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Crisis Management in Norwegian Nursing Homes During the Covid-19 Pandemic: Pragmatism and Performativity

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Abstract

Background: The outbreak of the Covid-19 pandemic in early 2020 imposed a severe crisis on nursing homes in Norway. Despite criticism in evaluations pointing to inadequate preparedness, nursing homes managed to keep infection and mortality rates low. Enhanced knowledge of crisis management in the aftermath of a crisis is important for preparedness and future crisis management and can contribute to ensuring sustainable healthcare and nursing services when the next crisis arises. *Aim:* To explore how nursing home managers performed crisis management during the first eight months of the Covid-19 pandemic. *Method:* Case studies at five Norwegian nursing homes, utilising thematic qualitative content analysis of interviews. *Results:* Findings indicate that nursing home managers responded swiftly, implementing creative solutions in close collaboration with staff. They performed pragmatic and performativity-sensitive crisis management, and this may have been a factor contributing to resilience in the Norwegian healthcare sector throughout the first phase of the pandemic. *Conclusion:* This study contributes to an enriched understanding of how, through performativity-sensitive pragmatic crisis management, experienced and professional healthcare managers contribute to robust, resilient and sustainable Norwegian nursing homes.

Keywords
Covid-19, nursing homes, organisational crisis, pragmatic crisis management, organisational resilience

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What is already known about the topic:
- Evaluation reports in the aftermath of the crisis posed by the outbreak of the Covid-19 pandemic raised criticism of nursing homes for not having adequate plans and procedures to manage a pandemic crisis.
- Nursing homes in Norway nevertheless had comparatively low mortality rates among residents during the crisis.

What this paper adds:
- Low rates of mortality and hospital transmission in Norwegian nursing homes during the Covid-19 pandemic may partly be ascribed to Norwegian nursing home managers' pragmatic and performativity-sensitive approach to crisis management.
- Managers with a background as experienced healthcare professionals in nursing homes are valuable assets in terms of resilience and robustness, and might play an important role at times of uncertainty and unruly problems.

Introduction

The outbreak of the coronavirus pandemic (Covid-19) in early 2020 fulfils the common criteria for constituting a *crisis* (Wiener & Kahn, 1962), as there were widespread fears among the general population of the potentially serious consequences of the disease, and how easily the virus might spread (Ørstavik, 2020). In fact, the Covid-19 pandemic has been described as one of the most severe crises on a global scale since the Second World War (Møller et al., 2022). The risk of severe illness and death due to Covid-19 increases with higher age, comorbidities and impaired health (Flodgren et al., 2020). Residents in Norwegian nursing homes are characterised by very high age, complex and long-term care needs, as well as frailty (Jacobsen et al., 2021). Nursing home residents were thus particularly vulnerable to Covid-19, and the pandemic did pose a very real and severe threat with regard to the nursing homes' *raison d'être*: their mission to care for and keep the residents safe and sound, and maintain their quality of life. Overall, it would not be too much of an exaggeration to claim that there was a strong sense of an *altered reality* – a sense of urgency and insecurity in the nursing homes, not unlike in society in general. There was also a sense of crisis.

During the first year of the pandemic, three per cent of residents in Norwegian nursing homes were infected with Covid-19, and around one in three of these died (Jacobsen et al., 2021). Furthermore, nursing homes in Norway had a low rate of infected residents transferred to hospitals; and studies have suggested that the fact that nursing homes treated the overwhelming majority of infected residents themselves was an important factor contributing to the hospital sector not being overwhelmed during the pandemic (Jacobsen et al., 2021). This may also help to explain the overall resilience of the Norwegian healthcare sector in general during the crisis period. Comparatively, Norway was among the countries with the lowest overall infection and mortality rates during the Covid-19 pandemic (Matsen et al., 2022). Within the Nordic countries, Sweden and Denmark were the countries with the most reported Covid-19-related deaths, mostly in 2020 (Møller et al., 2022). An important explanatory factor could be that to a great extent nursing homes in Norway succeeded in limiting virus infection rates by initiating infection control measures such as restrictions on visitors, social distancing and a temporary cessation of activities and services from healthcare providers outside the institutions (Danielsen et al., 2022; Jacobsen et al., 2021).

Several evaluation reports in the aftermath of the pandemic have nonetheless criticised Norwegian authorities and the healthcare sector for being insufficiently prepared, and specifically harsh criticism has been made of the lack of updated crisis plans (Jacobsen et al., 2021; Matsen et al., 2022; Melby et al., 2020). In this light, the resilience shown by the Norwegian healthcare system, and particularly by the nursing homes, during the pandemic crisis might therefore at first glance appear somewhat paradoxical. This seemingly paradoxical resilience of Norwegian nursing homes, despite a lack of preparedness, sets the stage for our enquiry in this article.

The level of crisis preparedness is one of several factors contributing to the resilience of healthcare service provision at times of emergencies and crises. Another important factor, once the state of emergency has materialised, is managing and handling the situation in a way that minimises potential negative impacts. In short, an important factor – and potentially part of the explanation for Norway's comparative success in dealing with the pandemic – is how *crisis management* was performed in nursing homes. Gaining more knowledge of crisis management in the aftermath of a crisis is of importance to future preparedness and future crisis management and can contribute to securing sustainable healthcare and nursing services if or when the next crisis arises. This leads to our research question in this study: *How did nursing home managers in Norway manage the first waves of the coronavirus crisis, and what characterised their crisis management approaches?*

Organisational crises and crisis management

External crises such as a pandemic affect multiple elements of society in various ways. An *organisational crisis* has been described as a situation which (1) is highly ambiguous, where causes and effects are unknown, (2) has a low probability of occurring, but nevertheless poses a major threat to the survival of an organisation and to organisational stakeholders, (3) offers little time to respond, (4) sometimes surprises organisational members and, finally, (5) presents a dilemma in need of a decision or judgement that will result in change for the better or worse (Pearson & Clair, 1998; Wang, 2008). In line with this definition, we therefore view the coronavirus pandemic as fulfilling the most common criteria for an organisational crisis, as viewed from the perspective of the nursing homes in Norway. A crisis has the potential to cause catastrophic or irreparable damage. At an individual level, a state of crisis may impose severe strains on organisational members' physical, emotional, behavioural and cognitive capacities, while at the organisational level, a crisis may destroy reputation and affect a wide range of stakeholders (Wang, 2008).

Pearson and Clair (1998) have defined effective crisis management as efforts carried out in crises which are effective when operations are sustained or resumed, and "(…) the organisation is able to maintain or regain the momentum of core activities necessary for transforming input to output at levels that satisfy the needs of key customers" (Pearson & Clair, 1998, pp. 61-62). Good crisis management, as depicted in earlier literature, was leaders making timely and often "big" decisions, linked to the notion of strong (crisis) leaders who dared to make critical decisions with little or no information, while under pressure of time (Boin & Lodge, 2021). The view of what constitutes best practice in crisis management has furthermore been leaning towards a "rationalistic" perspective. This view is associated with taken-for-granted elements, such as designing elaborate procedures for any foreseeable problem, and rapid information gathering with the aim of rational, top-down decision making (as quickly as possible) – based on whatever information is available (however scarce). Furthermore, the rationalistic approach advocates unambiguous communication from leaders, where any doubts and signs of uncertainty should ideally be avoided or at least

strictly downplayed, in the belief that this form of communication reassures and strengthens employees' image of – and faith in – a management which is on top of the situation (Ansell & Boin, 2019).

Pragmatism and performativity

Alternative approaches to crisis management do exist besides the traditional, rationalistic approach; in exploring our data for this paper, we reviewed and considered some of these. While the traditional approach to crisis management may be appropriate when problems are relatively simple and stable, Ansell and Boin (2019) claim that this will not necessarily work at times of unruly problems – and might even be counterproductive. They introduce what they call a *pragmatic approach* to strategic crisis management, labelled as such because their approach is grounded in the philosophical and social theory tradition of (neo-)pragmatism, and they have contrasted this pragmatic approach with the abovementioned rational(istic) perspective on crisis management (Ansell & Boin, 2019). In terms of a pragmatic perspective, one feature which characterises leaders who stand out at times of crisis is that they do not rely on rational, everyday approaches to overcome uncertainty, but realise that uncertainty is an inherent aspect of crises. A pragmatic approach "builds on the realisation that absolute certainty is impossible to achieve in the best of times, and certainly in a crisis" (Ansell & Boin, 2019, p. 1090). Thus, pragmatist leaders "work with what they have, making decisions based on a few core principles rather than a semi-complete picture of the situation" (Ansell & Boin, 2019, p. 1081), and furthermore "relying on the professionalism of their employees, offering communications that carefully balance imagery with facts" (Ansell & Boin, 2019, p. 1081).

While rational models of decision making assume that uncertainty can be erased through information collection, and although information is also important from the pragmatist perspective, in this latter perspective more emphasis is placed on how that information is interpreted and given meaning – in other words, the situational sense-making of decision makers (Ansell & Boin, 2019; Boin & Lodge, 2021). The importance of optimising access to information and supporting shared sense-making of the crisis situation among organisational members is tacit knowledge from the rational approach and in crisis management literature, and here, great efforts have been made to identify good practices and technological resources to improve information transmission (Adrot & Moriceau, 2013). However, a commonly shared picture of the situation can often prove difficult to accomplish, and information gaps are likely to occur, easily resulting in confusion which blocks the crisis response (Adrot & Moriceau, 2013).

Besides mere information transmission and sense-making, leaders' (and other organisational members') more symbolic behaviour during a crisis may also influence whether an organisational crisis response is successful or not. Adrot and Moriceau (2013) have introduced *performativity* as a conceptual lens to better understand the influence of responders' behaviour during a crisis response. As members of organisations are both actors and spectators of performances, they "contrastingly perform changes and justifications, interpretations, and judgements, while being both sincere and theatrical, rational and emotional. Information transmission is thus shaped by performative characteristics and behaviours that are watched as performances" (Adrot & Moriceau, 2013, p. 27). Acts of speaking, writing or moving are not solely intended to inform or create a common understanding, but also to encourage taking other views into consideration, reflecting, taking action, and performing. Seen from a performative perspective, what gets transmitted is not only informational or cognitive, but also emotional, affective, embodied and situated (Adrot & Moriceau, 2013).

In the exploring phases of analysing, through a stepwise inductive-deductive process, we found that viewing our data through alternative theoretical lenses to the traditional rationalistic one, bringing in the concepts of pragmatism and performativity in crisis management, could add an improved understanding of how crisis management was performed in Norwegian nursing homes during the coronavirus pandemic.

Design and methods

Study setting

In Norway, municipalities have the main responsibility for financing and providing public health and care services, as regulated by law, including institutional care in nursing homes (Ministry of Health and Care Services (MHCS), 2011). Municipalities have a great deal of autonomy with regard to adapting and organising service provision, although there is centralised control through legislation. Municipalities have the role of "the main backbone in the handling and containment of contagious diseases" (MHCS, 1994; Kvinnesland et al., 2021). This implies several responsibilities, among them preventive measures, screening, and outpatient treatment and care, as well as treatment and care in municipal healthcare institutions, e.g. nursing homes (Kvinnesland et al., 2021).[1]

The vast majority of Norwegian nursing homes are within the public healthcare system and are owned and operated by municipalities.[2] Previous research has shown that the care needs of nursing home residents in long-term care have increased over the last decade (Melby et al., 2019). Around eight out of ten nursing home residents have dementia or symptoms consistent with dementia (Selbæk et al., 2007), and the majority suffer from different conditions and take several medicines (Gulla, 2018).

Study design and data collection

This study is based on data from a larger project (Jacobsen et al., 2021), which aimed to obtain knowledge about how the pandemic was experienced in Norwegian nursing homes, including how managers, healthcare professionals and family caregivers experienced and handled the crisis during the first eight months of the Covid-19 pandemic.[3]

The main project builds empirically on five rich case studies carried out in five Norwegian municipalities, supplemented by an additional study to explore the incidence and rates of infection and death in the general nursing home population. The five cases differed in terms of virus spread and infection rates, as well as population infection levels in the surrounding communities. Furthermore, the five case municipalities differed in terms of population density and centrality, and were geographically located in five different regions. The five cases were investigated using qualitative methods. We conducted focus group interviews with the nursing staff in each of the five nursing homes. In addition, we held semi-structured individual interviews with nursing home managers, nursing home physicians and family members (Jacobsen et al., 2021). We developed a semi-structured interview guide through discussion

1. Furthermore, municipalities are responsible for gathering information on contagious diseases existing within the municipalities' borders and the degree of spread, informing the public and providing guidance on how to avoid infections and, finally, implementing (individual) preventive measures in line with decisions made in accordance with the Norwegian act on protection against contagious diseases.
2. In 2021, the proportion of nursing home beds managed by private non-profit and commercial operators was 8.4 per cent (Statistics Norway, 2022).
3. This period includes the two first waves of infection; the initial lockdown with heavy infection control measures, and an intermittent period of relaxing the most stringent measures, again followed by a second round of lockdown measures (following the second wave).

between the project group members, based on the objectives of the main project, and previous knowledge of the Covid-19 pandemic in nursing homes. The same interview guide was used for both the focus group interviews and the individual manager interviews. We started the interviews with enquiring topics related to the outbreak of the pandemic, e.g. how the nursing homes were prepared for a pandemic, including the participants' knowledge and use of guidelines, instructions and infection control plans related to a pandemic outbreak, and the availability of infection control equipment. Next, we encouraged the participants to reflect on how the pandemic was handled in the respective nursing homes. Relevant topics were the implementation of infection control measures, the effectiveness of the measures, care for the residents, prioritisation of tasks, and collaboration and communication with family caregivers, nursing home physicians, municipal and regional administrations, and national health authorities.

In the initial phase of the present study, we reviewed all empirical sources and chose to limit our analysis to interviews with the nursing home managers, ward managers and nursing staff. This limitation was applied on the grounds of relevance and credibility, considering our research objective (enquiry into crisis management performance), as the selected interviews should plausibly include expressions of first-hand experiences from the managers and ward managers themselves, as well as the staff working closest to these managers. An overview of the interviews included in this present study is presented in Table 1. In total, 13 registered nurses, ten auxiliary nurses, two nursing students and one assistant participated in the focus group interviews, averaging more than ten years' work experience in their respective current nursing homes. Moreover, five nursing home managers and three ward managers participated in the individual interviews. Seven of the nursing home managers/managers were registered nurses, and one was a social educator. In addition, five had master's degrees or postgraduate studies in management. On average, they had almost eight years' work experience as nursing home managers/ward managers and more than 20 years' experience with senior care.

All authors were members of the project group and participated in generating data. Due to social distancing measures in effect at the time, all interviews but one took place using electronic video communication or phone. One focus group was held physically.

Table 1 Overview of the nursing homes, participants and interviews included*

Nursing homes (NH) in study	Location	Total staff	Residents	Focus groups**	NH managers***	No. of interv., NH ward managers***
NH 1	Urban	300	140	8	1	1
NH 2	Urban	170	90	4	1	1
NH 3	Rural	25	25	3	1	0
NH 4	Semi-urban	150	130	6	1	1
NH 5	Rural	20	21	5	1	0
Total				**26**	**5**	**3**

* All interviews were carried out during the last six weeks of December 2020. The interview duration was between 65–90 minutes. All interviews were audio recorded and transcribed.
** Number of staff included in the focus group interviews.
*** Number of nursing home leaders or ward managers included in individual interviews.

Data analysis

In the analysis of the empirical material, we followed the principles of reflexive thematic analysis, as described by Braun and Clarke (2006, 2019). Our analysis process consisted of six steps: (1) familiarising oneself with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the report. In this study, all authors were familiar with the data (cf. step 1). Next, the first author performed the initial coding by using an inductive-deductive approach, searching for patterns in the codes, in a process whereby theoretical approach and empirical material were mutually informed by each other (cf. steps 2 and 3). The codes and initial themes were shared with the authors, and we held meetings where themes were discussed, refined, and finally defined and named (cf. steps 4 and 5). The analysis process took place in an iterative and recursive way, and the appropriateness of the codes and themes was continuously evaluated against the aim of the study and the research question (Braun & Clarke, 2006).

Ethical considerations

The project was registered by the Norwegian Centre for Research Data (Project Number 323341), which assessed and approved that the planned processing of the participants' personal data was in accordance with Norwegian data protection legislation. Moreover, the project was carried out in accordance with research ethics guidelines (World Medical Association, 2013). All participants gave written informed consent to participate in the study. Data was managed with respect for the anonymity and confidentiality of all participants.

Results

Based on the analysis of the empirical material, we organised the results into four main themes, constructed according to our research question. These themes were labelled (1) *the initial phase: experiences of chaos and unpreparedness*; (2) *swift action, flexibility, and creative solutions*; (3) *performativity*; and (4) *bending the rules.*

The initial phase: experiences of chaos and unpreparedness

In all of the five cases, our findings first and foremost show that the first eight months of the Covid-19 pandemic were experienced as a dramatic, chaotic and highly challenging period. Both the first and second waves of infection – each resulting in national lockdowns – imposed high pressure and demands on the local managers concerning both organisation and resource management. The first few days following the first national lockdown (12 March 2020) were described as particularly chaotic and dramatic. One of our informants paints it like this:

> "[I]t was a very dramatic situation when it came – very much so. Almost like a feeling of doomsday, right? Because you didn't know. What was this? Will all our residents be sick? It is obvious that we hadn't experienced anything like this before" (ward manager, NH 2).

During the very first initial period, not much was known about the coronavirus and information was scarce. Instructions and recommendations from central authorities to nursing homes were changing rapidly during this initial phase. This was a time of deep uncertainty, and new information and guideline changes came "pouring in from above" during this phase, spurring increased performance demands in nursing homes for managers and staff:

> "[F]rom day to day, information changed in this phase. One day there was announced no risk of airborne spread, and the next day it was considered a risk. So, we had to take all three contamination possibilities into account. (…) This meant we had to make new routines on the spot for every single thing we were supposed to do" (nursing home manager, NH 1).

The speed of these new information and guideline changes from above during this initial phase fuelled increased pressure and strain on nursing home managers:

> "[S]o, I read up each and every morning. 'Is there anything new? Are there any new things we have to prepare for?' I did this [reading] to be ready for that meeting at 9 a.m. … Sometimes I could bring the newest [information] at 9 a.m., but then we had to have a new meeting at 2 p.m., because then there were already new … guidelines" (nursing home manager, NH 1).

As mentioned earlier, evaluation reports in the aftermath of the Covid-19 pandemic have pointed out that in terms of centralised and local preparedness plans, nursing homes were inadequately equipped. As one nursing home manager (NH 5) put it, *"[in early winter 2020] we started to look a bit at our plan system – and very quickly we realised we didn't have updated plans"*. In all five nursing homes, informants described some infection control experiences and plans from handling outbreaks of norovirus, but they also reported either a lack of preparedness plans for a pandemic altogether, or inadequate/outdated plans. Moreover, our empirical material indicates that nursing homes' crisis preparedness plans were more sharply focused on situations like fires and evacuation, and electricity and water shortages, than on a pandemic. A ward manager at one case nursing home illustrates the unpreparedness and the feeling of novelty the coronavirus outbreak situation represented:

> "Well, I think we were not prepared for this, in the sense that we never had anything like this before, right? We've been used to various things like … – we've had infection regimes with the norovirus, for instance, that has in a sense been the worst in terms of contagiousness. So, at the outset [of the pandemic] we were not prepared, but we turned around extremely swiftly. Things got kind of sorted out in an incredibly short time, so it's like, when I look back at it now, … like 'wow, we've sure got some skills!' [laughing]. No, but we were really adaptive, and … uhm, yeah" (ward manager, NH 2).

Even though they were poorly prepared for a crisis like the Covid-19 pandemic, managers in all five nursing homes, in line with the department head cited above, described a surprisingly rapid adjustment to the new situation.

Swift action, flexibility and creative solutions

Our findings strongly indicate that managers manoeuvred and acted swiftly in the chaotic situation they experienced after 12 March 2020. They often came up with what we consider quite creative solutions to follow up instructions and guidelines, and they also implemented several measures that were not based on instructions or guidelines from centralised authorities. Examples were implementing digital communication platforms in various ways, so that residents could communicate with their families; courses for employees in infection control; and implementing various systems for visitor restrictions and control. One of the most important actions undertaken by the local managers when the pandemic hit was organising and managing human resources. More specifically, reorganising the staff in terms of tasks, locations and working hours, to prevent the spread of the virus. Depending on the physical

structures (buildings) of their nursing homes, managers reorganised their staff in terms of space, i.e. limiting allocation of departments and residents to certain, fixed staff members, and implementing new sanitary procedures for care tasks. But part of this human resource management effort also involved creating a sense of team spirit and increased motivation. As an example, one nursing home manager established "corona teams" among employees:

> "[W]e named it 'The Corona Team', (…) and it gave some sort of status being a part of that corona team. We made it a bit 'statusy' – and we made it a bit like (…) 'You can't be insulted if you get removed from care, because you get stressed there now, and you can't be. So, you'll retreat to the kitchen now, as it is crucial that you have hygienic competence to prevent contamination and to make and deliver food to the residents'" (nursing home manager, NH 2).

During the crisis, nursing home managers had to make changes with regard to roles, relationships and communication channels between people in their organisations. To a great extent they did this in collaboration with their staff and managed to find rapid solutions which contributed to maintaining the core activities at the nursing homes. Reports from nursing home managers in our interview material indicated a high degree of organisational agility. As one of the nursing home managers told us, staff were responding rapidly and adequately to managers' management and there was an experience of well-functioning communication and cooperation:

> "We had internal courses, we had information sheets for employees, theoretical and practical training, so it was very close to the staff. (…) There is no point in us performing good management if the employees don't know what to do, so it was unbelievable how fast people instantly turned around and just accepted the state of affairs" (ward manager, NH 2).

Our findings show how increased fluidity in roles and responsibility emerged, based on informal competence, as exemplified in this citation from an interview with one of the nursing home managers:

> "We had one [employee] who was an assistant, but she was studying to be something completely different, but who had an astonishing ability to gain knowledge and practical skills in contamination prevention. She was a clear choice compared to maybe a healthcare professional who didn't handle the situation as well as she did. So, we had to staff according to each employee's informal competence. Not only formal [educational] competence, but how they were as persons and how they coped with the situation" (nursing home manager, NH 2).

Our material furthermore indicates that interaction, communication and cooperation between managers and staff functioned well at times of crisis:

> "We talked together, we communicated continuously, and it worked really well; and I couldn't tell what does it (…), it was probably sufficiently good procedures, routines and forms of cooperation, and it developed into a completely natural form of cooperation which simply was completely natural for us there and then and which worked. And that is a very good feeling, to know that those decisions I made, I never made them on my own, I made them together with my team, (…) and we made good decisions (nursing home manager, NH 2).

Even though nursing homes mostly directly implemented the rapidly updated national directions and guidance, our material indicates that cooperation with infection prevention authorities at the municipal level was experienced as well-functioning by nursing home managers. Municipal infection control authorities contributed to organising seminars in infection prevention, and the use of infection-preventing equipment and routines. However, non-updated information was perceived as a problem, since keeping municipal websites updated and in line with the national guidance was a challenge.

Physically present and available managers, perhaps not surprisingly, are considered valuable by healthcare personnel – and even more so at times of crisis. In a focus group interview with healthcare personnel at one of our case nursing homes, the local manager was given credit for the way she informed and communicated with staff:

> "Respondent 3: The leader has done a good job briefing us; on communication, on the new things, and on the latest updates. We have been in regular contact with her all day. She is mostly physically present at her office. I consider it to be ok. And the assistant manager is either in the ward … she has an office position as assistant [manager], so it is mostly some of those leaders we can talk to and ask … She mostly has the main responsibility for that, so …" (focus group interview, nursing staff, NH 5).

Performativity

Much of the action nursing home managers took during the pandemic crisis can be said to contain apparent traces of performativity. As an illustrative example, in one of the interviews a nursing home manager, who had a clinical background as a nurse, told us how as a manager, she started to wear a nursing uniform when the pandemic hit:

> "(…) [B]efore the pandemic I didn't wear a uniform … for instance. (…) And it became a natural outfit at work, and it will be a natural outfit in the future. Nothing less. Because I think that, in a way, by wearing that, and being there … Well, … suddenly I was a better known person for my employees here.
>
> Interviewer: So, you started wearing a nursing uniform regularly?
>
> Informant: Yes, yes. I wear a uniform. I feel … In a way we are standing more together that way" (nursing home manager, NH 1).

In all of our five cases, the empirical material indicated that the nursing home managers communicated and informed (also) in an emotional way – something which was quite natural, given the seriousness of the situation. The managers all referred to "being there", at the chaotic frontline, so to speak. One of the nursing home managers gave us this description:

> "I saw that people were afraid, people crying, people who didn't want to be here when there was virus infections in the building. (…) I couldn't risk any more leaving, I had to go around and talk with them, right? I went from post to post. Nine wards …, I went and talked to people all the time; comforted them, supported them, informed and trained them. (…) So, we worked with the staff all the way" (nursing home manager, NH 2).

Bending the rules

More stable and lasting national directives and guidelines to regulate infection containment in nursing homes came some weeks into the pandemic. Strict visitor limitations and other regulations aimed at limiting social contact presented many ethical dilemmas for nursing

homes and their managers. The social restrictions had a clear negative effect on residents' opportunities for social contact and for cultural activities. Nursing home managers in our material described isolated and confused residents, and frustrated relatives, and had many heart-breaking stories of having to keep sick and dying residents from their families. The expected enforcement of centralised regulations seemed to put a strain on many managers, as this confronted them with malignant dilemmas. Faced with specific situations presenting ethical dilemmas, especially those involving visits by relatives in special circumstances, some of the managers bent the rules in order to minimise the negative effects of the anti-social-contact measures. As the nursing home manager in NH 4 told us, *"(…) we have … we do see to it that terminal patients do get visits – and we also did this while the nursing home was completely shut down"*. A manager at another nursing home described a situation where she bent the rules a bit regarding visitation regulations, but even then felt that her actions were insufficient:

> "Well, the nursing home was shut off for five weeks, and she [a relative] … had three weeks when she couldn't come visit – or two and a half. I personally followed her in and took responsibility for that … in the period when she was not supposed to come at all. But it wasn't good enough. She wanted to be there every day, right? So, in a way that wasn't good enough … for her experience" (nursing home manager, NH 1).

Managers also faced value-based dilemmas related to restrictions, guidelines and recommendations relevant to staff members. In the national social distancing guidelines, it was recommended to avoid using public transport. For institutions dependent on physically present human resources, such as nursing homes, blindly following this recommendation would have led to a lack of critical personnel:

> "(…) [B]ut we know we have many who are dependent on public transport … to get to work. And then we cannot put too much weight on that [restriction], because then … – they would struggle getting to work" (nursing home manager, NH 1).

Discussion

First of all, when defining the crisis responses in Norwegian nursing homes as *successful* crisis management, we should make it clear that by using the word "success" in this setting we are strictly referring to *comparably low infection and mortality rates*; overall, the nursing homes managed to fulfil their overarching task of keeping residents alive and (as) healthy (as possible). We are aware, however, that this should perhaps not be the only indicator of success, and that opinions differ on whether the success label really is appropriate, considering all the negative consequences with regard to the isolation and loneliness of the draconian social distancing measures which were imposed nationally.[4]

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4. Acknowledging this, we have nonetheless chosen to stick with the label *successful* crisis management here, reasoning as follows: The initial weeks and even several months after the WHO declared Covid-19 to be a pandemic (this study covers the first eight months after the declaration) were characterised by widespread uncertainties and fears regarding the severity and long-term consequences of the Covid-19 disease for individuals and societal institutions, placing the goal of avoiding the spread of the virus, infections and death at almost any cost in an undisputed, hegemonic position in the public debate in this phase, and putting other goals and values in the shadow. Given the almost undisputed position of this (mainly) unchallenged goal in Norwegian society, the healthcare sector and municipal nursing homes were expected to prioritise and achieve one goal; and in that sense, they certainly succeeded in their response to the pandemic crisis.

In Sweden, a similar country to Norway in terms of socioeconomics and healthcare system, the rate of Covid-19-related deaths in nursing homes during the pandemic was significantly higher than in Norway (Juul et al., 2022). While differences in the extent of Covid-19 measures between these countries, such as school closedowns and lockdowns, cannot be ruled out as explanatory factors, the government-appointed Swedish coronavirus commission has pointed out that there were fewer educated healthcare staff in Swedish nursing homes, a higher proportion of staff were part-time workers, and they were more likely to be at work even if they were ill, due to a lack of sick leave compensation for workers (Melin et al., 2020). Furthermore, Swedish service unit managers are responsible for more employees than their Norwegian counterparts, making it harder to be a visible and supporting manager for subordinate employees (Melin et al., 2020). Even though there were many other factors and explanations, we argue that the relative success of the Norwegian response to the Covid-19 crisis can at least partly be ascribed to the skilful crisis management performed by experienced nursing home managers – in close collaboration with their staff at nursing homes. We found that nursing home managers, in collaboration with staff, swiftly implemented creative new solutions, much in line with the findings in a study of Norwegian healthcare managers' use of innovative solutions during the Covid-19 pandemic (Lyng et al., 2021). The previously mentioned fact that nursing homes had a low rate of transfer of infected residents to hospitals (Jacobsen et al., 2021), thereby countering capacity overload in hospitals, was one factor contributing to the resilience of the Norwegian healthcare sector during the pandemic. Several aspects of the nursing home managers' actions can explain the low infection rates; in the empirical material we have seen many examples of crisis responses in line with pragmatic and performativity-sensitive approaches to crisis management, including flexibility, agility and incrementality, and performativity in communication aimed at shared meaning construction and dialogue (Adrot & Moriceau, 2013; Ansell & Boin, 2019; Boin & Lodge, 2021). Even though these main patterns were similar and found across all five case nursing homes, two of the cases stood out in terms of frequency of referred quotes in this paper, namely NH 1 and NH 2. These two case nursing homes are both large nursing homes located in urban areas that both experienced large infection outbreaks among patients and in their surroundings. It is thus an assumption that managers and other employees in these cases experienced a higher "intensity of required action" during the pandemic phase that is the subject of this enquiry.

What characterised the crisis management in nursing homes during the pandemic?

By analysing our material, we found that nursing home managers' crisis response actions clearly resonate with a pragmatic approach to crisis management (Ansell & Boin, 2019). As illustrated in the previous chapter, our empirical material tells us that nursing home managers approached the Covid-19 pandemic crisis with a sense of humility, and that they encouraged deliberation about emerging goals, values and interpretations among employees, rather than making "big" decisions on their own. Rather than giving top-down directives to their staff, they relied on dialogue – displaying a faith in the competence and ability of their employees. Crisis response measures were often creative, incremental in nature, and provisional. Moreover, some of the actions and measures taken by nursing home managers bring to mind the pragmatist attitude of bricolage – exploiting what resources are actually available and combining them through improvisation to address specific needs (Ansell & Boin, 2019).

Furthermore, our findings indicate that nursing home managers acknowledged the dramaturgy of crisis and acted in accordance with an understanding of the important role

played by symbolic communication, non-verbal cues and emotionality in influencing interpretation processes in the creation of shared meaning among organisation members, not least in times of crisis. Viewed from the lens of performativity, the acts of speaking, writing or moving are not solely intended to inform or create a common understanding, "but to have people consider other views, reflect, take actions, and perform at their turn. What gets transmitted is not only informational or cognitive, but also emotional, affective, embodied and situated" (Adrot & Moriceau, 2013, p. 28). We found that much of the behaviour of and many of the actions taken by the nursing home managers in their crisis response could fruitfully be understood in light of the concept of performativity in crisis management (Adrot & Moriceau, 2013), and that this may have contributed to enhanced collective sense-making, coordination and motivation among employees.

Experienced healthcare professional managers

What can explain the pragmatic approach to crisis management we found in Norwegian nursing homes during the first eight months of the pandemic crisis? All five nursing home managers interviewed in this study shared some background characteristics: they were all women, they were all trained nurses, and they all had previous (in most cases many years of) experience from municipal elderly care practice. In addition, one of the two ward managers interviewed was a nurse with long experience from elderly care, while the other ward manager (the only man) was a social worker. The fact that these managers were all both specialised and experienced within the field of elderly care could be a factor explaining their pragmatic approach to managing a crisis. In addition, in view of their rich experience from performing care tasks, and thereby a good understanding of residents' health conditions and care needs, combined with an embodied understanding of the nature of their subordinate colleagues' working lives and tasks, they could easily share and understand emotions, as well as the physical and mental challenges faced by their colleagues due to the pandemic. This may have enhanced their performativity-conscious ways of communicating, displaying emotions and acts of solidarity (Adrot & Moriceau, 2013).

Being experienced nurses within the field of care work, an assumption close to hand would be that these managers have a well-developed and finely-tuned ability to weigh the importance of interfering values, sometimes resulting in professional values outweighing the value of loyally following directives, i.e. *bending the rules* in a pragmatic way, as findings presented in our empirical material illustrate, in relation to visitor regulations under special circumstances, as well as employees' use of public transport.

Robustness and resilience explained?

Considering evaluation reports in the aftermath of the pandemic, the success of Norwegian nursing homes' response to the pandemic may seem paradoxical. However, the criticism raised in relation to centralised authorities, municipalities and nursing homes rests on the conventional, rationalistic perspective on crisis management. Besides pointing out low stocks of contamination-prevention equipment, critics mainly emphasised a lack of updated and sufficiently detailed preparedness plans and procedures (Kvinnesland et al., 2021; Matsen et al., 2022; Melby et al., 2020). Viewed through a lens encompassing pragmatism and performativity as crucial tools for successful crisis management, this seeming paradox might dissolve, however. From a pragmatic perspective on crisis management, in their crisis responses the nursing home managers displayed features, actions and behaviours in ways very much resembling what in the literature on the pragmatic approach are considered traits of skilled crisis managers (Ansell & Boin, 2019; Boin & Lodge, 2021). Despite lacking suffi-

ciently updated and detailed plans and procedures, emphasised by the traditional perspective on crisis management, nursing homes showed resilience during the pandemic. Insights from the pragmatic approach may, however, explain why experienced and specialised managers in nursing homes could have been an important factor contributing to the resilience and robustness of nursing homes, as well as the healthcare sector in general – a thus far underestimated, yet perhaps crucial and valuable asset for the resilience of the elderly care system in Norway.

Conclusions

This paper explores how nursing home managers handled the Covid-19 crisis during the first eight months of the pandemic. Our findings suggest that the successful crisis response, and the resilience and robustness of Norwegian nursing homes during the Covid-19 pandemic – despite authoritative claims of inadequate levels of preparedness – might be ascribed to Norwegian nursing home managers' pragmatic and performativity-sensitive approach to crisis management. We argue that the managers' background as experienced healthcare professionals might have played an important role. At times of uncertainty and unruly problems, the results from our study suggest that experienced and professional managers are prone to play on pragmatic and performativity-conscious strings, and that such managers can prove to be skilled and valuable crisis managers. Our study can serve to illustrate how a pragmatic perspective on crisis management could supplement the conventional approach and enrich the understanding of how organisations respond to crisis situations. In that sense, our study might be a valuable contribution to both crisis management literature and the field of healthcare practice.

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