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Review

A comparison of working in small-scale and large-scale nursing homes: A systematic review of quantitative and qualitative evidence

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ABSTRACT

Background and objective: Ongoing shortages of care workers, together with an ageing population, make it of utmost importance to increase the quality of working life in nursing homes. Since the 1970s, normalised and small-scale nursing homes have been increasingly introduced to provide care in a family and homelike environment, potentially providing a richer work life for care workers as well as improved living conditions for residents. 'Normalised' refers to the opportunities given to residents to live in a manner as close as possible to the everyday life of persons not needing care. The study purpose is to provide a synthesis and overview of empirical research comparing the quality of working life – together with related work and health outcomes – of professional care workers in normalised small-scale nursing homes as compared to conventional large-scale ones.
Design: A systematic review of qualitative and quantitative studies.
Data sources: A systematic literature search (April 2015) was performed using the electronic databases Pubmed, Embase, PsycInfo, CINAHL and Web of Science. References and citations were tracked to identify additional, relevant studies.
Review methods: We identified 825 studies in the selected databases. After checking the inclusion and exclusion criteria, nine studies were selected for review. Two additional studies were selected after reference and citation tracking. Three studies were excluded after requesting more information on the research setting.
Results: The findings from the individual studies suggest that levels of job control and job demands (all but "time pressure") are higher in normalised small-scale homes than in conventional large-scale nursing homes. Additionally, some studies suggested that social support and work motivation are higher, while risks of burnout and mental strain are lower, in normalised small-scale nursing homes. Other studies found no differences or even opposing findings. The studies reviewed showed that these inconclusive findings can be attributed to care workers in some normalised small-scale homes experiencing isolation and too high job demands in their work roles.
Conclusion: This systematic review suggests that normalised small-scale homes are a good starting point for creating a higher quality of working life in the nursing home sector. Higher job control enables care workers to manage higher job demands in normalised small-scale homes. However, some jobs would benefit from interventions to address care workers' perceptions of too low social support and of too high job demands. More research is needed to examine strategies to enhance these working life issues in normalised small-scale settings.

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What is already known about the topic?

- A vast amount literature has shown that nursing is a stressful job, which consequently can lead to a higher burnout risk and turnover rate. The stressfulness of care jobs is therefore related to the risk of potential labour shortages, associated with demographic evolutions.
- In the past decades, an increasing number of nursing homes have implemented small living units and homelike (normalised) environments for their residents.

What this paper adds

- This systematic review shows that empirical studies agree on the fact that care workers experience a higher job autonomy, higher emotional demands, more job completeness, and lower time pressures in normalised small-scale homes than in non-normalised large-scale homes.
- Empirical studies, however, were inconclusive on whether social support, work-related stress risks, burnout risks, and work motivation are higher, lower or do not differ between normalised small-scale and non-normalised large-scale nursing homes.
- We suggest future research in normalised small-scale homes to examine whether specific team settings and human resource practices increase social support and work motivation, and decrease job demands, stress and burnout risks of care workers.

1. Background

The United Nations (2015) project that between 2015 and 2100 the proportion of the population older than 64 years will double relative to those aged between 15 and 64, in both the United States and Europe. In the United States the percentage of the population older than 64 will increase from 22 to 48 percent, while in Europe it will rise from 26 to 53 percent. Although a majority of elderly people are cared for at home, an increasing number will be living in nursing homes (Willemse et al., 2014). As a consequence, the demand for care for the elderly will rise, whilst the working population decreases. These projections indicate a potential shortage of formal caregivers in nursing homes in the future. This necessitates consideration of how workers can be attracted to join, and remain within caregiving professions, which is not straightforward. A number of studies have revealed that nursing can be a stressful job (Kirkcaldy and Martin, 2000; Tyler and Cushway, 1998), with an associated risk of burnout and decreased work motivation leading to higher turnover rates (Clegg, 2001; Kirkcaldy and Martin, 2000). In short, the challenging nature of care-giver roles may exacerbate potential labour shortages associated with demographic change. Designing less stressful jobs for healthcare workers is therefore paramount for mitigating future labour shortages in the nursing home sector.

Stress in nursing roles can be explained by three types of psychosocial risk factors: job demands, job control, and social support (McGrath et al., 2003; Schmidt and Diestel, 2011). Job demands are defined as the psychological stressors involved in fulfilling a workload (Karasek, 1979). Job control refers to the authority that employees possess regarding their work-related tasks and how they behave (on the job) (Karasek, 1979). Social support takes account of interaction with supervisors and co-workers in the workplace, assistance received with work-related tasks, and the extent of workplace isolation (Johnson and Hall, 1988; Landsbergis, 1988). Following Hackman and Oldham (1975), Karasek and Theorell (1990), and Van Hootegem et al. (2014), we defined quality of working life based on these three psychosocial risk factors. We also took account of related work and health outcomes such as burnout (Bakker et al., 2005), work engagement (Bakker et al., 2007), and work-related strain (Karasek, 1979). The job demands-control-support model argues that a high level of job control and high social support reduce the risk of stress in roles with high job demands (Johnson and Hall, 1988; Karasek and Theorell, 1990; Landsbergis, 1988). In contrast, imbalance between levels of job demands, control and social support (e.g. high job demands, low job control and low social support) can increase the risk of work-related stress (Karasek and Theorell, 1990). This can, in turn, cause an increased likelihood of burnout, and decreased work engagement (Mauno et al., 2007; Willemse et al., 2012; Xie et al., 2011). Giving health care workers highly-quality jobs therefore requires a balance between job demands, job control, and social support.

Normalised living was first introduced in long-term care facilities for psychiatric patients during the 1950s, when residents were given the opportunity to live in a manner as close as possible to everyday life (Nirje, 1992). In the 1970s, the idea of normalisation was introduced into elderly care (Wolfensberger, 1978). In most nursing homes, this translated in combining normalised with small-scale living, with a limited number of residents living together in small units (e.g. Declercq et al., 2009; Malmberg and Zarit, 1993; Nakanishi et al., 2012; Rabig et al., 2006; Dettbarn-Reggentin, 2005; Te Boekhorst et al., 2008). The combination of normalised with small-scale living creates a family and homelike environment for residents and was established in a number of countries, exemplified by, for instance, group homes in Japan (Nakanishi et al., 2012), Green Houses or Eden Houses in the United States (Rabig et al., 2006), Wohngruppen in Germany (Dettbarn-Reggentin, 2005), normalised small-scale homes in Belgium (Declercq et al., 2009), as well as group living in Sweden (Malmberg and Zarit, 1993) and the Netherlands (Te Boekhorst et al., 2008).

In this study the opposite of – and alternative to – normalised small-scale home is defined as non-normalised large-scale home. Importantly, the terms “small-scale” and “large scale” do not refer to the total number of residents in a home, but rather to the number of residents at the lowest organisational level: the living unit. Non-normalised large-scale homes therefore have large living groups (Zeisel et al., 1994; Verbeek et al., 2009; Van Audenhove et al., 2003). Typically, resident rooms are located along long hallways (Den Hollander, 2009), with centralised basic facilities such as catering and laundry, in which the involvement of the residents is limited (Declercq, 2009). These characteristics make it difficult to maintain a full range of everyday activities, and to create a homelike atmosphere.

From an employee perspective, a number of studies have looked at the quality of care workers’ working life in normalised small-scale homes (Edvardsson et al., 2009; Suzumura et al., 2013; Wångblad et al., 2009). These studies identify relationships between job demands, job control, social support, and work and health outcomes in normalised small-scale living environments that are consistent with the general literature on the quality of working life (Karasek, 1979). For example, care workers in normalised small-scale homes experience high time pressure, high work load and conflicting work demands (Edvardsson et al., 2009). These need to be compensated by high social support (Wångblad et al., 2009) and high job control (Te Boekhorst et al., 2008) to mitigate high turnover (Suzumura et al., 2013). However, these findings do not reveal how the quality of working life in normalised small-scale homes compares to that in non-normalised large-scale homes. To address this question, studies comparing both settings under similar conditions are essential, because they can illuminate whether care workers experience a higher or lower quality of working life in normalised small-scale homes, relative to non-normalised large scale homes.

Currently a number of international studies have compared the quality of working life in normalised small-scale homes and