some team members questioned the legitimacy of the new role, unsure whether BNs could be trusted with clinical tasks or whether their involvement would improve care.

"It's heavily relying on others to make sure things are okay." – Participant 5, BN

-Activation

Staff attempted to navigate the new structure independently. This reliance on informal arrangements rather than structured delegation weakened team coherence and limited the formation of sustainable collaborative practices.

The resulting fragmentation not only disrupted internal processes but also risked impacting the quality of patient care and staff confidence.

"I don't want to work like that." – Participant 2, CN

These findings show that although collaborative intent was present, effective participation required clearer boundaries, consistent coordination, and stronger managerial involvement to translate individual efforts into a coherent team approach.

Collective Action: Putting the Intervention into Practice

-Interactional Workability

Functioning together as a team was challenging; this was evident in role ambiguity and chaotic task management.

"I couldn't check everything, it was so busy." – Participant 2, CN

-Relational Integration

The implementation of the Basic Nurse (BN) role faced several practical challenges that significantly affected how team members worked together. Coordinating nurses frequently reported overseeing or double-checking BN tasks, which increased their workload and disrupted workflow. This constant need for validation and clarification created inefficiencies and diluted team cohesion. Despite intentions to collaborate effectively, coordination proved difficult due to perceived limited autonomy for BNs, lack of trust in their role, and poor understanding of the scope and limitations of the new role.

> "*I came to a patient with a heavily saturated wound, and before I could start, I had to first show it to her so she could approve that I was going to do it correctly.*" – *Participant 5, BN*

-Skill-set Workability

Additionally, high patient loads and unclear task division contributed to fragmented care delivery and a diminished sense of control among staff. Coordinating nurses often felt overwhelmed and unable to maintain oversight.

> "*I couldn't check everything; it was so busy, and there were a lot of high-need patients. You can't be in two places at once.*" – *Participant 2, CN*

-Contextual Integration

Though some individual agreements were made to navigate practical limitations, these were improvised and lacked the consistency needed to sustain efficient collaboration. With limited role clarity, staff were repeatedly interrupted or forced to reassume tasks, undermining both efficiency and confidence.

> "*We did well together, and yes, I trust her with that, but if it's someone who's not allowed to provide full care, you keep getting interrupted: oh, that patient, they can have this or not, you keep getting disturbed.*" – *Participant 4, CN.*

Overall, the lack of structured delegation, role clarity, and consistent communication created a fragmented implementation experience, with professionals often compensating for system-level gaps on an ad hoc basis.

Reflexive Monitoring: Evaluating the Intervention in Practice

-Systematization

Team members reflected on the intervention and questioned its feasibility under the current conditions. A recurring theme was the disconnect between their professional values particularly the desire to deliver holistic, patient-centred care, and the fragmented, task-oriented model that emerged in practice. They expressed that the current healthcare structure made it impossible to fulfil their roles in a satisfactory manner.

> "*And I don't think you can fully care for your patient.*" – *Participant 2, CN*

-Communal Appraisal

This division of tasks led to confusion, duplicated efforts, and a lack of continuity in care. Basic Nurses often had to seek permission or clarification before acting, which delayed processes and affected team confidence. The absence of structural preparation, clear communication, and shared expectations significantly limited the intervention's effectiveness.

> "*She reported each time and said: look, I'm not allowed to do this or that. Eventually, I said: you can do it for me today."*

-Individual Appraisal

Participants also identified systemic issues in nursing education and the need for better role-specific training. Basic and Coordinating Nurses felt that quality care was compromised without clear expectations or preparation.

> "*The training itself has declined. These nursing students here, they're not trained at the bedside anymore.*" – *Participant 2, CN.*

Overall, staff were willing to evaluate and adapt, but feedback was largely informal. The lack of understanding, structural support, and adequate training contributed to difficulties with incorporating the intervention or assessing its long-term value.

> *"And she said: I run into this every time, I'm not allowed, I can't. Everything was reported at the table.*" – *Participant 4, CN.*

Relationships between NPT Constructs

The four constructs of Normalisation Process Theory (NPT) are interconnected and mutually reinforcing. In implementing the Basic Nurse (BN) role, shortcomings in one construct directly influenced the others, leading to a fragmented intervention process. Initially, there was a weak sense of coherence; team members did not share a clear understanding of the BN role, creating insecurity and confusion. This ambiguity hindered Cognitive Participation, making it difficult for team members to invest in the intervention. The challenges in generating commitment fed into difficulties in Collective Action, where poor coordination and insufficient autonomy for BNs led to disjointed collaboration and fragmented care delivery. These enactment challenges prompted negative Reflexive Monitoring, with team members critically evaluating the intervention and recognizing the need for systemic changes. The cyclical nature of NPT constructs means that critical reflections during Reflexive Monitoring could feed back into coherence, highlighting the need for more explicit role definition and shared training. However, in this case, the cycle stalled, and the necessary coherence to renew trust and shared understanding was not restored, perpetuating systemic gaps.

4. Discussion

Challenges

Previous research has shown that role ambiguity hinders the integration of new healthcare roles. Our findings align with this, as team members struggled to understand the Basic Nurse role. Navigating future roles in healthcare is a complex venture. [14]

Poor engagement with the new care model was mainly due to a perceived lack of or insufficient leadership support and unclear accountability. Our participants had difficulties delegating (CN) and expressing autonomy, which undermined new practices. [6] Barriers to implementing the nurse's role include scope of practice restrictions, heavy workloads, and inadequate education. [5] Although Busca et al. derived these barriers from primary care settings, they are echoed by data from our focus group.

Implications

Considering the latest reforms within the Belgian nursing landscape, it is essential that healthcare teams have a solid understanding of the Basic Nurse profile. This clarity supports the NPT construct ‘coherence’ and contributes to a shared understanding within structured care teams. This is important given the recent role differentiation through the amended WUG legislation and the designation of the Basic Nurse at level 5 of the Flemish Qualifications Framework.[15] [16]

Involving nurses and team leaders in implementing the Basic Nurse profile increases the feeling of control and acceptance of change. [15] This aligns with the NPT construct of 'cognitive participation' and is essential in Belgian hospitals. Practical challenges such as task distribution and modes of communication, for instance, must be addressed to facilitate smooth integration into practice. This relates to the NPT construct of 'collective action' and requires targeted support from leadership. Within the Belgian context, where collaboration with other healthcare professionals, such as healthcare assistants and nurse specialists, is becoming increasingly important, proper coordination is essential. [7]

Formal and informal feedback moments are necessary to sustain and integrate the implementation and effectiveness of the Basic Nurse profile. Under the NPT construct of 'reflexive monitoring,' these strategies are essential for Belgian hospitals that aim to implement high-quality, evidence-based care models.

Applicability of Findings

Although the findings originate from a single pilot project at a Belgian hospital, the contextual challenges, such as unclear role definition, lack of interprofessional communication, and stress due to role ambiguity, might resonate with other healthcare settings implementing similar innovations in care models. The detailed description of the setting and participants supports transferability but is limited by the small sample size and the early implementation phase. Further exploration in different wards, institutions, or health systems may validate and expand the applicability of these findings.

Strengths and Limitations

A key strength of this study is the use of the Normalisation Process Theory (NPT) as a guiding framework, which allowed a structured interpretation of team dynamics, resistance, and perceived barriers to implementation. The inclusion of multiple professional roles in the focus group enriched the data by providing a multidimensional perspective. However, the small number of participants and the short intervention duration limit the findings' depth and generalizability. Additionally, social desirability bias may have influenced participant responses despite efforts to create a safe discussion environment.

Recommendations

To ensure the effective integration of basic nurses into healthcare teams, it is essential to develop clear legal and operational frameworks that define their scope of practice, responsibilities, and delegation rights.[6] [15] Basic Nurse Role-specific training should be implemented before deployment to improve care delivery and promote teamwork.[6]Hospital policies should support new care models, and practice recommendations may include context-specific, multifaceted approaches.[7] Interprofessional collaboration and proactive leadership, investing in communication and feedback systems, and creating standardised supervision protocols.[7].[15] Further research should focus on implementation outcomes, including patient perspectives, and evaluating training efficacy.

5. Conclusion

In the exploration of how care teams experienced the introduction of the "Basic Nurse" profile, it was found that there was a lack of coherence. The new nursing profile was not adequately introduced, causing diminished understanding. Barriers to cognitive participation were identified as

a lack of general leadership and obscure responsibilities. Role confusion, ineffective communication surrounding the basic nurse role, and workflow obstruction caused collective action fragmentation. Without structural changes and proper training, heightened frustration resulted in an implementation that did not feel feasible. High priority should be given to clarifying the role of the "Basic Nurse," engaging leadership, and ensuring mutual trust among healthcare professionals. Practice policies should prioritize the methodical implementation of the new nursing profile, which in turn is efficiently communicated to structured care teams.

Key recommendations may include specific training tailored to the “Basic Nurse” profile. Providing a clear pathway for communicating and delegating tasks. Leadership engagement throughout the entire implementation process and subsequent evaluations is an essential measure.

6. Ethical Considerations

Ethical approval was obtained from the Committee for Medical Ethics (CME) for protocol number FT-20240012.

7. Acknowledgements, Funding, and Conflict of Interest

The researcher would like to acknowledge the contributions of UHasselt’s faculty members of the Department of Medicine and Life Sciences, who assisted in the peer review. Thank you to the researchers of THINK³ simulation and innovation lab for their support and guidance. Sincere gratitude is also extended to ZOL campus Genk for making this work possible, as well as the nursing team that participated in the pilot and focus groups. No funding was received for this study, and no conflict of interest should be declared.

8. Literature

1. Aiken LH, Sloane DM, Griffiths P, Rafferty AM, Bruyneel L, McHugh MD, et al. Nursing skill mix in European hospitals: cross-sectional study of the association with mortality, patient ratings, and quality of care. BMJ Qual Saf. 2016;25(7):457–66.

2. Beckett CD, Zadvinskis IM, Dean J, Iseler J, Powell JM, Buck-Maxwell B. An integrative review of team nursing and delegation: implications for nurse staffing during COVID-19. Worldviews Evid Based Nurs. 2021;18(4):251–60. https://doi.org/10.1111/wvn.12523

3. Belgisch Staatsblad. Wet van 28/06/2023 tot wijziging van de wet betreffende de uitoefening van de gezondheidszorgberoepen, gecoördineerd op 10 mei 2015, teneinde de huidige titel van verpleegkundige aan richtlijn 2005/36/eg te verduidelijken en de basisverpleegkundige en de klinisch verpleegkundig onderzoeker hierin op te nemen [Internet]. 2023 [cited 2025 Feb 18]. Available from: https://etaamb.openjustice.be/nl/wet-van-28-juni-2023_n2023043266

4. Beroepskwalificatie | De Vlaamse kwalificatiestructuur [Internet]. Available from: https://app.akov.be/pls/pakov/f?p=VLAAMSE_KWALIFICATIESTRUCTUUR:BEROEPSKWALIFICATIE:::1020:P1020_BK_DOSSIER_ID,P1020_HEEFT_DEELKWALIFICATIES:8301,NEE

5. Busca E, Savatteri A, Calafato TL, Mazzoleni B, Barisone M, Molin AD. Barriers and facilitators to the implementation of nurse's role in primary care settings: an integrative review. BMC Nurs. 2021;20(1). https://doi.org/10.1186/s12912-021-00696-y

6. Campbell AR, Layne D, Scott E, Wei H. Interventions to promote teamwork, delegation and communication among registered nurses and nursing assistants: an integrative review. J Nurs Manag. 2020;28(7):1465–72. https://doi.org/10.1111/jonm.13083

7. Fontaine G, Vinette B, Weight C, Maheu-Cadotte MA, Lavallée A, Deschênes MF, et al. Effects of implementation strategies on nursing practice and patient outcomes: a comprehensive systematic review and meta-analysis. Implement Sci. 2024 Sep 30;19(1). https://doi.org/10.1186/s13012-024-01398-0

8. Johnson L, Mardo J, Demain S. Understanding implementation of a complex intervention in a stroke rehabilitation research trial: a qualitative evaluation using Normalisation Process Theory. PLoS One. 2023;18(9):e0282612. https://doi.org/10.1371/journal.pone.0282612

9. Koninklijk Besluit van 14 april 2024. Koninklijk besluit tot wijziging van het koninklijk besluit van 20 september 2023 bepalende de lijst van de verpleegkundige technische verstrekkingen betreffende de basisverpleegkundige, alsmede hun uitoefeningsvoorwaarden. Belgisch Staatsblad. 2024 Apr 25. Available from: https://etaamb.openjustice.be/nl/koninklijk-besluit-van-14-april-2024_n2024003889.html

10. Koninklijk Besluit van 20 september 2023. Koninklijk besluit bepalende de lijst van de verpleegkundige technische verstrekkingen betreffende de basisverpleegkundige, alsmede hun uitoefeningsvoorwaarden. Belgisch Staatsblad. 2023 Oct 30. Available from: https://etaamb.openjustice.be/nl/koninklijk-besluit-van-20-september-2023_n2023045525.html

11. Lavergne T. Tekort aan verpleegkundigen en crisis van het "zorgen voor." In: Janssen H, editor. Brussel: Instituut voor de gelijkheid van vrouwen en mannen; 2020.

12. May CR, Albers B, Bracher M, Mair FS, Murray E, Rapley T, et al. Translational framework for implementation evaluation and research: a normalisation process theory coding manual for qualitative research and instrument development. Implement Sci. 2022;17(1):19. https://doi.org/10.1186/s13012-022-01191-x

13. McEvoy R, Ballini L, Maltoni S, O'Donnell CA, Mair FS, MacFarlane A. A qualitative systematic review of studies using the normalization process theory to research implementation processes. Implement Sci. 2014;9:2. https://doi.org/10.1186/1748-5908-9-2

14. Spanos S, Leask E, Patel R, Datyner M, Loh E, Braithwaite J. Healthcare leaders navigating complexity: a scoping review of key trends in future roles and competencies. BMC Med Educ. 2024;24(1). https://doi.org/10.1186/s12909-024-05689-4

15. Wilson NJ, Pracilio A, Morphet J, Kersten M, Buckley T, Trollor JN, et al. A scoping review of registered nurses' delegating care and support to unlicensed care and support workers. J Clin Nurs. 2023;32(17–18):6000–11. https://doi.org/10.1111/jocn.16724

16. Zorgnet-Icuro. De hervorming van het verpleegkundig beroep: een overzicht [Internet]. 2024 [cited 2025 Apr 22]. Available from: https://www.zorgneticuro.be/kennisdomeinen/verpleegkundig-beroep/hervorming

9. Appendix

Interview guide

Interview Guide
Project Title: Integration of Basic Nurses in a Structured Hospital Care Team **Location:** Ziekenhuis Oost-Limburg **Date:** January 21-23, 2025 **Target Group:** Nurses involved in the pilot implementation
Today's session will be a focus group. The aim is to discuss your experiences during the test days of integrating basic nurses in the hospital department on January 21, 22, and 23, 2025, in department GA35. The session will last approximately one hour. Several questions will be asked to guide the conversation. If there is a need for a break, it will certainly be provided upon request. The Master student will assist the lead researcher during the conversation.

Guidelines for the Focus Group:

- The central focus is on personal experiences, thoughts, and opinions.
- All answers are valuable.
- Differences in opinion are normal and certainly welcome.
- Why you personally think certain things are important.
- As much discussion among participants as possible is encouraged.
- The moderator/ interviewer, is there to steer the pace.
- The master student will take notes, and an audio recording will also be made. This recording will be kept confidential to facilitate later coding (we ask for your explicit consent for this); after data analysis, the recording will be deleted.
- All reports from the focus group will be anonymized.
- If feedback is needed, this is possible in a subsequent meeting or via email.
- Are there any questions before we begin? Does everyone agree to start the recording?

Introduction (Introduction by the Moderator)

- Welcome and thank you for your participation.
- Today's session is a focus group about your experiences with implementing basic nurses during the test days.
- The conversation will last approximately 60 minutes.
- Everything shared will remain confidential. We will make an audio recording strictly for scientific analysis.
- Consent is requested for the recording.

Preliminary Information

- Moderator: Lab Manager, THINK³ simulation & innovation lab UHasselt
- Assistant: Master's student Healthcare Innovation
- Recording: Yes (after verbal consent)
- Notes: Will be taken by the assistant
- Anonymity: Guaranteed

Structure of the Questionnaire

1. **Opening**
    - How did you experience the collaboration and division of tasks during the test days with the basic nurse within the team?
2. **Introductory Question**
    - What stood out most while working with a basic nurse?
3. **In-depth Questions**
    - What more can you tell about that?
    - How did you experience this?
    - What meaning do you give to this?
    - How did you deal with it?
    - Can you give a concrete example?
4. **Themes (with sub-questions)**
    - **General**
        - What did you learn from these three days?
        - How do you see the role of the basic nurse?
        - What advantages or concerns do you see?
    - **Collaboration and Division of Roles**
        - How will the collaboration with doctors and other caregivers proceed?
        - Which tasks do you find suitable or unsuitable for the basic nurse?
    - **Quality of Care**
        - How will this profile contribute to the quality of care?
        - What risks are there?
    - **Implementation & Acceptance**

        - What would a successful introduction look like?
        - What do you need to support this change?
    - **Future Vision**
        - How do you see the development of this profile in the future?
        - Does this affect your motivation?
    - **Job Satisfaction & Work Pressure**
        - How do you experience work pressure?
        - What impact do you expect on job satisfaction and balance?
    - **Team Dynamics**
        - How will this affect the team?
        - Are there concerns about collaboration?
5. **Conclusion**
    - What would you like to convey to the hospital management about this project?

Table 2:Normalisation process Theory

Constructs	Components	Codes	Descriptors/Examples
1. **Coherence** (How people work together to understand and plan the activities required to implement an intervention in practice.) *CMO domain: Mechanism*	**Differentiation**: (Understanding the content of the intervention)	-Insight	**To what extent do healthcare providers understand, comprehend, and interpret the intervention?** "Actually, during briefings, you should tell the Basic Nurse... those are your patients and also your responsibility." CN
		-Unclear role division	**Confusion about the responsibilities of Basic Nurses compared to other roles.** "But I think you wrongfully thought they weren't allowed to take blood samples through a PIC line." BN
		-Comparison with existing roles	**The extent to which Basic Nurses are compared to other profiles.** "We know what nursing aides can do, but for Basic Nurses, I have no idea what their clinical reasoning is or what they can do when they observe a wound or a parameter." BV
		-Expectations	**Does the new function match team expectations?** "It's more of a replacement for those nurses leaving, not an extra." BV
	Internalization: (Understanding the value, benefits, and importance of the intervention)	-Values, norms, attitudes	**How do personal and professional beliefs influence acceptance and collaboration with Basic Nurses?** "By dividing up tasks, the patient feels like just a number." CN
		-Trust	**To what extent do professionals (and patients?) trust the skills and decisions of the Basic Nurse?**

			"If it is really a Basic Nurse, there's a bit of trust issue. Can they do it or not?" CN
	-Communal specification: Communal Specification (How people collectively agree on the purpose of the intervention)	-Satisfaction with one's own work	**How positive do professionals feel about their performance under the new intervention?** "I felt like I didn't do my job properly. I didn't know various things. I had no real picture of all my patients." CN
	-**Individual specification:** (To what extent do team members understand what is expected of them individually)	-Competence	**The extent to which professionals feel confident and competent in their roles within a new team structure.** - "I had to show her the wound first before I could start because she had to approve it." BV - "It wasn't clear who had what task." CN - "And we kept getting medication questions: 'Can I give this?" CN
2. Cognitive Participation (How networks and practice communities are established through collaboration) CMO Domain: Mechanism	-**Initiation**: (Leaders take responsibility for implementation)	-Clinical Leadership	**To what extent do experienced team members and leaders support the integration of Basic Nurses into the current team?** -"Either the charge nurse arranges it and tells you you have to take care of this and that, or the responsibility is less for me." CN
	Legitimation: (The extent to which team members agree that the intervention	-Job Attractiveness	**In what way does the introduction of associate nurses affect the job**

	is appropriate and should be integrated.)		**attractiveness for members of the structured care team?** "The only thing I did experience was when I was working with a patient, for example, I had this thought in the back of my mind like, okay, my colleague is still continuing with the other side." BV
	-**Enrolment**: (How do team members engage in the intervention?)	-Fear	**The degree of uncertainty or resistance among healthcare providers regarding the impact of "Basic Nurses" on their own roles.** "I really don't want to work like that." CN
		-Organising care	**How care processes, structures, and collaborations are organized and coordinated.** -"We each went into a room and did what had to be done." BV -"And you had your own patients but still had to go perform many actions for the Basic Nurse because they weren't allowed to." CN
		-Clinical Reasoning	**How systematic thinking processes are used to gather, analyze, and interpret relevant information to make evidence-based decisions.** "The medication isn't right." CN "No, then we ourselves really have to think carefully about what they're allowed to give." CN
		-Willingness	**How open caregivers are to changes in workflows, team roles, and responsibilities due to the introduction of Basic Nurses.** "Yes, we tried. Yes, we tried." CN
	-**Activation**: (How team members support the intervention)	-Delegating	**"The process by which healthcare providers delegate certain tasks, responsibilities, or decisions"**

			"I think if you have to coordinate fourteen, you have to hand over a lot." **(CN)**
3. Collective Action (How people work together to practically carry out interventions) CMO Domain: Mechanism	**-Relational Integration:** (How does the implementation of the intervention impact mutual trust?)	-Team-dynamics -Communication	**How well do Basic Nurses collaborate with the team, and how much trust is there in their role?** "We actually did that really well together, and yes, I trust her in that. But in the end, if it's someone who's not allowed to perform full care, you keep getting interrupted." **(CN)** **How effectively are information and tasks relayed within the team?** "And then you have to do the handover at midday, and she's still busy there… I don't know what she's done." **(CN)** "There was no time for consultation."(BN)
	-**Interactional workability**: (How is the intervention executed by team members?)	-Hierarchy -Time constraints	**In what way are authority, decision-making, and responsibilities distributed within the care team?** "And then you had to go to the responsible… coordinating nurse and say: yes, I did that, but I'm not allowed to." **The level of pressure experienced due to a lack of time to provide quality care within working hours** "Everything just has to go fast, fast." **(CN)**

		-Continuity	**How Basic Nurses contribute to smooth handover of care and collaboration within the team** "You have three people doing something for one patient." **(CN)** "And yes, your total care is gone; your complete picture of the patient is also gone." **(CN)** "Because at every moment that you have to hand something over to someone else, something can go wrong. Something can be lost." **(BV)**
	-**Contextual integration**: (To what extent is the intervention supported by the healthcare organization?)	-Control -Autonomy -Workload	**To what extent do nurses maintain oversight and control over care processes, task distribution, and decisions, even after delegating to Basic Nurses?** "I really had no overview of all my patients." **(CN)** **Refers to the level of self-reliance among care providers within the new team structure.** "I kept asking every time whether I was allowed to do it." **(BV)** **To what degree do Basic Nurses** alleviate or burden the team's workload? -"ik kon niet alles nakijken het was zo druk, heel veel zware patiënten"CN
	-**Skill set workability**: (Appropriate task allocation: Which caregiver is	-Planning	**How do caregivers organize, structure, and coordinate tasks?** "Yes, yes, we made agreements. She said, 'Okay, I'll take this

	responsible for which tasks?)	-Responsability	room,' and I said, 'Okay, then I'll take that room.'" **(BV)** **Awareness of one's own role and tasks within the care team and the willingness to take ownership of patient care, decisions, and personal actions** "And I think we had 14 patients. That was really too much responsibility." **(CN)**
4. Reflexive Monitoring (How people work together to evaluate an intervention) CMO Domain: Outcomes	**Systematisation** (How do team members gain access to the effects of the intervention?)	-Feedback	**The way in which the team reflects on the contribution of Basic Nurses and identifies areas for improvement** "And then she briefed every time and said: look, I'm not allowed to do this and that. Eventually, I said: you can do that for me today. And then they say: that's the issue — it's not allowed, it can't be done. Everything was debriefed at the tables." **(CN)**
	-**Individual appraisal**: (How caregivers individually understand and evaluate the intervention)	-Personal performance Satisfaction	**The extent to which a caregiver feels competent, effective, and valued in their actions** – "I want to deliver my work properly, you know." – "Yeah, no, that's task-based nursing, right? What you're doing there… that's going backward." **(CN)** – "…that the patients are satisfied, when they say 'okay, great, thank you.' That appreciation from them

		-Loss of control -Insecurity	— you do a lot for that, right? That gives you a good feeling." **(CN)** **Loss of Control** **The feeling of losing grip on one's work or work environment due to unclear roles, high workload, or organizational changes** – "I felt like I hadn't done my work properly. I didn't know several things." **(CN)** **Uncertainty** **Refers to feelings of doubt or confusion about one's role as a caregiver and responsibilities during the implementation of the intervention** "Where does the responsibility go then? Who is it for?" **Coordinating Nurse (CN)**
	-**Reconfiguration** (How do people adapt their tasks in response to the intervention?)	-Continuity	**How do Basic Nurses contribute to a smooth handover of care and collaboration within the team?** "Someone takes a parameter, another does something else, and in the end, you're the coordinating nurse standing there with the medication... yeah." **Coordinating Nurse (CN)**
	Communal Appraisal (How do team members collectively assess whether an intervention is valuable?)	-Patient-Centered Care	**To what extent are patients' needs, preferences, and values prioritized in the deployment of Basic Nurses?** "And I don't think you can fully finish your patient's care." **(CN)** "When you get your patients assigned in the morning, you want them to be okay by the end of the day. So you can go home with peace of mind, knowing they're

			okay, pain-free, not nauseous, and so on. They're good." **(BV)**
		-Quality of care	**How does the basic nurse contribute to the overall standard of care and its continuous improvement?** "You get this false impression like, 'Oh yeah, it's done.'" **(BV)**
		-Patient Satisfaction	**Patient Satisfaction** **How do patients experience care when Basic Nurses are involved in their treatment?** "They noticed there was chaos with me." **(CN)** "Yeah, patients didn't notice anything from our side." **(CN)**
		-Education	**How are formal and informal training, education, and development organized to support Basic Nurses in acquiring and strengthening competencies?** "The education itself has deteriorated. These nursing students here... they're not being trained at the bedside anymore." **(CN)**