


## RESEARCH ARTICLE

# To what extent do home care nurses feel free to assess the care that is needed for their patients? A nationwide survey in the Netherlands

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## Abstract

**Background and Aims:** Patients receiving nursing care at home require a needs assessment. There are indications that practice variation exists in needs assessments performed by Dutch home care nurses. One possible cause is that nurses are differentially influenced by others when performing needs assessments. Instruments recommending what is appropriate care have the potential to protect nurses against unwarranted influences. In the Netherlands, a framework exists including general norms about performing needs assessments. We aimed to achieve insight into whether nurses, who have heard of the framework, feel more free to assess the care that is needed for their patients, and whether other actors play a role in performing needs assessments.

**Methods:** An online questionnaire was sent to members of the Dutch Nursing Staff Panel (response 47%;  $n = 302$ ) in November 2019. Only nurses who perform needs assessments were included in the analyses ( $n = 141$ ).  $\chi^2$ -tests were used to assess the relationships between the variables of having heard of the framework, feeling free to assess the care that is needed, and the influences of others.

**Results:** We found no relationships between having heard of the framework and feeling free to assess the care that is needed for patients or reporting influence of others. However, home care nurses who state that they are not influenced by others, feel more free to assess the care that is needed for their patients. In contrast, those who state that they are influenced by informal caregivers, or health care insurers, feel less free to assess the care that is needed.

**Conclusion:** It appears that the framework for performing needs assessments does not, in its current form, protect against influences of others. Further research is recommended to examine what kind of instruments nurses need to perform unambiguous and good needs assessments and, as such, reduce unwarranted practice variation.

## KEYWORDS

health services research, home care services, needs assessment, nurses, nursing assessment, practice guideline, practice patterns nurses'

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## 1 | INTRODUCTION

The balance of long-term care within many European countries is tending to shift toward provision at home. This is not only because patients prefer to receive care at home but also because it is more cost-effective than care in institutions.<sup>1</sup> Home care comprises, among other things, personal and technical nursing care, which can be received for both shorter and longer periods.<sup>2</sup> Patients receiving nursing care at home require an assessment of their needs. The type of professional who performs such assessments differs between countries. For example, in France, a social worker or nurse performs the assessment.<sup>3</sup> However, in Germany, this is performed by the Medical Review Boards, which are operated jointly by sickness funds and long-term care funds.<sup>4</sup> In the United Kingdom, local authorities play a role in assessing the needs of patients.<sup>3,5</sup> In the Netherlands, the focus of this study, a long-term care reform, took place in 2015. Since the reform, needs assessments are performed by home care nurses, whereas before 2015, this was carried out by a central assessment agency at the national level (see Table 1 for more information about the Dutch situation).<sup>6</sup> Home care nurses determine which care is necessary for patients, based on their care needs, personal situation, and social context.

There are indications that variation exists in the needs assessments performed by Dutch home care nurses.<sup>11</sup> This means that patients with similar care needs, personal situation, and social context, do not receive the same care. Practice variation in the assessment and provision of home care is not only observed in the Netherlands, but also in, for instance, the United States.<sup>12,13</sup> In England, attention has been paid to the different ways of classifying and exploring needs assessments and the challenges they pose.<sup>14</sup>

Based on the definition of Wennberg,<sup>15</sup> we consider variation in needs assessments as warranted, if the variation can be explained by the patient's care needs, personal situation, and social context. In all other situations, variation can be labeled as unwarranted. The underlying causes of variation in needs assessments by home care nurses are not known at the moment.<sup>11</sup> Insight into these causes is necessary as it gives perspectives on how to improve needs assessments. Our starting point in getting insight in these causes is a theoretical model explaining practice variation, based on our previous research.<sup>16,17</sup> This model distinguishes three levels, that is, micro, meso, and macro, at which variation may be found and were explanations for the occurrence of variation have to be sought (see Figure 1). Based on this model, we reason that practice variation among home care nurses in needs assessment can have different causes at different levels. These include on the side of the professional system the level of the individual nurses, the team of the nurses, the organization the nurses work for, and the payers of home care, which, in the Netherlands, are the health care insurers. On the side of the care receivers, it includes the level of the patients and of the social network of the patients, that is, informal carers.<sup>11</sup>

In line with this model, one possible cause of this variation is that individual nurses are influenced by other actors when performing needs assessments. In general, the influences of others can result in both unwarranted and warranted variation and can occur at all three

**TABLE 1** Description of home care nursing in the Netherlands and the six general norms included in the framework for performing needs assessments

### Home care nursing in the Netherlands

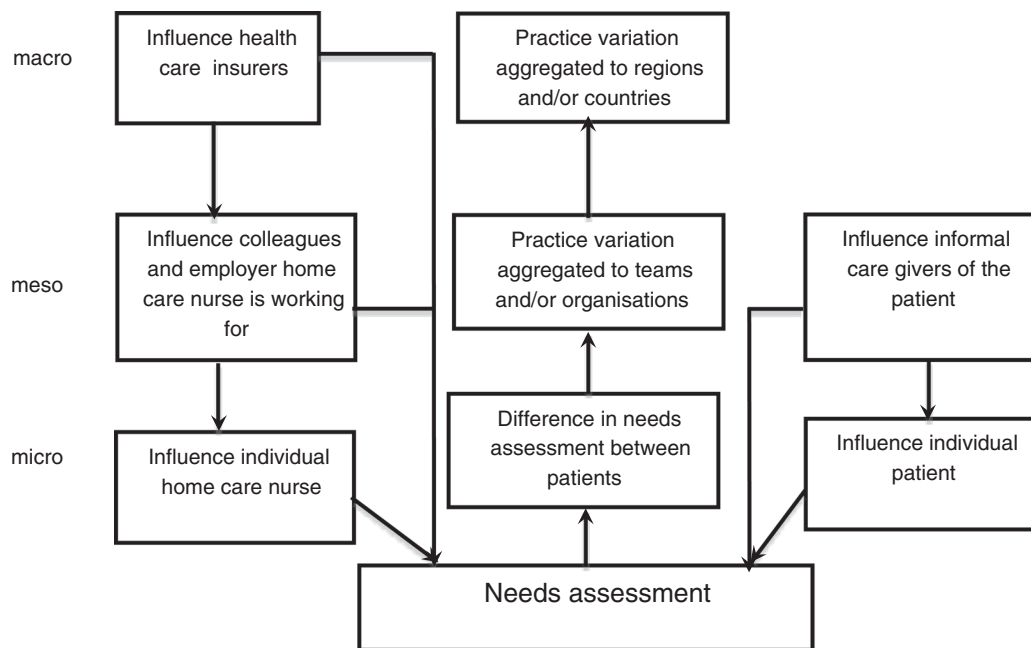
A reform of long-term care took place in the Netherlands in 2015.<sup>6</sup> Since this reform, home care has been part of the basic benefits package of obligatory health insurance. There are no out-of-pocket payments for home care.<sup>7</sup> In 2018, about 589 000 people, mainly elderly, received home care in the Netherlands.<sup>8</sup>

Before the reform, needs assessments were performed by various professionals, not necessarily nurses, at a national level by the Care Assessment Agency (in Dutch: Centrum Indicatiestelling Zorg). Since the reform, however, the authority to make assessments has returned to home care nurses. In principle, only home care nurses with a bachelor's degree have the legal authority to perform needs assessments.<sup>9</sup> Due to a shortage of nurses with a bachelor's degree, however, an agreement had been drawn up in 2014 and was extended in 2017.<sup>10</sup> This states that nurses with a secondary vocational education are also allowed to perform needs assessments if they meet the following conditions: 1) the home care nurse is an expert within home care, that is if he or she has five years' experience of working in home care; 2) if he or she works for a minimum of 24 hours a week in home care, and 3) if he or she is currently following a bachelor's programme in nursing.<sup>10</sup> After performing needs assessments home care nurses complete a care plan and organize the care that is needed for their patients. Health insurers might later check the needs assessments based on inspection of randomly selected cases.

### The six general norms included in the framework for performing needs assessments

The framework includes the following six general norms: (1) needs assessments are based on professional autonomy; (2) needs assessments are performed by nurses with a bachelor's or master's degree; (3) needs assessments are aimed at strengthening the self-reliance of patients and their informal caregivers; (4) decision-making during needs assessments is based on the nursing process (ie, assessment, nursing diagnoses, planning, implementation, and evaluation); (5) the documentation of needs assessments follows the Dutch guideline on nursing documentation; and (6) handovers in home care follow nationwide standards.<sup>9</sup>

levels. For instance, nurses may be influenced by patients (micro level Figure 1) and their social context (meso level Figure 1), such as the availability of informal caregivers. These influences should not be seen as resulting in unwarranted variation as the personal situation and social context of a patient have to be taken into account when performing needs assessments. For example, it can be reasoned that less care will be needed when patients have an informal caregiver who can support them in their care needs. What patients can do themselves and what can be done by their informal caregivers are expected to be essential parts of the assessment.<sup>9</sup> On the other hand, when an informal caregiver demands for something (eg, more hours of care) that is against the professional judgment of the home care nurse, then this is unwarranted. Home care nurses can also be influenced, both warranted and unwarranted, by colleagues in their team (meso level Figure 1). Nurses can adapt to the tacit norms of the team and thus demonstrate the same actions as colleagues.<sup>18</sup> These tacit norms may reflect the professional norms, but they may also be more focused on,



**FIGURE 1** Theoretical model explaining practice variation in needs assessment by home care nurses: influences of different actors in the study (based on<sup>16,17</sup>)

for example, reducing the team's workload. The home care organizations (meso level Figure 1) in which nurses work may have an interest in the type and amount of care that has to be provided according to the needs assessment. This interest may, for example, be related to the availability of staff. The health care insurers (macro level Figure 1) may have an interest in the costs of home care and may make that interest felt directly or indirectly via the nurses employers.

Guidelines and protocols are institutional mechanisms that have the potential to protect home care nurses who perform needs assessments against unwarranted influences. Such instruments give recommendations about appropriate care. As a result, they are expected to reduce variation, as care providers are expected to practice in an increasingly predictable manner.<sup>19-21</sup> However, there are no specific guidelines within the Netherlands for performing needs assessments. In 2014, the Dutch Nurses Association developed a framework including six general norms (see Table 1 for the norms) to adhere to when performing needs assessments and when organizing nursing care at patients' homes.<sup>9</sup> This framework served as guidance for home care nurses who started performing the needs assessments in 2015. It is, however, not an instrument that home care nurses can use in daily practice when performing needs assessments at home. It can be reasoned that this framework should be able to reduce the unwarranted influence of others on the assessment. For example, the first norm states that home care nurses assess and organize care based on professional autonomy (ie, professional competences and decision-making<sup>22</sup>). This implies that they solely perform needs assessments based on the care needs, the personal situation, and the social context of their patients. A precondition for the framework to work as a protection against unwarranted influences is that nurses have heard of it and use the framework in a similar way.

This study, therefore, aims to answer the following questions: "Do nurses, who have heard of the framework, feel more free to assess the care that is needed for their patients? And, to what extent do other actors play a role in performing needs assessments?" Achieving an answer to these questions offers an initial insight into the role that a framework, such as the Dutch framework for performing needs assessments, can play in protecting against unwarranted influences from others when performing needs assessments, and, thus, reduce unwarranted practice variation. This is not only relevant for the Dutch situation but also for other countries where needs assessments for home care are performed by professionals, such as nurses. A high quality of care depends upon an unambiguous and good needs assessment.

## 2 | METHODS

### 2.1 | Setting

This study has a cross-sectional survey design. We performed a secondary analysis using data collected from the Dutch Nursing Staff Panel of Nivel (the Netherlands Institute for Health Services Research). This panel investigates opinions and experiences of nursing staff concerning their daily working practice. Panel members all provide direct nursing care to patients in various healthcare settings, including home care. They are recruited via two pension funds by random sampling nursing staff employed in the healthcare sector. Participation is voluntary and anonymous. Both registered nurses (RNs) and certified nursing assistants (CNAs) participate. In the Netherlands, RNs are educated to two levels, namely to the secondary

vocational level (a nursing qualification after completing secondary vocational education) and to the bachelor's degree level (a degree in nursing after education at a university of applied sciences). In principle, only home care nurses with a bachelor's degree perform needs assessments, as they have the legal authority to do this<sup>9</sup> (see Table 1).

This study was conducted in accordance with the General Data Protection Regulation, and, as such, strictly safeguarded the anonymity of the participants. Panel members were free to answer the questions or not and gave their informed consent when becoming a panel member. Further ethical approval of this study was not required under the applicable Dutch legislation (<https://english.ccmo.nl/investigators/legal-framework-for-medical-scientific-research/your-research-is-it-subject-to-the-wmo-or-not>).

## 2.2 | Questionnaire

In November 2019, an online questionnaire was sent to a sample of 638 members of the Dutch Nursing Staff Panel, all working in home care. The questionnaire was focused on the quality of home care and included, among others, questions about performing needs assessments. Most questions had prestructured response options. Two electronic reminders were sent to panel members who had not yet responded. The closing date was four weeks after the questionnaire was first sent out. The questionnaire was returned by 302 panel members (response rate 47%). For the purpose of this study, we only included nurses in the analyses who indicated that they perform needs assessments (N = 141).

## 2.3 | Measurements

To gain insight into whether nurses have heard of the framework when performing needs assessments, we asked: "Have you heard of the 'framework needs assessment' of the Dutch Nurses Association (in Dutch: *Verpleegkundigen & Verzorgenden Nederland*)?" Here we used fixed answer options (1 = yes, and 2 = no).

The extent to which nurses who perform needs assessments feel free to assess the care that is needed was measured with the following question: "Do you feel free to assess the care that, in your opinion, is required for patients?" The question could be answered using the following options: 1) totally not, 2) to some degree, 3) reasonably, 4) highly, and 5) completely. The answer options were recoded into two categories: "feeling completely free" (coded as 1, including the answer option "completely") and "not feeling completely free" (coded as 2, including the answer options "totally not," "to some degree," "reasonably," and "highly").

Whether nurses feel influenced by others when performing needs assessments was measured by the following question: "Do you notice that you are sometimes influenced by others while performing needs assessments?" The answer options were: 1) No; 2) Yes, by patients; 3) Yes, by informal caregivers; 4) Yes, by colleagues within my team; 5) Yes, by my employer; 6) Yes, by health care insurers; and 7) Yes, by

others, namely... For this question, multiple answers were possible; however, the option "No" could not be filled out with the other options.

Three socio-demographic characteristics were available. Those were age (continuous), gender (1 = man, 2 = woman), and educational level (1 = certified nursing assistant, 2 = registered nurse at secondary vocational level, and 3 = registered nurse with a bachelor's degree).

## 2.4 | Statistical analyses

Firstly, descriptive statistics were performed to gain insight into the data. Secondly, relationships between the variables of having heard of the framework, feeling free to assess the care that is needed, and the influences of others, were examined using  $\chi^2$ -tests. More specifically, we tested the relationships between: 1) having heard of the framework and feeling free to assess the care that is needed; 2) having heard of the framework and the influences of others; and 3) the influences of others and feeling free to assess the care this is needed. The level of statistical significance for the  $\chi^2$ -tests was carried at 0.05. All analyses were performed using Stata, version 15.0.

**TABLE 2** Descriptive statistics of the respondents (n = 141)

		n	% or mean (SD)
Age		141	49,1 (11,6) (24-66 y)
Gender	Male	7	5%
	Female	134	95%
Educational level	Certified nursing assistant	5	4%
	Secondary vocational education	22	16%
	Bachelor's degree	114	81%
Having heard of the framework	Yes	111	79%
	No	30	21%
Feeling completely free to assess the care that is needed	Yes	67	48%
	No	74	52%
Influenced by others while performing needs assessments <sup>a</sup>	No	30	21%
	Yes, by patients	40	28%
	Yes, by informal caregivers	62	44%
	Yes, by colleagues within my team	61	43%
	Yes, by my employer	21	15%
	Yes, by health care insurers	49	35%
	Yes, by others	10	7%

<sup>a</sup>For this question multiple answers were possible, however, the option "No" could not be filled out with the other options.

### 3 | RESULTS

Ninety-five percent of the 141 nurses who indicated that they perform needs assessments were female (see Table 2). The mean age of the nurses was 49.1 years (range 24-66 years). The majority of the nurses (81%,  $n = 114$ ) had a bachelor's degree. 16% ( $n = 22$ ) completed a secondary vocational education, and a few ( $n = 5$ ) indicated that they are certified nursing assistants. In principle, nurses that completed a secondary vocational education and certified nursing assistants are not allowed to perform needs assessments (see Table 1). However, due to shortage of personnel, in practice, they appear to perform assessments.

Table 2 shows that almost eight out of ten (79%,  $n = 111$ ) nurses indicated that they have heard of the framework. Approximately, half of the nurses (48%,  $n = 67$ ) indicated that they felt completely free to assess the care that is needed for their patients. Less than half of the

nurses indicated that they are influenced by informal care givers (44%,  $n = 62$ ) or colleagues (43%,  $n = 61$ ), followed by health care insurers (35%,  $n = 49$ ). A few nurses ( $n = 10$ ) mentioned that they were influenced by others. Examples of answers mentioned here were "the law," or "the general practitioner." Two out of ten (21%,  $n = 30$ ) nurses stated that they are not influenced by others when performing needs assessments (see Table 1).

#### 3.1 | Relationships between having heard of the framework, feeling free to assess the care that is needed, and being influenced by others

No significant relationship was found between having heard of the framework and feeling completely free to assess the care that is

**TABLE 3** The relationship between having heard of the framework and feeling free to assess the care that is needed for patients ( $n = 141$ )

	Having heard of the framework	Not having heard of the framework	Total	P-value
Feeling completely free to assess the care that is needed for patients	48% ( $n = 53$ )	47% ( $n = 14$ )	48% ( $n = 67$ )	0.916
Not feeling completely free to assess the care that is needed for patients	52% ( $n = 58$ )	53% ( $n = 16$ )	52% ( $n = 74$ )	

**TABLE 4** The relationship between having heard of the framework and being influenced by others ( $n = 141$ )

Influenced by...	Having heard of the framework	Not having heard of the framework	Total	P-value
nobody	22% ( $n = 24$ )	20% ( $n = 6$ )	21% ( $n = 30$ )	0.847
patients	32% ( $n = 35$ )	17% ( $n = 5$ )	28% ( $n = 40$ )	0.109
informal caregivers	47% ( $n = 52$ )	33% ( $n = 10$ )	44% ( $n = 62$ )	0.186
colleagues	41% ( $n = 46$ )	50% ( $n = 15$ )	43% ( $n = 61$ )	0.401
my employer	16% ( $n = 18$ )	10% ( $n = 3$ )	15% ( $n = 21$ )	0.396
health care insurers	37% ( $n = 41$ )	27% ( $n = 8$ )	35% ( $n = 49$ )	0.295

**TABLE 5** The relationship between being influenced by others and feeling free to assess the care that is needed for patients ( $n = 141$ )

Influenced by...	Feeling completely free to assess the care that is needed for patients		Not feeling completely free to assess the care that is needed for patients		P-value
	no	yes	no	yes	
nobody	no	42% ( $n = 47$ )	no	58% ( $n = 64$ )	<b>0.018</b>
	yes	67% ( $n = 20$ )	yes	33% ( $n = 10$ )	
patient	no	51% ( $n = 51$ )	no	50% ( $n = 50$ )	0.261
	yes	40% ( $n = 16$ )	yes	60% ( $n = 24$ )	
informal caregivers	no	56% ( $n = 44$ )	no	44% ( $n = 35$ )	<b>0.028</b>
	yes	37% ( $n = 23$ )	yes	63% ( $n = 39$ )	
colleagues	no	48% ( $n = 38$ )	no	53% ( $n = 42$ )	0.996
	yes	48% ( $n = 29$ )	yes	52% ( $n = 32$ )	
my employer	no	49% ( $n = 59$ )	no	51% ( $n = 61$ )	0.349
	yes	38% ( $n = 8$ )	yes	62% ( $n = 13$ )	
health care insurers	no	55% ( $n = 51$ )	no	45% ( $n = 41$ )	<b>0.010</b>
	yes	33% ( $n = 16$ )	yes	67% ( $n = 33$ )	
Total		48% ( $n = 67$ )		52% ( $n = 74$ )	na

Note: Bold means a  $p$ -value  $< 0.05$ .

needed for patients ( $P = 0.916$ ) (see Table 3). Both among nurses who have heard of the framework, and among nurses who are not, approximately half of the nurses indicated that they felt completely free to assess the care that is needed for patients. In addition, no significant relationship was found between having heard of the framework and being influenced by others when performing needs assessments. Nurses who had heard of the framework did not indicate more often that they are not influenced compared to nurses that were not ( $P = 0.847$ ) (see Table 4).

Table 5 shows that nurses who stated that they are *not* influenced by others when performing needs assessments felt more free to assess the care that is needed for their patients ( $P = 0.018$ ). Among these nurses, 67% stated that they felt completely free to indicate the care that is needed for their patients. Alternatively, nurses who stated that they were influenced by informal caregivers or health care insurers felt less free to assess the care that is needed for their patients ( $P = 0.028$  and  $P = 0.010$ , respectively) (see Table 5). Among nurses who indicated that they are influenced by informal caregivers, 63% did not feel completely free to assess the care that is needed for their patients. By comparison of the nurses who stated that they were not being influenced by informal care givers, 44% did not feel completely free. Furthermore, two-thirds (67%) of the nurses who stated to be influenced by health care insurers did not feel completely free to assess the care that is needed for their patients. This figure is 45% among nurses who indicated that they were not being influenced by health care insurers (see Table 5).

## 4 | DISCUSSION

Our results showed no relationship between having heard of the framework and feeling more free to assess the care that is needed for patients. Neither was there any relationship observed between having heard of the framework and home care nurses indicating that they were influenced by others. We found, however, that home care nurses who stated that they were not influenced by others felt more free to assess the care that is needed for their patients. In contrast, home care nurses who stated that they were influenced by informal caregivers or health care insurers felt less free to assess the care that is needed.

The Dutch framework was introduced as a guidance for home care nurses when they started performing needs assessments following a long-term care reform in 2015. Although the framework includes six general norms relating to performing needs assessments, it is not an instrument that home care nurses can use in daily practice when performing such needs assessments at patient's homes. This might explain why we did not find a relationship between having heard of the framework on the one hand, and both feeling free to assess the care that is needed, and being influenced by others, on the other. Recently, the Dutch Nurses Association published the documents, "A Conceptual Framework for Performing Needs Assessments" (In Dutch: Begrippenkader Indicatieproces) and "A Toolbox for Performing Needs Assessments"

(In Dutch: Toolbox Indicatiestelling). The first document gives a further explanation of the six norms, whereas the second consists of tools for supporting decision-making when assessing the care needs of patients.<sup>23,24</sup> In future research, it is recommended examining whether these documents contribute to feeling free to assess the care that is needed for patients, and whether their use is related to practice variation in needs assessments.

The underlying idea of a framework is that it works as a protection against unwarranted influences of other actors when performing needs assessments. As such, it is an example of a mechanism, which relates to professional norms. In this case, professional norms were developed at the macro level by the professional organization and may exert their influence at the meso level through reinforcement and support of norms by the work organization and team, and at the micro level through the actual use of the framework by home care nurses. The first norm states that nurses perform needs assessments based on their professional autonomy.<sup>9</sup> If home care nurses do, indeed, assess and organize care based on professional autonomy, then they are not expected to be influenced by others but to perform assessments solely on the needs, the personal situation, and the social context, of their patients. If this, in theory, is the case, then all the practice variation observed is warranted. However, our results show that some nurses are influenced by others when performing needs assessments. Further research has to examine in which way and to what extent they are influenced, and subsequently, the implications of this for practice variation in needs assessments. When nurses state to be influenced by others, this coincides with a higher percentage who state that they do not feel completely free to assess the care that is needed. The exception to this is feeling influenced by colleagues, which does not relate to the feeling of freedom to assess what is needed. However, we did find two significant associations.

Firstly, nurses who stated to be influenced by informal caregivers felt less free to assess the care that is needed for their patients. The fact that informal caregivers appear to play a role in the needs assessment is in line with earlier qualitative research. For example, Fraser et al<sup>25</sup> found that family-related factors (eg, family support) play an important role in resource allocation decisions. While Moshabela et al<sup>26</sup> observed that the provision of care by community care workers depends, among others, on the social support network of patients. The question is whether such influences are warranted or not. A needs assessment has to be based on the care needs, personal situation, and social context of the patients, and, furthermore, it is aimed at strengthening the self-reliance and independence of both the patients and their social context.<sup>9</sup> Informal caregivers might have valuable information on the patient's situation and, as such, contribute to an assessment that takes the care needs, personal situation, and social context into account. On the other hand, the influences of informal caregivers might be unwarranted if they, for example, explicitly ask for more care than is needed according to the home care nurse. As such, the preferences and endowments (such as education or income) of both patients and their social context as well as the interaction between patients, their social context, and home care nurses are

expected to be important mechanisms in explaining variation in needs assessment.

The second significant difference was found in the perceived influence of health care insurers. Home care nurses who perceived that they were influenced by health care insurers more often stated that they do not feel free to assess the care that is needed. The structure of the care system—that is the relationships between parts of the system (in this case, the relationship between insurance organizations and home care providers)—may explain this result. In particular, in the first years immediately following the long-term care reform, insurers may have been uncertain about the amount of home care they should contract for and could have tended to act on the “safe side.” This may have been the case because they found themselves in a situation where the true need for home care was unknown, and there was no established tradition of trust in the professional autonomy of home care nurses. Thus, both health care insurers and home care nurses may have an interest in a transparent set of norms for the needs assessment process. The insurer in order to have an idea about whether the care that is actually assessed comes closer to true but unknown need. And the home care nurses to protect their professional autonomy against unwarranted influences.

Lastly, several certified nursing assistants ( $n = 5$ ) or nurses with a secondary vocational education ( $n = 22$ ) indicated that they perform assessments. A reason that they performed needs assessment might be the shortage of nurses with a bachelor's degree. Due to this shortage, there is currently an arrangement that nurses with a secondary vocational education who meet the conditions mentioned in Table 1 are also allowed to perform assessments.<sup>10</sup> Based on our data, we cannot conclude whether our respondents with a secondary vocational education meet these conditions. We know only that 67% of these staff work at least the minimum of 24 hours a week (ie, norm 2) (data not shown).

#### 4.1 | Strengths and weaknesses

The strengths of this study are the response rate of approximately 50%, and that the survey was conducted among a representative panel of nurses in the Netherlands. Nevertheless, the respondents are slightly older (mean age 49,1 years) compared to all nurses working in the Dutch home care setting (mean age 44,7 years in 2017).<sup>27</sup> A limitation might be that we did not use a validated questionnaire as none was available on this topic. The questions were developed for other purposes by one of the authors who is also working as a home care nurse (KdG). This was, however, developed in consultation with several other experts in the field of home care. Another limitation is that we measured all the variables at one point in time. Our data therefore do not give insight into the question of causality. Lastly, our study examined only one possible cause of practice variation in needs assessments. Further research is recommended to examine other possible causes. Despite these limitations, we believe our study contributes to the knowledge of an area of research and nursing practice that is rarely studied.

## 5 | CONCLUSIONS

Our results did not show a relationship between having heard of a framework including general norms for performing needs assessments and feeling free to assess the care that is needed for patients. We observed, however, that nurses who stated to be influenced by informal caregivers or health insurers felt less free to assess the care that is needed for their patients. Based on our results, it appears that the Dutch framework, including its six general norms for performing needs assessments, does not, in its current form, protect against the influences of others. As such, nurses might not feel free to assess the care that is needed for patients. Further research is recommended to examine what kind of instruments home care nurses need to perform unambiguous and good needs assessments and, therefore, reduce unwarranted practice variation. This study is not only relevant for the Dutch situation but also for other countries where needs assessments for home care are performed by professionals, such as nurses, as a high quality of care depends on unambiguous and good needs assessments.

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### CONFLICT OF INTEREST

The authors declare that they have no conflict of interest.

### AUTHOR CONTRIBUTIONS

Conceptualization: Anne Brabers, Kim de Groot, Peter Groenewegen, and Judith de Jong.

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Anne Brabers confirms that she had full access to all of the data in the study and takes complete responsibility for the integrity of the data and the accuracy of the data analysis.


### TRANSPARENCY STATEMENT

Anne Brabers declares that the manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

## DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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