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Feature Article

Are nursing home care workers' health and presenteeism associated with implicit rationing of care? A cross-sectional multi-site study

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ABSTRACT

To explore associations between care workers' health and implicit rationing of care. Diverse studies have linked impaired health to reduced work performance – a factor measured through omission of required tasks. This cross-sectional study gathered data from 3239 care workers in 162 Swiss nursing homes. Data were analyzed via a linear logistic regression model using general estimating equations. Overall, rationing of care occurred “never” to “seldom.” Rationing of activities of daily living was positively associated with care workers' joint pain (β 0.04, CI 0.001–0.07), emotional exhaustion (β 0.11, CI 0.07–0.15), and presenteeism (β 0.05, CI 0.004–0.09). Rationing of caring, rehabilitation, and monitoring was positively associated with care workers' joint pain (β 0.05, CI 0.01–0.09) and emotional exhaustion (β 0.2, CI 1.16–0.24). Care workers' health complaints are strongly associated with rationing of tasks directly related to resident care.

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Introduction

Health care workers are frequently required to perform demanding tasks^{1,2} often under unhealthy working conditions,³ which can compromise care workers' physical and mental health.^{3,4} Emphasizing the importance of a healthy workplace to organizations' sustainability, Burton (2010) and Neira (2010)^{4,5} defined four key workplace components that influence employee health and safety: the physical work environment; the psychosocial work environment; personal health resources; and enterprise community involvement. This model suggests that employees who

work through illness perform below their normal capacity, which may compromise the quality of client service, i.e., patient care.⁴ In the context of this study, work performance refers to the employee's cognitive performance,⁶ including visuomotor, verbal, and decision-making functions.⁷

Work performance can be assessed through error and omission rates in relation to required tasks,⁶ often referred to as rationing of care. Within the scope of this study, in addition to the omission of actions defined in standard operating procedures,⁶ task omission was operationally defined as any reduction of standard clinical practice. This often includes fundamental nursing tasks directly related to patient care and safety. Kalisch et al (2009) reported that 73% of their study's hospital nurses omitted interventions and basic care,⁸ while 53% of psychosocial care related activities were left undone.⁹ Depending on the cognitive processes of the involved nurses, these activities may be categorized as missed,⁸ left undone,¹⁰ or implicitly rationed¹¹; however, all reflect care workers' partial or total omission of necessary tasks.^{8,12}

Factors that influence work performance most noticeably have been reflected in the literature. Particularly, impaired health has been linked to performance deterioration in numerous work

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settings, including health care.^{13,14} In this context, the concept of presenteeism has attracted considerable interest in health care research, as it is particularly relevant among health care workers. Presenteeism is the practice of attending work despite illness, which has been demonstrated to reduce at-work performance.^{14,15} Several studies^{13,15,16} have attributed poor work performance to ill care workers' reduced capacities to meet their jobs' standards of quantity and quality. In the US, studies of the general population have revealed that common pain (e.g., back pain) while at-work resulted in reduced work performance and loss of productive time.¹⁷ Similarly, in Switzerland, 25% of the surveyed general population reported decreased work performance due to back pain¹⁸; and in the Netherlands, Alavinia et al (2009) showed a significant association between self-reported work-related health problems and decreased performance, i.e., work volume during regular hours, among workers in various occupations.¹⁹ Elsewhere, research on hospital nurses has demonstrated that musculoskeletal pain negatively influenced work performance.²⁰ In long-term care facilities, musculoskeletal pain among nursing personnel compels workers to modify work tasks or seek extra help from fellow care workers to fulfill their duties.²¹ In addition to physical health, mental health (e.g., depression) could also affect care worker performance²⁰ by sapping mental and physical energy and hindering concentration.²² An investigation of their relationships between physical and mental fatigue and nursing work performance among US registered nurses (in hospital, community, and nursing home settings) measured their frequency of divergence from organizational patient safety guidelines, short cuts in patient care, and modification of organizational standards to accelerate task completion. Findings revealed that the higher the reported fatigue level, the lower the perceived work performance.¹³

There is consensus that ill direct care providers cannot fully meet their organizations' work standards.²⁰ However, to date, no studies have investigated the relationship between care workers' health, presenteeism and rationing of nursing care in nursing homes. To address this gap, the current study's guiding framework is an adaptation of the WHO Healthy Workplace Model⁴ (Fig. 1), drawing on the relationship between unhealthy work environments, work-related physical and mental health stressors, and presenteeism vis-à-vis negative influences on employees' work performance, e.g., rationing of care. Previous cross-sectional studies of the Swiss Nursing Homes Human Resources Project (SHURP) indicated that work environment factors such as perceived staffing adequacy and leadership were inversely related both to care workers' health problems³ and to presenteeism.²³ Furthermore, high-perceived staffing adequacy functioned as a predictor of lower rationing of care.²⁴

Accordingly, utilizing data from the SHURP study and building on previous findings, this study had two aims: 1) to assess the prevalence of implicit rationing of direct resident care, including rationing of activities of daily living and of caring, rehabilitation, and monitoring; and 2) to explore the relationship between care workers' health and presenteeism regarding implicit rationing of care.

Methods

Study design, setting, and sample

This is a secondary analysis of data from the multi-center cross-sectional Swiss Nursing Homes Human Resources Project (SHURP). From 1600 Swiss nursing homes, a representative sample of approximately 10% (162 nursing homes) was randomly selected, then stratified according to language region and size: small (<50 beds), medium (50–99 beds), and large (>100 beds). Selection criteria were as follows: official designation as a nursing home with at least 20 resident beds and 15 care workers. Nursing homes with fewer than 20 beds, residential homes, and geriatric rehabilitation clinics were excluded. Nursing home care workers of all educational levels, facility administrators and nursing managers were invited to complete the survey questionnaire. Care workers who worked less than 8 h weekly, less than 1 month on the unit, or who were students were excluded. A total of 5323 care workers returned their questionnaires, resulting in an overall response rate of 76.6%. SHURP study's sampling and survey methods are described in detail elsewhere.²⁵ In the current study, we included only staff care workers (i.e., registered nurses, licensed practical nurses, certified assistant nurses, and nurse aides) directly involved in resident care, and excluded nursing managers and unit supervisors, resulting in a sub-sample of 3239 care workers.

Data sources, variables and measurements

Socio-demographic and professional data on care workers, including their perceptions of their own health and quality of care, were collected using the SHURP study's Care Worker Personnel Questionnaire. Nursing home facility characteristics were captured from the SHURP Facility Profile questionnaire. The SHURP researchers established the content validity of each scale used by testing the relevance of each variable and scale separately to obtain an item content validity index (I-CVI) and a scale content validity index (S-CVI), respectively. Further information regarding the survey's development and validity pre-testing are described elsewhere.²⁵

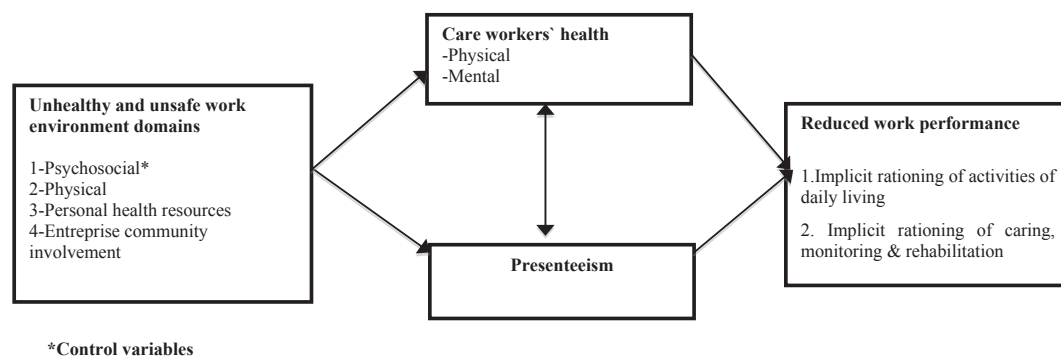


Fig. 1. The WHO framework of "Effects of an Unhealthy Workplace on Employees."

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