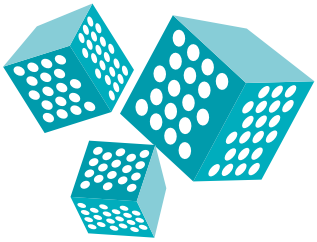
Development of business information for autonomous teams within the institutional care

Ecare Services BV.

Master Thesis



ecare.
Puur voor zorg

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Master Thesis
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| Preface (Dutch)

Nu ik begin met schrijven van dit voorwoord, realiseer ik me dat ik mijn studententijd achter me laat en dat er nu een einde komt aan een lange periode van studie. Na mijn Hbo-opleiding 'Commerciële economie' besloot ik de master 'Business administration' te gaan volgen op de Universiteit Twente. Bedrijfsculturen, organisatiestructuren en innovatie hebben me erg getrokken aan deze master. Daarnaast heb ik goede vrienden overgehouden aan deze leuke periode van studie. Omdat ik naast mijn studie al werkzaam was binnen Ecare en zij mij de optie boden bij hen af te studeren, was de keuze vrij snel gemaakt om dat ook daadwerkelijk te doen. De kanteling die we bij Nederlandse zorgorganisaties zien van een hiërarchisch georiënteerde en controle gedreven organisatie naar een meer horizontale en vrije organisatie waarin eigenaarschap centraal staat, boeit mij enorm. Daarom heb ik me daar tijdens deze scriptie in verdiept. In deze scriptie zult u lezen wat bruikbare en relevante (bedrijfs)informatie is voor zelfsturende teams binnen de intramurale sector. Ik besef me al te goed dat ik deze scriptie niet had kunnen voltooien zonder de medewerking van een aantal mensen die ik graag zou willen bedanken.

Matthias de Visser, ontzettend bedankt voor je goede begeleiding bij het schrijven van deze scriptie. Je hebt me tijdens onze gesprekken gemotiveerd en goed geholpen. Mede dankzij jou ben ik erg tevreden met het eindresultaat. Michel Ehrenhard, hartelijk bedankt dat je als tweede lezer wilde acteren bij de beoordeling van mijn scriptie en je bijdrage aan dit eindresultaat.

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Ook wil ik alle respondenten bedanken, Ina Kerkdijk, Eefje Stokvis, Jan Zieleman en Rolf Lucas van ZorgAccent, Marie-Louise Engbers en Mandy Steggink van Trivium Meulenbelt Zorg, zonder jullie had ik deze scriptie niet tot voltooiing kunnen brengen.

Als laatste bedank ik graag mijn familie, mijn vriendin Marjon en mijn vrienden. Jullie waren er altijd om mijn te motiveren en mijn tegenslagen aan te horen.

Ik wens u veel plezier met het lezen van mijn scriptie.

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| Abstract

The institutional care within the Netherlands has changed a lot over the past couple of years and is still changing. The institutional care will decrease in number of patients but the care to be delivered will cost more and will be more complex (Verbeek-Oudijk & Eggink, 2014; InVoorZorg, 2015). In order to sufficiently be prepared and to have quick response to the changes, the Rhineland way of organizing is being adapted within the sector. As part of the concept, the autonomous way of working is being introduced.

To make sure that the autonomous teams are working according to the vision of the organization and the restrictions of the stakeholders, boarders are introduced, this identifies the areas in which the autonomous teams can then operate (Graaf, 2015). These boarders are set up by the organization itself based on, among others, the influence of (external) stakeholders: the government, care agencies and the organization itself. When these boarders have been set up, these boarders might be translated to KPI's or other facilitating information for the autonomous teams. The central question during this research is: *"What business information can be supportive for autonomous teams within the institutional care sector?"*

Based on the literature, the stakeholders find the following information important regarding quality of care: personal care and support towards the clients, living and health, safety, ability to learn and improve for employees, leadership, governance and management, composition of personnel, use of resources, use of information, structural capture and monitoring incidents and structural capture of care information (Zorginstituut, 2017).Other relevant pieces of information based on the literature are: client satisfaction, employee satisfaction, employee expertise and productivity (Embregts, 2014).

In order to answer the research question, there have been interviews with people of the managing board and the autonomous teams itself. The participative method has been used to find out which KPI's are relevant for the autonomous teams. The two organizations that has been interviewed are Trivium ZorgAccent and Trivium Meulenbelt Zorg. The data of the autonomous teams had been gathered by focus group interviews (2 interviews). The data of the managing board had been gathered by one-to-one interviews (2 interviews).

It can be stated that KPI's are useful for the 'exact' information, the information from which one can easily derive conclusions. It that sense this research pointed out that the following information is relevant: the number of deployable hours, the capacity within the team (too much or too less) and absenteeism. The more 'facilitating' information is reflective, can bring up discussions and provides input for learning. No hard conclusions can be derived from this kind of information since one needs context. Facilitating information is related to care content. According to this research it can be stated that the following facilitating information is relevant: notifications of the number of incidents (related to fall and medication), happiness (satisfaction) of clients, relatives and employees, deployment of restraints, the extent of self-

reliance of clients and risk-attention fields. All of this information needs context, no hard conclusions be derived from it.

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1 | Introduction

This research has been conducted in narrow collaboration with Ecare. Ecare is an IT-company, developing software for the healthcare-sector (community care, education - i.e. nursing courses- and institutional care). The focus of Ecare is on organizations which adapt the Rhineland way of thinking and organizing. They are supporting these organizations with appropriate IT and counselling. Ecare is not leading in this research but provided support and their network.

1.1 | Relevance

A very well-known trend within the care-sector is the shift from a more vertical way of organizing to a more horizontal, autonomous way of organizing, also known as the Rhineland way of organizing. Lots of organizations, mainly within the community care sector, have introduced this way of organizing. Buurtzorg is a well-known community care organization which implemented this concept (Veur, 2014). Within this organization, teams are working autonomously at a maximum size of 12 nurses within one team (Monsen, 2013). Since the experienced successes of autonomous teams within the community care sector (Benders, Missiaen, & Hootegem, van, 2013), the institutional care-sector (long-term care) is experimenting with this way of organizing as well (InVoorZorg, 2015).

The expectation with the institutional care is that it will change radically within the coming years. On the one hand, the institutional care will decrease in the number of patients, (Verbeek-Oudijk & Eggink, 2014), but on the other hand the providing care will be more complex and bigger (InVoorZorg, 2015). This is, among others, because only clients with a complex care demand are able to live within institutions. Care demanding people in the Netherlands needs to live at their home as long as possible and are only able to enter an institution with an index rate (expression of heaviness of care) of at least 4 or 5 (before 2007 it was possible to enter institutions with an index rate of 1 or 2) (Stevens, 2015). It can thus be concluded that there is a need to respond quickly to the ever-changing demand of care and to the increase of costs. These changes with the long-term care are expected to have effects on the current and future nurses, patients and organizations (InVoorZorg, 2015). According to Hoogland & Boon (2013) the Rhineland way of organizing can bring outcome in order to decrease the costs (scrapping management layers), make the work more interesting for higher educated nurses and it will put the primary process back into place from which the client eventually will benefit. The community care sector serves as an example (Hoogland & Boon, 2013), for the institutional care sector. There are already institutional care organizations working according the Rhineland way (InVoorZorg, 2015; Zimmerman, Shier, Saliba, 2014).

The changes within the elderly care are consistent with the changes in the regulations and demands as set by the government (Asbreuk, 2008). These demands are the expediency of the organization, the experienced quality of care by the clients and the quality of the personnel (Almekinders, 2006). Thus, not only the clients and the government are stakeholders in the process, the employees as well are part of the process. The organization has a high interest that the employees are dedicated to the organization and thus make sure that these employees feel a collective connection towards the organization. In growing and hierarchical organizations, this bonding is less obvious. Besides, hierarchical organizations are less flexible because of their hierarchy and the policy of the organization is less recognized by the personnel (Asbreuk, 2008). When the choice has been made to work more autonomously there is no longer any question of complex and hierarchical coordination mechanisms. Instead, there is space for a new coordination mechanism with a more coaching character.

The autonomous teams will need to know what their responsibilities are, to make sure they are doing the right things. In order to make sure that these responsibilities are clear, the organization has to make clear the goals and boarders, so the autonomous teams can work accordingly. Boarders, in this sense, are the framework in between which the autonomous teams should work. The set goals and boarders are according to the vision and mission of the concerning organization with influence from the stakeholders (Graaf, de, 2015).

The autonomously working teams can operate within the determined boarders and goals. The goals and boarders may be expressed in KPI's or other facilitating information (which is reflective and brings up discussion and learning) in which the teams itself has insights. To ensure the organization is using the correct KPI's, they can make use of the framework as introduced by Parmenter (2015). At first, the organization uses the boarders and goals as determined (Parmenter, 2015). Then the organization has to find their success factors, and determine the measures that will work with their organization. Finally, the organization gets the measures to drive performance by the team (Parmenter, 2015). KPI's are then for example productivity of the team (for example a productivity of 65% should be met), employee satisfaction (for example a minimum number of 7,5), patients' satisfaction (for example a minimum number of 9), team functioning, etc. (Embregts, 2014). These KPI's can then be consulted by any team member (Leppers, & Eikenaar, 2011) without intervention of the coordination mechanism or management. Within the community care sector this approach has proven to be effective, this is shown by organizations as Buurtzorg where the overhead could be decreased to a minimum and where teams were able to work fully autonomously (Most, 2007). Attempts to find literature about the KPI's or other facilitating information which seems to be interesting and successful in relation to the institutional care, resulted in a gap in the literature. Thus, in this research the following question is leading and will be answered:

"What business information can be supportive for autonomous teams within the institutional care?"

To answer the main question (as shown above) a few sub-questions will be treated in this research as well. The first sub-question is about the design of the (institutional) care in the Netherlands. This is, among others, to understand the ever-changing demand of care and the importance to be flexible as an organization. This topic does as well provide an understanding for people not knowing to much about the care design in the Netherlands. The second sub-question is about the Rhineland way of organizing. What does it include and why is it important? This is followed up by a success story of Buurtzorg which implemented this concept within their organization. This topic tells something about the autonomous way of working and is in that sense important to answer the research question. The third sub question is about the stakeholders by whom the boarders for the organization are and eventually for the autonomous teams are determined. This topic will be discussed to introduce possible KPI's that are important according to the stakeholders (literature). The fourth sub-question is about the way KPI's can be determined and which KPI's are possibly relevant for the autonomous teams to work with.

Summarized the sub questions are the following:

- How is the institutional care designed within the Netherlands?
- What does include the autonomous way of working (Rhineland way of organizing)?
- Who are important stakeholders to determine boarders for autonomous teams?
- What are possible relevant KPI's for the institutional care according to literature?

All of these sub questions will be answered within the theoretical framework (chapter 2). Thereafter the methodology will be discussed in order to answer the main question. Then the results will be discussed, followed by the analysis, limitations and further research and eventually the conclusion.

2 | Theoretical framework

This theoretical framework provides context to the research question and is providing answers to the sub questions. Context will be provided by first discussing the structure of the care within the Netherlands and provide definitions to the different types of care within the Netherlands. Thereafter the Rhineland way of organizing is being discussed and why it is/may be relevant for the institutional care. This concept will then be discussed considering an organization who has put this way of organizing into practice. Then there will be more elaboration on determining the boarders towards autonomous teams in the institutional care where as well be the model for this research will be introduced. According to this model and the arisen stakeholders the relevant KPI's according to literature will be discussed.

2.1 |The care in the Netherlands

This research is conducted within the Netherlands and is thus based on the Dutch legislation. A general description about the design of the care in the Netherlands will be provided. The brief explanation given in this paragraph will help to understand the quickly changing demand of care and the extent to which an organization needs to be flexible to catch up with these changes. The main focus will be on the institutional care. This section provides answer to the first sub question: "How is the institutional care designed within the Netherlands?"

'Care' is a very versatile understanding. With the understanding of care, a distinction can be made in 'cure' and 'care' (Fry, 1978). Cure is a type of care which is most frequently provided within hospitals and can be defined as highly complex medical care (Fry, 1978). The understanding of 'care' may be related to institutional-, community-, transmural-, ambulant-, curative-, semimural-, somatic- and palliative care (Verbeek-Oudijk & Eggink, 2014). Within the scope of this research there will only be focus on institutional care with some examples of the community care. Community care can be defined as nursing which is usually delivered at patient's homes. Institutional care can be defined as care which will be delivered within the walls (institutions) and is also known as residential care (Hoe, Hancock, Livingston, & Orrell, 2006).

The institutional care has changed a lot over the past few years. When people are getting older and more dependent on care, they were quickly able to live within an institution. But, the first changes according to this system, basically finance-related, appeared in 2007. A new system was introduced in which the gravity of the care was indicated and indexed (Baank, 2007). The amount of care provided, depends on the index of a person (heaviness of care). The indexes are ranging from 1 to 5 in which 1 is light- and 5 is heavy-, more complex care. An index rate of 5 are for example clients which are heavily dependent on care because of

diseases as dementia. Where in the past it was possible to enter an institution with an index rate of 1, it is now only possible to enter an institution with an index rate of at least 4 (Stevens, 2015). These changes in the long-term care are closely associated with the increasing number of older people within the Netherlands. The mentioned changes are necessary to be able to provide everyone the care they need. By letting people stay at their homes and make use of the support system of the client, the costs of care can be reduced (Klerk, de, 2011). However, there are still a lot of older people moving to institutions, these people have an index rate of 4 or 5 and need more intensive care (Stevens, 2015).
The changes within the care sector and especially within the home- and institutional care are closely related to the demographical changes within the Netherlands and the pressure on costs. For the institutions, it means that they must specialize more and more in order to keep the clients within their institutions, especially since the care to be delivered within the institutions becomes more complex (Centraal Bureau voor de Statistiek (CBS), 2014). It also means that they as well must deal with the everlasting pressure on costs. A new way of organizing in this case, might bring solution (paragraph 2.2) to the dynamic market of care.

2.2 |Rhineland way

A very well-known trend in the care are the autonomously working teams in which teams have the freedom to operate within an established framework. These autonomous teams are a derivative of the Rhineland model. This is a proven way of working within the community care (Nandram, & Koster, 2014). As well in the institutional care sector, the concept of autonomously working teams is adapted (Zimmerman, Shier, Saliba, 2014). But why has it become important and why is the concept so popular? In this paragraph, more explanation will be provided about the Rhineland way of organizing. The autonomous teams that are part of the concept, and why it may be/is relevant for the institutional care a well. This paragraph provides an answer to the second sub question: “What does include the autonomous way of working (Rhineland way of organizing)?”

2.2.1 |What includes the Rhineland way?

According to Peters and Weggeman (2009) the focus for organizations, from a Rhineland based view, should lie in important values such as: attention, care, involvement and quality. Albert (1991) describes the Rhineland model as a comprehensive system with social security and social legislation. The Rhineland way of thinking turns away from modelling methods which are purely directed to efficiency, output management and short term oriented turnovers with belonging control mechanisms (Veur, 2014). The Rhineland way of thinking pleats for renewed attention for quality, more in-depth, trust and authenticity. Moreover, the Rhineland model calls for craftsmanship (because it is concerned with people who are

seriously into something), connection (to be able to do it together) and trust (because sometimes other people just know- or can do it better) (Veur, 2014). Where a lot of organizations wants to make profits for themselves and for their shareholders, the Rhineland model will lay focus on every stakeholder within the process. Not only for shareholders but as well for the professionals working in the primary process.
Furthermore, in the Rhineland way of organizing, the primarily process is central. Its main focus is to deliver quality and value to the end customer. The craftsman needs enough space and trust in order to complete the work in a correct manner (Peters, & Heringa, 2009). The Rhineland way of organizing fits perfectly within organizations who wants their employees to work autonomous and employees who are taking initiatives. Within these types of organizations there are employees working who seriously want to work with that certain organization, with autonomy. They want to do it for themselves, not because a manager wants them to do it. The professionals themselves have to determine their own vision on what is good and what is not (Veur, 2014). These contexts/visions may differ al lot per organization and are thus not to be grasped within rules or protocols. This is what autonomously working is all about. Determine the situation and then come up with solutions which suits the best for that certain situation. If these findings are to be compared with the care, one can say that the Rhineland concept perfectly fits. Every nurse, working within institutions or working within the community wants the best for their clients. There is no need for too much restrictions and protocols since the nurses knows themselves what is best for the clients. It is, however, important to have boarders. Within these boarders there is space for own interpretation and design the work the way an autonomous team wants it to (Shortell, et al., 2004). Examples of boarders could be, meeting a set productivity per team or meeting a set happiness of customers (Embregts, 2014).

2.2.1 |Autonomous teams

A lot of organizations chose for the implementation of autonomous teams or at least experimented with it. Autonomous teams are most likely giving an answer to the question how an organization can function more cheaper and efficiently. It is a much cheaper way of organizing in the sense of the exclusion of the middle management of the organization (Vermeer & Wenting, 2014). Autonomous teams can be defined as:

> *'A fixed group of employees who are together responsible for the total process in which products of services are being given. Those are then delivered towards internal or external customers. The whole team is planning and monitoring the progress of the process, problem solving of day-to-day issues and is improving processes and working methods without constantly asking for help from leading or supporting services (Amelsvoort, 1993; Kengen & Jagtman, 2010).'*

These autonomous teams are part of the Rhineland way of organizing (Veur, 2014). According to Balk & Wierda (2016) it eventually leads to a flatter organization in which choices can be made more decentralized. This also includes, since the middle-management is not that important anymore, it leads to a more efficiently way of business conduction. Employees are getting more chances to free their minds and use their talents, they eventually will take more responsibility. By giving more responsibilities to the employees, they will experience the contribution to the company which leads to more joy within their jobs and they will behave more innovative which boosts the total innovation power of the company (Beune, 2015 p.11). According to the report of Falke and Verbaan, a company specialized in organization consultancy, the absenteeism number will even decrease with mature autonomously working teams (Balk & Wierda, 2016).

2.2.2 | Relevance of autonomous teams in institutional care

Related to the Dutch legislation of the institutional care, is the increase of complexity. Where it was possible up to 2007 to enter an institution with an index rate of 1, it will now only be possible to enter with at least an index rate of 4 of 5 (Stevens, 2015). The care to be delivered within institutions becomes more complex which demands for better educated personnel (Cott, 1997; Mather & Bakas, 2002). Since the deliverable care in institutions used to be less complex, traditionally lower educated personnel was working with the institutional care. That is also why there is, traditionally, not enough higher educated personnel (Diemen-Steenvoorde, van, 2016). Another problem with recruiting higher educated personnel for the institutional care, is the lack of autonomy within institutions and the fact that the work might not be challenging enough (Kalverda, 2016). Implementing autonomous teams within these institutions will make the work more attractive to higher educated personnel. This implementation may eventually lead to better quality in the institutions (Diemen-Steenvoorde, 2016).

As mentioned, the institutional care has changed a lot over the past years and there is a high pressure on costs especially with respect to personnel. In the past, organizations tried to secure the quality by adding management layers and control mechanism (Diemen-Steenvoorde, 2016). Recent changes at organizations who experimented with autonomous teams, show that working with autonomous teams actually can decrease the number of management layers since the teams can make the decisions themselves. Cut out these management layers finally led to a huge reduction in the costs. There is however, even with the success stories, still a kind of coordination mechanism needed, to secure the processes and adjust where there is a need for it (Kuperus, Ploegman, Trompenaars, Ogink, Ruigrok, Oosterwaal, 2015). Within the next paragraph there will be more elaboration on this specific topic.

Another consequence due to all the management layers, the communication became a serious problem. The management did know what was happening in the field and how it was

experienced by the employees. On the contrary, the employees did not know what the management was doing in order to solve problems they were experiencing (Kuperus, et al., 2015). Working with autonomous teams provides a more transparent and clear process with as less as possible management layers and overhead.
Another very important reason that underpins the relevance of working with autonomous teams, is the health of the client and the quality of the care to be delivered. Only working task-oriented in a managed organization, does not provide the possibility to deliver custom care. Since the type of care delivered to clients are not a 'one-size-fits-all', the care has to be customized per client. A task- and management oriented organization does not provide this possibility (Kuperus, et al., 2015).
It can be stated that there is a relevance of working with autonomous teams in institutional care. It can also be stated that it will demand more from the employees. It does ask for a more 'case-managerial' role. The role of a nurse does not stop by just delivering the care, it does ask to see the importance of the role of family, caregivers and volunteers in relation to the client. In this case, it is important to have a clear framework in which a nurse can conduct their practices. It should be well understood by the team what their responsibilities are and what not. Communication is in this case from exceptional importance. There are as well different roles which has a clear description. But how the role exactly has to be filled in, is up to the members of the team. Results that should be met and the productivity of a team are things that could be framed as well (Kuperus, et al., 2015). These are boarders and goals as determined by the organization. By whom these boarders and goals are set and how it can be measured if the they are met, will be discussed later on.

2.3 |The concept in practice

In this paragraph, there will some elaboration on the 'Rhineland concept' in practice. One of the first known organizations who in implemented the concept according to the Rhineland way of organizing in the community care, is Buurtzorg (Lieshout, van, 2016). Buurtzorg implemented a concept with four kinds of pillars, ICT (IT) support, attunement to the client, craftsmanship and entrepreneurial self-managed teams (figure 1, Nandram & Koster, 2014). IT support, one of the important pillars plays a central role in this research. According to the importance of IT support, more elaboration within this paragraph will be provided.

Buurtzorg introduced a new concept of care delivery, the success lies in its focus of organizing and putting the client at the centre (Nandram & Koster, 2014). The mission is underpinned by several underlying innovations, including the creative use of information and communication technology (ICT), the delivery of care via series of autonomous teams, the emphasis on autonomy for front-line nurses to experience professional discretion in delivering care and the integration of care with others in a chain of care (Nandram & Koster, p. 174-175, 2014).

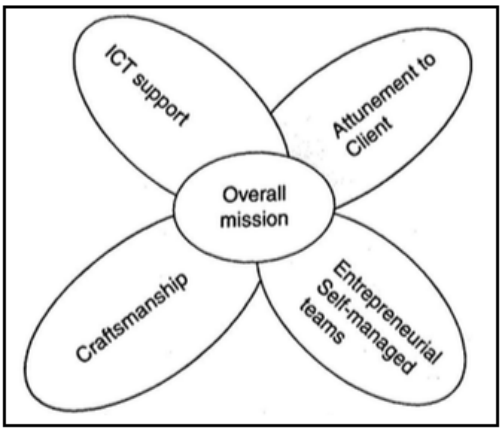

***Figure 1**: Buurtzorg' concept main pillars (Nandram & Koster, 2014)*

IT is an indispensable, essential part in the concept as the concept is built within the IT. While writing software, the constant idea was to "keep it simple". The IT should be easy accessible, user-friendly and the users should administer as less as possible. The overall goal with the software is to humanize and increase the quality of care delivery. Because of this goal, the bureaucracy should decrease. Other interesting features of the software are communication within and among teams and with the back-office. By this, the employees can share experiences and skills (Nandram & Koster, 2014).

Furthermore, within the software, the relationship between client and professional is central, the moment they share, and the care a client needs, not the allocated time to a certain intervention. Time is, in that case, not the starting point or focus within the software, the moment the nurse and the client are sharing is most important here. Also, important in the software development process is the collaboration with end-users, since the professionals are the ones that should be able to work with it. Within the whole concept, trust is crucial (see paragraph 2.2). Since trust is the base, control mechanisms should be limited (Nandram & Koster, 2014). The elaborated process of software development is crucial towards the Rhineland way. But as already mentioned in paragraph 2.2 boarders and goals set by the organization are as well a very important part of the Rhineland concept (Shortell, et al., 2004). Examples of boarders Buurtzorg set towards their employees, are productivity per team or an average index of the satisfaction of clients (Embregts, 2014). These boarders are set by the healthcare organization itself (Buurtzorg in this case). Research made clear that the top-management of an organization sets out the boarders which has to be met by the autonomous team(s). If these boarders and goals are not clear to the team or there is no clear, valid vision with the organization, the implementation of the concept are doomed to fail (Graaf, de, 2015). To support the idea of autonomous teams, software is essential to the concept as has been mentioned (and since it is one of the four pillars). It is essential within the sector of community care, it is essential within the institutional care. Boarders and goals are not only set by the

healthcare organization itself, but as well by other stakeholders. More elaboration will be provided in the next paragraph.

2.4 |Stakeholders

This paragraph will provide insights in the different stakeholders by whom the boarders for the autonomous teams are determined. The most important, distinguished stakeholders are the government (fixed influence), the care agencies (semi-fixed/semi variable influence) and the institutional healthcare organization (variable). They all influence the boarders for the autonomous teams to a (semi-) fixed or variable extent. Finally, all these stakeholders will be summarized in a model. Where after more elaboration will be given on the managing board and the coordination mechanism of the healthcare organization to ensure the determined boarders. Moreover, this paragraph provides the answer to the third sub question: "Who are important stakeholders to determine boarders for autonomous teams?"

2.4.1 |Government

The government of the Netherlands (Rijksoverheid) has created a set of restrictions which a healthcare organization must meet. These restrictions are general but do say something about the quality of the care to be delivered. That is why this influence can be seen as a fixed influence, there is no variety per organization on this influence.

A recent development in which the government tries to ensure the quality of the institutional care, is the quality restriction document for the institutional care (Kwaliteitskader verpleeghuiszorg) (Adriaansen, 2017; Zorginstituut, 2017). This document has been introduced to ensure the quality of care within the institutional care and will be enclosed within the legal register of the Dutch care institution (Zorginstituut). There will be a little more elaboration on the main principles of the document, which every organization in the institutional care must meet. For a more detailed description of the principles, there will be pointed towards the 'Kwaliteitskader verpleeghuiszorg'.

Personal care and support is the first principle which has been described. Personal care and support is about the way in which a client is the base for the care to be delivered in all the domains of life. Every client is unique, which demands for support and expertise from organizations (Zorginstituut, 2017). The second principle is living and health. This basically includes the way in which the care professionals take care for the most optimal way of living for the client and the way they can be supportive towards it (Zorginstituut, 2017). The third principle is safety. A client should be prevented for a much as health problems as possible. Safety for the client as well has to do with medication they have to take and the way in which this is provided. When something unforeseen happens according with respect to safety in relation to the client, it should be reported and stored by the healthcare organization (Zorginstituut, 2017). The fourth mentioned point is the ability to learn and improve for the

care professionals. Every healthcare organization needs to make a plan in which has to be made clear that the ability towards the care professionals is provided to improve themselves. This can for example be done by training (Zorginstituut, 2017). The fifth principle is leadership, governance and management. This includes that every organization needs to have a clear vision on the care they deliver, they have to focus on their core values and the roles and positions of internal organs has to be clear (Zorginstituut, 2017). The sixth principle is about the composition of the teams. Within every organization, the composition of the employees (education level, expertise) has to be coincided with their target groups. Only then the best care can be delivered for the clients (Zorginstituut, 2017). The seventh principle is about the use of resources in order to stimulate quality. This can be for example the use of domotica, wearables and other technological resources. The resources have to be facilitating to the primary process (Zorginstituut, 2017). The eight and last principle is about the use of information. Information can be measuring the satisfaction of clients that has been questioned. Another type of information can be the use of an electronic heath record from which data can be derived. It is the intelligence that can be made up from information that has been gathered by the organization (Zorginstituut, 2017).

As the government of The Netherlands want to secure the quality of care in organizations, there are/is as well inspections/research within the companies, done by the government. Recent research (2016) pointed out that in some cases (11 of the 150 institutional care organizations) the quality of the delivered care is inferior (Diemen-Steenvoorde, van, 2016). The aforementioned principles are the new standard in which quality is measured at institutions (Zorginstituut, 2017). Because the boarders, as determined by the government are clear, organizations and autonomous teams should make sure they operate in between these boarders.

2.4.2 |Care agencies

Care agencies are agencies which are in between the care-needed people and the executing healthcare organization. Their function is to set up and agree upon contracts with healthcare organizations, execute care requests of healthcare organizations, determine quality standards and match care-needed people to the right healthcare organization (Janssen & Choy, 2003). Care agencies are a very important link in the process for a care-needed person to get the belonging care with an institution. Since there are different care agencies among the Netherlands, and every care agency is demanding for other quality standards (as derived from the mentioned standards in paragraph 2.4.1) or demanding for ‘organization specific’ contract agreements, the influence of the care agencies on healthcare organizations can be considered as semi-fixed.

In order to get a contract with a care agency as a healthcare organization, requirements set by the care agency needs to be met. In the Netherlands, there are 31 care agencies divided under 9 big care insurance companies. Every insurance company has their own requirements for a healthcare organization to gain a contract. Requirements may deviate for care quality,

procedures for contracting, processes, etc. Without going to deep into detail about the deviations, some general requirements are set in a general document by all the care agencies (Zorgverzekeraars Nederland, 2015). There are general requirements set according to quality. Quality norms are for example, improvements for wound healing, improvements for mouth care, physical restraints and a well process for medication safety. Another important dimension to monitor are the client experiences. Though it is mentioned in the general requirements, it is as well elaborated in the procurement policies for the insurance companies itself (Zorgverzekeraars Nederland, 2015).

In order to make sure that the quality of care is assured by every healthcare organization, the general requirements are good. But if one wants to measure performance in terms of quality it needs stipulated consequently. A very well-known way to do this, is by an electronic health record in which every nurse stores the information the same way (classification system). This eventually leads to knowledge discovery (Koster, 2015). This knowledge can as well be used by the care agencies or insurance companies to compare healthcare organizations with each other. Benchmarking these organizations eventually can lead to a better position to negotiate about prices with care agencies. Furthermore, it proves that the quality of the care delivered within a certain healthcare organization may be better than in another (Gijzen & Hijnen, 2016).

2.4.3 |Healthcare organization

The healthcare organization is executing the care. Their main goal is to stay financially healthy and deliver the care the clients need (Loghum, van, 2011). Furthermore, healthcare organizations must deal with the boarders as set by the government and the care agencies as mentioned before. Based on as well their influence, probably the most important responsibility of the healthcare organization is to set up a clear mission, vision and core values for the organization (Koster & Stolze, 2003). The vision of a healthcare organization might include the choice to work with autonomous teams as well. This is, among others, why the vision of a healthcare organization is important to set out boarders. According to this mission and vision, the board of directors can set out the specifically organizational boarders for the autonomous teams. Since the mission and vision of an organization may deviate per organization, this influence can be considered as variable influence.

2.4.4 |Model introduction

The most important stakeholders to determine the boarders in which an autonomous team can operate have been elaborated in this chapter. The government is the first stakeholder that has been elaborated. The government has a fixed influence, implying that they have the most power in determining boarders and setting up criteria which must be met. Their power has influence on the care agencies which sets up more detailed criteria according to quality and gaining contracts for healthcare organizations (Janssen & Choy, 2003). The influence of the care agencies is semi-fixed as the healthcare organizations itself can make specific agreements

upon care delivery. The healthcare organizations itself should determine its own mission, vision and determine their core values. All these obligations and norms are input the eventually determination of the boarders for the autonomous teams.

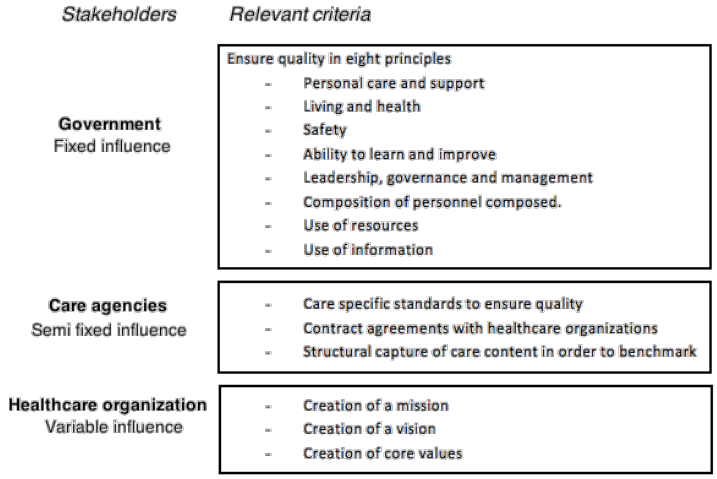

***Figure 2**: Stakeholder model*

2.4.5 |Managing board

The managing board is gathering all the norms and obligations by the different stakeholders. It is up to the managing board to determine the exact boarders for the autonomous teams. By determining the exact boarders, all the norms and obligations as set by the stakeholders must be considered. In order to work successfully with autonomous teams, it is very important to set out the boarders and setting up the targets for these autonomous teams. In these boarders, all of the requirements of the stakeholders are taken into account. When these boarders are not set, the ability of accomplishment will be significantly lower (Shortell, et al., 2004).

The quality of care is a very important measure/boarder. The general description, provided by the government provide some kind of a boarder. However, the care agencies are giving a more detailed description on what quality of care is and how it should/can be measured (Eijck, van, 2016; Gijzen & Hijnen, 2016). But still it is hard to define what quality of care actually is. That is why it is as well up to the managing board to set their own boarders to define their quality of care (Eijck, van, 2016). When the mission and vision are determined by the healthcare organization and the boarders and goals are clear for the autonomous teams, there is no more need for many rules and protocols (Graaf, de, 2015; Zorginstituut, 2017). The responsibilities for the employees needs to be clear though. This is as well a responsibility of the managing board even as it is to make sure that the personnel within the team is composed as good as possible.

Other important measures/boarders that can be set by the managing board are for example the aiming number of client satisfaction. Care agencies and the inspection services of the

government may judge these indexes. Recent research showed that 91 percent of the tested organizations used these indexes. As well 88% percent uses a service for complaints settlement (Diemen-Steenvoorde, van, 2016). Besides the client satisfaction, other boarders such as expertise of personnel, employee satisfaction, making use of the right coordination mechanism and productivity of personnel seems to be important as well (Embregts, 2014). These are boarders which can be set by every organization (managing board) itself. Productivity can be determined in terms of staying financially healthy (Diemen-Steenvoorde, van, 2016). To get this information and provide it to the inspection of the government of the Netherlands, it is important to gain the right to measure. This is responsibility of the healthcare organization (Zorginstituut, 2017).

2.4.6 |Coordination mechanism

In this paragraph, there will be some more elaboration on the coordination mechanisms that can be used when the choice has been made to work with autonomous teams. Working with autonomous teams does not include that the organization has to be organized as horizontal as possible without any form of coordination mechanism in between. It is up to organization to determine whether they want to make use of a coordination mechanism and what their role exactly has to be (Popta, 2015).

Working with a flat organization demands ideally for a horizontal way of coordination according to Amelsfoort & Jaarsveld (2000). This can be done in different ways: 1) there is a fixed team-coordinator who combines leading, managing and coaching; 2) the function of coordinator will rotate among the different team members or 3) make use of the starmodel in which every team member takes care of a certain role, for example finance or innovation (Popta, 2015). Comparing these findings with the current model of organizations who implemented autonomous teams, the pattern of a fixed team-coordinator can be recognized (Kuperus, et al., 2015). Diana Kole, knowledge manager in the care (InVoorZorg), mentioned that there are mostly fixed team-coordinators with a coaching character within the institutional care. The autonomous teams in the institutional and community care, mostly consists of employees with varied educational backgrounds. Generalizing spoken, higher educated employees can function perfect under the autonomous circumstances. They are proactive, willing to undertake action, take lots of responsibilities and are searching for creative solutions. Lower educated healthcare personnel working in the institutional care, needs some more support. In the first-place support can be found with colleagues from their team (Graaf, de, 2015).

Once the goals and boarders are established, the managing board needs to step back and let the teams do their work and give them freedom to make mistakes (Graaf, de, 2015). Coaches or another coordination mechanism, needs to be there when the teams need support, when there are issues within the team itself, when the set goals are not achieved or when the boarders are unclear in a way. Coaches or another coordination mechanism should certainly not try to manage and fall back in their own habits (Graaf, de, 2015). Recent research showed

that within (autonomously working) healthcare organizations in the institutional care, there is a lack of coordination. Team members are struggling to ask questions and the tasks within the teams are unclear. Communication within team and with the coordinator is very important to avoid these kind of scenarios (Diemen-Steenvoorde, van, 2016).

2.4.7 |Explaining model

This second model is explaining the previously mentioned relevant criteria of the elaborated stakeholders. The arising tasks for the managing board and the coordination mechanism are included. The relevant criteria of the stakeholders provide the most important input for the managing board to eventually determine the boarders for the autonomous teams. Once the final boarders are set by the managing board, the main task for the coordination mechanism is to maintain the boarders and be supportive towards the autonomous teams. The autonomous teams are finally operating in between the determined boarders.

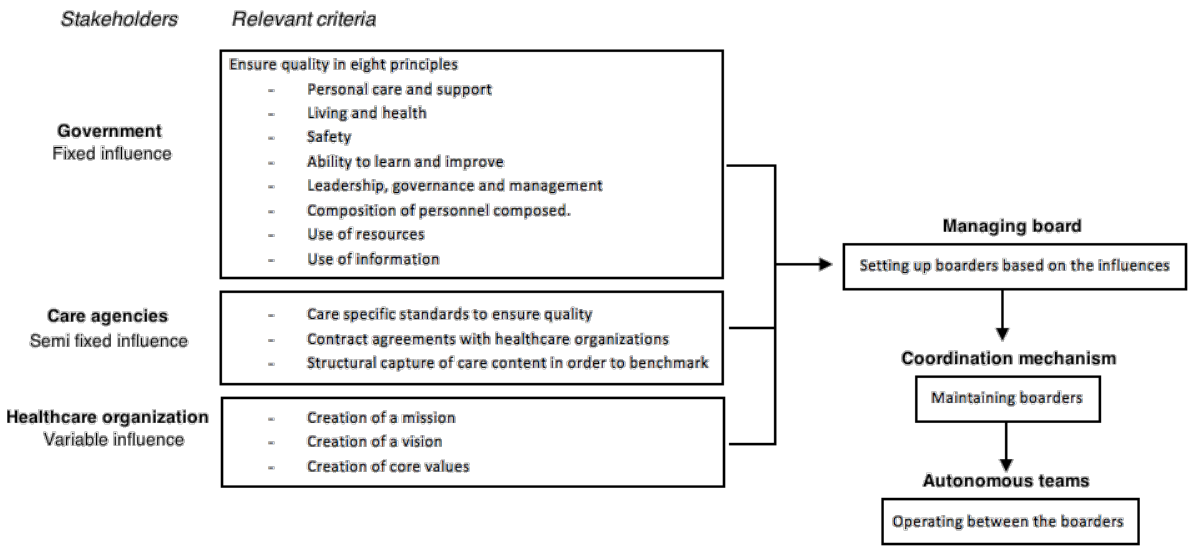

Figure 3: *Explaining model*

2.5 |Introduction to KPI's

This paragraph provides and introduction to KPI's (Key Performance Indicators). Besides, there will be elaboration on possible relevant KPI's for the institutional care. This paragraph provides an answer to the fourth sub question: "What are possible relevant KPI's for the institutional care according to literature?"

As previously discussed it is important to determine clear borders and make sure the goals are clear for everyone within the autonomous team. This is based on the influence of the stakeholders. The government and care agencies place great emphasis on the aspect of quality

(Eijck, van, 2016; Gijzen & Hijnen, 2016). There is less emphasis on the financial health of a healthcare organization and on the satisfaction of their employees. Those items are the responsibility of the organization itself (Loghum, van, 2011). When the boarders amongst these desired outcomes are set by the managing board of the healthcare organization, the autonomous teams have to be informed about these boarders and the way they behave amongst these boarders. This can be done by a feedback system in which every team-member has insights (Jassies, 2012). These desired outcomes can then be compared with the actual results of the autonomous team. Comparison between the goals and the results can perfectly be done by Key Performance Indicators (KPI's). A KPI can be defined as follows:

> *"An indicator, or more precisely a Key Performance Indicator (KPI), is an industry term for a measure or metric that evaluates performance with respect to some objective. Indicators are used routinely by organizations to measure both success and quality in fulfilling strategic goals, enacting processes, or delivering products/services (Barone, Jiang, Amyot & Mylopoulos, 2011)."*

KPI's can as well be offered to the autonomous teams. The most obvious way to facilitate the KPI's per team, is displaying them in a dashboard. Within this dashboard, the boarders are defined as KPI's in which the team can monitor their own performance in comparison to the desired outcomes of the organization (Wetzstein & Leymann, 2008). The KPI's offered within the dashboard are dependent on the determined boarders by the organization (Kuperus, et al., 2015).

2.5.1 | KPI's in relation to institutional care

To be able to monitor the achievements within the autonomous teams it should be visible for the team. When this is visible in the team, they can monitor results to eventually conclude if they are on the right track (Kuperus, et al., 2015). As mentioned previously, this can be done by a dashboard with all the relevant KPI's included. Based on the literature as previously discussed (paragraph 2.4) suggestions for possible KPI's can be provided. The aim of the research is eventually to investigate to what extend these suggestions are relevant for autonomous teams.

Quality of the care is a recurring understanding which is important to a high extend. Healthcare organizations are about to be judged by the quality of care they deliver (Diemen-Steenvoorde, van, 2016). As previously mentioned some norms are given to the quality of care by the government and the care agencies. Considering those quality standards (which are influencing the boarders) it is to say that these norms can be translated into KPI's for autonomous teams. The quality KPI's (according to the stakeholders) should then be about 'personal care and support towards the clients', 'living and health', 'safety', 'ability to learn and improve for employees', 'leadership, governance and management', 'composition of personnel composed', 'use of resources', 'use of information', 'structural capture and

monitoring incidents' and 'structural capture of care information (health intelligence)' (Zorginstituut, 2017; Gijzen & Hijnen, 2016; Zorgverzekeraars Nederland, 2015). To what extent all of these KPI's and boarders according to quality are relevant towards the autonomous teams, has yet to be determined.

Besides the KPI's according to quality, there are as well measures important for the wellbeing of the healthcare organization. The other relevant KPI's could then be 'client satisfaction', 'employee satisfaction', 'employee expertise' and 'productivity'. To what extent all of these KPI's and boarders are relevant towards the autonomous teams, has yet to be determined (Embregts, 2014).

3 | Methodology

This chapter provides a framework to the research. First the design of the research will be discussed. There will as well be elaboration in the way this research has been conducted and the way it has been set up. Then the instrumentation will be discussed, with the belonging research instruments and procedures. There will as well be attention to the participants of the research and the way of analysing the data after collection.

3.1 | Design

The aim of this research is to find out which KPI's are relevant for autonomous teams within the institutional care sector. In order to understand the way this research had been set up, the following process model has been made.

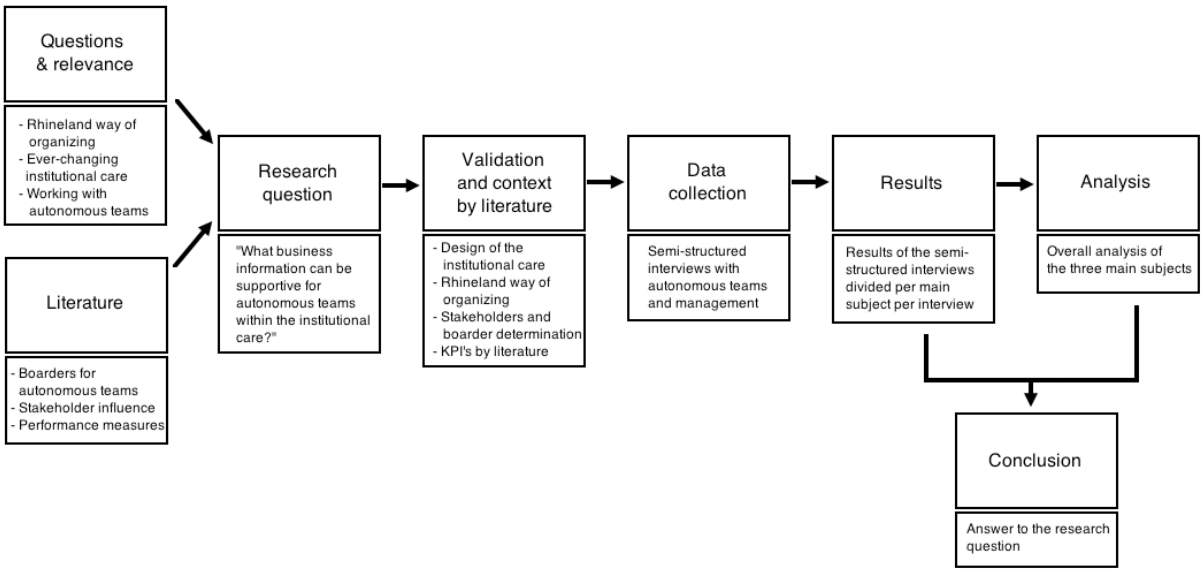

Figure 4: *Process model*

The process started with questions about relevant information for autonomous teams working according to the Rhineland way within the ever-changing institutional care. With the existing literature in mind, about the boarder determination for autonomous teams with the stakeholder influence and the possible usage of a performance measurement system, the research question has been set up ("What business information can be supportive for autonomous teams within the institutional care?"). To understand the research question, context to the question has been provided with relevant literature which provided answers to the four sub questions ("How is the institutional care designed within the Netherlands?"; "What does include the autonomous way of working (Rhineland way of organizing)?"; Who are important

stakeholders to determine boarders for autonomous teams?"; "What are possible relevant KPI's for the institutional care according to literature?"). Then the data collection will be done about which context is provided in this particular chapter. There will be semi-structured interviews with autonomous teams and the management. When the data is gathered, results can be provided of the four semi-structured interviews divided per main subject per interview. Out of the results the overall analysis follows of the 3 main subjects of all of the interviews (Rhineland way of organizing, boarder determination and KPI's). Eventually, from the results and the analysis, a conclusion will be provided in which the answer is given to the research question. Eventually the research design looks as follows:

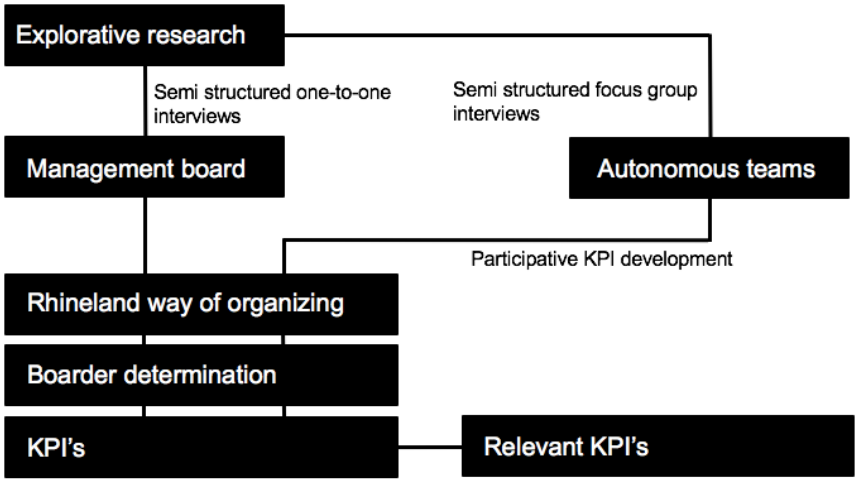

Figure 4: *Research design*

3.2 | Development of KPI's

According to Evers, Gravesteijn, Molenveld and Wilderom, (2011) the systemically usage and development of KPI's, results and norm- or key figures are as well known as a performance measurement system (PMS). The development, introduction and implementation of KPI's, part of the PMS, can be done in two different ways. Standardizing the operational work and work processes done by the management is called 'coercive development'. The other kind of development of KPI's is called 'enabling development' which is participative by going into dialogues with the end-users (Evers et al., 2011).

The coercive development is control based and when there are deviations from the standard method there will be interactions from the management. The translation of the goals from the organization towards relevant KPI's is mainly done by the middle management. According to Euske, Lebas and McNair (1993) this can eventually lead to problems because the employees in the primarily process are not part of the decisions being made on the top of the organization (Evers et al., 2011). This method of development does not seem to suit at any point of view to the Rhineland way of organizing. This way of organizing pleats for a more

bottom-up philosophy in which the employees are making decisions out of the primarily process (Veur, 2014).
The participative way of development of KPI's calls for dialogues with the employees from the primarily process to gather information which eventually can lead to a bottom-up development. Thus, it provides the possibility to have dialogues about the figures with the management (Evers et al., 2011). Evers et al,. (2011), based their research on the five leading principles of Wouters and Wilderom (2008) for the participative development of KPI's. The first leading principle of Wouters and Wilderom (2008) is that the employees from the primarily process are using their own experiences and knowledge to come up with relevant KPI's. Research of Groen, Wouters and Wilderom (2011) showed that employees, part group interventions, in which they can come up with possible KPI's, are more proactively involved in the development process. The second principle of Wouters and Wilderom (2008) is that the management needs to provide the time and space to develop participative KPI's. This is important for the employees in order to find out what exactly is being expected from them. Eventually the behavioural norm will be clear because of different professional insights which is the third leading principle. Employees consider the self-developed KPI's as a credible instrument and will accept it more above imposed KPI's. These bottom-up developed KPI's are being used to continuously improve the work process. The KPI's are providing important feedback to the employees which eventually to more knowledge about the work processes (Evers et al., p.65). The last leading principles according to Wouters and Wilderom (2008) are team-trust and openness (fourth principle) and transformational leadership (fifth principle).
When these findings are being compared with the Rhineland way of organizing, it can be stated that the participative way of development of KPI's suits best. This, because the employees are involved in the determination process based on their own findings, knowledge and experiences (Evers et al., 2011). KPI's can be developed for the institutional care in the same way, with participation of the employees themselves.
The determination of KPI's is the responsibility of the managing board and the employees of the healthcare organization. Based on the boarders as established by the management board, KPI's can as well be established with possible input from the autonomous teams themselves (Evers et al., 2011; Berden, Berrevoets, & Winasti, 2016).

The design of this research knows two facets. Because the managing board has a very important role in determining the boarders and KPI's for the autonomous teams, interviews with the managing board seems to be very relevant to understand the way they determine these boarders which eventually leads to KPI's for the autonomous teams. Since the autonomous teams eventually have to work with these determined boarders and KPI's, it is relevant to know if these boarders and determined KPI's are enough to work with and to evaluate their own functioning. Besides, they can provide valuable input for the KPI's if these are not yet in place. There has not been previous research on this specific topic, meaning that

KPI determination and evaluation for autonomous teams within the institutional care is very explorative. Even besides the fact that there are already institutional care organizations working according to the Rhineland way and as well determined their own boarders. Focus group interviews seem to be a very interesting way to collect data according to the explorative character of the research (Feddes, Vermetten, Brand-Gruwel, & Wopereis, 2003). More elaboration on the chosen instruments will be provided in the next paragraph.

3.3 |Instruments and procedure

As already mentioned in the previous paragraph, the instruments used within this research will be interviews and focus group interviews, both used for other target groups. The one-to-one interviews will be used for the managing board and the focus group interviews will be used for the autonomous teams.

3.3.1 |Managing board

According to Reulink & Lindeman (2005) explorative research can be considered as a part of qualitative research in which the possible outcomes are related to the nature and the characteristics of the investigated principle. The instrument belonging to this qualitative way of research are interviews. For the purpose of this research it is only important to know why the managing board chose to set the boarders in the way they did it and how and which KPI's they have formulated (if they have formulated them). This information can be perfectly gained with one-to-one interviews.

The interviews will be semi-structured implying that there are a few general topics to discuss. Examples of general topics are: "The way the organization coloured the Rhineland concept", "The determination of the boarders", "The role of stakeholders in this determination process", "If the organization has yet determined relevant KPI's", "The KPI's determinations according to the determined boarders", "Whether the KPI's are helping to gain their targets", "The possible KPI's based on literature", etc. All the questions can be found in appendix A, with a brief elaboration per question.

3.3.2 |Autonomous teams

The main purpose by questioning the autonomous teams is to discover how they are using (existing) KPI's. It is as well relevant to know what KPI's are considered relevant by the teams and if there might be missing KPI's. When there are no KPI's offered, what information is then relevant for the autonomous teams? The way to discover this, is by questioning autonomous teams with focus group interviews. This type of research seems to fit best to the situation since there is lack of existing research which makes this research explorative. Besides, it is not the opinion of a single person that is important, all the team members may have different ideas about the KPI's to be shown which makes a focus group interview very interesting. This

way of having dialogues is al well part of the participative way of KPI development. Rather than a quick choice for the favourite of two, or a few, opinions, a decision which attempts to meet the need of everyone, will require the group to produce a wide range of proposals. Often more imaginative and creative possibilities are discovered in focus group interviews; the ideas of one another may influence the opinion of others (Avery, 1981). Besides, focus group interviews require people to consider and demonstrate such values as respect for other opinions, responsibility for the group and cooperation which seems to be very helpful in this situation (Avery, 1981).
The focus group interviews will be semi-structured implying that there are a few general topics to discuss. Examples of general topics are: “The determination of the boarders by the managing board”, “Whether the boarders are clear or not”, “Whether there are existing KPI’s or not”, “The missing KPI’s”, “The possible KPI’s based on literature”, “Whether these KPI’s are helping them working autonomously or not”, etc. All of the questions can be found in appendix A, with a brief elaboration per question.

3.4 | Participants

Gaining the participants for the interviews (managing board) and focus group interviews (autonomous teams) has been done by using network of Ecare and writings to organizations with the question if they were willing to participate. There have been two organizations willing to participate in this research, which provided enough information to draw interesting conclusions.
ZorgAccent is the first company in which data has been collected. ZorgAccent is a Dutch care organization in the institutional- and community care sector. The interviewee from the management of ZorgAccent is Ina Kerkdijk, manager of the institutional care. The interview with the autonomous teams has been done in focus group setting with three people from three different teams. Jan Zieleman, Rolf Lucas and Eefje Stokvis were the participants. They are all nurses in different autonomous teams with side-tasks as councils.
Trivium Meulenbelt Zorg is a Dutch organization delivering care in as well the community as in institutions. The interviewee from the management of Trivium Meulenbelt Zorg is Marie-Louise Engbers, manager of the personal care in Hengelo for 2 locations. She is as well project-leader of the committee of personal care. The interview with the autonomous team has been conducted with Mandy Steggink. She delivers the care and has a coaching role related to the other nurses on the same department.

3.5 |Analysing data

Analysing the data will be done in the same way for both the outcomes of the one-to-one interviews with the managing board as for the outcomes of the focus group interviews with the autonomous teams. Within the outcomes of all the interviews, a few main themes will be distinguished. The main themes are: Rhineland way of organizing, boarder determination and KPI's. This is the case for as well the management interviews as the focus group interviews. Per theme, conclusions will be drawn. Eventually the outcomes of the research itself can then be compared with the outcomes of the literature.

4 | Results

This chapter provides the outcomes of the (focus group) interviews. Per interview the main results are provided with quotes and text summaries. There has been made a distinction per organization, per interview. The main topics per interview are briefly discussed. The main themes per interview are: Rhineland way of organizing, boarder determination and KPI's. The Rhineland way of organizing is an important subject to discuss because every organization may fill in the concept in different way. One organizing may for example still have coordination mechanisms in place while the other hasn't or one organization may still have control mechanisms while the other hasn't. Thus, the possible KPI's may differ per organization. The boarder determination is an important aspect, in order to find out who (stakeholders) were involved in the determination process and to extent they had influence. Eventually the aim is to know what the KPI's are if they are in place and they have come up with these KPI's.

4.1 |ZorgAccent

The first company in which data has been collected is ZorgAccent. ZorgAccent is a Dutch care organization delivering care within the institutional- and community care sector. There is as well a community care variant named ZorgAccent. The institutional care of ZorgAccent includes approximately 80 autonomous teams.

4.1.1 |ZorgAccent management

The interviewee from the management of ZorgAccent is Ina Kerkdijk, manager of the institutional care.

Rhineland way of organizing

ZorgAccent has made the choice to work according the Rhineland way, approximately 4 years ago. There has been a clear vision on how to organize and what should be central within the organization. "Client, employees and relatives are the important triangle which forms the centre. In order to put these triangle in the centre, there has been chosen to work according the Rhineland way. It includes maximum control for the employees and a simple way of organizing. Protocols and a hierarchal oriented organization does not fit in this principle. The main reason there has been chosen to work according the Rhineland way, is the quality of care which can be ensured more when the employees have maximum control which is provided by the organization. The hierarchal way of organizing knew a lot of protocols and procedures in which, when the employee had bad luck, was about to get through all of the management layers in order to get something done."

"Working autonomously is not a target on itself, it is the way one fulfils it."

There is no coordination mechanism known within ZorgAccent other than the director herself. "Teams have the freedom to come to me whenever there is something they want to ask. At least once a year I talk to every team within the organization to get to know what their concerns are and how I can help them getting things done and to facilitate. This is on the level of the team, not me being a manager."

Boarder determination

Within ZorgAccent boarders has been formulated. There are approximately 16 uniform boarders for each team. The boarders have been set up by the organizing with influences of the teams itself. External stakeholders as well have had influence on the determination of the boarders. "We are not doing everything the external stakeholders wants us to do, but they do have influence especially when it comes to the quality of care. We are somewhat deviating from the standard lists the external stakeholders do sometimes request, but we are providing them all the context about why we are doing things as we do them."

"Boarders are necessary to some extent, but we do not need boarders like we had protocols."

Examples of boarders that are yet in place are: "We have boarders about formation, about the number of hours a team can use in certain period. No central planners, this is regulated by the team itself. We also have boarders about the financial administration per team, how teams are financially organized. Or about the amount of education an employee is taking a year."

KPI's

"Teams do have a small dashboard with two items currently, knowing: absenteeism and the number of hours used over a month. This is what teams requested themselves. When they request, I want to facilitate. If I am about to offer it, something is going wrong because the learning element will be lower if they do not request it themselves."
"I do not believe in dashboards because they only project numbers and they do not tell the whole story with it. I'd rather prefer the social control which is there within the teams itself. Ownership plays an important role then. The financial administration per team is regulated by the team itself. When there is a gap in their administration, they will have a discussion and regulate it themselves with each other. Like it is going within households. No intervention from a manager is needed."

"I do not like the word 'KPI', that is management language."

Figures does not tell relevant things if you do not have the context. But can one then conclude that certain dashboards with as well information about care content (population, target groups, etc.) is never relevant? “No, that is not the case. There should be a discussion with the team about what they think is relevant, then there can be a consideration whether it really helps them or not. This goes as well for the topics in the ‘Kwaliteitskader’.”

4.1.2 |ZorgAccent teams

This interview has been done in focus group setting with three people from three different teams. Jan Zieleman and Rolf Lucas both are working within a small autonomous team as a nurse. They are both as well part of the company’s council. Eefje Stokvis works as well as a nurse in a small autonomous team with some secondary activities. During the interview, there was a lot of consensus within the group. On some small points, there was some discussion but overall, they agreed to each other.

Rhineland way of organizing

As mentioned, ZorgAccent made the choice to work according the Rhineland way. “The client satisfaction and employee satisfaction were both low, the organization needed to make a choice.” The employees are happy with this way of work. “When you are at home, you have the freedom to make all the choices yourself without too many rules, why then do I need 1200 protocols to do the work I studied for? I know what I have to do. We have asked ourselves the question: What are we doing? We do not need that many protocols anymore since these protocols are based on normal behaviour, things one would expect you to do, we do not need a protocol for that. Still there are people finding it hard work without hierarchy, since they have been used to it. Besides, some people are not that decisively and search for other people in the team, that are decisively. This is sometimes hard within the teams. We have no coordination mechanism in place other than our director, this is as well hard sometimes because the threshold seems to be high, this will be better in future.”

> *“There has been a clear, understandable vision on how to change the organization to work autonomously”*

Boarders within the autonomous way of working

“Previously we had like 1200 protocols, now we have approximately 300 protocols including the care related protocols. We now have freedom to choose even though there are boarders. Boarders within our organization are for example: you are working according to the vision of ZorgAccent and the current care principle, boarders that are finance related, how the team uses the formation according to personnel, healthy scheduling, etc. These ‘common sense’ boarders as well in place to make the employees feel safe within their teams. The boarders

are not that strict, under some circumstances it is possible to discuss about it when there is good argumentation."

"We remain critical at everything we do, to make sure we are doing the right things."

"External influences are as well important and they influence the boarders. We, as nurses, have as well to deal with these external stakeholders such as the IGZ. But we do not deliver everything the ask for, because sometimes it does not make any sense if you do not tell the reasons why you have done it like that. When you have the position to explain why you have made the choices, they are willing to listen and will understand."

KPI's

"We currently have a small dashboard with some exact information on it, regarding absenteeism and some financial numbers about the used hours. For this exact information, we would say that it can be helpful but when it comes to more subjective information, like the quality of care we would say that it is hard to draw conclusions out of it. We cannot say what is relevant for us to have, but what we can say is that when it will be offered it should be reflective information. Information that provide the possibility to have discussions within team and learn from it. Still, it is hard because when figures are shown, it does not tell the whole story. Because of that, we want it to be reflective so that we can learn from it. What it certainly not should be is a system in which information will be provided that can as well be seen by the management. Because when people know what information will be shared with the management, it will not be, or at least in less extent, filled. We certainly do not want a control system, there may be drawn hard conclusions out of it."

"We are getting more and more horizontally integrated in which the client and relatives are the most important stakeholders."

"Information that possibly can be provided is information according to the care content from which we can learn. For example, the notifications of incidents. Still you cannot draw conclusions out of it but it might be input for learning and discussion. The most important indicator can then be happy clients and relatives, but this is as well hard to conclude in figures." On this point, there was no consensus and brought some discussion. "When you provide the possibility to fill in a questionnaire about the care provided to a relative, it will be filled in with a lower score to force better care for my relative." There was though a lot of consensus about the way to determine possible information for the autonomous teams. "Teams are different, one team might find these indicators relevant, the other team might find other indicators relevant. When you really want to know, you have to go by all these teams in order to find out, what is relevant. You need to ask the question: Why do you think this is good care? This is not about to be explained in a facilitating dashboard."

4.2 |Trivium Meulenbelt Zorg

Trivium Meulenbelt Zorg (hereafter: TMZ) is a Dutch organization delivering care in as well the community as within institutions. They are focused on the east side of the Netherlands (Twente). Relation between client, employees and other involved people are central within the organization.

4.2.1 |Trivium Meulenbelt Zorg management

The interviewee from the management of TMZ is Marie-Louise Engbers, manager of the personal care at TMZ in Hengelo for 2 locations. She is as well project-leader of the committee of personal care and is working with TMZ for 5 years already.

Rhineland way of organizing

"TMZ has been a centralized organization with a lot of coordination mechanisms. In 2012, we have decided to work according to the Rhineland way which was a project at that time. By that time, we have had a very clear vision on how to arrange a cooperative organization. This includes, involving all the concerned people to the organization meaning the clients, volunteers, family, employees, etc. By providing them the possibility to deliver input, the organization becomes 'ours'."

"Autonomy can be found in collaboration and ownership."

"We still do have coordination mechanism in the form of a supervisor which remains responsible for the results and personnel of a few teams. However, this supervisor has a coaching character and very approachable. The coaching character of the supervisor can be remained even while he/she is responsible for the results. The teams are being coached to make the choices themselves, when there is no consensus or the team cannot solve problems, the coach will be in place. We do not have the illusion that the role of supervisor will disappear within the upcoming years.

Boarder determination

"At TMZ, we have a clear vision, but only the vision seemed to be hard to interpret by the employees. That is why we have introduced some boarders. The boarders which are in place are delivery of good care, satisfied clients, family and network, satisfied employees and volunteers and being a financially healthy organization. These boarders are in place to provide a framework for the autonomous teams. Sensitively, these boarders are not very often consulted but mainly in the starting period, people needed these boarders as a kind of grip. Not everything needs to be taken into account when determining the boarders because a lot things people will do without knowing it is a boarder (common sense)."

> *"There is however a tension between the amount of structure and freedom you give while working autonomously."*

"Care agencies and IGZ are as well very important stakeholders in the boarder determination process. It is not that we are honour every aspect of their requirements, we want to be in discussion with them and frame the boarders accordingly."

KPI's

"According to the determined boarders within the organization we have been creating a dashboard with facilitating information. But we finally decided not to do it because it is hard to draw conclusions out of it. Besides, one might provide information that is irrelevant because you already know things within the small team you are working in. Still we are working on some KPI's that can be offered towards the autonomous teams, in the form of real-time measures. For example, measures according to the client satisfaction and employee satisfaction. These real-time measures will help the team by making things debateable. Provide information to create discussion within the team is on premise. With that in mind I can think of some other relevant KPI's as well. According to quality of care we can state that facilitating information can be helpful to create discussion within team, not to draw hard conclusions out of it. For example, the number of incidents related to fall, incidents related to medication or the deployment of restraints."

> *"Some amount of control is good, but on the other hand it is very important that we are able to motivate and move people."*

"When we take a look at the more 'hard' information related to figures and numbers, the number of deployable hours might be relevant for every team. It might as well be relevant to know if there too much or too less capacity within the team related to employees and clients. With these kind of measures, it is very important that people remain thinking and not draw too hard conclusions out of it. It should be facilitating in every way, not to draw conclusions without the right context."

4.2.2 |Trivium Meulenbelt Zorg autonomous team

This interview is conducted with Mandy Steggink, who works as a nurse. She delivers the care and has a coaching role related to the other nurses on the same department. She is already working 3 years for TMZ.

Rhineland way of organizing

"Within TMZ we are working according to a cooperative model which includes that operating personnel has a lot of influence in the decision-making process. The managing board is involved and is sometime working along with us. The organization choose to work according

to the Rhineland way because employees wanted more freedom and we wanted to deliver the best care. Client- and employee satisfaction both increased since we are organized like this. We do not have a secretary anymore making the schedules and planning, these tasks are carried out by ourselves now. Besides, we are experiencing a lot of freedom according to the coordination of care. We are a learning organization, we are learning from other teams and other regions about the deployment of care."

> *"Personally, I like working autonomously because you are not just an employee but you have the freedom to make choices based on your profession. Besides I can use my own creativity in my job."*

"We do have a manager who is coaching us in our work. However, we do not have to give account to our manager all the time, we are able to make choices ourselves. When we need support, we can consult our manager."

Boarders within the autonomous way of working

"We are working with a few boarders, knowing: delivery of good care, satisfied clients, family and network, satisfied employees and volunteers and being a financially healthy organization. For us, this provides a framework in which between we can make choices. If we take a look a staying financially healthy we are able to provide 2.2 FTE per client. Another boarder that we have is the amount of training we need to do, we need to gather a certain amount of points a year." Not a lot of elaboration on the boarders was given besides the amount FTE per client and the amount of training.

"What we do encounter with the boarders is that especially for employees with a lower education, it is very relevant. This is because these people often need more steering."

KPI's

"We do not have a dashboard with KPI's. However, I do think this might be relevant for us because by then, we immediately know our performance. I think you stay motivated and continuous improvement will be there."

> *"The use of a dashboard might bring the common responsibility to higher level, especially because you then know that the responsibilities are not all with the management."*

"I think a lot of information can be gathered from our EHR (electronic health record). We have to make sure however, that we are not increasing the administrative load for the nurses. Possible relevant information may then for example be: self-reliance, in which we can see how much care our clients exactly need (based on care content related to the EHR). In this way, we can deploy the personnel most efficiently. Other relevant information may be the risk

attention fields. So that we for example know how to prevent more diseases within our target group. It can be a kind of check in which we can see if did not forget any attention field. Currently we are receiving the number of mentioned incidents quarterly. It might be as well relevant to receive this real time so that we can learn from them."

"Other relevant measures are for example client- and employee satisfaction. Client satisfaction may eventually lead to discussions within the team, which is good. Employee satisfaction is currently questioned randomly but mainly for control purposes. In the best scenario, we are questioning this on a more frequent base, as well to make sure that it is a snapshot to a lesser extent. I would say that benchmark within the organization can be very helpful to learn from each other. From that point of view, we need a kind of dashboard in order to monitor performance. Regarding the deployment of personnel, I do not see the adding value because I think that we already know within the team how many people we can deploy based on our clients. Overall, I would say that we always should remain critical on the things we are doing, not just following protocols but remain thinking ourselves. When a dashboard can help doing that, it can be very useful."

5 | Analysis

Within this chapter the results of the interviews will be analysed. No hard conclusions will be drawn but a comparison between the different organizations will be provided. The analysis has been divided per main-subject. The main subjects are Rhineland way of organizing, boarder determination and KPI's.

5.1 |Rhineland way of organizing

As considered in paragraph 2.2 the Rhineland way of organizing provides a framework for an organization. This framework includes that it is not a 'concrete' concept but freely interpretable. This can as well be made up from the interviews with the organizations. They all embrace the concept but have their own interpretations when it comes to the fulfilment of the framework.
It can be concluded that there is a lot of overlap in the way the management and the autonomous teams are looking to the way of organizing for both the organizations. It can however be stated that there are differentiations among the way the coordination mechanism is used across the organizations. TMZ is for example using multiple supervisors who are responsible for the results while ZorgAccent has just 1 coach which is the director. This is illustrating for the interpretation for the concept of the Rhineland way of organizing.

> *"We do have a manager who is coaching us in our work. However, we do not have to give account to our manager all the time, we are able to make choices ourselves. When we need support, we can consult our manager."* ***– Mandy Steggink, TMZ***

> *"We have no coordination mechanism in place other than our director, this is hard sometimes because the threshold seems to be high, this will be better in future."* ***– Autonomous teams, ZorgAccent***

It is questionable to what extend the autonomy can be experienced if one has a manager who is responsible for the results.

5.2 |Boarder determination

The literature provided relevant boarders based on the requirements of the (external) stakeholders. In paragraph 2.4 and 2.5 it has been assumed that these requirements are good input for KPI's towards autonomous teams (Zorginstituut, 2017; Gijzen & Hijnen, 2016;

Zorgverzekeraars Nederland, 2015). This assumption is about right, the (external) stakeholders are providing valuable input for the boarders which eventually can lead to relevant KPI's. However, the input the external stakeholders provide, is not that rigid as has been assumed. This research pointed out that the healthcare organizations do seek the discussion with the external stakeholders. They explain why they are doing the things as they do it and why some requirements from these external stakeholders do not fit within their organizations. This implicates that the external stakeholders do have influence but of lower extent. They are open for discussion, which makes them less rigid than assumed. This does as well implicate that facilitating information towards the autonomous teams may differ because of the agreements made with the external stakeholders.

> *"We are not doing everything the external stakeholders wants us to do, but they do have influence especially when it comes to the quality of care. We are somewhat deviating from the standard lists the external stakeholders do sometimes request, but we are providing them all the context about why we are doing things as we do them."* ***– Ina Kerkdijk, ZorgAccent***

> *"External influences are as well important and they influence the boarders. We, as nurses, have as well to deal with these external stakeholders such as the IGZ. But we do not deliver everything they ask for, because sometimes it does not make any sense if you do not tell the reasons why you have done it like that. When you have the position to explain why you have made the choices, they are willing to listen and will understand."* ***– Autonomous teams, ZorgAccent***

> *"Care agencies and IGZ are as well very important stakeholders in the boarder determination process. It is not that we honour every aspect of their requirements, we want to be in discussion with them and frame the boarders accordingly."* ***– Marie-Louise Engbers, TMZ***

The boarders that have been set up are not consulted a lot during the daily work process. It seems to be "once you know them, you know them". Still the boarders are important because by these boarders, the people know what they may and may not do within their work. As well for lower educated personnel it seems to be relevant.

> *"During the daily work, the boarders are not often consulted. In extreme situations, we question ourselves: "What does the boarder tells us about this?"* ***– Autonomous teams, ZorgAccent***

"The boarders are in place to provides a framework for the autonomous teams. Sensitively, these boarders are not very often consulted but mainly in the starting period, people needed these boarders as a kind of grip." ***– Marie-Louise Engbers, TMZ***

"What we do encounter with the boarders, is that especially for employees with a lower education, it is very relevant. This is because these people often need more steering." ***– Mandy Steggink, TMZ***

5.3 |KPI's

When it comes to relevant KPI's which can be used, there are different opinions across the organizations. ZorgAccent is questioning the utility of a dashboard with belonging KPI's, while TMZ find it relevant to have it. Both the organizations do think that a dashboard with KPI's does suit best when there is 'exact' information in there (meaning financial parameters).

"I do not believe in dashboards because they only project numbers and they do not tell the whole story with it. I'd rather prefer the social control which is there within the teams itself. ***– Ina Kerkdijk, ZorgAccent***

"For exact information, we would say that it can be helpful to have a dashboard with KPI's but when it comes to more subjective information, like the quality of care we would say that it is hard to draw conclusions out of it." ***– Autonomous teams, ZorgAccent***

When it comes to the more care-related information one should always keep in mind that figures do not tell the whole story. It is necessary for one to know the context in which the results derive to be able to draw conclusions from the results.

"It should be facilitating in every way, not to draw conclusions without the right context." ***– Marie-Louise Engbers, TMZ***

"According to quality of care we can state that facilitating information can be helpful to create discussion within team, not to draw hard conclusions out of it. For example, the number of incidents related to fall, incidents related to medication or the deployment of restraints." ***– Marie-Louise Engbers, TMZ***

"We cannot say what is relevant for us to have, but what we can say is that when it will be offered it should be reflective information. Information that provides the possibility to have discussions within team and learn from it." ***– Autonomous teams, ZorgAccent***

According to the quotes given by the different organizations, it can be concluded that the information offered towards the teams should be facilitating in every way. It should increase the learning within the teams itself. Especially when it comes to the quality of care, no hard conclusions can be drawn from it. When one wants to know why the figures are high or low, there always needs to be discussion about it.

5.3.1 | Exact and facilitating information

According to the interviewed organizations a rough distinction can be made in 'exact' information and 'facilitating' information. 'Exact' information in this context is information from which direct conclusions can be derived. For example, the number of absenteeism within a team or the formation. 'Facilitating' information in this context is reflective information which can bring up discussions or is contributing to it but from which no hard conclusions can be derived. Examples can then be care-related figures according to the number of incidents. The following has been said about the 'exact' information.

> *"When we take a look at the exact information related to figures and numbers, the number of deployable hours might be relevant for every team. It might as well be relevant to know if there is too much or too less capacity within the team related to employees and clients."* ***– Marie-Louise Engbers, TMZ***

> *"Teams do have a small dashboard with two items currently, knowing: absenteeism and the number of hours used over a month. This is what teams requested themselves. When they request, I want to facilitate."* ***– Ina Kerkdijk, ZorgAccent***

The mentioned exact information can be helpful and interesting, conclusions can easily be derived from these kinds of measures. These indicators can as well help to measure performance. The interviewed organizations did as well mention relevant 'facilitating' information. This information can be considered as KPI's but only to some extent because it is hard to derive conclusions from it.

> *"Information that possibly can be provided is information according to the care content from which we can learn. For example, the notifications of incidents. Still you cannot draw conclusions out of it but it might be input for learning and discussion. The most important indicator can then be happy clients and relatives, but this is as well hard to conclude in figures."* ***– Autonomous teams, ZorgAccent***

> *"Still we are working on some KPI's that can be offered towards the autonomous teams, in the form of real-time measures. For example, measures according to the client*

satisfaction and employee satisfaction. Provide information to create discussion within the team is on premise." ***– Marie-Louise Engbers, TMZ***

"According to quality of care we can state that facilitating information can be helpful to create discussion within team, not to draw hard conclusions out of it. For example, the number of incidents related to fall, incidents related to medication or the deployment of restraints." ***– Marie-Louise Engbers, TMZ***

"A possible relevant KPI may then for example be self-reliance, in which we can see how much care our clients exactly need (based on care content related to the EHR). In this way, we can deploy the personnel most efficiently. Another relevant KPI may be the risk attention fields. So that we for example know how to prevent more diseases within our target group." ***– Mandy Steggink, TMZ***

"Other relevant measures are for example client- and employee satisfaction. Client satisfaction may eventually lead to discussions within the team, which is good." ***– Mandy Steggink, TMZ***

It can be stated that information about the care content is relevant as long as it is facilitating. No direct conclusions can be derived from such information. But as mentioned by the interviewed, it is relevant to know and it can help in the work that they conduct. Besides, it provides input for discussion and learning.

5.4 |Literature comparison

As been discussed in the previous paragraphs (2.4.1 and 2.5.1) literature provided input for possible KPI's for the autonomous teams. The provided input is to measure quality and some other metrics (Zorginstituut, 2017; Embregts, 2014). Within this paragraph the comparison will be made between the possible KPI's raised from the literature and the mentioned KPI's during the interviews.

When the results of this research are being compared with the possible KPI's as derived from the literature, a similar pattern can be found, although there are some distinctions. Zorginstituut (2017) provided the Kwaliteitskader, previously discussed in paragraph 2.4.1. The eight principles discussed in this chapter has as well served as input for the interviews and possible boarders and thus possible KPI's. Some elements, which are in the 'Kwaliteitskader', has also been mentioned during the interviews. It needs to be said that when it comes to

information about the quality of care it can be seen as 'facilitating' information from which no hard conclusions can be derived.
The first principle of the 'Kwaliteitskader' autonomy of the client, seems to be relevant to know for the composition of the number of employees working on a certain department. Besides it provides valuable information about the self-reliance of the clients. The second principle is about living and health. This can be measured to some extent with client satisfaction and the relatives' satisfaction which both are mentioned by the interviewees. The number of incidents according to fall or medication does as well seem to be a relevant measure (third principle). It can be helpful to see this information because it provides input for discussion and learning. The use of restraints as well seems to be relevant regarding this third principle. Another measure which contributes to this third principle are the risk attention fields, so that the employees know how to prevent more diseases within their target group. The other principles are not mentioned to such extent except for education (principle six). Education has been mentioned a couple of times during the interviews and is a boarder at, for example TMZ and ZorgAccent. This, however, not seemed to be a relevant KPI since the employees knows themselves when and what they need to educate for.
Embregts (2014) mentioned some other KPI's besides the KPI's related to the quality of care. For example, the employee satisfaction which as well seems to be relevant for the autonomous teams (as derived from the interviews). Productivity has as well been mentioned by Embregts (2014). The interviewees mentioned that it might be relevant to see the number of deployable hours for every team. They as well mentioned that it might be relevant to see whether there is too much or too little capacity within the team related to clients. This can be interpreted as a kind of productivity measure to see whether the team is performing well or not.
Another measure that is not suggested within the literature is the number of absenteeism. This is used with ZorgAccent currently and helps the team monitor the number of absent employees within the team.

6 | Limitations and future research

The aim of this research is to find out what relevant business information (KPI's) is for autonomous teams in the institutional care. From a literature perspective, (external) stakeholders have requirements to the healthcare organizations. The requirements can be interpreted as boarders which may be translated to relevant KPI's for the autonomous teams within the organization. Research points out that there are indeed KPI's relevant for the autonomous teams which are as well suggested by the literature. However, there are as well items, with respect to the quality of care, relevant for the autonomous teams that are not really an indicator of performance. These items are more facilitating in way but do not directly tell something about performance without the right context.

Even though a lot of steps were taken to make sure that this research is reliable and valid, this research also has its limitations that should be taken into account when interpretation the results.

First, it should be taken into account that this research has a strong explorative character. The research was mainly focused on how organizations are structured, how boarders are set and what boarders are used. Because there was no literature testing these KPI's, it was necessary to first explore this domain of institutional care. This research provides new insights in knowledge about KPI's for autonomous teams in the institutional care. Therefore, for future research it is advisable to further test the formation of KPI's for autonomous teams in institutional care. The outcomes of this research (the relevant KPI's) should be further tested in future research. To test the relevant KPI's that were concluded in this research, an experiment should be conducted in which the exact and facilitating information is being tested. It can as well be very interesting to further investigate the distinction between exact- and facilitating information and what kind of KPI's are typical for both types of information.

Secondly, it is a limitation that this research was really focused on the Rhineland way of organizing. It is a possibility that when other types of organizations are used for interviews or focus groups, other results will occur. For example, classical organizations are possibly more into having control (on their autonomous teams) and therefore will develop more control focused KPI's. Future research should take into account that the character of an organization can influence the resulting KPI's.

A third limitation is that in one of the focus groups (at TMZ) there was only one participant. Other participants did not join this interview, which only left one participant in this focus group. The other limitation of the instrument is the amount of focus groups that were used to require the data. To more extensively research the formation of relevant KPI's, more interviews and focus groups should be held in different types of organizations. When more different organizations are used for the research, it will be easier and more reliable to discover

themes and most common relevant KPI's.

Final limitation of this research is that the instrument that is used could be seen as 'emotionally insensitive' towards participants. When examining the opinion of different members at the same time, members could respond to each other, which could result in some severe emotions/clashes. According to Avery, (1981), it is hard for the group leader to control the emotions of the different members in order to strive for constructive focus group interviews (Avery, 1981). Another disadvantage is comparison. The results from the focus group interviews are hard to compare with other results. In each focus group interview different opinions could emerge, which might not come up in other focus group interviews. This makes it hard to compare, because the group in which the suggestion has not been given could also prefer this opinion/suggestion (Avery, 1981).

7 | Conclusion

The aim of this research is to find out what kind of business information is supportive for autonomous teams within the institutional care. The participative way of KPI determination has been used to provide an answer to this question. Therefore, interviews had been conducted with the autonomous teams and the management board. It can be concluded that there are roughly two types of information which are relevant for the autonomous teams: 'exact'- and 'facilitating' information. The 'exact' information is information from which one can easily derive conclusions. From that point of view, it can be stated from this research, that it is relevant for the autonomous teams to know the number of deployable hours, the capacity within the team (too much or too little) and absenteeism.

'Facilitating' information is reflective, can bring up discussions and provides input for learning. With this type of information, it is hard to derive hard conclusions since the numbers does not tell the whole story behind it, the context is missing. This research pointed out that the following information is relevant when it comes to facilitating information: notifications of the number of incidents (related to fall and medication), happiness (satisfaction) of clients, relatives and employees, deployment of restraints, the extent of self-reliance of clients and risk-attention fields. All this information requires context, no hard conclusions can be derived from it as a result.

It can as well be concluded that the Rhineland way of organizing is an organization method which can be interpreted differently among organizations. There is no good or bad in this context but it can be concluded that there are distinct differences. For example, the use of the coordination mechanism with the responsibilities they have. TMZ still has middle management while ZorgAccent has none.

References

Adriaansen, M. (2017). Waardigheid en trots. *Tijdschrift voor verpleegkundigen*, *127*(1), 1-1.

Albert M. (1991), Capatalisme contre Capatilisme, Paris, Editions de Seuil

Almekinders, M. (2006). *'Teams beter thuis in thuiszorg?': resultaatverbetering in thuiszorg met behulp van sociotechnische organisatievernieuwing*. [Sl]: Stichting Sensire.

Amelsvoort, P. J. L. M., & Scholtes, G. (1993). *Zelfsturende teams: ontwerpen, invoeren en begeleiden*. ST-groep.

Amelsfoort, G. van & Jaarsveld, J. van (2000). Teamontwikkeling en leidinggeven.

Asbreuk, A., (2008), Zelfsturende teams in de ouderenzorg, geen taak maar een proces. Instituut beleid en management gezondheidszorg, Erasmus Universiteit Rotterdam.

Avery, M. (1981). Building United Judgment: A Handbook for Consensus Decision Making.

Baank, E. (2007). Effecten van implementatie van zorgzwaartepakketten: wat het zwaarst is, moet het zwaarst wegen.

Balk, A. & Wierda, S. (2016). Zelfsturing: een tijdelijke hype of een waardevolle, blijvende omslag in de het organisatiebeleid?

Barone, D., Jiang, L., Amyot, D., & Mylopoulos, J. (2011, November). Reasoning with key performance indicators. In *IFIP Working Conference on The Practice of Enterprise Modeling* (pp. 82-96). Springer Berlin Heidelberg.

Benders, J., Missiaen, C., & Van Hootegem, G. (2013). De innovatieve arbeidsorganisatie in de zorg.

Berden, B., Berrevoets, L., & Winasti, W. (2016). 7.1 Wat is performancemanagement?–78 7.2 Rol van management–78 7.3 Performancemanagement is een continu proces–79 7.4 Stuur waarop je invloed hebt–80 7.5 Beschouwing–80. *Capaciteitsplanning in de zorg*, 77.

Beune, E. H. A. Th. (2015). Meer zorg minder papier. Dwingeloo: Kavanah

Bohn Stafleu van Loghum. (2011). Overstag–Hans Hoonakker. *Skipr*, *4*, 49-49.

Centraal Bureau voor de Statistiek (CBS). (2014, maart 3). *Bevolingspiramide*. Opgeroepen op maart 3, 2014, van Leeftijdsopbouw

Cott, C. (1997). “We decide, you carry it out”: A social network analysis of multidisciplinary long-term care teams. *Social Science & Medicine, 45, 1411-1421.*

Eijck, van, J. (2016). Menzis zorginkoopbeleid 2017. Algemeen inkoopbeleid.

Embregts, T. (2014). Effectief leidinggeven en werken in het sociaal domein na de decentralisaties van 2015.

Euske, K.J., M.J. Lebas, en L.J. McNair – Performance measurement in an international setting. – In: Management Accounting Research 4 (1993), nr. 4, p. 275-299

Evers, F., Gravesteijn, M., Molenveld, M., & Wilderom, C. P. M. (2011). Leren van presteren op de werkvloer via zelfontwikkelde prestatie-indicatoren. *M&O: tijdschrift voor management en organisatie*, *2011*(sept/okt).

Diemen-Steenvoorde, van, J.A.A.M. (2016). Eindrapportage toezicht IGZ op 150 verpleegzorginstellingen. *Inspectie voor de gezondheidszorg Ministerie voor de volksgezondheid en sport*

Feddes, R., Vermetten, Y., Brand-Gruwel, S., & Wopereis, I. (2003). Strategische kennis over het oplossen van informatieproblemen: een exploratief onderzoek [Strategic knowledge about information problem solving: an explorative study]. Pedagogische Studiën, 80, 210-225.

Fry, J. (1978). Cure and Care. In *A New Approach to Medicine* (pp. 71-79). Springer Netherlands.

Graaf, de, T. (2015). InVoorZorg, Dossier voor zelfsturende teams. *Tijdschrift voor verpleegkundig experts* (3), 11-24

Groen, B.A.C., M.J.F. Wouters, en C.P.M. Wilderom – Why do employees take greater initiatives for performance improvement if they develop their own performance measures? A field study. – Manuscript onder revisie voor een internationaal tijdschriften geaccepteerd voor presentatie op de jaarlijkse zomerconferentie van de Academy of Management (2011)

Gijzen, J., Hijnen, Y., (2016). CZ. Selectieve zorginkoop, hoe bepalen we onze kwalitietseisen?

Hoe, J., Hancock, G., Livingston, G., & Orrell, M. (2006). Quality of life of people with dementia in residential care homes. *The British Journal of Psychiatry*, *188*(5), 460-464.

Hoogland, S., & Boon, G., (2013). Optimale HR-ondersteuning in een zelfsturende organisatie. *Hogeschool van Amsterdam*

InVoorZorg (2015). De langdurige zorg 2020: Trends organisatie.

Janssen, R. & Choy, T., (2003). Zorgkantoren, maatschappelijk verantwoord? *ZM Magazine*, pp 10-15.

Jassies, R. (2012). *Het feedbacksysteem voor continue ontwikkeling van zelfsturende teams in de zorg: Een proces naar en voorwaarde voor succes: Een onderzoek naar ervaringen, meningen en wensen van belanghebbenden* (University of Twente).

Kalverda, M. (2016). Inzet HBO-verpleegkundigen in de intramurale ouderenzorg.

Kengen, M., & Jagtman, P., (2010). Leren in zelfsturende teams.

Klerk, de, M. (2011). Zorg in de laatste jaren.

Koster, J. M., & Stolze, P. W. (2003). Heeft u al een missie en een visie?. *Over de zin en onzin van moderne zinspreuken. Managementsite. nl*.

Koster, N. (2015). Analyzing client characteristics and needs in home health care.

Kuperus, K., Ploegman, P., Trompenaars, F., Ogink, A., Ruigrok, L., Oosterwaal, A., (2015). Zelfsturing in de zorg: Zes openhartige gesprekken over dillema's in de dagelijkse praktijk. *KPMG*

Leppers, D., & Eikenaar, G. (2011). *Zelfsturing: een nieuwe kijk op organisaties*. Pearson Education.

Lieshout, P. van, (2016). Nieuwe spelers en andere zekerheden. *SOCIALE (ON)-ZEKERHEID*.

Mather, K.F. & Bakas, T., (2002). Nursing assistants' perceptions of their ability to provide continence care. *Geriatric Nursing,* 23, 76-81.

Monsen, K. (2013). Buurtzorg Nederland. *AJN The American Journal of Nursing*, *113*(8), 55-59.

Most, van der, M. (2007). 'Buurtzorg'wint Best Practice Award. *TvZ*, (7/8), 34.

Nandram, S., & Koster, N. (2014). Organizational innovation and integrated care: lessons from Buurtzorg. *Journal of Integrated Care*, *22*(4), 174-184.

NieuwOrganiseren (2011). Nieuw Organiseren

Parmenter, D. (2015). *Key performance indicators: developing, implementing, and using winning KPIs*. John Wiley & Sons.

Popta, van J. (2015). Sturen op zelfsturing en zelfsturende teams. Vrijheid in verbondenheid. *Lectoraat innovatie en verscheidenheid.*

Peters, J., & Heringa, H. (2009). Bij welke reorganisatie werk jij? Culemborg: Van Duuren.

Peters, J., & Weggeman, M. (2009). Het Rijnland boekje, Amsterdam: Business Contact.

Reulink, N., & Lindeman, L. (2005). Kwalitatief onderzoek. *Observatie, interviewen*.

Rijksoverheid (2016). Het Nederlandse zorgstelsel. *Ministerie van VWS*

Rijksoverheid (2017). Kwaliteitseisen zorginstellingen.

Shortell, S. M., Marsteller, J. A., Lin, M., Pearson, M. L., Wu, S. Y., Mendel, P., ... & Rosen, M. (2004). The role of perceived team effectiveness in improving chronic illness care. *Medical care*, *42*(11), 1040-1048.

Stevens, J. L. (2015). Fluitend naar werk? De tevredenheid van verzorgenden in Nederland.

Verbeek-Oudijk, D., & Eggink, E. (2014). De grens van extramuralisering is nog niet bereikt. *Tijdschrift voor Gerontologie en Geriatrie*, *45*(4), 188-196.

Vermeer, A., & Wenting, B. (2014). Zelfsturende teams in de praktijk. Amsterdam: Reed Business Education

Veur, R. V. D. (2014). De winst van waarden.

Wetzstein, B., Ma, Z., & Leymann, F. (2008, May). Towards measuring key performance indicators of semantic business processes. In *International Conference on Business Information Systems* (pp. 227-238). Springer Berlin Heidelberg.

Wouters, M., en C. Wilderom – Developing performance-measurement systems as enabling formalization: A longitudinal field study of a logistics department. – In: Accounting, Organizations & Society 33 (2008), nr. 4/5, p. 488-516

Zimmerman, S., Shier, V., & Saliba, D. (2014). Transforming nursing home culture: Evidence for practice and policy. *The Gerontologist*, *54* (Suppl 1), S1-S5.

Zorginstituut (2017). Kwaliteitskader Verpleeghuiszorg. *Samen leren en verbeteren.*

Zorgverzekeraars Nederland (2015). Inkoopkader langdurige zorg 2016 (verpleging en verzorging).

Appendix A | Questionnaires

In order to find out what KPI's is relevant and supportive for the autonomous teams, questions had been asked to the management of the care organizations and the autonomous teams itself. In this appendix, the questions asked are written out. The question is mentioned in bold and italic, the reason why the questions was asked, is worked out after every question (in normal type, not bold nor italic).

Questionnaire | Management

Overall introduction
Ask for an introduction to the company

"Rhineland way of organizing"

- ***This organization is working according to the Rhineland way, what are typical characters for this way of organizing within this organization?***
  Every organization is organized differently even though they may all proclaim to work according to the Rhineland way. To get a feeling about the way of organizing, this question is being asked.
- ***Responsibilities low in the organization, how far does the freedom of choice reach?***
  This question is as well being asked to get a feeling with the organization and to what extend the employees are getting to freedom to make choices (i.e. how far does the freedom goes and where can the boarders be recognized)?
- ***What is the coordination mechanism that the organization is using?***
  Autonomously working teams is a character of the Rhineland way of working, although the literature tells something about the coordination mechanisms that can be in place to support the autonomous teams. How does this organization make sure that the teams can work autonomously? Are they using a coordination mechanism, or how is this designed at this organization?
- ***How is the autonomous way of working ensured?***
  There might be use of a coordination mechanism. When there is, how can then the autonomously way or work be ensured? How can it be ensured that the coordination mechanism is not taking over the process and is making the choices?

"***The determination of the boarders"***

- ***Which stakeholders do have influence on the determination of the boarders?***
  This question is being asked to find out which stakeholders are involved for this particular company. From a literature point of view, the care agencies, government and the organization itself should be mentioned, is this really the case?

- ***How is the decision-making process designed?***
  How are the stakeholders involved and how are conclusions being drawn based their influence?
- ***How do you make sure the teams are performing according to the restrictions of the IGZ? (restrictions in terms of reduction of restraints, coordination of safety, actual care plans)***
  Every organization needs to pay attention to the IGZ and the restrictions coming from them. How does this organization make sure that all the restrictions are considered? Do they all have to be considered?

Introduction about KPI's

→ When there is no current use of KPI's

- ***Why does this organization does not use any KPI's?***
  If the company has boarders, how does the company then make sure the teams are performing?
- ***Does the organization think it is worth full to offer KPI's directly to the teams?***
  Why doesn't the organization have KPI's in place yet? Do they think it is not supportive towards the autonomous teams? Or do they think it is supportive but they do not have resources to investigate or purchase?
- ***Which KPI's might be relevant to offer and on what front?***
  What KPI's are relevant to this particular organization? Are these KPI's in line with the literature?

Introduction to the literature KPI's and discuss

→ When the organization does use KPI's for the autonomous teams

- ***Did the organization define the KPI's to make sure the autonomous teams are able to measure their performance?***
  Why are the KPI's in place? Is it supportive, is it to measure performance, is it to facilitate their autonomous way of working or is to meet the restrictions of the stakeholders?
- ***Which KPI's are being offered to the teams?***
  Why are especially these KPI's offered?
- ***How does the organization offer these KPI's?***
  Is there a dashboard being offered to the teams? What role is IT playing? And why did the organization choose for this was of offering?

Introduction to the KPI's based on the literature and discuss

"Secure quality of care"

- ***How does the organization secure the quality of the care being delivered?***
  Quality of care is hard to define. The 'kwaliteitskader' has been introduced to provide a framework for it, how is this taken into account?
- ***To what extend the quality of care can be ensured in the KPI's?***
  Is quality of care playing a role in the KPI's that are being offered to the autonomous teams?

"Whether the KPI's are helping to gain their targets"

- ***Is there any difference from the moment the organization introduced KPI's to the teams?***
  Does is matter that there are KPI's? Is the difference measureable?
- ***How is the performance evolving?***
  Can the organization measure anyhow that performance is positively influenced by the introduction of the KPI's?
- ***Are there any boarders not included in the offered KPI's?***
  Why are there boarders that are not included?

Indicators based on the literature: personal care and support towards the clients, living and health, safety, ability to learn and improve for employees, leadership, governance and management, composition of personnel, use of resources, use of information, structural capture and monitoring incidents, structural capture of care information (health intelligence) Client satisfaction, employee satisfaction, employee expertise, productivity.

Questionnaire | Teams

Overall introduction
Ask for an introduction to the company

"The Rhineland way of organizing"

- ***Why did you choose to work for an organization that is working according to the Rhineland way?***
  This question is being asked to find out what the reason is people want to work for autonomously working oriented organizations. This can help to understand to what extend the freedom is being experienced.
- ***To what extend you feel there is management?***
  When people are working autonomous, they should not experience management nor have the experience they are managed.
- ***How do you feel you are settled on measures?***
  Working autonomously does not mean you can do whatever you want and that there is not a single kind of control in place. There might be control to some degree.
- ***How are you experiencing the degrees of freedom?***
  Do the employees have the feeling they can do whatever they want? How do they experience their ownership according to their responsibility?

"Boarders within the autonomous way of working"

- ***Do you exactly know what is expected of you?***
  This is question is being asked to find out if the boarders that are determined, are all communicated clearly.
- ***To what extent you feel helped by the boarders the company has determined?***
  The boarders that are in place within the organization are, most likely, in place to provide a framework for the employees. To what extent the employees feel helped by these boarders to determine how far their autonomy goes?
- ***Do you think all of the boarders are relevant to you?***
  Boarders are there to provide a framework but some might be in place but are never used, nor relevant. Are there any non-relevant boarders?
- ***Why do you think these boarders are in place and whom has had influence by setting them up?***
  It might be possible that the employees are not aware of the external stakeholders such as the care agencies of the government. What is the opinion of the determination of the boarders by the employees?

Introduction about KPI's

→ *When there is no current use of KPI's*

- ***How do you know what the boarders are?***
  When there are no KPI's in place, it should somehow be clear to the employees what is being expected of them, how they should operate and how far their responsibilities go.
- ***Is there any control on the boarders? How does the organization make sure you are performing according to these boarders?***
  When there are no KPI's in place which can be consulted, how then is there is control? Or isn't there any kind of control?
- ***How do you monitor performance within the team?***
  Is performance an important measure for the team? Are there any restrictions from the organization regarding this? How does the team monitors performance in that matter?
- ***To what extent could KPI's help you doing your job?***
  Can KPI's help in doing the job? How can they? This is an important question in order to find out which KPI's might be relevant.
- ***To what extent could these KPI's help you monitoring your own performance?***
  If the team is interested in the mentioned KPI's, can they then as well help in monitoring performance? Does this seem to be relevant?
- ***To what extent could these KPI's help you measuring/monitoring the quality of care delivered?***
  KPI's might not only be relevant for measuring performance, they can as well be relevant gain insights in the delivered care. In that case it might not be named a KPI's (indicating it has only to do with performance) but more 'facilitating information'.
- ***What KPI's do you think are relevant? KPI's with respect to care content? About the population, you are delivering care to? KPI's with respect to personnel or finance related KPI's, etc.***
  This last question is in place to summarize all that has been discussed before. What are relevant KPI's? Are they relevant for care content? Are they relevant for measuring performance? What are these KPI's then?

Introduction to the KPI's based on the literature and discuss

→ *When there is a current use of KPI's for the autonomous teams*

- ***What KPI's are in use now?***
  What KPI's are there now, how are they used, how are they offered and why are especially these KPI's offered?
- ***To what extent are these KPI's supportive to your work?***
  This question is asked to find out if these KPI's are adding any type of value.

- ***Which KPI's are most relevant to you and why?***
  There might be difference in the degree to which all the KPI's are relevant or not. Which KPI's are most relevant in that matter and why are they?
- ***Do you have the feeling you miss any relevant KPI's and if, which?***
  The offered KPI's might be the choice of the management. There may be some KPI's or other indicators that helps the team performing. Which KPI's are then missing?
- ***Do you have the feeling you know enough about the care content (care you deliver)?***
  This question is being asked to get know whether the care content-related KPI's (facilitating information) are clear enough to draw conclusions from. Conclusions can as well be related to personnel based on the target groups the team serves.
- ***To what extent does/can these KPI's help you working autonomously?***
  This question is in place to find out to what extent KPI's are a part of a key to work autonomously. Maybe they have experience in working with and without KPI's.
- ***To what extent does/can these KPI help to ensure the quality of care to be delivered?***
  This question is in place to find out what main goals the KPI's offered are serving. Is it only relevant regarding performance or is it as well relevant regarding the quality of care?

Introduction to the literature KPI's and discuss

Indicators based on the literature: personal care and support towards the clients, living and health, safety, ability to learn and improve for employees, leadership, governance and management, composition of personnel, use of resources, use of information, structural capture and monitoring incidents, structural capture of care information (health intelligence) Client satisfaction, employee satisfaction, employee expertise, productivity.

Appendix B | Interviews

Within this section the interviews are worked out. A summary is given of all of the interviews itself. The interviews are worked out in Dutch since the interviews had been taken in Dutch. The recordings of the interviews are as well available.

ZorgAccent | Management

Dit interview is afgenomen met Ina Kerkdijk, directeur van ZorgAccent.

Rijnlandse manier van organiseren

“De kanteling die ZorgAccent heeft meegemaakt is vanuit de kwaliteit van zorg gedreven. We waren een organisatie met veel protocollen en procedures. Er waren veel managers die de problemen oplosten zonder dat het personeel op de werkvloer daar een direct aandeel in had. Daardoor kwam de kwaliteit van zorg in het gedrang. Wanneer je een vraag had was het zo stroperig dat als je pech je had, je de hele boom omhoog moest tot aan het MT. Dan was de situatie al niet eens meer relevant door alle tijd die je verdeed.”

“We hebben een sterke visie neergezet en de uitgangspunten daarbij bekeken: waar staan we voor en wat willen we uitdragen? De cliënt, de naasten en medewerkers staan centraal in deze visie. Als we willen werken met deze visie dan past het Rijnlands organiseren daar het beste bij. Dat zijn kleinschalige teams waarbij de verantwoordlijkheden binnen de teams zelf liggen. Een simpele manier van organiseren met maximale regelruimte om ter plekke de beste oplossingen te kiezen. Protocollen en een centraal aangestuurde organisatie passen daar dus niet bij. Wel is het zo dat zelfsturing (afgeleide van het Rijnlands organiseren) geen doel op zich is maar een middel om volgens je visie te kunnen werken, zo zien we dat.”

“Binnen ZorgAccent hebben we er dan ook niet voor gekozen om coördinatie mechanismen aan te houden. Ik ben de het enige coördinatie mechanisme dat er is. Wanneer teams vragen hebben of gecoacht moeten worden, dan mogen ze altijd bij mij komen en zal ik ze helpen. Minimaal 1 keer per jaar spreek ik met de mensen binnen de teams om te kijken wat er verbetert kan worden, niet om te controleren maar om te kijken waar geholpen kan worden. Echt op teamniveau wordt er gesproken met de teamleden en wat op dat front verbetert kan worden.”

Kaderbepaling

“Binnen ZorgAccent zijn er kaders opgesteld die het autonoom werken kunnen borgen. Kaders hebben betrekking op verschillende elementen zoals bijvoorbeeld formatie-inzet. Hoeveel uren zet je in binnen je team? Hierbij zijn er geen centrale planners maar dit regel je zelf binnen je team. Belangrijke kanttekening hierbij is dat het aan overall moet kloppen. Een

ander kader is bijvoorbeeld het financiële huishoudboekje per team. Dit regel je als team zelf. Als team zorg je ervoor dat je in de groene cijfers blijft. Het is net zoals thuis, daar ga je er ook verantwoordelijk mee om. Omdat het gemeenschapsgeld is, is het belangrijk dat er een huishoudboekje wordt bijgehouden. Hoe de teams dit doen, dat mogen de teams zelf bepalen. Dit wordt op verschillende manieren gedaan. Steekproefsgewijs worden hier controles op uitgevoerd. Hierin willen we eigenlijk veel meer toe naar een horizontale verantwoording in plaats van de verticale verantwoording steekproefsgewijs. Horizontale verantwoording vindt dan plaats richting de familie. We willen hen medeverantwoordelijk maken voor de keuzes die gemaakt worden door de zorgverleners. Een droom daarbij is de externe stakeholders (IGZ en zorgkantoren) onderdeel te laten zijn van die horizontale verantwoording. Dit is echter toekomstmuziek."

"De kaders zijn tot stand gekomen door overleg en input met de teams zelf. Toch moet je hier wel kritisch op zijn omdat je niet aan elke wens tegemoet kunt komen, als organisatie moeten we wel in de groene cijfers blijven. Soms worden er kaders opgesteld die al geborgd zijn waardoor ze als kader minder relevant lijken maar eigenlijk in het proces al worden afgevangen door simpelweg je verstand te gebruiken. Ook externe stakeholders hebben invloed op het bepalen van de kaders. We tuigen niet alles op van wat de externe stakeholders willen maar ze hebben er zeker invloed op, ook als je kijkt naar de kwaliteit van zorg. Ze zijn zeker belangrijk maar het is belangrijk dat de context gegeven wordt bij de dingen die we doen. Daarin wijken we af van wat standaarden voorschijven, we redeneren vanuit de cliënt."

KPI's

"Ik houd niet van het woord 'KPI' of 'indicator' want dat is managementtaal. Ik vind mezelf ook geen manager. Teams moeten zelf de mogelijkheid hebben om zelf de keuzes te maken. Daarbij mogen teams dan ook zelf zaken aandragen die ze in hun dashboard willen zien. De teams hebben nu een klein dashboard met daarin 2 items: verzuim binnen het team en de inzet van de uren. Dit is waar de teams zelf om hebben gevraagd. Ook om het gesprek met elkaar te voeren, waarom is dat verzuim dan zo hoog? Verder zijn er geen concrete zaken aangedragen door de teams zelf waar we direct iets mee moeten doen."

"In een zelfsturende organisatie staat eigenaarschap centraal, bijvoorbeeld met scholingen. Je moet verplicht twee keer per jaar een scholing volgen aangaande de doelgroep waar je je als teamlid mee bezig houdt. Scholing 'BHV' is voor veel groepen ook een verplichte scholing. Hierin nemen de mensen zelf hun verantwoordelijkheid. Ze weten zelf dat ze dat moeten doen. Binnen een zelfsturende organisatie is ook veel meer sociale controle. Eigenaarschap speelt hierin een grote rol. Bijvoorbeeld met het huishoudboekje, als er een gat in het huishoudboekje zit, dan wordt daar sociale controle op uitgevoerd zonder dat een manager dat hoeft te doen, dat gebeurt thuis ook. Het is ook ge-end op vertrouwen, dat is voor veel organisaties een drempel, het zal ongetwijfeld weleens gebeuren dat er een gat zit in het

huishoudboekje maar het is gebaseerd op vertrouwen en eigenaarschap en dat vertrouwen hebben we in de medewerkers."
"Het lastige met cijfers en dashboards is dat deze niet het gehele verhaal niet vertellen. Een voorbeeld zijn de MIC (meldingen incidenten cliënt). Deze meldingen verdwenen van de medewerker. Er werd een melding gedaan en er werd door een manager controle op uitgevoerd. De afdeling kwaliteit make een kwartaaloverzicht en dat werd neergelegd bij de manager. De manager zag de rapportage en dacht: "Zo, wat een hoop ongevallen." Maar na gesprekken met het team bleek er een duidelijke reden voor te zijn en zijn keuzes gemaakt omdat deze het beste waren voor de cliënt. Cijfers zeggen zo weinig en geven geen context mee. Daarmee hoef je niet de conclusie te trekken dat dashboards geen zin hebben maar door gesprekken met de teams aan te gaan en de vraag te stellen: "Wat hebben jullie nodig om te kunnen leren en te kunnen verbeteren", kunnen er zaken zijn die wel relevant zijn voor de teams. Dit is dus niet vanuit het management gestuurd. Ik moet niks aanbieden, ik wil iets maken als er een vraag om is. Als ik iets aan ga bieden gaat er iets niet goed, het leerelement is lager als ik het zelf ga aanbieden."

"Zou het relevant zijn de punten vanuit het kwaliteitskader terug te geven aan de teams om zo te kijken of ze aan de kwaliteit van zorg voldoen zoals het IGZ dat verwacht?" "De belangrijkste stakeholder is de cliënt zelf. Kwaliteit is door management en/of stafmensen weggeregeld van de teams. Het eigenaarschap voor kwaliteit ligt bij de teams zelf en ik geloof niet in algemene uniforme regels. Er moet niet vanuit standaarden worden geredeneerd. Uniforme regels worden niet altijd uitgevoerd maar er wordt vanuit de cliënt geredeneerd. Daarbij is de casuïstiek van de cliënt en de context erg belangrijk. Vanuit daar zijn bepaalde keuzes gemaakt en dan zegt een lijstje (over de inzet van standaardinstrumenten) veel minder. Organisaties zijn bezig met het opstellen van ingewikkelde verslagen waarin context wordt gegeven aan het kwaliteitskader. Dat zie ik mezelf niet doen. Het is een vrije interpretatie, zo is het kader opgesteld en zo gaan we het doen, de bedoelingen zijn goed."

ZorgAccent | Teams

Dit interview heeft plaatsgevonden in een focusgroep setting. Met drie medewerkers van drie verschillende autonome teams. De geïnterviewde zijn: Jan Zieleman, Rolf Lucas en Eefje Stokvis. Gedurende het interview bleek er veel consensus te zijn. Op enkele fronten weken de meningen af.

Rijnlandse manier van organiseren
"De organisatie heeft 10 jaar geleden een transitie doorgemaakt. De redenen waren dat het financieel niet goed ging en medewerker- en cliënttevredenheid was laag. Er moest een

kanteling komen van een centraal gestuurde naar decentraal gestuurde organisatie. Ongeveer 4 geleden is de kanteling naar zelfsturing gemaakt bij ZorgAccent. Wat daarbij centraal heeft gestaan is de sterke visie. We werken nu in een organisatie waarbij de verantwoordelijkheden bij de teams zelf liggen. Thuis heb je alle vrijheid om keuzes te maken, dat zou in het vak dat geleerd hebt ook zo moeten kunnen, het is gek dat dat niet zou kunnen. Er waren 1200 protocollen waardoor alles geregeld was. Protocollen waren er wel maar feitelijk doe je veel zaken ook al zelf en maak je de juiste keuze zonder dat daarbij een protocol nodig is."
"Een uitdaging aan deze decentrale manier van werken is dat mensen het moeilijk vinden om het eigenaarschap naar zich toe te trekken. Je merkt dat wanneer er keuzes gemaakt moeten worden er toch behoefte is aan een hiërarchisch model. Mensen vinden het soms moeilijk om in consensus een keuze te maken. Ze zoeken binnen het team altijd iemand die keuzes durft te maken. We hebben geen coördinatie mechanisme anders dan de directeur die onze direct leidinggevende is. Dat is soms wel echt lastig. Want die drempel lijkt nog steeds hoog te zijn voor bepaalde medewerkers, langzaam gaat het beter maar dat moet echt slijten."
"Toch zie je ook nog regelmatig organisaties die het zelfsturende niet aandurven. "Dat kunnen ze (de medewerkers) niet, ik vertrouw mijn personeel niet." Daar gaat het mis met zelfsturing. Om zelfsturing te kunnen introduceren heb je vertrouwen en visie nodig."

Kaders binnen het autonoom werken

"Binnen ZorgAccent zijn er bepaalde kaders opgesteld. Voorbeelden van deze kaders zijn: je werkt binnen ZorgAccent dus je werkt volgens die visie. Je werkt volgens het geldige zorgconcept. Er zijn kaders omtrent financiën, personeelsinzet, gezond roosteren. Het zijn 'gezond verstandkaders', die je soms al wel weet zonder dat je het kader daarvoor hoeft te raadplegen. Het zijn geen harde kaders, ze zijn bespreekbaar. De kaders zijn er ook met name om de veiligheid van de medewerkers te borgen, zodat ze weten wat ze moeten doen binnen een bepaalde context. In het dagelijks werk komen die kaders eigenlijk nooit ter sprake. In extreme gevallen komen de kaders weleens aan bod, dan wordt er gevraagd: "Wat zegt het kader hierover?" Het kader rondom formatie komt wel geregeld terug. Kaders zijn wel bespreekbaar, onderhandelbaar. Als je bijvoorbeeld extra mensen nodig hebt in een bepaalde periode, dan is dat gewoon bespreekbaar."
"De IGZ is een belangrijke stakeholder voor ZorgAccent. Op zowel het vlak van kaders als op het vlak van verantwoording. Echter is het niet zo dat we alles doen wat er ons wordt gevraagd. Soms wijken we af van de manier die het IGZ het liefste ziet, maar met de juiste context kunnen we veel met hen bespreken en uitleggen waarom het doen zoals we het doen. Controles en lijstjes zijn dan een wassen neus en vertellen zo weinig over hetgeen er gebeurt op de werkvloer, je mist elke vorm van context. Je moet ook lef hebben om tegen een IGZ in te gaan mits je maar aangeeft wat dan jouw ideeën erbij zijn. En hoe je het dan wel op zou willen lossen, dat is belangrijk. Overall gezien moet je te allen tijde kritisch blijven op hetgeen

je doet. Medewerkers moeten kunnen zeggen: “Ik kies hiervoor want…”, dat is erg belangrijk, de gehele organisatie moet doordrenkt zijn met de visie.”

KPI’s

“Een dashboard kan heel mooi zijn en faciliterend werken. Wat belangrijk is, is de gedachte achter het dashboard met de KPI’s die worden aangeboden. Als het financieel gedreven is dan heeft het geen zin binnen de teams, het moet hen helpen zonder dat er indirect controle wordt uitgevoerd. Wat wel heel mooi kan zijn van een dashboard is dat het gesprekonderwerpen kunnen zijn en reden kan zijn tot discussie binnen het team. Het werkt alleen als het een reflectiemethode is op de manier van werken. Er mogen geen harde conclusies aan worden verbonden (op dit onderwerp was veel consensus). Wanneer het een reflectiemethode is laat het, het team ook vrij om het te gebruiken, ze moeten er niet toe verplicht worden.”

“De data die de teams zien, mogen niet beschikbaar zijn voor het management, daarmee loop je weer het risico dat het als controlemechanisme wordt gezien, en dat zou je niet moeten willen. Ik ga het niet invullen als ik weet dat er externe stakeholders naar kunnen kijken. Als ik zeker weet dat dat niet het geval is, dan zou het een goed hulpmiddel kunnen zijn. Als organisatie raken we steeds meer horizontaal geïntegreerd. Dit, over de as van medewerkers in relatie tot de cliënten en de verwanten van de cliënten. De enige indicator die dan echt van belang is, is: “Hoe ervaart de cliënt de zorg die is geleverd?” Daarmee willen we laten zien dat we goede zorg leveren maar de uitdrukking van goede zorg kan per team verschillen. Je zou hierbij dan bij alle teams langs moeten gaan om hun mening te vragen over wat zij interessant vinden om te zien en wat zij goede zorg vinden (consensus).”

“Een relevant KPI zou kunnen zijn: de ‘MIC-meldingen’. Dit is meer een zorginhoudelijke KPI. Alhoewel dit cijfer ook weer zo weinig zegt. Als er veel gemeld wordt, doen we het dan goed of juiste niet? Cijfers zeggen zo weinig zonder de juiste context. Wel zou het als gespreksonderwerp kunnen dienen waardoor het binnen het team bespreekbaar wordt. Ook kan het interessant en relevant zijn als teams informatie met elkaar gaan delen en willen en kunnen leren van elkaar. Maar je moet echt uitkijken dat het geen verantwoordingssysteem wordt.”

“Als de informatie wordt geprojecteerd in een dashboard dan worden meldingen niet gedaan omdat ze bang zijn dat er aan de achterkant iets mee gebeurd. Daarnaast zouden naasten bij het invullen van bijvoorbeeld de cliënttevredenheid een manipulerende gedachte kunnen hebben. Ik geef een lage score zodat de zorg voor mijn verwant beter wordt (geen consensus op dit onderwerp)”.

“Wanneer je zaken gaat aanbieden in een dashboard die gelieerd zijn aan financiën, ziekteverzuim, rooster of vakantie, dan kun je allemaal goed bijhouden maar kwaliteit van zorg is echt niet te vatten in een dashboard (consensus). Als we dan bijvoorbeeld kijken naar het kwaliteitskader dan zien we een duidelijke visie. Er staan wel een aantal checklists in die,

wanneer je die uitvoert, alsnog weinig zeggen over de kwaliteit van zorg omdat je alleen maar een checklist aan het uitvoeren bent. De ideeën van het kader zijn goed maar de checklists zeggen alsnog niks voer kwaliteit van zorg. Als het reflecterend is, is het goed maar je mist de context als het uitsluitend cijfermatig is.”

Trivium Meulenbelt Zorg | Management

Het interview binnen Trivium Meulenbelt Zorg (hierna TMZ) is afgenomen met Marie-Louise Engbers, regiomanager Hengelo van de persoonlijke zorg.

Rijnlandse manier van organiseren

“Binnen TMZ hebben we hele duidelijke visie gehad om een coöperatieve organisatie neer te zetten. Het idee daarbij is dat de organisatie niet alleen van de medewerkers is maar juist van alle mensen die erbij betrokken zijn. Bijvoorbeeld de mantelzorgers en de vrijwilligers. Eigenlijk zijn we dan met elkaar de organisatie. Om die verbinding zo sterk mogelijk te maken zijn bij het vormen van de visie en dergelijke in een vroeg stadium al de cliënten betrokken (cliëntenraad). Ook is de ondernemingsraad betrokken en de verpleegkundige adviesraad, omdat het belangrijk is om de medewerkers ook een rol te geven over waar de organisatie heen gaat/moet. Ook is er een medische adviesraad (multidisciplinaire adviesraad) opgericht met behandelaren. Maar uitsluitend met deze adviesraden kun je niet de organisatie niet bepalen, dit moet ook op tactisch, operationeel niveau en daar is een project van gemaakt en dat is persoonlijke zorg genoemd. Daar ben ik regiomanager van.”

“Voordat de transitie werd ingezet was het een centraal aangestuurde organisatie. Er is niet gezegd dat vanuit alle belangen het Rijnlandse model het beste paste. Vóór 2012 is het Rijnlands organiseren een project geweest en dat is vertaald naar TMZ. Binnen de Raad van Bestuur is daar een keuze voor gemaakt en dat is dan weer de voorzet voor de coöperatieve organisatie die we nu hebben.”

“Binnen TMZ hebben we gekozen voor een leidinggevende die verantwoordelijk is voor de resultaten maar met een coachend karakter. Deze leidinggevende is verantwoordelijk voor verschillende afdelingen. Het functioneren van het personeel is dan ook onder de hoede van een leidinggevende. In eerste instantie moet dit binnen het team worden opgepakt maar daarna heeft ook de leidinggevende een rol hierin. Ook bij ziekte heeft een leidinggevende een belangrijke rol. Ook is er een rol voor kwalitatief goede zorg, hoe lever je dat nou precies? Het coachende karakter kan zelfs met de verantwoordelijkheid voor de resultaten worden geborgd. Het team moet zelf de keuzes maken maar als er geen consensus kan worden gevormd dan moet het team gecoacht worden. Dan is er een leidinggevende die knopen kan doorhakken. Uiteindelijk zou het kunnen dat een leidinggevende niet meer nodig is, omdat teams volledig autonoom kunnen werken en zelf verantwoordelijk zijn voor de resultaten. Maar vooralsnog hebben we niet het idee dat deze functie zal veranderen. Het is een ideale situatie waar we waarschijnlijk nooit terecht zullen komen. Zelfsturing gaat om samenwerking verbeteren en om eigenaarschap binnen TMZ.”

“TMZ heeft een lage overhead door bijvoorbeeld geen budgetten te hanteren. Als regiocoach ben je dan wel verantwoordelijk voor de salarissen maar niet materieel. We hebben niet

zoveel mensen op de financiële administratie die alles op kostenplaats moeten zetten, ze gooien alles in 1 bak."

Kaderbepaling

"Visie vinden mensen lastig omdat ze niet precies weten wat ze moeten doen op basis van die visie. Maar hier is heel bewust voor gekozen om zo de autonomie te borgen. Wel zijn er wel kaders opgesteld waarbinnen men moet opereren. De kaders die TMZ hanteert zijn: Goede kwaliteit van zorg (zorginhoudelijke veiligheid: MIC en risico-inventarisering, kwaliteit van dienstverlening zoals vastgesteld binnen protocollen en procedures, deskundigheid en kwaliteit van zorg en opleiding en scholing), tevreden cliënten en familie/netwerk (samenwerking tussen professionals, vrijwilligers, mantelzorgers en tevreden cliënten), tevreden medewerkers en vrijwilligers (teamgrootte, rollen en aandachtsvelden, leidinggevenden en ondersteuning van de teams) en een financieel gezonde organisatie (formatie, budget, zelf opstellen van vacatures, verzuim, nakoming van zorgafspraken met zorgkantoor en zorgverzekeraar). Deze kaders worden gevoelsmatig niet vaak geraadpleegd, dit was met name in het begin erg van belang omdat mensen toch een soort van houvast nodig hadden/hebben. Er zitten geen harde cijfers bij met harde normeringen wat het makkelijk te interpreteren maakt."

"Er gebeurd ook een hoop zonder dat men weet dat het een kader is. Dit gebeurd op basis van gezond verstand dat iedereen heeft. Daarom hoeft ook niet alles gevat te worden in protocollen en/of kaders. Er zit wel een spanningsveld tussen hoeveel structuur geef je en hoeveel ruimte je geeft. Bij het opstellen van de kaders zijn de zorgverzekeraars en IGZ belangrijke stakeholders. Maar we durven wel zaken ter discussie te stellen. We proberen er op die manier wel invloed op uit te oefenen. Bij het kwaliteitskader zie je ook dat je zicht hebt op de kwaliteit van zorg die je levert zonder dat ze echt harde eisen stellen. Hier zijn we druk mee bezig."

KPI's

"Er is een paar jaar geleden bij de invoering van zelfsturing een dashboard in ontwikkeling geweest. Dit is echter nooit helemaal doorgevoerd, omdat dit ook best wel lastig is. Het lastige is om conclusies te verbinden de cijfers die je ziet. Daarnaast weet je als team al een hele hoop zonder dat je er cijfers bij nodig hebt, zoals bijvoorbeeld de bedbezetting. Maar ook bijvoorbeeld medewerkerstevredenheid. Dat kan met vragenlijsten en een cijfer in een dashboard maar kan ook aan het begin van een teambijeenkomst. Als we kijken naar valincidenten en een team heeft veel incidenten gemeld, doen ze het dan goed of doen ze het dan niet goed? Je zou het niet moeten aanbieden om een normering te behalen maar om het lerend te laten zijn. Dat zou heel mooi zijn en dan zijn er ook wel zaken relevant."

"Medicatiefouten blijven gemaakt worden, je streeft naar 'nul' maar dat haal je niet, je wilt zo min mogelijk fouten maken. Wat je wilt is dat het bespreekbaar wordt gemaakt en dat je het

gesprek aangaat waarom iets gebeurd is en hoe je het in de toekomst kunt voorkomen. Niet alleen: “We moeten er alert zijn op…” Je wilt meer dan dat. Het cijfer geeft dan te weinig informatie. Je moet de informatie aanbieden waarmee je het gesprek aan kunt gaan.”
“Hetgeen we dan nog zouden moeten doen is het leren analyseren van fouten, dit kan niet iedereen. Ze moeten er niet op afgerekend worden, als ze erop afgerekend worden dan zal je zien dat alle cijfers groen zijn, terwijl er misschien wel veel meer aan de hand is.”
“Toch is het stukje monitoring aan de achterkant wel belangrijk. Cijfers kunnen wel helpen maar alleen cijfers is niet genoeg. Bepaalde mate van controle is goed maar aan de andere kant is het belangrijk dat we mensen in beweging brengen. Afdelingshoofden willen ook informatie zien en zien dit ook, bijvoorbeeld salariskosten maar dit is informatie die niets zegt richting de teams, dit is meer stuurinformatie. Teams willen weten, hoeveel uren we kunnen inzetten. Dit is een relevante KPI. We kijken niet naar de formatie op basis van zorgzwaartepakketten. We hebben een gemiddelde berekend en vanuit daar kan je inzetten. Ook kan het interessant zijn om te weten of er op basis van het aantal cliënten in zorg een over-of een onderbezetting is. Wel moet je hierbij heel erg goed borgen dat mensen wel blijven nadenken en blijven denken: welke zorg is er nodig in plaats van allerlei conclusies op te hangen aan een cijfer.”
“Medewerkerstevredenheid kan heel relevant zijn als ondersteuning, anderzijds weet jij in een klein team precies hoe de vlag erbij hangt binnen een team. Het zou kunnen helpen als teams het lastig vinden om het bespreekbaar te maken. Een korte real-time meting zou daarbij goed kunnen helpen. Ziekteverzuim is niet relevant omdat je als klein team weet wat er gebeurd. Clienttevredenheid is interessant en relevant, ook om het gesprek op gang te helpen. Hier wordt ook een real-time meting voor gemaakt. Tegelijkertijd willen we weten hoe de samenwerking wordt ervaren door de belanghebbenden. De inzet van vrijheidsbeperkende maatregelen zou ook een relevante indicator kunnen zijn. Als we verder kijken naar het kwaliteitskader dan zien we daarin geen harde normeringen uitgewerkt.”

Trivium Meulenbelt Zorg | Team

Het interview met het autonome team bij TMZ is afgenomen met Mandy Steggink. Helaas waren er niet meer mensen die konden aansluiten bij dit interview waardoor een focusgroepsgesprek uitbleef.

Rijnlandse manier van organiseren
“Binnen TMZ werken we volgens het coöperatief model. Wat inhoudt dat de mensen op de werkvloer veel input kunnen leveren en dat zij een belangrijke schakel zijn in het besluitvormingsproces. De raad van bestuur loopt ook regelmatig mee met de mensen op de werkvloer. De keuze voor deze manier van werken is gemaakt op basis vanuit de wensen van

de cliënt en die van de medewerkers. Cliënttevredenheid en medewerkerstevredenheid is toegenomen in de loop der tijd sinds de invoering van zelfsturing."
"We merken dat we meer autonomie hebben gekregen. We hebben geen secretaresse meer die de dienstroosters maakt of onze afspraken inplant, deze taken voeren we allemaal zelf uit. Maar ook als het gaat over de coördinatie van zorg dan merken we dat we zelf keuzes mogen maken. De kaders om de autonomie te borgen zijn in de loop der tijd gemaakt en zijn tot uitvoering gebracht, eind 2016. We zijn uitgebreid geschoold, ook om ervoor te zorgen dat iedereen weet waar de verantwoordelijkheden liggen en hoe je de zorg inzet (aan de hand van de uren die je tot je beschikking hebt)."
"We hebben we een afdelingshoofd die niet echt een manager is, maar meer een coachend karakter heeft. Ze is de coach voor het gehele huis. We hoeven geen verantwoording af te leggen aan haar maar we mogen zelf de keuzes maken. Wanneer we daar als team niet uitkomen dan kan het afdelingshoofd bijgeschakeld worden. We merken dat de autonomie best ver gaat. Momenteel staan we financieel iets onder druk, we moeten goed omgaan met de inzet van de uren, ook hierin moeten wij meedenken en zelf keuzes maken. Ik vind die zelfsturing heel prettig, je bent niet alleen werknemer die werkt voor de baas werkt maar je bent zelf vrij om keuzes te maken en daarin kan je je eigen creativiteit ook kwijt."
"Binnen de organisatie zie je per regio verschillen. Bijvoorbeeld regio's met betrokken mantelzorgers. Die zie je meer in een kleine dorpen. We kijken ook naar andere organisaties en zien daarbij dat het nog heel anders gaat, dat zelfsturing niet goed van de grond komt omdat medewerkers te weinig begeleid worden en niet weten wat en hoe ze het werk moeten uitvoeren."

Kader binnen het autonoom werken

"Binnen TMZ werken we met 4 appels, dit zijn onze kaders (in een flyer worden de kaders grafisch weergegeven als appels aan een boom. De kaders die TMZ hanteert zijn: Goede kwaliteit van zorg (zorginhoudelijke veiligheid: MIC en risico-inventarisering, kwaliteit van dienstverlening zoals vastgesteld binnen protocollen en procedures, deskundigheid en kwaliteit van zorg en opleiding en scholing), tevreden cliënten en familie/netwerk (samenwerking tussen professionals, vrijwilligers, mantelzorgers en tevreden cliënten), tevreden medewerkers en vrijwilligers (teamgrootte, rollen en aandachtsvelden, leidinggevenden en ondersteuning van de teams) en een financieel gezonde organisatie (formatie, budget, zelf opstellen van vacatures, verzuim, nakoming van zorgafspraken met zorgkantoor en zorgverzekeraar). Een belangrijk kader is de hoeveelheid FTE dat ingezet mag worden per cliënt in zorg (financieel gedreven kader). MIC-meldingen worden bijgehouden en wordt aangeleverd door het afdelingshoofd (zorg gerelateerd kader). Daarbij komt de vraag naar voren: "Wordt er nou actie ondernomen op de verbeterpunten?" Daarnaast moeten we binnen TMZ ook de nodige scholingen volgen. Dit kan variëren van computerscholingen tot klassikale scholingen (zorg gerelateerd kader).

"Wat we merken is dat de kaders met name van belang zijn voor de medewerkers met een lagere opleiding. Voor hen is sturing benodigd."

KPI's

"We hebben binnen TMZ geen dashboard met KPI's. Ik zou het wellicht wel nuttig vinden om te zien omdat je daarmee gelijk je performance ziet. Ik denk wel dat je erdoor gemotiveerd blijft."

"Ik denk dat wanneer we de zelfredzaamheid van cliënten in kaart brengen dat handig kan zijn om te kunnen zien hoeveel zorg deze cliënt nou nodig heeft. Dit zou een hele mooie indicator zijn. Dan kan je dan zo efficiënt mogelijk omgaan met de inzet van personeel. We doen ook risico-inventarisaties waarin we kijken of er valgevaar is voor bepaalde cliënten en hoe we omgaan met het medicatiegebruik van de cliënt. We kijken daarbij ook of het eetgedrag een stoornis is waardoor de kans op diabetes groter is. Eigenlijk weet je dit al wel per cliënt maar een dashboard kan hierbij wel helpen. Juist om ervoor te zorgen dat je niets vergeet en dat alle aandachtsgebieden met de juiste aandacht worden bekeken. "Wat zijn nou de grootste risicogebieden binnen onze afdeling?" Het kan een soort check zijn om te kijken of je alles goed hebt beoordeeld."

"Clienttevredenheid wordt wel teruggegeven aan de medewerkers maar dan vanuit zorgkaart. Het zou leuk zijn om dit per team te kunnen zien dat geeft reden tot gesprek binnen het team. Medewerkerstevredenheid is ook wel een mooie om dit periodiek te doen. Nu wordt dat vanuit controle gedaan maar eigenlijk wil je dit periodiek doen. Wat je ziet is dat wanneer het vanuit de controle wordt gedaan het op bepaalde momenten wordt gedaan, niet periodiek maar juist met langere tussenpozen, daardoor kunnen mensen heel negatief reageren en komt alle gal er één keer uit."

"MIC-meldingen kunnen ook heel handig zijn, je weet daardoor gericht waar je mee bezig moet. We krijgen deze nu al één keer per kwartaal aangeleverd maar het lijkt me juist interessant om real-time te zien wat er aan de hand is in plaats van per kwartaal."

"Qua personeelssamenstelling zie ik niet zozeer heel veel toegevoegde waarde omdat je binnen het team wel weet wat voor mensen je nodig hebt, ook wat voor persoonlijkheden je nodig hebt binnen het team."

Benchmark tussen teams lijkt me ook heel handig. We kijken nu al wel naar andere teams en hoe zij omgaan met bepaalde zaken bijvoorbeeld met inzet van zorg. Dus we leren nu ook al van elkaar maar een dashboard zou daarin al kunnen helpen en het makkelijker maken."

Ik denk wel dat het goed is om jezelf de vraag te blijven stellen: "Waarom doe je de dingen zoals je ze doet?" Het is goed om kritisch te blijven op het hetgeen je doet. Niet zomaar klakkeloos het protocol volgen maar ook je oogkleppen afzetten en gericht kijken naar de situatie. Uiteindelijk denk ik dan ook dat er sturing nodig is om de kwaliteit van zorg te borgen en ik denk dat een dashboard met faciliterende informatie kan helpen. Hiermee zorg je er ook wel voor dat we gezamenlijk de verantwoordelijkheid dragen zonder dat de conclusies worden

getrokken dat het allemaal bij het management ligt. Wel moeten we uitkijken dat we niet de administratieve last verhogen.”