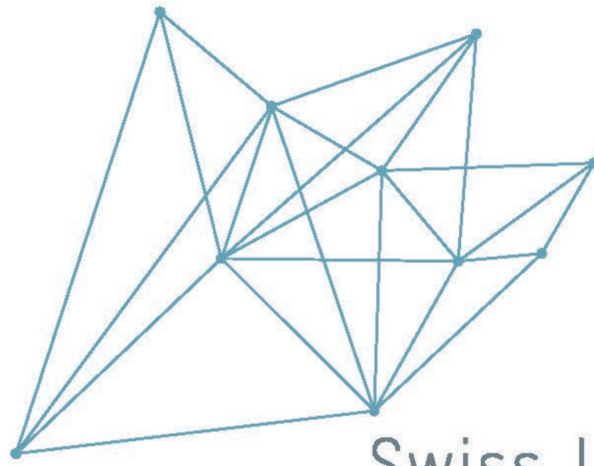

Striving to Improve Working Conditions in Swiss Nursing Homes

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Policy Brief #19

Keywords

Long-term care, nursing home, staff shortage, care worker, working conditions, supportive leadership, organizational autonomy, documentation burden, digitalization.

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Table of Contents

Key Messages 4

Background and Context 5

Current Movements to Improve Working Conditions of Caregivers in Switzerland 6

The Issue 7

Recommendations for action 8

Implementation Considerations 14

Policy Briefs and Stakeholder Dialogues of the Swiss Learning Health System 15

Acknowledgements 15

References 16

Key Messages

- There is increasing demand for care in Swiss nursing homes and a shortage of staff, thereby putting pressure on the ability to deliver high quality of care.
- High turnover further increases the stress on care workers[1] in nursing homes and creates a situation where workers become absent, quit the nursing homes or leave the sector all together.
- Despite various initiatives and strategies to improve the recruitment and retention of caregivers across the health sector, the desired results have not yet been attained.
- Future interventions aiming to improve working conditions and reduce turnover in Swiss nursing homes can draw on several recommendations:
    - Provide a culture of leadership that is both receptive and supportive of frontline workers in day-to-day operations.
    - Co-design the organization of care and work in the nursing homes through organizational autonomy.
    - Decrease documentation burden with digital platforms that are tailored to the needs of caregivers and residents.

[1] The terms *care worker* and *caregiver* are used interchangeably. The terms refer to front line care workers who are in direct contact with residents on a regular basis. This includes but is not limited to nurses, care assistants and other intermediate care personnel.

Background and Context

As the Swiss population ages and chronic conditions become more prevalent, the demand for long-term care[2] (LTC) is rising [1]. This increase in demand is putting pressure on the LTC workforce. Nursing homes are experiencing these changes firsthand, as although the global number of residents is decreasing, the average care level of residents is increasing [2]. Indeed, people are staying at home longer and therefore entering nursing homes at older ages with more complex ailments. Reflecting this reality, a higher proportion of the LTC workforce works in nursing homes despite more people receiving LTC services at home. In 2021, care workers in institutions composed 61% (n = 83'342) of the formal LTC workforce in Switzerland, with the rest being mostly carers at home [3]. Caregivers working in Swiss nursing homes consist of approximately 25% registered nurses with tertiary education, and intermediate caregivers and nursing assistants for the remaining 75% [4].

Care workers in Swiss nursing homes have expressed dissatisfaction with their working environment due to below-standard working conditions [5]. The caregiving profession inherently carries a significant emotional and physical burden [6]. Moreover, the financing and inflexible planning of care services often fail to accommodate the fluctuating needs of nursing home residents [7]. The provision of care in nursing homes risks becoming overly focused on meeting predefined criteria, disregarding the varying daily needs of residents. Additionally, these criteria overlook the relational needs of residents, for whom the nursing home serves as their primary residence and care professionals as their main source of social interaction and support [7]. Furthermore, the extensive documentation required to adhere to these output-driven standards adds to the stress of caregivers and detracts from their capacity to provide relational care. Consequently, caregivers often work over hours to ensure all tasks are done to the expected quality to ensure financial compensation by health insurances. These conditions have resulted in high staff turnover rates and even a high attrition rate of LTC professionals leaving the field [8].

Unsurprisingly, the quality of working conditions for care workers has been associated with the quality of care that is provided [9]. When workers are satisfied and less physically and emotionally strained, the ability to provide quality care is also higher. Therefore, improving the working conditions do not only serve to satisfy the increasing demand for nursing home care workers, but also to improve the quality of services and provision of care. Recent work from the Swiss Learning Health System has identified staff satisfaction and availabilities as crucial elements of quality in LTC [10].

Working conditions and workforce satisfaction also affect the costs of LTC. Nursing homes are expensive: 20.2% of healthcare expenditure went towards LTC in 2022, and more specifically,

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[2] *World Health Organization definition of long-term care*: LTC includes a broad range of personal, social, and medical services and support that ensure people with, or at risk of, a significant loss of intrinsic capacity (due to mental or physical illness and disability) can maintain a level of functional ability consistent with their basic rights and human dignity. LTC is provided over extended periods of time by family members, friends or other community members (also called informal caregivers) or by care professionals (also called formal caregivers). Formal LTC aims to prevent, reduce, or rehabilitate functional decline and it can be provided in different settings, such as home care, community-based care, residential care, or hospital care.

12.3% of healthcare expenditure was generated within nursing homes [3]. It has been assumed and shown in the past that for nursing homes, high turnover rates are associated with increased human resource and administrative costs as well as lost knowledge of workflows, patients, and team-cohesion [11]. However, one study has also shown that keeping turnover rates high may have a cost-saving effect for nursing homes, by keeping staff costs low and hiring lower skilled staff [12]. This could be one reason for which high turnover rates have persisted for so long. Nevertheless, as mentioned previously, with high turnover rates the burden on the staff increases and the work environment becomes less attractive. In fact, staffing instability contributes to higher rates of emergency department visits, worsening mobility among residents and increased support required with activities of daily living, thus associated with higher expenditure [13]. Improving working conditions is of interest not only for the benefit of caregivers and patients, but also for the economic sustainability of health care systems.

Current Movements to Improve Working Conditions of Caregivers in Switzerland

The Swiss population has acknowledged the general urgency of the situation by accepting the Nursing Care Initiative in November 2021. This initiative aims to recognize the importance of nursing care and support nurses accordingly, by improving their working conditions, developing continuing education opportunities, and raising wages [14]. The main subjects of this initiative are nurses, somewhat sidelining other professionals involved in nursing homes and LTC more generally, such as care assistants and other intermediate care personnel. However, recent data suggests that the levels of turnover intention, job satisfaction and burnout are just as worrisome for these critical but sometimes less visible health professions[3].

Furthermore, the implementation of this initiative has not yet touched upon improving working conditions in other innovative ways such as fostering autonomy in the care workforce or transformative leadership styles. Providing a greater degree of autonomy leads to higher job satisfaction [15], particularly in the form of organizational autonomy [16]. This autonomy aspect is highlighted by the SBK/ASI, which considers it as the number one objective in its vision for the next years: "Pflege 2030" [17]. While these movements target nurses specifically, this evidence brief's aim, which is presented below, concerns all caregivers working in Swiss nursing homes.

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[3] Results from the Swiss Cohort of Healthcare Professionals and Informal Caregivers (SCOHPICA) indicate that intermediate care personnel have the lowest intent to stay in the profession, and nursing professions in general still report the least resources available to do their job among all healthcare professions. Moreover, professionals in nursing homes report significantly lower intent to stay in their profession and in the health domain compared to other work contexts (hospitals or practices for instance). More results available on www.scohpica.ch.

The Issue

- There is a vicious cycle of poor working conditions in nursing homes due to over-burdened staff, causing dissatisfaction and high turnover rates among care professionals. These factors then lead to staff shortages, which further deteriorates the working conditions and threatens the quality of care that is being provided.
- Important issues leading to dissatisfaction have been identified as excess overtime due to staff shortages, lack of time for relational care and documentation burden.
- At the same time that employee turnover and dissatisfaction are increasing, the need for LTC is growing. People are staying at home longer, meaning that the care level and complexity of residents entering nursing homes is intensifying.
- This critical situation has been recognized and vital initiatives are underway to improve recruitment and retention of caregivers in Switzerland. However, operational changes encompassing all care workers are still needed to rectify the situation and improve the working conditions in Swiss nursing homes.

This Evidence Brief aims at providing recommendations to improve working conditions of caregivers in Swiss nursing homes by considering examples of good practice together with findings from our own research, which is based on national qualitative and quantitative data as well as reports from relevant organizations and the international literature. We hope that these recommendations will inspire concrete action plans to increase retention rates and protect the quality of care that is being provided in nursing homes across Switzerland.

We acknowledge that the issue does not stop at care workers in nursing homes, and other professions such as social workers or home care workers are also at risk. However, their work organization and working experiences are different to a degree, so we opted to restrict the scope to stay as consistent as possible. The expectation is that improvements in working conditions may have a cross-cutting effect, whereby advancements in one area serve as inspiration for corresponding changes in other contexts.

Recommendations for action

1. **Develop supportive leadership, including effective communication and enhanced recognition.**
   Nursing home leaders at the forefront actively encourage and sustain direct communication with frontline care workers, continuously assess their needs, and provide support to ensure the accomplishment of organizational objectives in their day-to-day activities [18, 19, 20].

Leadership is a mindset and set of actions that lead to the accomplishment of a collective goal [21, 22]. In this instance, we refer to official leadership positions such as nursing home management as well as head nurses or ward management, although other persons within nursing homes may show leadership. These are leadership positions that influence the goals that are set, and the outcomes reached by all those working in the teams under their respective leadership. The mindset and actions taken by persons within these leadership positions may have either a positive or negative effect on the goals and outcomes reached. The following leadership behaviors have been associated with the positive outcomes that we aim to reach in nursing homes, including retaining workforce as well as improving the health outcomes of both the nursing home residents and the workforce:

a. Support and Recognition

Giving care workers praise and recognition when a job is well done is a sign of a supportive work environment and positive leadership. Receiving recognition has been associated with improved coping of stress when workloads exceed normal levels as well as better mental health outcomes for the care workforce [6]. It has also been indirectly associated with reduced rationing of care, meaning that when recognition is given, caregivers are less likely to withhold care measures when resources are limited [23]. When care is rationed due to the feeling of high workloads and limited resources, necessary care measures are cut and therefore nursing home residents may face negative outcomes such as falls or infections [24]. Leadership showing support for their teams has similar outcomes as providing recognition [6, 25-29]. Support may be shown from leadership by showing understanding for the challenges being faced [27]. This is especially important when workloads increase, and resources and staffing become tight [26].

b. Clear Communication of Goals

Communicating goals and values of the team and organization is important for not only individuals' job satisfaction, affective organizational commitment (employees' emotional attachment to, identification with, and involvement in the organization [31]) and performance, but also interprofessional communication and patient care [26, 32]. When collective goals are clear, teams may better work together and care for patients and thus also feel more satisfied [32, 33]. This was even associated with feelings of more closeness with patients [34].

c. Collaboration

Goals must be clearly communicated from leadership; however, the decision-making process should be collaborative. Multidisciplinary meetings should be held so that communication is multidirectional and that everyone has the feeling of being connected and involved [30, 35].

Collaboration between employees and leadership and the feeling of being involved in decision-making is an important predictor of affective organizational commitment [26]. Leadership that fosters collaboration shows commitment to their employees, thus fostering a supportive work environment associated with positive outcomes [36, 37].

d. Treating Mistakes as Learning Opportunities

Mistakes are common, especially when the workload is high, and resources are limited [38]. Leadership that treats mistakes as learning opportunities rather than criticism have staff that are more committed and healthier [26].

e. Tailored Education Opportunities

Leadership may also create a supportive environment by providing opportunities for their employees to follow ongoing and tailored educational opportunities. This is an important step to ensure the workforce feels supported and ensuring the workforce is effectively fulfilling the needs of the residents [30]. Training should target both workforce and patient health and safety, including mental health, behavior management and support, and medications [30].

Case Example

At Lindenhof Oftringen, they strive to increase staff satisfaction by adapting leadership style and rearranging internal structures. They view their success through adopting three pillars for a good workplace environment:

i. Support: proactive on sick incidents, monthly HR meetings, strong orientation training, always solution oriented rather than critique oriented.
ii. Collaboration and a good team environment: open feedback system (continuous improvements), “open door” policy and clear contact people established for feedback.
iii. Lifelong learning / professional development [39].

2. Increase autonomy and influence of nursing home staff on work decisions.

Allow the care workforce to have a say in in-house decision-making and organizational issues. Provide opportunities where workers can exercise autonomy based on their expertise and experience [40].

Job autonomy is a critical component of job satisfaction in every sector and it benefits both the workforce themselves and the “clients” they interact with. For this brief, we specifically look at the structure of autonomy in a nursing home in terms of how care is delivered and how workers engage with autonomy. Autonomy can be a particularly useful tool in care delivery as it gives the care worker the opportunity to respond to unexpected events. It could be defined as “having the authority to make decisions and the freedom to act in accordance with one’s professional knowledge base” [41 (p. 2226)]. These unexpected events tend to be frequent and therefore planning can be difficult. The autonomy essentially allows the worker to follow the “logic of care” which is in fact the “ability to act” [42]. By allowing this process to unfold, it takes more strain off workers to respond appropriately instead of having to implicitly ration or

triage care [8]. The following will convey the types of autonomy for workers and the effect it can have on the working conditions and staff turnover rate.

a. Clinical versus Organizational autonomy

In nursing homes there is always a degree of autonomy for the workers, both so they can respond to events (as described above) and to be engaged with their work. In reality, there needs to be a further distinction in what autonomy means for workers in a nursing home setting. Essentially a worker can experience two modes of autonomy in which they have autonomy at the individual (or clinical) level or at the organizational level. Clinical autonomy gives the care worker the ability for individual decision making with regard to the resident's care [43]. Legal frameworks heavily influence the level of clinical autonomy of each skill-level of care worker. Nursing homes can enable maximum clinical autonomy to their workers, within the legal framework, by clearly defining roles and tasks and defining the delegation of work, in order to manage expectations, enable seamless teamwork, and ensure maximum clinical autonomy within roles [44].

In organizational autonomy, the goal is to provide the worker and their unit with the ability to govern their workflows and procedures as well as provide inputs into the broader organization. It allows the care workers the agency to shape policies and resource allocation on a individual, unit or departmental, and institutional level [45, 46]. Organizational autonomy appears to be an area where nursing homes could explore to further engage their workers, as it was found that many nurses feel empowered and respected in delivering high quality care when they experience this form of autonomy [47]. However, it can be difficult to find the balance in determining how much autonomy can be given as there are external legal and medical standards found outside the organization.

Case example

Leadership at Lindenhof Oftringen encourages ideas and solutions to come from the “bottom-up” as they acknowledge they have 300 experts to consult on a variety of diverse issues. They have three objectives: corporate, departmental and employee, on which they solicit feedback from workers. They recognize that beyond wage incentives, having this feedback system and giving the workers a “voice” is important to maintain a satisfied workforce. More information in [48].

a. Finding the balance in organizational autonomy

As described above it can prove difficult to navigate the balance between too little and too much autonomy for workers in nursing homes. There are internal factors, such as organizational culture and leadership initiative, and external factors, such as funding and care regulations, that can contribute to this difficulty. However, we can see there are opportunities to promote a high degree of organizational autonomy for nursing home workers at both the micro and macro level.

At the micro or rather organizational level, nursing homes can focus on transforming their internal practices so that care workers can obtain more organizational autonomy while still meeting external standards. Lopez (2006, p. 137) describes this process as a form of organizational emotional care where the organizational rules, procedures, and recordkeeping, can be utilized to create types of organizational spaces where caring relationships can develop [40]. It attempts to find a balance where organizational interventions are used to extend autonomy to provide care, while maintaining a structure to ensure quality. For example, rigid, task-oriented structures can limit workers' ability to provide personalized emotional care. On the other hand, flexible work schedules and allowing staff more time with residents supports the development of deeper relationships and thus, better care.

At the macro level, nursing homes can focus on aspects of organizational autonomy by providing institutional processes to solicit worker input on the organization of care. The main avenue to encourage these processes is through a form of shared governance and social dialogue, which were advocated by both the ILO (2022) and OECD (2023) in recent reports [49, 50]. Concretely, these propose that nursing homes should aim to collaborate with unions in order to elicit and utilize the voice of their workers. This would allow care workers and their representatives to participate in planning and reflect their autonomy in decision making on the delivery of care.

Case Example

The state of Minnesota in the United States passed legislation last year that created the Minnesota Nursing Home Workforce Standards Board which brought workers, employers and government together to set minimum workplace standards in the sector. Its main objective is to solve the problem of employee turnover by focusing on working conditions and input of workers. It is unique because:

i. It gives workers a voice to set standards and processes in the sector (promoting their organizational autonomy).
ii. The board has legislative power, it does not need further political approval when decisions are made for standards.
iii. The board must develop and adjust standards every two years [51].

3. **Implement electronic health records to decrease documentation burden and free time for relational care.**
   Implementing electronic health records has shown to increase effectiveness and enable operational improvements [52, 53]. Successful implementation requires that nursing home managers carefully select their information technology infrastructure by involving and paying attention to the needs of the care workers and residents [54].

Electronic Health Records[4] (EHRs) are a cornerstone of digitalization in nursing homes, centralizing residents' health data and streamlining documentation processes. The type of data components documented in EHRs encompass daily charting, compliance reporting, physical assessment, admission nursing note, nursing care plan, referral, present complaint (e.g. symptoms), past medical history, physical examination, diagnoses, tests, procedures, treatment, medication, and immunization [55]. Concrete examples include the digital tracking of medication administration to ensure residents receive the correct dosage at the right time together with automated reminders and digital logs to minimize errors and streamline medication distribution. The adoption of EHRs in LTC facilities lags other areas of the healthcare industry [53].

Early adopters in LTC facilities found that EHRs were cost effective and that there was a reduction in nursing overtime as medical record management became more automated [52]. Since then, systematic reviews have showed that by digitizing medical histories, care plans, and health metrics, EHRs reduce the time care staff spend on paperwork, improve data accuracy, and enhance communication among caregivers, residents, and families [53, 56]. Integrated with other digital tools - such as wearable devices, telemedicine platforms, and mobile access for bedside documentation - EHRs may enable more efficient, data-driven care, allowing nursing home staff to focus on residents' well-being and personalized support. However, there are also significant barriers in terms of initial costs, user perceptions and implementation problems [57].

Data from Switzerland showed that 73.9% of care workers in nursing homes felt strongly or rather strongly burdened by documentation or other administrative tasks, with one third reporting to spend two hours or more during a normal day performing those tasks [58]. In contrast, a high percentage of care workers considered that EHR systems guaranteed safe care and treatment (69.4%) and allowed quick access to relevant information on the residents (78.3%) [54]. Finally, only 46.6% of the care workers reported sufficient computers on their unit to allow timely documentation, which highlights again the barriers in terms of implementation [54]. The adoption of EHRs in Switzerland is mandatory for hospitals and voluntary for other providers [59].

A successful implementation of EHRs in Swiss nursing homes relies on several key criteria. These criteria should help ensure that EHRs improve efficiency, care quality, and staff satisfaction without imposing excessive burdens on the nursing home's resources.

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[4] Defined here *a minima* as an infrastructure to view, record and store all patient information in a standardised format.

a. User-Friendly Interface and Customization

EHR systems need to be intuitive and customizable to suit the specific needs of nursing home workflows [60]. Systems that allow easy data entry and retrieval save time and reduce errors, thus supporting care quality [57]. Tailored interfaces that meet the unique requirements of long-term care facilities further promote staff adoption and ease of use [54].

b. Comprehensive Staff Training and Ongoing Support

Adequate staff training is crucial for effective EHR use. Training should include basic digital skills, specific EHR functionalities, and how to maintain data security. Studies show that consistent, structured training improves staff confidence and reduces frustration, leading to higher system utilization [56]. Ongoing technical support ensures that any issues are promptly resolved, minimizing disruptions in care delivery [57].

c. Interoperability with Other Systems

For EHRs to be effective, they should integrate with other healthcare systems, allowing seamless information sharing between for instance nursing homes and hospitals. Interoperability is essential for continuity of care, particularly for residents who frequently transition between care settings [61].

d. Data Security and Privacy Protections

Given the sensitive nature of health data, EHR systems must adhere to strict data protection standards, including compliance with the Swiss Federal Act on Data Protection (FADP) and General Data Protection Regulation (GDPR) in the EU. Ensuring data security builds trust with residents and families while protecting against data breaches [59]. Systems should include access controls, encryption, and regular security audits.

e. Effective Change Management and Staff Involvement

Successful EHR implementation requires strong change management practices, involving staff early in the decision-making and customization processes. Staff input helps identify potential issues and improves system relevance, increasing the likelihood of adoption [62]. Engaging staff in the rollout process also reduces resistance to change and fosters a sense of ownership [54].

f. Continuous Monitoring and Evaluation

Regular assessment of EHR performance, including feedback from users and data quality checks, ensures the system meets evolving needs. Continuous evaluation allows for adjustments, keeping the EHR aligned with care standards and regulatory requirements [63]. Nursing homes that monitor metrics such as documentation time, error rates, and user satisfaction can make data-driven improvements to enhance EHR effectiveness.

Case Example

The Lindenhof Oftringen developed a digital platform that connects all patient information, including diagnoses and goals, and employee tasks, streamlining the planning, documentation and reimbursement of care. This has allowed all involved staff to work together toward a common goal, simplifying interdisciplinary work and workflows. This has contributed to better team cohesion, reducing miscommunications, reducing documentation burden, and enabling more relational care time for their residents. Their goal is to, in the future, be able to connect it to national electronic patient records to enable a better continuity of care across the health care system.

Implementation Considerations

Barriers to implementation include:

- Changing traditional care structures and workflows may face resistance and require lots of convincing.
- Implementing a new digital system and EHR will require a substantial initial investment. Failure to provide adequate equipment to the workers, such as sufficient numbers of computers, may create a reverse effect and increase the burden due to inefficiencies.
- A lot of the unique work done by care workers is invisible, or rather embedded in the medical-technical tasks (i.e., relational work); how can this be highlighted and measured to evaluate implementation success.

Facilitators to implementation include:

- Most of the major actors (state, employers, workers) recognize there is a problem of the vicious cycle of care, and turnover and working conditions are the primary factors. There is a large consensus that things must change.
- Some of the recommendations presented here, such as the implementation of EHRs, fit well in current national programs, DigiSanté for instance [64].

Policy Briefs and Stakeholder Dialogues of the Swiss Learning Health System

The Swiss Learning Health System (SLHS) was established as a nationwide project in 2017, involving academic partners across Switzerland. One of its overarching objectives is to bridge research, policy, and practice by providing an infrastructure that supports learning cycles.

Learning cycles enable the continuous integration of evidence into policy and practice by:

- continuously identifying issues relevant to the health system,
- systemizing relevant evidence,
- presenting potential courses of action, and
- if necessary, revising and reshaping responses.

Key features of learning cycles in the SLHS include the development of **Policy Briefs** that serve as a basis for **Stakeholder Dialogues**.

A **Policy Brief** describes the issue at stake by explaining the relevant contextual factors. It formulates a number of recommendations to address the issue (evidence-informed recommendations, when available), and for each possible recommendation, it explains relevant aspects and potential barriers and facilitators to their implementation.
Policy Briefs serve as standalone products to inform interested audiences on potential courses of actions to address the issue, as well as input for Stakeholder Dialogues.

A **Stakeholder Dialogue** is a structured interaction where a variety of key stakeholders are brought together for the purpose of defining a common ground and to identify areas of agreement and disagreement on how to solve issues in the Swiss health system. Based on a Policy Brief, stakeholders discuss the issue, recommendations, and barriers and facilitators, and work collaboratively towards a common understanding of the issue and the best course of action. The dialogue takes the form of a deliberation to ensure that stakeholders work together to develop an understanding and solutions that are acceptable to all parties.

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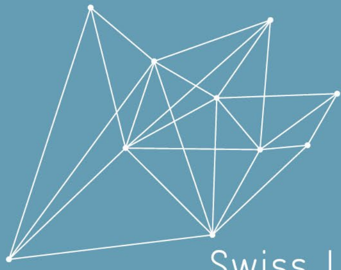
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