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Contradictory management requirements and organisation of daily work in Norwegian nursing homes

A qualitative study

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Preface

We all know how it should be, and we know that we do not have the money for it, so it is a conflicting situation that one chooses to stay in. One cannot spend more money than is allocated in the nursing home's budget. So, as a manager, you must take a stand in order to explain to the staff why things are the way they are and, together, try to find new solutions to organise the work in a different and more efficient way (Siri, front-line manager and study participant).

The complexity of the organisation of daily work (i.e., how care is organised) in nursing homes has been an area of great interest for me. Indeed, during the almost 14 years I have practiced nursing in nursing homes, I repeatedly wondered why I felt increasing inadequate in my work. When I was promoted to front-line manager, I often felt like I was “fighting windmills”, trying to balance tensions between professional values with scarce economic resources as also expressed by Siri in the quote above.

I started to wonder what creates these tensions and how nursing home employees plan and organise their daily work to handle them. This is what I have explored in my PhD dissertation. I outline how NPM inspired reforms and their focus on efficiency and standardisation meet professional values, creating tensions and contradiction in daily work. Not only are NPM ideas inconsistent by themselves, new contradictions arise when NPM ideas and requirements meet existing practices in nursing homes.

This dissertation is also motivated by my master thesis in public administration. The main findings in the theses were that increased use of performance management was not reflected as intended by central leaders in the daily practices of nursing home employees. Indeed, the findings showed that the employees at the wards ignored demands to increase the use performance management (i.e. the use of objective standardised forms) thus protecting their professional values.

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Margrethe Kristiansen

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Abstract

The focus of this dissertation is on contradictory management requirements in daily work that are created when ideas from NPM are introduced into public nursing homes. New Public Management (NPM) was introduced in the 1970 – 80 as a response to inefficient hierarchical bureaucracy and continued growth in the public sector. It is not a unified theory for streamlining public services. It should rather be seen as an ideological reform wave in which the public sector has been heavily shaped by a variety of models from the private sector (Pollitt and Bouckaert, 2011). The NPM ideology includes a greater emphasis on competition, standardisation and performance management to improve quality and efficiency in public organisations.

Focusing on marketization and managerialism, the ideological argument is that NPM is a necessary means to get more and better public services out of the available funds. However, NPM ideas do not replace existing practices in public organisations. The market-based ideas of NPM are often added on top of existing practices, creating tensions in daily work. The ideas of NPM are in many ways contrary to traditional professional practices in nursing homes where professional practitioners are more concerned with quality than with efficiency in work (Evetts, 2013; Freidson, 2001). Originating from different value- and belief-systems, NPM ideas and professional values can be seen as contradicting management requirements. Each has its unique principles, practices and symbols that influence employees' behaviour in various ways (Greenwood et. al., 2011; Thornton et. al., 2012).

The influence of NPM on the performance of health care services has gained increased academic interest (Dahle and Thorsen, 2004; Kamp and Hvid, 2012; Meagher and Szebehely, 2013; Newman and Lawler, 2009; Rankin and Campbell, 2006; Reay and Hinings, 2009; Vabo and Vabø, 2014). Taking various perspectives, these studies demonstrate limitations of NPM ideas regarding solutions to key challenges in health care. A key argument here is that instead of ensuring holistic care and optimal use of resources, NPM inspired reforms has led to fragmentation and weakened the quality of health care services. Further, based in NPM's rather weak emphasis on professional values, previous studies demonstrate that traditional professional practices are

challenged, resulting in tensions and dilemmas that are not intelligible or meaningful for the employees in daily work.

It is argued that NPM inspired reforms over the last few years are being replaced by the ideology of New Public Governance (NPG), also known as post-NPM (Røiseland and Vabo, 2012; Osborn, 2010). However, according to Osborn (2010) NPG do not replace, but rather represent a supplement to NPM ideas. Thus, NPM is still of relevance.

Taking into consideration that NPM ideas are implemented in various ways according to particular contexts, I chose to study contradictions in daily work at a micro level within the context of public nursing homes. Through interviews and observations of employees holding various positions in three different nursing homes my aim was to shed light on how employees relate to contradictory management requirements in the organisation of daily work. I focus on how nursing home employees handle, understands, and carry out contradictory management requirements in their organisation of daily work.

The analysis demonstrate that nursing home employees related to contradictory management requirements in various ways. In an attempt to balance NPM requirements and professional values, employees found new and creative ways to modify existing practices that allowed them to retain their professional values in daily work. These new practices involved establishment of certain *coping strategies*. Nursing homes employees clarified incongruity between new management requirements and professional values by creating new *sensemaking* of their professional role in daily work. They carried out changes in how daily work was planned and organised through establishment of new *nursing leadership processes*. Through highlighting these new and modified practices as part of daily work, the study demonstrate that NPM ideas were not ignored or rejected by the employees in daily work. Instead, nursing home employees created room for NPM requirements and professional values to co-exist in daily work.

Critics of the NPM ideology argue that its ideas are incompatible with traditional professional practices and that it is therefore ignored by professional practitioners. The findings in this dissertation however demonstrate that NPM requirements are neither ignored nor rejected, but rather integrated into daily work in nursing homes. Whether

these new practices are being established to safeguard traditional professional management, or if they are simply a way to deal with imposed NPM requirements, is less clear. However, instead of exploring contradicting management requirements as a two-sided process, where one logic are compromising the other, it is more interesting to investigate and understand what happens in daily practises. This approach is of more relevance taking into consideration what consequences new practices might have for the fundamental values of professionalism and for the quality of care.

The findings of this dissertation further suggest that there is a tendency in which nursing home employees renegotiate traditional professional management by considering NPM requirements as constructive elements in the organisation of daily work. What consequences this might have for the quality of care in nursing homes needs further research.

By demonstrating how NPM requirements and professional values balances in daily work, and how tensions created by these contradicting management requirements lead to new and modified practices, the dissertation contribute with new knowledge about some effects, opportunities, and limitations that NPM inspired reforms have introduced into the way daily work in nursing homes is governed. Such knowledge is vital in order to obtain a deeper understanding about the impact of NPM inspired reforms and how to create and sustain improvement in the delivery of healthcare services in nursing homes. In fact, increased awareness of how employees relate to and develop new practices when facing efficiency and quality demands is of high relevance considering ongoing work to ensure efficient care services of high quality in nursing homes.

The dissertation contributes also into the ongoing debate within management and health care literature in how to study organisational change in health care institutions. According to Vabo and Vabø (2014) health care institutions and their organisations has only to a small degree been studied as an own research field within health care sciences. The use of the institutional logic perspective is thus an untraditional approach that may inspire more researchers to investigate questions about management, organisation and change in health care organisations.

Sammendrag

I denne avhandlingen retter jeg fokus på motstridende styringskrav i det daglige arbeidet som skapes når ideer fra NPM tas i bruk i offentlige sykehjem. New Public Management (NPM) ble introdusert til offentlig sektor i 1970 – 80 årene som svar på ineffektivt, hierarkisk byråkrati og stadig økende vekst. NPM er ingen enhetlig teori for å effektivisere offentlig sektor og offentlige tjenester, men bør snarere ses som en ideologisk reformbølge inspirert av styringsmodeller og styringsverktøy hentet fra privat sektor (Pollitt and Bouckaert, 2011). NPM ideologien innebærer vektlegging av konkurranse, standardisering, og mål- og resultatstyring for å fremme effektivitet og kvalitet i offentlige tjenester.

Gjennom NPM mer markedsbaserte styringsverktøy tas i bruk som virkemiddel for å sikre mer og bedre offentlige tjenester ut fra tilgjengelige ressurser. Men, selv om NPM inspirerte styringsmodeller introduseres så betyr det ikke at de erstatter eksisterende praksis i offentlige organisasjoner. De nye markedsinspirerte styringsmodellene blir ofte et tillegg til eksisterende praksiser. Dette skaper spenninger i utførelsen av det daglige arbeidet fordi ide- og verdigrunnlaget til NPM på mange måter står i sterk kontrast til tradisjonelle profesjonsverdier med større fokus på kvalitet enn effektivitet (Evetts, 2013; Freidson, 2001). NPM inspirerte styringsverktøy og profesjonsstyring er grunnlagt på ulike verdi- og kontroll system og kan derfor bli sett på som motstridende styringslogikker. Med andre ord, hver logikk har egne prinsipper, praksiser og symboler som på ulike måter innvirker på ansattes adferd (Greenwood et. al. 2011; Thornton et. al., 2012).

Motstridende styringskrav er et kjent fenomen innenfor organiseringen av pleie og omsorgstjenester, (se for eksempel, Dahle & Thorsen, 2004; Kamp & Hvid, 2012; Meagher & Szebehely, 2013; S. Newman & Lawler, 2009; Rankin & Campbell, 2006; Reay & Hinings, 2009; Vabø & Vabo, 2014). Ved å ta ulike perspektiver, viser disse studiene begrensninger med NPM inspirerte styringsverktøy i pleie og omsorgstjenester. Et kjerneargument er at i motsetning til å sikre helhetlig og individuell omsorg har NPM inspirerte reformer bidratt til fragmenterte tjenester med svekket kvalitet. Videre, med bakgrunn i NPMs manglende fokus på profesjonsfaglige grunnverdier demonstrerer

overnevnte studier hvordan tradisjonell profesjonspraksiser har blitt utfordret. NPM inspirerte reformer har skapt spenning og krysspress i det daglige arbeidet og mange ansatte strever med å finne mening i arbeidet.

I den senere tid har det blitt argumentert for at NPM inspirerte reformer er i ferd med å bli erstattet av New Public Governance (NPG) som styringsideologi, også kjent som post-NPM (Røisland and Vabo, 2012; Osborn, 2010). Det er imidlertid ikke slik at NPM blir erstattet med NPG, men representerer snarere et supplement til NPM (Osborn, 2010). NPM er derfor fortsatt like relevant.

Ved å ta utgangspunkt i at NPM ideer implementeres ulikt innenfor ulike kontekster, velger jeg å studere motstridende styringskrav i det daglige arbeidet i tre ulike offentlige sykehjem. Gjennom intervju og observasjoner av ansatte på ulike nivå var målet med studien å belyse hvordan ansatte i sykehjem håndterte, forstod og utøvde motstridende styringskrav i organiseringen av det daglige arbeidet.

I avhandlingen viser jeg at ansatte forholdt seg til motstridende styringskrav på ulike måter. I forsøk på å forene faglige verdier med markedsideologiske styringskrav, viser resultatene at ansatte i sykehjem finner frem til kreative arbeidsmåter for å kunne beholde faglig handlingsrom i eget arbeid. Disse nye praksisene involverte etablering av ulike *mestringsstrategier*. Ansatte i sykehjem avklarte uoverensstemmelser mellom nye styringskrav og profesjonelle verdier gjennom å skape nye *forståelser* av eget arbeid og deres rolle som profesjonsutøvere. De utøvde endringer i måten det daglige arbeidet ble organisert og planlagt gjennom etablering av nye *sykepleierledelsesprosesser*. Gjennom å belyse disse nye og modifiserte praksiser som del av det daglige arbeidet, demonstrerer studien at NPM ideer ikke ble ignorert eller avvist av de ansatte. Studien viser at ansatte i sykehjem skapte rom for at NPM ideer og profesjonsverdier kunne sameksistere i det daglige arbeidet.

Kritikere av NPM framholder at dens ideer er i uoverensstemmelse med tradisjonell profesjonsstyring og at profesjonsutøvere derfor ignorerer dem. Resultatene i denne avhandlingen viser at ideer og styringskrav fra NPM hverken er ignorert eller frastøtt, men derimot integrert som en del av det daglige arbeidet i sykehjem. Hvorvidt slik

etablering av nye praksiser handler om å ivareta profesjonsstyring på nye måter eller om slike tilpasninger i organiseringen av arbeidet er en form for reproduksjon av pålagte NPM inspirerte styringskrav er derimot mindre relevant. I stedet for å se på motstridende styringskrav som en tosidig prosess, hvor den ene går på bekostning av det andre, er det mer interessant å undersøke og forstå hva som skjer i praksis. En slik tilnærming er mer relevant med tanke på hvilke konsekvenser nye praksiser vil kunne få for profesjonsfaglige grunnverdier og kvalitet og pasientsikkerhet i omsorgen.

Resultatene viser videre tendenser til at ansatte reforhandler tradisjonell profesjonsstyring gjennom å vurdere NPM inspirerte styringskrav som konstruktive elementer i organiseringen av arbeidet. Ytterligere forskning må til for å finne ut hvilke konsekvenser dette kan ha for kvaliteten på omsorgen i sykehjem.

Gjennom å demonstrere hvordan NPM inspirerte styringskrav og profesjonelle verdier balanseres i det daglige arbeidet og hvordan spenningen mellom disse motstridende styringskravene bidrar til etablering av nye og modifiserte praksiser, bidrar denne avhandlingen med ny kunnskap om hvilke effekter, muligheter og begrensninger NPM inspirerte reformer har fått for organiseringen av daglig arbeid i sykehjem. Denne kunnskapen er viktig for å forstå virkningen av NPM inspirerte reformer og hvordan skape og opprettholde forbedringer i utøvelsen av helse- og omsorgstjenester i sykehjem. Økt forståelse av hvordan ansatte forholder seg og utvikler nye praksiser i møte med effektivitets- og kvalitetskrav er svært relevant med tanke på pågående arbeid med å sikre effektive helse- og omsorgstjenester av høy kvalitet i sykehjem.

Avhandlingen bidrar også i den pågående debatten innenfor organisering av helse- og omsorgstjenester. I henhold til Vabo og Vabø (2014) så er helse- og omsorgssektorens institusjoner og organisasjoner i liten grad vært løftet fram som et eget studiefelt i helse- og velferdsforskningen. Ved bruk av institusjonell teori bidrar avhandlingen til en utradisjonell tilnærming, som kan forhåpentlig inspirere flere forskere til å stille kritiske spørsmål ved styring, organisering og endring i (helse- og omsorgsorganisasjoner.

List of articles

This dissertation is based on the following articles:

1. Kristiansen M, Obstfelder A, Lotherington AT. (2016) *Contradicting logics in everyday practice: The complex dynamics of performance management and professionalism in Norwegian nursing homes*. Journal of Health Organization and Management, Vol. 30, Iss 1 pp 57-72.
2. Kristiansen M, Obstfelder A, Lotherington AT. (2015) *Nurses sensemaking of contradicting logics, an underexplored aspect of organisational work in nursing homes*. Scandinavian Journal of Management, Vol 31, Iss 3 pp 330-337.
3. Kristiansen M, Westernen KI, Obstfelder A, Lotherington AT. *Coping with increased managerial tasks- tensions and dilemmas in nursing leadership*. Journal of Research in Nursing (Accepted for publication 13- April 2016)

1. Introduction

Reports on scandals in nursing homes are commonplace in mainstream media. Accounts of deficiencies in medical treatment, of residents who have to sleep in bathrooms or who do not get the help they need, are frequent. When nursing homes employees are asked about such deficiencies in care, they often answer that efficiency demands grounded in New Public Management (NPM) ideas hinders and detract them from acting in accordance to their professional values and ethics in daily care. Indeed, NPM is often portrayed as the main reason to most problems in health care organisations. However, strong economical constraints with hard ranking of financial and quality priorities also existed long before NPM was introduced to the public sector in the 1970 – 80. The central ideas of NPM include competition, standardisation and performance evaluation (Pollitt and Bouckaert, 2011) as means to ensure efficiency. These ideas was pushed forward as response to inefficient hierarchical bureaucracy and continued growth in the public sector to ensure that services became cheaper, more efficient and more responsive to its “consumers” (Lægreid et al., 2007).

NPM can be seen as an ideology that contains a common set of ideas rather than a common practice (Clarke et al., 2000; Hood, 1991). With principles imported from the private sector, NPM ideas are contradictory to traditional professional practice in health care organisations. NPM emphasize competition and performance measures with strong focus on standardisation, and control (Dooren et al., 2010). Traditional professional practices focus on professional values and involve a high degree of self-leadership based on professional autonomy, i.e., self-regulation of work guided by codes of professional ethics, collegiality, and trust (Freidson, 2001; Evetts, 2013).

Critical voices have pointed out that NPM inspired reforms overshadow professional values in health care organisations (Dahle and Thorsen, 2004; Ingstad, 2010; Kamp and Hvid, 2012; Newman and Lawler, 2009; Olsvold, 2010; Orvik et al., 2013; Rankin and Campbell, 2006; Szebehely, 2006; Thorsen and Wærness, 1999; Vabø, 2007; Vabø and Vabø, 2014). This overshadowing could also be described as a movement from a professional logic towards a managerial logic (Greenwood et al., 2011) in which contradictory management requirements arise.

Contradictions in daily work have always been a part of nursing, and could be described as situations with inconsistent elements (Kelly, 2012), i.e. dilemmas. This could be ethical dilemmas, medical dilemmas, personal dilemmas, cooperation dilemmas, and various organisational dilemmas, all of which are a constant part of nurses' daily work. The last 30 years' NPM inspired reforms in health care organisations could thus be seen to add a new dimension of contradictions in nursing. Although NPM inspired reforms have triggered protest from and collective action among professional employees in hospitals and home care, there is little material in the research literature about contradictory management requirements and how employees balance NPM ideas and professional values in the organisation of daily work (i.e., how care is organised) in public nursing homes. Do nursing home employees adopt NPM ideas in their daily work? Are NPM ideas rejected and ignored, or are new practices developed to cope with different forms of tensions resulting from contradictory management requirements? These are questions I focus on in the dissertation.

The organisation of daily work is as an essential driver in nursing and of patient care and are often referred to as the "glue" in health care institutions (Allen, 2014). Organisation of daily work relates to coordination of work, division of labour, goal- setting, decision making, management and other steering and organisational processes. When looking into various aspects of the organisation of daily work in health care organisations, studies demonstrate that health care employees are continually seeking acceptable solutions that will allow them to provide quality care despite implementation of stronger efficiency demands (Kamp and Hvid, 2012; Orvik et al., 2013; Meagher and Szebehely, 2013; Rankin and Campbell, 2006; Allen, 2014; Olsvold, 2012; Rasmussen, 2011; Szebehely, 2006).

With the implementation of NPM reforms, employees search for new solutions and new practices in organising daily care. The contents of these new solutions and practices would however vary from one country and one sector to the next, pointing out the need to explore how contradictory management requirements is manifested by employees within the context of nursing homes.

To get an in-depth and differentiated understanding of this complexity I have chosen to use a theoretical framework originating from the organisational literature: the institutional logic perspective (Thornton et al., 2012). The institutional logic perspective allows me to study how nursing home employees through establishment of new and modification of existing

practices, relate to NPM requirements while balancing and maintaining their professional values.

I would like to point out that I do not see this dissertation as an organisational study. Rather, by drawing on theories from the organisational literature I hope to demonstrate the need to search for new theoretical frameworks in order to better understand the complexity of health care organisations and its responses to contradictory management requirements in everyday practice.

2. Background

2.1 The complex organisation of nursing home

Nursing homes are an archetypal example of a complex organisation. In Norway, nursing homes have their roots in the institutionalisation of poverty care in the 1950s (Hauge and Heggen, 2008), but today they are seen as medical institutions that provide accommodation and medical care to elderly individuals who can no longer get suitable care in their homes, but do not need hospital care (Jacobsen, 2005). From being state-operated, the responsibility for nursing homes were delegated to local municipalities in 1988. Today, the vast majority of nursing homes are publicly owned, although some private facilities have contracts with the municipalities to provide care (Jacobsen and Mekki, 2012). Nursing homes are regulated by law in addition to a number of national guidelines for the content of care (Kvalitetsforskrift for pleie og omsorg (2003); Verdighetsgarantiforskriften, 2011). In addition, nursing homes are funded by national taxes filtered through local priorities in addition to law regulated individual payment from the residents (Forskrift for sykehjem, 1989; Vederlagsforskriften, 2012). Strong public regulations ensures that nursing homes have a structural and organisational similarity, although their individual authority and behaviour may vary across different municipalities. Each municipality is free to organise the care service as they believe appropriate to fulfil their obligations according to the medical and social standards determined by law. Some variations in service provision may occur according to the municipality's demographic, geographic, and economic situation. However, over time nursing homes have come to be viewed as stable health care organisations that constitute a cornerstone of the Norwegian welfare state.

In order to become a resident at a nursing home, elderly individuals must have special needs in factors such as sickness or disability. There is no clear "right" to care or absolute "criterion" that makes one eligible for entry into a nursing home. Each allocation is based on an individual assessment (Brevik, 2010). The threshold for obtaining a place in a nursing home is getting higher (Jacobsen and Mekki, 2012). As response to the coordination reform (White Paper. 47) more responsibility for health care services is delegated to municipalities. Due to shorter hospital stays, elderly applying for places in nursing homes are getting sicker and have more complex medical illnesses (Vabo and Vabø, 2014).

Increased focus on medical treatment influence the organisation of daily work and makes nursing homes into “mini” hospitals more than homes (Næss et al., 2013). One structural change resulting from this is that an increasing number of municipalities choose to regulate nursing homes as differentiated services. Nursing homes can be broadly classified into regular care units and special care units for persons with dementia and mental disorders. In addition, some nursing homes have special short-term wards for respite and rehabilitation. Instead of staying in one place, elderly can be moved around according to the differences in nursing homes services.

2.1.1 Nursing homes as professional organisations

As professional organisations, nursing homes offer care services given by healthcare professionals with different occupational backgrounds. By law, all Norwegian nursing homes are required to have one unit manager: a nurse who is in charge of patient care (Forskrift for sykehjem, 1989). The unit manager at the nursing home is responsible for economic issues, personnel, and the quality of the care services, and is in charge of anywhere from 30 to 90 residents. Front-line managers, also referred to as nurse managers in this dissertation, are next in the nursing home hierarchy. They supervise the nurses (clinical nurses), assistant nurses and unskilled staff who work with the residents at the wards. Normally there is one front-line manager with responsibility for the quality of care at each ward with anywhere from 8 to 30 residents.

The majority of unit managers, front-line managers and clinical nurses are registered nurses with three years of higher education. Nursing homes also have physiotherapists, physicians, and occupational therapists in part time positions, as well as unskilled care workers with no education, or who have taken only short courses (e.g., assistant staff). In line with other countries, there is concern that the number of unskilled staff is too high in Norwegian nursing homes (Harrington et al., 2012). There are no formal staffing standards for nursing homes, meaning that each can choose their own staffing level. However, an unofficial standard for staffing is a ratio of 0.94 full-time equivalent employees for each resident (Harrington et al., 2012). This includes all personnel categories combined.

The characteristics of the employees working in nursing homes will significantly contribute to the way nursing homes are seen as professional organisations. Referring to Mintzberg (1983) and his term professional bureaucracies, he argued that professional bureaucracies are not tied

to the traditional, formal structures that exist in what he calls machine bureaucracies. Instead, professional bureaucracies are tied to the presence of professional standards. In other words, the methods developed within professional standards and practices will to a large degree develop the behaviour of the employees in nursing homes.

According to Busch and Murdock (2014) the activities in professional organisations are centred on employees' ability to produce good care services. As distinct from NPM inspired management, professionals are given authority in decision-making and there is a high degree of specialisation, where the control is derived from employees satisfying specific educational requirements.

2.1.2 Nursing homes as political organisations

Nursing homes are also viewed as political organisations. Although nursing homes are considered necessary to provide services to elderly individuals in need of extensive care, they are constantly a political newstalk in the media and elsewhere (Næss et al., 2014). The notion of crisis in nursing homes are used to advance a constant quest for improvement and are ranked as one of the most decisive issues shaping the voting behaviours of Norwegian voters. However, that nursing home media scandals affect policy doesn't mean that underlying structural conditions in organising daily work are being addressed (Lloyd et al., 2013). Although improving services in nursing homes is portrayed as an important political issue, the feedback from nursing home employees is that many good intentions never reach practice. For instance, despite that the number of elderly are increasing and the demand for nursing home services rises, no additional beds are been allocated the last years (Næss et al., 2013).

Instead, nursing homes face new pressures due to more sick elderly and shorter hospital stays as response to the coordination Reform (White Paper.47). These changes are political issues that are not initiated by employees working in nursing homes, but health care workers are an occupational group that tends to be at the forefront of these changes. Nevertheless, many of the elderly and their relatives still view nursing homes as a more suitable option than having them stay home, or providing in-home care (Næss et al., 2013).

2.2 NPM reforms in Norwegian elderly care

Over the last 50 years, the public sector has gone through numerous modernization reforms that can be related to New Public Management (NPM). According to Hood (1991) who first started to use the term NPM, the emergence of NPM was an answer to a public sector that grew uncontrolled and became more and more bureaucratic and ineffective. The NPM ideology is not a consistent and integrated theory for modernizing public sector, it is characterized as a wave of reforms composed of ideas imported from the business and private sector (Pollitt and Bouckaert, 2011). Here, reform is a term that describe an active and deliberate attempt by political and administrative leaders to change structural or cultural features of organisations. NPM reforms is to be understood as an attempt to coordinate and control public organisations and constitute a set of management requirements that can be used as tools by leaders for influencing the work of employees via a system of rewards and sanctions (Christensen et al., 2007). Clarke et al., (2000) offers a list of management requirements typically ascribed to NPM reforms in health care organisations:

- Attention to outputs and performance rather than inputs
- Replacing trust relationships with contractual management
- Separation of purchaser - provider role and client - contractor role
- Increased use of competition
- Decentralisation of budgetary and personal authority further down in the organisations

As the list indicate, the NPM is not merely about economic efficiency and cutting costs. It can also be seen as a new way of managing daily work.

Request for economic efficiency has always been a concern in public organisations both before and after NPM (Busch et al., 2005). Therefore there is a need to separate contradictions that are mainly economically related and independent of NPM inspired reforms, from contradictions that occurs as responses to such reforms. In the dissertation I focus on the latter.

In the book *Elderly care in Transition*, Kamp and Hvid (2012) write that elderly care has been used as a testing ground for NPM ideas and is the sector in which its principles and methods have been applied the most to rationalise and increase the efficiency of health care services. Indeed, the increasing number of elderly individuals in most countries has triggered the need not only for more health care services, but also for more efficient services that maintain the

same quality of care (Busch et al., 2005). Nevertheless, in order to understand how NPM ideas affect daily work and organisational structure, it is important to know how these NPM inspired reforms come about and how they vary between countries.

Indeed, because NPM inspired reforms are context dependent, they will have different effects in different countries. For instance, NPM inspired reforms in Norway differ from those in countries such as the United Kingdom and New Zealand. Busch et al. (2005) write that the NPM ideology can be divided in two different directions, the first being *marketisation* and the second being *managerialisation*. Marketisation is about increased privatisation, i.e., transferring large parts of public health care to the private sector, which seen in countries such as New Zealand and the United Kingdom (McLaughlin et al., 2002; Osborne, 2010). Managerialisation is less market-oriented (Christensen et al., 2007; Meagher and Szebehely, 2013). In Norway, the reforms are more representative of managerialism, characterised by a comprehensive decentralisation of responsibility to the organisations themselves, along with new managerial tools that are used to control subordinate organisations from “arm’s length” distance (Lægreid et al., 2007). Instead of privatisation of the public sector, there has been an increased focus on competition, standardisation and performance management. This line of NPM ideology involve use of stricter predefined financial targets or work outcomes, in addition to standardised staff procedures and monitoring systems to measure performance (Brunsson et al., 2005; Dooren et al., 2010). Over time the many NPM inspired reforms we have seen;

.. consist of deliberate changes to the structures and processes of public sector organisations with the objective of getting them (in some sense) to run better (Pollitt and Bouckaert, 2004:8)

In many countries, critics argue that NPM inspired reforms have gone wrong and not lived up to the expectations of them (Pollitt and Bouckaert, 2011). They may fail to produce the claimed benefits, and in worst cases they may generate adverse results making daily processes worse than they previously were. In a research report about the marketisation of elderly care in the Scandinavian countries, Meagher and Szebehely (2013) wrote that traditional bureaucratic management and central control are being gradually replaced by local, market-inspired systems. There has been a comprehensive decentralisation of responsibility for care services, which has been moved from the state and county level to the local municipal level.

These managerial changes have provoked changes in the health care organisations themselves and in the norms of elderly care.

Meagher and Szebehely (2013) write critically about the NPM ideology's rather weak emphasis on professional values in health care organisations, demonstrating how professional values are being overshadowed by NPM. They referred firstly to the establishment of a two-level model in the form of a purchaser-provider system and secondly to the increased use of performance management, also named Management by Objectives (Dooren et al., 2010). Both have been implemented in the Scandinavian countries and has influenced the health care organisations there.

2.2.1 The two-level model

The two-level model, also called the flat structure model, was introduced to reduce the number of leadership levels in the municipalities (Torsteinsen, 2006). Its aim was to reduce the distance between service users and those making decisions about how available resources were to be used. Today 80% of all municipalities in Norway are organised according to the two-level model, with the municipalities located directly below the state (Christensen et al., 2007). As a result, unit managers in nursing homes answer directly to municipal leaders, with the aim to reduce administrative costs. Budgetary responsibilities also lie with the position of the unit managers. According to Torsteinsen (2006), unit managers constitute a new type of leader with both an internal and external focus in their work. As they are responsible for economic issues, personnel, and care services, unit managers have the authority and the freedom to lead their organisations as they see fit.

According to the list of management requirements typically ascribed to NPM inspired reforms the two-level model contain decentralisation of budgetary and personal authority further down in the organisations and makes a clearer distinction between a purchaser and provider role (Clarke et al., 2000). The main idea of such decentralisation is the combination of managerial freedom with performance agreement; "let managers manage" (Dooren et al., 2010).

2.2.2 The performance management model

The performance management model is strongly related to the two-level model. Johnsen (2010) writes that when central administration delegates tasks to municipal organisations, they must adopt new managerial tools that allow them to govern from a distance. Currently, these tools consist of standardised forms and recording of activities and resources used,

focusing on outputs and performance rather than inputs. Through providing standardised information, Dooren et al., (2010) writes that performance management is a type of management that incorporates and use performance information for decision-making. Performance information such as economic costs, staffing, and quality of care can be used in political decision making to determine further financing and achievement.

Increased standardisation is integral to the performance management model, and for this, central administration use contracts. Contracts between central administration and unit managers in underlying organisations outline the activities, outputs, and outcomes expected by central administration (Brunsson et al., 2005). Through contractual management the content of the service provided by the unit managers become determined, as well as the objectives that will be the basis for assessment (Lægreid et al., 2006; Torsteinsen, 2006). Vabø and Vabo (2014) writes that leader contracts renders a high degree of agreement in service delivery between central administration and unit managers, who are responsible for fulfilling the services laid out in the contracts. Further, increased focus on performance information form the basis for the use of competitions between private and public enterprises. Benchmarking and sanctions are used to promote efficiency, appropriate behaviour, motivation, and innovation among the members of an organisation (Dooren et al., 2010; Johnsen, 2010).

However, in contrast, non-use of performance information is a waste of time. Moreover, poor quality information may not be used, which consequently may lead to wrong decisions and actions. Hence, considering the complexity of health care organisation's vague and mutable goals, performance management will often appear as problematic in the light of demands for clarity and accountability. A key argument here is that performance management contribute to a strong focus on efficiency that breaks with professional values and ideals.

2.3 NPM reforms and the organisation of nursing work

There is a large number of studies on effects of NPM ideas on health care organisations (Allen, 2014; Jacobsen and Mekki, 2012; Kamp and Hvid, 2012; Orvik et al., 2013; Rankin and Campbell, 2006; Vabø, 2012; Vabø and Vabo, 2014). Many of these studies give rich descriptions about how health care practices change when professionals are expected to complete an increased number of managerial tasks, which in many ways are in contrast to

traditional professional management. Most of these studies are from hospitals and home care, while little has been done on this topic in nursing homes. However, as nursing homes face many of the same conditions, studies done on this topic within other health-care organisations can also be applied to a nursing home setting.

In one study on nurses' responsibility practices in hospital care, Olsvold (2012) writes that to understand how nurses successfully integrate new managerial tasks, it is crucial to understand the small details of nursing work and how they fit into the larger scheme of nurses' responsibility practices. A key aspect of nursing work is to coordinate patient care; activities and tasks must be distributed in and across organisational and professional boundaries. Those who are responsible for implementing managerial changes must be aware of the cooperative nature of nursing work, which involve a number of informally delegated and unspecified tasks (Olsvold, 2010).

In line with Allen (2014), Olsvold (2010, 2012) demonstrated how nurses contribute to health care services in ways that reach far beyond direct contact with patients. Through coordinating, planning, communicating, mobilising, organising action, relating to available resources, taking responsibility, and facilitating daily handovers, nurses play a key role in controlling and organising daily care in all health care organisations. Therefore, Allen (2014) argues that it is important to have a more thorough knowledge about the organisational aspects of nursing work to better understand how to ensure high-quality care, better productivity, higher efficiency, and fewer patient complaints. This argument is also underlined by Orvik (2004), who argue that there is a need for more knowledge about organisation and organising work among employees in health care organisations to understand how NPM ideas affect nursing work.

Allen (2014) argued that the organisational aspects of nursing work are not accorded their rightful, individual importance. Instead organisational aspects are often referred to as a distraction from patient care. Going to the nursing literature the main tasks of nurses have been described as responsibility for patients' physical, mental, social, and spiritual needs (Hamran, 1993; Kirkevold, 2001). Nurses has been characterised as an occupational group with a high degree of professional autonomy (Elstad, 2014; Kirkevold, 2001; Slettebø, 2013). Nurses operate in close contact with patients and handle the individuality and unpredictability of care based on their expert knowledge and the ethics and norms they have acquired through

education and vocational training. The distinctive quality of nursing work and of the occupational group itself has been described using terms like “nursing culture” (Hamran, 1993), and “care rationality” (Thorsen and Wærness, 1999).

These concepts demonstrate that the care work inherent in nursing is characterised by a rationale that in many ways separates this work from the context of new managerial tasks. Nurses’ professional judgment is based mainly on ethical and moral norms (Slettebø, 2013), which reinforces a strong professional role identity among nurses (Abbott, 1988; Molander and Terum, 2008, 2013). Within this understanding, NPM inspired reforms are often referred to as threatening because nurses are being taken away from their true vocation.

However, there are studies that approach the relationship between NPM and nursing work in a more nuanced way (Allen, 2014; Muzio and Kirkpatrick, 2011; Numerato, et al., 2012; Olsvold, 2012). These studies are not primarily concerned with how new managerial tasks undermine the ethical aspects of nursing work; instead they focus on how these changes force nurses to renegotiate their professional culture, identity, and autonomy. The studies explore how NPM inspired reforms have influenced nursing work, professional identity, and health care work in general. Instead of limiting their view of NPM to something that is destructive to nursing work, they demonstrate the need to look at new managerial tasks also as a constructive and pragmatic development in nursing work.

As already mentioned, there is a limited number of studies focusing strictly on contradictions resulting from NPM inspired reforms when organising daily work in nursing homes. NPM is instead used as a backdrop to explain changes in nurses’ clinical work. Based on empirical data from Norwegian nursing homes Jacobsen (2005) used a rich description of nursing work to show the presence of a strong work culture among nurses. This “struggling culture”, as he named it, created a working environment that provided resistance to increased managerial tasks in daily work. His findings indicated that increased managerial tasks were seen as destructive by the staff and based in a strong work culture nurses could allow themselves to ignore managerial tasks that were seen as threatening to their professional values and focus on care tasks. For the nurses, the maintenance of quality and continuity of care was more important than adjusting to new managerial requirements. This behaviour was also shown in a later paper from the same study, in which Jacobsen wrote about continuity

and change in Norwegian nursing homes, focusing on organisational and architectural development (Jacobsen, 2013).

In another study, Haukelien (2013) aimed to describe and analyse the articulation between “holistic care” and ways of re-organising the welfare state along the lines of goal-oriented governance, specialisation and hierarchical authority. Studying care services in municipal elderly care, including nursing homes, Haukelien (2013) demonstrated how dilemmas and value conflicts were experienced, dealt with, carried out, and transformed by nurses and assistant nurses in detail. In her thesis she showed that female employees often found themselves conforming to standards of work that reflect priorities to which they are deeply opposed, thus undermining the values that are important to them. Drawing on Roy Rappaport’s theory, Haukelien (2013) explained how employees were able to legitimise new managerial tasks in care to themselves and others. In this way the study shows how NPM inspired reforms make collective action more difficult, and how it become harder to change course once it is clear that such a change is in fact needed. To ensure professional standards along with new managerial tasks employees had to work faster feeling that their work was more hectic. They had more responsibilities and less visible leadership. Ingstad (2010, 2011) also demonstrates similar changes in daily work in her study of nurses’ working conditions in nursing homes.

3. Rational and aims

As response to NPM inspired reforms, nursing homes are adapting new managerial tasks that stand in contrast to traditional professional values, resulting in contradictory management requirements in daily work. This study on contradictions in daily work aims to contribute with knowledge about effects, opportunities and limitations on how NPM inspired reforms are put into motion by nursing home employees when organising daily work. This knowledge is important in order to understand what matters most if better system performance is to be attained. Without this knowledge, such reforms can become ineffective, and at worst they can become an obstacle to nursing practices.

Previous studies on contradictory management requirements cover various research areas and give a good picture of the organisational complexity in healthcare organisations. However, there is a lack of knowledge about the impact of NPM ideas and the actual processes of change in daily work related to contradictory management requirements in nursing homes. In order to understand processes of change and its effects on daily work it is necessary to explore how daily practices arise from various institutional structures, and how employees in the field affect these processes and the institutional structures. In an attempt to fill this research gap, this dissertation will explore how employees handle, understand, and carry out (i.e., relate to) contradictory management requirements when organising daily work in nursing homes.

The clinical aspects of direct patient care activities will not be covered. Instead, the research objective is to describe organisational elements (routines, instructions, rules, norms, values) that nursing home employees create and use as guidelines when relating to tensions between professional values and NPM inspired requirements in daily work. The employees' language and actions are considered as expressions of these organisational elements.

The main research question is:

How do nursing home employees relate to contradictory management requirements in the organisation of daily work in public nursing homes?

The main research question is operationalised into three underlying research questions which address the main research question from different angles. The three underlying research questions are addressed in three articles included in this dissertation.

Article 1.

The aim of this article was to identify the coping strategies nursing home employees used to handle contradictory management requirements in daily work. Drawing on the concept of *scripts*, change in routines, documentation and procedures were of particular interests. The research question addressed in this article was:

1. *How do nurses handle contradicting logics of performance management and professionalism in everyday practices?*

Article 2.

The aim of this article was to explore the underlying sensemaking processes involved in handling contradictory management requirements in daily work. Drawing on the concept of *sensemaking*, change in how nursing home employees saw themselves and their work were of particular interest. The research question addressed in this article was:

2. *How do nurses make sense of contradicting management requirements in the organisation of daily work?*

Article 3.

The aim of this article was to explore how contradictory management requirements contribute to how nursing home employees saw and acted out nursing leadership in daily work. Drawing on the concepts of *management* and *leadership*, change in nursing leadership processes were of particular interests. The research question addressed in this article was:

3. *How do increased managerial tasks influence nursing leadership in nursing homes?*

4. Theoretical framework

Theories give researchers different «lenses» through which to look at complicated problems and social issues. Theory helps to give direction to the research process and are necessary to provide the most comprehensive and accurate description of empirical complexity (Aakvaag, 2008).

In this dissertation I draw on the institutional logic perspective as a theoretical framework (Thornton et al., 2012). The institutional logic perspective helps me to understand how the logics of NPM requirements and traditional professional values govern organisational structures and shape the behaviour of individuals in their practices. This theoretical approach allows me to focus on the interplay between nursing homes employees and structural elements within various aspects of the organisation of daily work. While the institutional logic perspective is strong in highlighting the importance of wider societal belief systems in explaining change in practice, I chose to combine the institutional logic perspective with the more practice-based complementary theory of *sensemaking* in explaining the interplay of the micro- macro, as well as the symbolic and material (Friedland and Alford, 1991; Weick et al., 2005). In addition, the study is supported by theory of nursing leadership and management (Kelly, 2012).

4.1 The institutional logic perspective

The institutional logic perspective is a theoretical framework for analysing the relationship between institutions, individuals, and organisations in social systems (Thornton et al., 2012). The institutional logic perspective represents a new theoretical approach to culture, structure, and processes to explain change in organisations.

Friedland and Alford (1991) introduced the institutional logic perspective as a criticism of earlier neo-institutional theory, which they felt did not situate actors in the social context. Neo-institutional theory focuses on a set of expectations related to strong ideas about how to act, how to behave, and how to avoid surprises in daily work. These expectations can be described as scripts/typifications that actors follow in practice (Barley and Tolbert, 1997; Zucker, 1988). The focus of neo-institutional theory is to understand why actors follow these scripts and what the scripts are (Meyer and Rowan, 1977). However, after DiMaggio and Powell (1983, 1991) demonstrated how similar organisations can be heterogeneous in their

practices, it was revealed that neo-institutional theory has a limited capacity to explain agency and the micro foundations of institutions, institutional heterogeneity, and change. Instead of focusing on differences in structures, Friedland and Alford (1991) were more interested in exploring how differences in institutions occurred by focusing on the actors and showing how the sources of rationality change with different institutional logics in daily processes.

The interest in using the institutional logic perspective as its own theoretical direction started in 2002. In 2008 it was acknowledged as a separate perspective, and today the institutional logic perspective is regarded as a key perspective within sociology and organisational theory (Thornton et al., 2012). The institutional logic perspective is methodologically positioned within a social constructivist philosophy (Berger and Luckmann, 1984). Within this philosophical approach, individuals' subjective meanings are not simply imprinted, but are formed through interactions with others and through historical and cultural norms that operate in individuals' lives (Berger and Luckmann, 1984; Lock and Strong, 2014). In this way, the institutional logic perspective include the social system to explain what influence actors' understanding and action in daily practices (Thornton et al., 2012).

Health care organisations typically face multiple logics that may or may not be mutually incompatible. Contradicting or conflicting logics generate challenges and tensions for the organisations exposed to them (Greenwood et al., 2011). Thornton et al. (2012) developed six ideal types of institutional logic: the *market*, *corporations*, *professions*, the *state*, the *family*, and *religion*. Each has distinctive characteristics that are useful for studying logics in conflict. In the dissertation I concentrate on two of the logics; the market and the professions. Each logics is associated with a set of materiel practices and symbolic constructions (Friedland and Alford, 1991:248). In other words, logics provide guidelines on how to interpret and function in social situations (Greenwood et al., 2011). Thornton and Ocasio (2008) describe institutional logics as;

...the socially constructed, historical patterns of cultural symbols and material practices, including assumptions, values and beliefs, by which individuals and organisations provide meaning to their daily activity, organize time and space, and reproduce their lives and experiences” (Thornton and Ocasio, 2008:2).

However, to be active, the logics require carriers such as individuals and organisations that affirm, embody, transmit, and act in accordance with these characteristics (Thornton et al., 2012).

The institutional logic perspective accounts for the dynamics of both material and symbolic change. *Material* aspects of institutions refer to organisational structures and practices such as regulations, routines and rules. While *symbolic* aspects on the other side refer to actors' identity and meanings such as values, norms and culture. Thornton et al. (2012) argues that a basic principle of the institutional logic perspective is that each of the institutional orders in society has both material and symbolic elements that are intertwined. This means that without the symbolic aspect of institutions, there is little opportunity to theorise institutional heterogeneity and change because social practices become institutionalised only in the sense that they achieve collective meaning.

A core premise of the institutional logic perspective is that the interests, identities, values, and assumptions of individuals and organisations are embedded within dominant institutional logics. This shows how structural and institutional logics can be analysed without resigning to methodological individualism and the requirement that all social phenomena are the result of individual actors' rational choices of action. As Thornton et al. (2012) argues, the key to understand the question of social structure and action is not to see it as a binary contrast between rational and non-rational actors. Instead, the goal is to examine how action depends on how individuals and organisations are situated within and influenced by the sphere of different social structures, each of which presents a unique view of rationality.

Early work on institutional logics focused mainly on change in the dominant logic of a field level over time (Scott, 2000, 2008). This line of research is typified by how new competing managerial logics triggered field-level change. This change was going from professional toward a more managerial logic. However, more recent studies recognise that organisational fields can also be characterised by multiple institutional logics that coexist over a period of time (Greenwood et al., 2011; Lounsbury, 2007, 2008; Reay and Hinings, 2009). Such co-existence is possible through cooperation between professions and through hybrid forms of professionalism (Greenwood et al., 2011). Research has shown that contradicting management requirements are fairly common in health care organisations (Greenwood et al., 2011; Scott, 2000), and even though these studies focused mainly on hospitals, one can expect

the same to be of true for nursing homes. Various meanings and normative understandings concerning care issues create inconsistent expectations among professionals that generate challenges for organisation of daily work.

Although research attention in this area is growing, further research on organisational complexity are needed to understand how contradictory management requirements are sustained and translated into stability in the organisation of daily work. More research on the relevance of interconnected action at the individual and the micro level is needed to understand organisational behaviour and change.

Summing up, this dissertation is based on the institutional logic perspective, in which I focus on the relationship between nursing homes employees' interpretations of their daily work and overarching contradicting institutional logics. In other words, I am concentrating on the contradiction between managerial logics (stemming from NPM inspired requirements) and professional logics (stemming from traditional professional values) in the organisation of daily work in nursing homes.

4.1.1 Professionalism and managerialism as contradicting logics

Professionalism and managerialism are often presented in the literature as contradicting logics that influence every day practises in different ways (Evetts, 2003; Greenwood et al., 2011). Each of the logics has its own set of assumptions and its own form of rationality, and each is associated with a special set of expected behaviours, rules, and norms (Thornton et al., 2012).

Professionalism relates to nursing homes employees as health professionals. In other words, professionalism refers to the institutional circumstance in which the members of the occupation—rather than consumers or the market—control daily work (Freidson, 2001). As professions, nursing homes employees are distinguished from other occupational groups by their autonomy to determine how professional knowledge is practiced and how the work should be done and evaluated. However, professionalism evolves in organisations and must be understood in the context of shifts in practice (Evetts, 2003; Molander and Terum, 2008).

Professionalism is often considered to comprise two elements: a *normative value system* based on professionals' norms and identities, and an *ideology* emphasising the power of

professionals' autonomy and self-control (Evetts (2003, 2013)). The balance between these elements varies and depends on how professionalism is constructed and operationalised within the occupational group. Professional identity and the character of the person is also of relevance. Within this understanding, nursing homes can be seen as autonomous organisations in which professional employees seek to preserve their autonomy in the performance and organisation of care in order to control the delivery of services.

This is in line with Freidson's (2001) understanding of professionalism as the third logic, where he makes a comparison between professionalism, bureaucracy, and market and seeks to give professionalism the same theoretical status as the free market and rational managerial ideology. In this way, professionalism is seen as an independent logic and a way to ensure professional activities that have been strongly challenged by the managerial logic (resulting from NPM inspired requirements).

Molander and Smeby (2013) write that although professions are used in different types of organisations and social structures they have rarely been studied from an organisational perspective. However, it is important to highlight that professionals are organisation- and system-dependent (Muzio and Kirkpatrick, 2011). Therefore, many have argued for a new research agenda characterised by the discovery of the organisational dimensions of professional work (Olsvold, 2012; Allen, 2014). By combining theoretical perspectives on professional organisations and professional occupations, we can explore how professionals are guided not only by professional values, but also by specific organisational and management requirements.

Managerialism on the other side, relates to stronger focus on efficiency. Managerialism is a process of establishing managerial authority over resources and decisions and is related to the process of managerialisation. In this way, managerialisation refer to processes by which an occupational group claims to be the processor of a distinctive and valuable sort of expertise, and uses that expertise as the basis for acquiring organisational and social power (Clarke et al., 2000:8). In contrast to professionalism, which focuses on values and beliefs according to professionals' norms and values, managerialisation is inspired by market-based techniques and ideas taken from the business and private sector. It represents a set of expectations, values, and beliefs that are expressed by the use of standards, control and performance measures.

Within this understanding managerialism relate to the concept of governance and the act of governing. Governance is important to achieve policy or organisational objects, and could refer to organisational structures, administrative processes, managerial judgement, systems of incentives and rules, administrative philosophies, or combination of these elements (Lynn et.al., 2000). Managerialism has always existed in health care organisations to achieve economic control. However, with NPM inspired reforms, managerialism has been seen as a new mode of governance structure, coordinating and controlling health care organisations guided by neo-liberalism to increase efficiency, reduce cost, and improve the quality of services, while reducing direct government involvement (Broadbent and Laughlin, 2002; Pollitt and Bouckaert, 2011).

A central issue in the managerialisation of the public sector has been the concerted effort to displace or subordinate the claims of professionalism (Clarke et al., 2000; Evetts, 2011). Continued focus on efficiency and performance achievement, with strong central control and tendency toward standardisation of work practices, continues to exert pressure on health care organisations and the employees that work within them.

4.2 Sensemaking

The institutional logic perspective seeks to integrate other, more practice-based perspectives to develop a more balanced approach to understand organisational change. The theory of sensemaking is one of these. Sensemaking was proposed by Weick (1995) and focuses on the relationship between understanding and action. Sensemaking is referred to as the key mechanism of social interaction that situates the identities and practices of actors within the broader social structure (Weber and Glynn, 2006). In this way, sensemaking was introduced to encompass the myriad of complex social interactions that mediate institutional logics and the dynamics of organisational practices and identities (Thornton et al., 2012).

In the dissertation I draw on sensemaking to explore how nursing home employees make sense of contradictory management requirements when organising daily work. Sensemaking refers to on-going retrospective processes that rationalise organisational behaviour, helping to resolve ambiguity in ways that enable activity to occur (Hernes and Maitlis, 2010). Ambiguity is here understood as several incoherent meanings without the possibility to determine which

one is “the best” and no fixed way to act (Alvesson and Sveningsson, 2011). For instance, when increased focus on managerialism creates incongruity in how to organise daily care, employees attempt to clarify the situation, and the process of clarification entails sensemaking. Based on how sensemaking is carried out, i.e., whether it is triggered by external or internal guiding logics, helps us to get greater insight into the processes that reproduce and alter daily practices.

Within this understanding, sensemaking is an ongoing process that focuses on occasions of sensemaking rather than on the sensemakers. Sensemaking addresses cognitive and social mechanisms for dealing with unexpected events, uncertainty, and ambiguity in organisations and helps to explain actors’ behaviour in practice. In this manner, sensemaking can be viewed as “the feedstock for institutionalization” (Weick et al., 2005). Still, research studies that combine institutional theory with sensemaking processes are few in number (Jensen et al., 2009; Maitlis and Christianson, 2013).

4.3 Nursing leadership and management

All organisational work contains leadership in one or another way. The health care literature contains various definitions and understandings of nursing leadership. For instance, Huber (2014) and Kelly (2012) defined nursing leadership as the process of influencing people to accomplish goals. Within this understanding, nursing leadership implies that the practice of leadership is not confined to formal leaders, but can be practiced by personnel at all levels. In other words, all health care professionals perform leadership when they inspire, enliven, and engage others to participate in care.

This process-oriented view of leadership is of particular relevance within professional organisations, since professionals largely practice self-leadership (Busch and Murdock, 2014), meaning that professionals traditionally have fewer restrictions on their work performance because of their professional autonomy (Evetts, 2009). Because nursing leadership requires interaction with others, it can only be understood through studying interactions between managers and employees (Busch and Murdock, 2014).

Going to organisational literature, leadership is defined as a goal-setting, problem-solving, and language-creating interaction between relevant persons (Johnsen, 2006). Leadership

involve developing goals through negotiations and interpretation, solving problems that hinder the achievement of goals, and developing a language to work with goal-setting and problem-solving (Bush and Murdock, 2014; Johnsen, 2006). Within this understanding, leadership requires interaction at all levels of an organisation, whereby the formal leaders are responsible for these interactions. A similar, more ambitious definition was given by Jones (2007), who defined nursing leadership as the process of envisioning a new and better world, communicating the vision to others, motivating others and enticing them to join the efforts to realise the vision, thinking in a different way, challenging the status quo, taking risks, and facilitating change.

The common features about these definitions of leadership are that they all describe leadership as a process with five components: leader (s), follower(s), situations (context), communication processes, and goals. In addition, one cannot talk about nursing leadership without access to the resources necessary in a given situation (context).

When referring to nursing leadership, the terms leadership and management are often used interchangeably, but they are not synonymous. Both are seen as components of nursing leadership that are used to accomplish goals, but they have different focuses. Management focuses on the structures that attend to rules and details and emphasises the use of control and rules to get people to do things right. Leadership on the other side is value-based, focusing on how to achieve a common vision and is about creating and carrying values and rules to do the right things (Huber, 2014; Kelly, 2012; Ladegård and Vabo, 2010).

In an ideal world, leaders would be good managers and managers would be effective leaders. However, that is not the case in complex health care organisations. As Patrick and Laschinger (2006) stated, to leave room for professional autonomy and avoid over-managed health care organisations, there must be access to opportunity, information, resources, support, formal power, and informal power in work. This implies that good nursing leadership is central to the delivery of high-quality and effective care services. Good management and leadership are being put more in centre as the key element in order to be able to meet the significant challenges posed by NPM inspired reforms (Kerridge and Ryder, 2013).

5. Methods

This dissertation is based on qualitative methods to collect knowledge about how nursing homes employees relate to contradictory management requirements in the organisation of daily work. In order to explore tensions between NPM inspired requirements and traditional professional practice, in-depth investigations are required. Professional employees in nursing homes are not standard entities, thus NPM reforms will travel and be translated in various ways according to particular contexts. I therefore seek to explore everyday practices as they are described and understood by nursing home employees from inside of the organisation. My goal is to outline a discussion that reflects the complexity of the relationship between management tasks inspired by NPM and traditional professional practices in the organisation of daily work in public nursing homes.

Daily practices as they appear to the individuals will always have an undetermined character affected by the existing situation. Thus, a qualitative methodological approach does not give a whole picture of what happens inside the organisation. Instead, I will get detailed and realistic descriptions on parts of nursing homes employees' daily work. I use observation and interviews to provide nuanced data of everyday practices to employees holding various positions in three different nursing homes. Individual interviews and observations of daily practices complement each other and give rich access to explore daily practices as they appear for individuals inside an organisation (Cassel and Symon 2004; Fangen, 2010; Kvale and Brinkmann, 2009).

5.1 Participants

The study includes three nursing homes located in three different municipalities in the northern part of Norway. All nursing homes were public, owned and operated by the municipalities. The municipalities varied in size; from around 1000 inhabitants in the smallest, around 10 000 in the middle, up to around 23 000 in the largest municipality. In all the municipalities central administration used NPM inspired management tasks to control subordinate organisations. The municipalities were organised according to the two-level model after the purchaser and provider idea in which underlying organisations were governed and controlled through increased use of standards and performance management. Tension between NPM requirements and professional practices were thus expected to be present within the nursing homes.

The nursing homes were strategically selected to ensure optimal variation in size and content of work (see for instance (Creswell, 2007)). In addition to selecting nursing homes from three different municipalities, the largest nursing home in each municipality was included in the study. This was based on the assumption that larger nursing homes would have more variation in nursing home employees and daily tasks. Further, by including three nursing homes it was easier to ensure confidentiality among employees holding a leader position. Generally, there are normally in addition to unit managers, only two to four front-line managers in nursing homes.

Nursing home A was from the largest municipality and operated with 39 beds divided into three wards. Nursing home B was from the smallest municipality and operated with 27 beds divided into three wards. Nursing home C was from middle sized municipality and operated with 90 beds divided into nine wards. In common, all the nursing homes operated as separate entities (in accordance with the two-level model) where the unit managers together with front-line managers had the autonomy and responsibility to control economic issues, quality of care, and personnel tasks in daily care. In the dissertation I refer to the nursing homes as nursing home A, B and C.

The main concern in each of the nursing homes was to produce good quality care services to their residents. The nursing homes provided day continuous services and were characterized by continuous replacement of employees who worked in shifts. Everyday practices varied continuously in line with the residents' change in needs along with central and local recommendations. The variety in daily work could change between the morning and night shifts, and according to who was at work and what type of tasks that had to be done. Based on this variety in daily work, the dynamic relationship between NPM requirements and professional values shaped and were shaped by nursing home employees as part of daily work.

After the selection of the nursing homes I contacted the unit managers in each nursing home through e-mail with information about the study (see appendix 3), asking them to participate. All answered that they were positive to participate. The unit managers forwarded information about the project to the front-line managers and to the clinical and assistant nurses at the wards (see appendix 4). Employees at the wards who were interested and volunteered to

participate told the front-line manager, who then passed the information back to me. In nursing homes A and B the participants had been recruited through the front-line manager before I arrived to do interviews and observations. In nursing home C the participants had been recruited through front-line managers on the same day as the first interviews and observations took place. Interviews and observations was organised in cooperation with the unit managers and front-line managers in each nursing home.

In the recruiting process I tried to ensure variation in both leadership and nursing position. It was important to select participants who could give insight into contradictory situations at various organisational levels in the nursing homes. Therefore, one unit manager, two front-line managers and three clinical/assistant nurses were consecutively recruited at each nursing home. To be eligible, participants had to have at least 1 year of experience in a permanent position in a nursing home and had to be working full time. In total there were 18 participants (15 women and three men): three unit managers (one at each nursing home), six front-line managers (two at each nursing home) and six clinical/assistant nurses (three at each nursing home), see Table 1. The majority of the participants were educated as registered nurses. Participants' average work experience in nursing homes was 11 years.

To receive further access to nursing home employees' daily practices, I chose to do one week observation at each nursing home. Through open and mainly passive observation I observed the participants during planned meetings and daily handovers at the wards. These were arenas that gave access to typical situations in how daily work was planned and organised. To the greatest extent possible, I attempted to combine observations with follow-up interviews of the participants. In this way observation functioned as background information to ensure thoroughgoing interviews. In each nursing home I observed 11 daily handovers and two-three staff/leader meetings, totalling 40 observations and 100 hours field notes, see table 1.

Table 1. Number of study participants, interviews and observations in the three nursing homes

Nursing home	Interviews	Observations
	<i>Unit managers/ front-line managers</i>	<i>Daily handovers</i>
NH A	3	11
NH B	3	11
NH C	3	11
	<i>Nurses/assistant nurses</i>	<i>Staff and leader meetings</i>
NH A	3	2
NH B	3	3
NH C	3	2
Total	18	40

NH: Nursing home.

5.2 Data collection

Data were collected from January to February 2012. The use of individual interviews along with observations were considered the best methods to collect rich data about the complex relationship between NPM requirements and professional values in the context in which they occurred.

5.2.1 Interviews

The interviews were based on an interview guide (see appendix 5), which was prepared on the basis of theory, my own personal knowledge from working as a nurse/front-line manager in nursing homes and previous research in the field. The interview guide was designed around three focus areas. These areas focused on different aspects of nursing homes employees' organisation of daily work. I considered "NPM requirements" and "tensions in work" as abstract terms that could be hard to talk about. In line with Kvale and Brinkmann (2009) I therefore chose to operationalize the relationship between NPM requirements and

professional values into concrete subjects that were more recognisable and familiar to the participants.

For instance, instead of asking about how they related to management tasks inspired by NPM I focused on content of daily work processes. I asked if the participants had experienced any change in work and if so, how it had influenced daily work, what aim they worked toward, where there any dilemmas in work and if so, what it was about. Through these focus areas I was able to collect rich descriptions and concrete stories about various elements of tensions in work and how they and their colleagues planned and organised daily work to handle these contradictions.

In each interview I started by asking the participants to say something about themselves, and to state their profession, age, and their experience from working in the nursing home. This was followed by an open question in which participants were asked to describe the contents of a normal day at work. I also asked how the work was organised and coordinated, if there were any changes in duties and responsibilities and if so, what they were, their experiences of predictability and dilemmas in everyday practice. In the interviews I told the participants to articulate their concrete experiences through describing the situations as detailed as possible. Additional questions were posed as needed to clarify answers. In this way, the interviews were not performed as free dialogues, but as an influential form of conversation where I as the interviewer set the stage and scripts according to my research focus (Kvale, 2006).

The same interview guide was used regardless of participants' position and working place. This helped me to collect rich descriptions around each focus area, although the nature of the participants' involvement in daily work differed depending on their position. Too much structure in the interview can limit participants, and certain information might not come to light. To avoid that, each interview both started and ended with an open question. In addition, I let the participants guide the conversation, but ensured that all focus areas were asked about and discussed. All the interviews were undertaken during participants' working hours and lasted around an hour. The interviews were all tape recorded and later transcribed by me.

5.2.2 Observations

The overarching aim of observation is to study and describe what individuals say and do in contexts that are not structured or affected by the researcher (Fangen, 2010). In this study I

chose to observe daily handovers at the wards (morning, afternoon, and evening) in addition to planned meetings. Before the field work I prepared a list of keywords to guide my observations (see appendix 6). This guide was used more as a support than an instruction during the observation.

Daily handovers are meetings with employees going off and on shift in which information about the residents are shared and where the employees coordinate and make plans and decisions for the next shift. A typical handover started with the nurse responsible for the off-going shift giving information about each resident and handing over a report about what had occurred during the previous shift. Such exchange of information is common at any nursing home as it is considered essential in order to coordinate and organise care services in the best possible way. In each nursing home handover meetings was held at the nursing office at the wards. Although the time and content of handovers varied, their structure was quite similar across the nursing homes.

In addition to daily handovers, I chose to observe planned staff and leader meetings that took place during my one week stay at each nursing home. Staff meetings were an arena in which front-line managers met with nurses and assistant nurses to evaluate their routines and discuss dilemmas that had been raised, or new management tasks that the central administration wanted them to implement. For instance, cost savings were discussed in these meetings at all three nursing homes. On a more strategic level, leader meetings were carried out between unit managers and front-line managers. In these meetings they focused on the interpretation of, and response to performance information they had achieved from standardised forms and programs. I wrote field notes continuously during the observations which I later wrote into complementary text.

Through the observation I got access to verbal exchanges and actions between the employees at each nursing home. The observations provided useful additional information about tensions in daily work and how NPM requirements were handled in relation to the participants' professional practices. I focused especially on the actions of the participants, the tools that they used, and the narratives they applied when planning and organising daily work. Through the observations I was able to study first-hand the

day-to-day experiences and behaviours of the participants in particular situations, and if necessary talk to them about their feelings and interpretations around the situations.

5.3 Data analysis

The purpose of this study is to explore how nursing home employees relate to contradictory management requirements when organising daily work in nursing homes. In this way, the rationale and aim of the study give direction to what the analysis should involve, also referred to as an attempt to answer a 1000 pages question (of transcribed text) (Kvale and Brinkmann, 2009). Qualitative content analysis (Schreier, 2012) was used to analyse the data. Qualitative content analyses overlaps with thematic analysis which refers to a group of techniques for thematically organising and analysing qualitative data (King, 1998). I will now describe the analysis technique in more detail by going through each step of the analysis process.

5.3.1 Analysis process and pattern identification

Firstly, I reread the transcribed text of interviews and observations, trying to identify patterns. To help organise the large amount of data I used the main questions from the interview guide as pre- defined themes. These themes were; contents of work, aims and responsibility, predictability and dilemmas. In this way, the interview guide was used as a template to sort parts of interview and observation text under “right” themes.

Secondly, I started to analyse the organised text within each theme by attaching codes to segments of the transcribed text. The coding process were guided after the concepts; *control, direction, and coordination*. These are concepts that stems from the concept of *governance* that according to management literature contain core elements about steering processes in daily work. Governance refer to the means of achieving direction, control and coordination of wholly or partially autonomous individuals or organisations on behalf of interests to which they jointly contribute (Hill & Lynn, 2005). For instance data that contained stories about aims in care work showed empirical descriptions for employees’ choice of direction in daily work. Further, data that contained stories about implementation of new check lists showed empirical descriptions for how employees were relating to increased control in work. In this way, the coding process helped to identify elements in daily practice that employees created and used as guidelines in daily work.

Thirdly, after having systemised the data according to the preconceived codes I started to look into each of the codes searching for patterns, coherence, common features and differences of activities and interactions that reflected daily practices when nursing home employees faced contradictory management requirements. The content of each code was then categorised further into three themes that became the result section of article 1. In this part of the analysis, I followed a step-by-step process where I went back and forth between theory and empirical data, also described as an abductive approach (Blaikie, 2009; Schreier, 2012; Tjora, 2012).

Working with article 2 and 3 I choose to reread the transcribed texts of the interviews and observation again. In this part of the analysis I chose to stick to the same strategy as in article 1. However, this time the coding process was not informed by the concept of governance. To avoid becoming to theory- driven in my analysis, I choose to follow a more data-driven approach focusing on how the participants reflected on their own practice and gave meaning to the way they organised daily work. When coding the data I tried to be as close as possible to the original text, allowing the codes to flow from the data (Kvale and Brinkmann, 2009; Tjora, 2012).

In the analysis process of article 2, my interest was on how the participants gave meaning to how they organised daily work influenced by tension between NPM requirements and professional values. I searched for units of meanings in the data material concerning how the participants reflected about contradictions in daily work when saying; “to me contradictions gave meaning because...” This analysis approach were inspired by sensemaking (Weick, 1995). Each meaning unit were coded and organised into three themes. By following this analyse approach I was able to gather new and various dimensions of how contradictory management requirements gave meaning to employees in daily work.

In the analysis process of article 3 my interest was on nursing leadership processes in daily work. Without having asked the participant directly about leadership in the interviews or used leadership as a focus area in the observations, nevertheless much of the data material centred around nursing leadership as response to contradictions in work. I followed the same principles as in article 2, searching for meaning units about nursing leadership processes, which I then organised into three themes. Identified themes were seen in accordance to existing research and theory on management and nursing leadership (Huber, 2014; Kelly, 2012).

In the analysis process I used the software program Nvivo. The coding was conducted in Norwegian and quotes were later translated into English for the purpose of publishing the findings in scientific journals.

5.4 Ethical considerations

Nursing homes are complex organisations where various professions provide care services to its residents. In order to show respect for employees and residents I reflected on the ethical issues surrounding my research. Ethical reflection is an integral part of all research work and requires steady adjustment and reorientation of the research process (Alver and Øyen, 2007). For instance, I chose to do my observations of employees' daily practices within nursing offices to not interfere unnecessarily with the residents. In other words, I chose not to include the residents in the study. However, I still had access to sensitive information about the residents, especially when I did my observations during the handovers at the wards. The Regional Medical Research Ethics Committee (REK) was therefore consulted to get employees' exemption from confidentiality according to the law of Health Personnel §29 and Administration §13 (see appendix 1). During the observations I took great care to inform all the employees that participated at the handovers that the study was approved both by REK and The Norwegian Social Science Data Service (NSD). It was important for them to know that they were exempt from confidentiality in order to avoid ethical dilemmas when sharing resident sensitive information.

Another ethical issue when doing observation at the handovers was that there were little opportunity for the colleagues of study participants to avoid participating in the research, as everyone had to be present at meetings and handovers. Being subject to observation and interpretation by others can be experienced as degrading and can put pressure on the "non-participants" who are present during observation. To avoid this ethical dilemma it was essential that during the observation I introduced myself as a researcher and informed all employees that was present about the aim of the study. In addition, I informed the participants that they could chose to withdraw from the study at any time.

Informed consent was obtained before each interview. Anonymity was ensured in the presentation of the results and pseudonyms are used in the quotes. The study is approved by

(NSD) and conducted according to the Guidelines for Research Ethics in Social Sciences, Law and the Humanities (REK) (see appendix 2).

5.5 Reliability and validity

Reliability and validity is often determined by the rigour or trustworthiness of the qualitative research (Kvale and Brinkmann, 2009). To be able to say something about contradictions in nursing homes it is necessary to ensure collection of right and enough data. In addition, the structure of the study and the choices along the way must be as transparent as possible to ensure dependability.

As a former nurse and front-line manager with experience from working in nursing homes, I brought my previous knowledge about the field and my assumptions into the way I planned and carried out the study. For instance, I knew that daily handovers and meetings were arenas that would give access to typical situations in how daily work was planned and organised. The advantage of performing research in an area that was familiar to me was that I had experiences that made it easier to understand the participants' expressions and descriptions about daily work. This contributes to strengthen my data.

On the other hand, I was aware that previous assumptions about the field could make it harder for me to elucidate new aspects in the field. The danger with pre- understanding is that my focus can be to confirm my own assumptions (Kvale and Brinkmann, 2009). To avoid that, I tried to be conscious of my pre- understanding during interviews and observations. For instance, I followed up participants with questions to challenge or confirm my pre- understanding and I used this technique deliberately to avoid that my interpretation was formed too much by my pre- understanding. I recognised that when participants in the study got to know my previous experience from working in nursing homes, it became important to ask about underlying meanings that the participants otherwise easily could think I would recognise and understand the meaning of. In addition, the interview guide helped me to stick to my focus areas.

As previously stated, there are few qualitative studies focusing on contradictory management requirements in daily work in nursing homes. This means that there are few studies, which I could compare my results with to increase the study's trustworthiness. However, since the

study is based on the criterion of optimal variation in data collection, identifying the same patterns among the employees across the nursing homes increases the credibility of the study.

In this study I was especially surprised by the increased delegation of responsibility and use of standardised forms among the nursing home employees in the organisation of daily work. In addition, I was surprised about the lack of leadership in daily care as response to what I considered to be increased numbers of managerial tasks in daily work. These findings were not part of my pre-understanding that increases the trustworthiness of the study.

6. Results

Three central themes were identified during the analysis process that were of relevance for all participants, regardless of the nursing home they worked at and the position they held. These themes were; 1) *coping with contradictory management requirements*, 2) *establishing new meaning in daily work in handling contradictory management requirements*, and 3) *changes in nursing leadership processes*.

Originating from different theoretical concepts, each of the three themes allowed me to discuss the dissertation's main research question from various angles. I will describe the results from each article in more detail.

6.1 Article 1

Contradicting logics in everyday practice: The complex dynamics of performance management and professionalism in Norwegian nursing homes

Article 1 is based on the first central theme, and focuses on how nurses develop new material/organisational structures (coping strategies) to handle contradictory management requirements in the organisation of daily work. This article explored how the contradicting logics of managerialism and professionalism are interpreted and handled by unit and front-line managers and clinical nurses in everyday practice. Three coping strategies were identified that were used by the employees to handle contradicting logics:

The adjustment of professionalism to standards

As a consequence of comprehensive decentralisation, unit managers and front-line managers had increased responsibility for budget and administrative duties, whereas clinical nurses were delegated increased responsibility for quality of care. However, with this increased responsibility and greater autonomy, there were also performance principles, which involved enlarged specification and standardisation of care. Therefore, the organisation of daily work changed from being built on trust-based relationships and professional autonomy, to being built on managerial accounting activities. Increased standardisation became a part of professionalism that was seen as so pervasive that managers and nurses saw no alternative but to incorporate them into the organisation of their daily work.

The reinforcement of professional flexibility and problem solving

To cope with standardisation and increased managerial tasks, the employees became more flexible and took on more problem solving in their daily work. During this process, professional knowledge was used to identify areas that needed improvement while simultaneously incorporating NPM requirements in daily care. This coping strategy involved changes in routines and daily plans. The coexistence of professional and managerial logics was seen as necessary if managers as well the clinical nurses were to perform as required in daily care.

The strategic adoption of documentation

A third way of handling contradictory managerial requirements in the organisation of daily work was to adopt performance management principles that spoke to employees' own interests. Both unit managers and front-line managers, and clinical nurses strategically integrated standardised rules and documentation routines into their daily work with the aim to safeguard their own professional interests. This coping strategy involved that they had to redefine traditional documentation so that it was more in line with the logic of performance management.

Contribution

The article shows that the establishment of new organisational structures allowed contradicting logics to coexist in daily work through establishment of new activities and interactions. The article provides new insight into how employees reshape internal organisational structures to cope with contradicting logics in nursing homes. However, to gain a deeper understanding of the meaning of these coping strategies, further research on how employees give meaning to contradictory managerial requirements was needed. This became the main focus of Article 2.

6.2 Article 2

Nurses sensemaking of contradicting logics, an underexplored aspect of organisational work in nursing homes

Article 2 explored how employees in nursing homes made sense of contradicting logics. The article attempted to highlight how incongruity in organisation of daily work after the implementation of NPM reforms became a trigger for sensemaking. By combining the

institutional logic perspective with sensemaking theory, the study demonstrates how contradicting logics created new patterns and routines in the organisation of daily work through nurses' sensemaking. Three themes emerged:

Sensemaking through adjusting to tight budgets

The employees used sensemaking to define acceptable or unacceptable behaviour in care. Acceptable behaviour involved the establishment of stricter staffing routines and the avoidance of overtime. Compared to clinical nurses, unit managers and front-line managers expressed greater understanding and accepted the new mandate imposed by tight budgets. By considering themselves and their daily activities as part of a larger system, managers were able to clarify and cope with the uncertainty that stemmed from tight budgets. Following the lead of the front-line managers, it made sense to clinical nurses to cope with stricter regulations even when they conflicted with their professional values. Through sensemaking, employees were able to create new practices that restricted their ability to exercise professional control in order to adjust to a tight budget.

Sensemaking through adjustment of documentation

Because both managers and clinical nurses feared the disappearance of professional values, increased use of documentation made sense to them as a form of resistance toward increased managerial tasks in daily care. This shows that employees in nursing homes cannot be considered passive recipients; they operate as active players in adapting to managerial agency. I argue that nurses' sensemaking indicates that both professional and managerial interests can be served simultaneously.

Sensemaking through working harder

Clinical nurses made sense of compensating for time lost to increased managerial tasks by working longer and harder. This sensemaking was based on their moral responsibility as female professionals and on their loyalty to their immediate supervisor and colleagues. However, the risk of being flexible was that one might be taken for granted, thus it also made sense to clarify work expectations and targets with leaders. This shows how increased individual self-discipline at work might undermine the collegial form of professional logic in the organisation of daily work. I argue that clinical nurses' sensemaking in this area could lead to a minimising of professional logic in favour of managerial logic.

Contribution

The article indicates how contradicting logics create a high degree of incongruity in the organisation of daily work, which employees in nursing homes try to clarify through sensemaking. These sensemaking processes play a critical role in how daily work is shaped and perceived. By revealing these sensemaking processes, the study contributes with a new understanding of underlying processes of contradictions in organisation of daily work in nursing homes.

6.3 Article 3

Coping with increased managerial tasks- tensions and dilemmas in nursing leadership

Article 3 explored how increased managerial tasks influence on nursing leadership in nursing homes. By drawing on the literature on nursing leadership and management, the article demonstrated three changes in how the employees saw and performed nursing leadership in daily work. These changes represent a movement from professional leadership toward becoming an administrative manager, which has significantly weakened nursing leadership in nursing homes:

Leading daily care from a distance

Unit managers and front-line managers focused more on managerial tasks than on patient-related care as a consequence of increased responsibility and pressure to improve efficiency in care. This change in function made them focus more on managerial goals rather than on professional goals. Front-line managers were seen more as office clerks than professional leaders, controlling daily care from a distance. Instead, nurses functioned as front-line managers, through so called 'administrative days'.

Lack of support in problem- solving

As front-line managers lacked the time to motivate and to support nurses at the wards in problem- solving, nurses at the ward became uncertain about who was in charge. Without any instruction or delegated authority to solve important issues in care, nurses found it hard to reach decisions in care, which in turn left room for subcultures to develop.

Difficulties in adopting new managerial language

Both managers and nurses were encouraged to adopt managerial language in daily work. Such translation of care issues helped to combine professional motives and managerial demands. Changes in nursing leadership gave nurses the opportunity to advocate for more professional values in care, in addition to controlling the system. To avoid professional weakness nursing leadership roles became associated with the ability to translate managerial language.

Contribution

The article demonstrates that managers take on a more administrative role that in turn weakens their ability to supervise and motivate nurses in daily care. Lack of reciprocal relationship between managers and nurses in goal achievement has significantly weakened nursing leadership in nursing homes. The study contributes with greater awareness of how nursing leadership processes weakens as response to changes in nurses' roles with increased managerial tasks.

7. Discussion

The present study explores how employees at various positions in nursing homes relate to contradictory management requirements following NPM inspired reforms in the organisation of daily work. Although, tensions (dilemmas) between quality and economy always has been part of health care services, these tensions has been reinforced with implementation of NPM inspired reforms.

By focusing on the routines, instructions, norms, rules and values employees create and use as guidelines in daily work, this study contributes with new understanding on how contradictory management requirements is handled, understood and carried out in nursing homes. To do that, I used the perspective of institutional logic (Thornton et. al., 2012). This perspective helped me to connect individual action to institutional structures to explain how nursing home employees adjust within and are being influenced by both professional values and NPM requirements in the organisation of daily work.

Through both irrational and rational behaviour among nursing home employees, the findings indicate that daily practices are reshaped and that new and modified practices are established. As the results from the study's articles demonstrate, the way nursing home employees relate to contradictory management requirements is made possible through *coping strategies*, *sensemaking*, and *change in nursing leadership processes*. These practices create room for the logic of professionalism and the logic of managerialism to co-exist. In other words, nursing homes employees do not ignore or reject NPM requirements; instead, they relate to both logics trying to balance values of professionalism and managerialism in new ways in the organisation of daily work. Such co-existence between the logic of professionalism and managerialism were made possible by the employees themselves and were performed differently in various aspects of employees' position in the nursing homes.

Based on the study findings, the way nursing home employees relate to contradictory management requirements can be broken down into three movements (actions) that take the findings one step further. These movements indicate how employees tried to oblige the influence of NPM requirements by reorienting this logic to a more professional-based logic in the organisation of daily work. I have chosen to name the movements: 1) *from internal to*

external focus in daily work, 2) from invisibility to professional visibility in daily work, and 3) from direct to indirect nursing leadership in daily work.

Each movement indicates changes in daily practices in how nursing home employees relate to contradictory management requirements. In common, the findings indicate that these movements are about safeguarding professional values in new ways as response to NPM requirements. I argue that NPM inspired reforms have influenced nursing home employees to renegotiate traditional professional practices by considering NPM ideas as an essential management requirement in organising daily work.

I will now discuss each movement in more detail.

7.1 From internal to external focus in daily work

The findings indicate that as a consequence of expanded use of performance management, daily work was progressively organised and constructed according to strong focus on budget and monitoring economic costs. This change in practice indicates a movement toward a managerial logic. Expansive delegation of external economic demands increased the focus on efficiency as part of employees' daily work. One structural change that underpinned this movement was the way employees adjusted their professional work to standards in controlling daily work, as shown in Article 1. Increased numbers of managerial tasks constituted a major part of nursing homes employees' daily work in order to rationalise and increase efficiency in care. Although there were employees who expressed that these new tasks involved too much reporting and regulation of activities in care, they did not feel that they could overlook them. External managerial and efficiency demands were seen as so pervasive by the employees that they saw no other way than to incorporate them into their daily work. Instead they tried as best they could to adjust the professional aspects of their work to fit with the new structure. This was done through use of various checklists made by the employees themselves.

In addition to standardised schemes that were implemented by the central administration, temporary lists were developed to shed light on professional aspects of work. This could involve lists to measure residents' user needs as a way to identify needs for resource input. These were lists that came in addition to registration list nurses used to control residents fluid

intake and food. New registration lists took time away from patient care and indicates a movement from internal toward external focus in work.

The findings further indicate that many employees were able to cope with tight budgets and increased standardisation by focusing on problem-solving. This coping strategy involved a reinforcement of professional flexibility based on their professional expert knowledge. Although increased focus on performance management were hard to understand and was contradictory to employees' professional values in the organisation of daily care, it became apparent that one way to deal with increased standardisation was that they had the opportunity to give input on own work. Front-line managers had to take time to ask and discuss challenges they faced in daily work with their personnel. This suggest that there were rom to find a general understanding of the need to take into consideration professional aspects in care in response to new managerial tasks. In this way, new solutions for efficiency were also based on employees' expert knowledge.

This practice indicates that employees' professional knowledge was considered to be significant in order to deal with NPM requirements. In addition, employees' willingness to find new solutions indicate a general acceptance for implementing new managerial tasks. In light of this coping strategy I argue that employees are able to handle increased standardisation in care by drawing on both the logic of professionalism and the logic of managerialism.

What makes this situation more complicated is that "core functions" in care did not disappear when new managerial tasks were given. Traditional professional functions had to be carried out in addition to new managerial tasks, however in new ways. As explained by Hill and Lynn (2005): "it is not so much that the horizontal relationships have supplanted the vertical ones, but rather that the horizontal links have been added to the vertical ones". In light of this understanding it becomes apparent that the tension between professional values and NPM requirements increases when employees has to deal with increased standardisation in addition to patient care. In line with Haukelien (2013) and Ingstad (2010), the findings indicate increased dilemmas and value conflicts that made daily work more hectic.

Increased tension challenged employees to hold on to professional values while simultaneously dealing with increased standardisation demands in care. Such incongruent

events triggered the need for new meaning constellations, as demonstrated in Article 2. Increased standardisation and tight budgets involved a high degree of incongruity in care that employees tried to clarify through sensemaking. The findings showed that unit managers and front-line managers tried to clarify this incongruence by considering the nursing home in a larger context, i.e., by comparing nursing homes with schools, day care centres, and other care units in the municipality. Through this comparison, it made sense that nursing homes were not given priority in budget negotiations, and by seeing nursing homes as being in competition with other care units, it was easier for the managers to be loyal to external demands even when professional values were being undermined.

Based in the findings I argue that increased external focus in daily work helped the employees to clarify some of the tensions in the situation and create meaningful work. In this way, incongruity in daily work became a less threat to professional values. Instead, the tension between professionalism and managerialism was adjusted and adapted through sensemaking. How this affected the quality of care and the fundamental values to professionals is however more unclear.

Similar, reconstruction of sensemaking in elderly care is also shown by Kamp and Hvid (2012), who demonstrated how NPM reforms contribute to changes in meaning and identity at work linked to the holistic perspective of care. Here I agree with Kamp and Hvid (2012) that sensemaking might help care staff to set boundaries in work situations that seem all-encompassing and limitless. However, the danger is that although increased external focus in employees' sensemaking may protect them from self-intensification in their work, the situation involves a greater risk of restricted professional autonomy. The danger of gradually undermining the possibility of professional holism in care work is also discussed by Haukelien (2013), who argued that it might imply a reduction in professional trust in care. This also corresponds with the results of Evetts (2011), who argued that increased managerialisation legitimises new practices that overshadow professional values, resulting in deprofessionalisation that challenges traditional professionalism in care.

Based on the findings cited above, the shift in focus (internal to external) in the organisation of daily work might indicate a movement from a professional logic toward a managerial logic. This change in practice is contrary to Jacobsen (2005) study, who found resistance and boycott among nurses following the introduction of new managerial tasks in nursing homes.

Equivalent resistance toward standardisation in care were found among home care staff (Vabø, 2007). In both studies, the researchers argue that the strength of professional logic goes beyond that of managerial logic, which again enables the dominance of professional values and that autonomy is maintained in daily care. However, as shown in my study, budget discipline and standardisation in care has been so interwoven into daily practices that most of the nursing home employees see it more as a necessary organisational steering instruction in work. One explanation to this finding is that increased use of contractual management and performance measurements underpins nurses' quality and economic responsibilities in the organisation of daily work.

The present study indicate that first-line managers tended to delegate responsibility for quality of care to clinical nurses to avoid professional weakness in care. Whether this coping strategy was sufficient to ensure quality of care is however more unclear. On the one hand, the findings showed that to handle an increased workload many employees compensated by working faster. In addition to established care tasks, they had to take responsibility for a number of informally delegated and unspecified tasks. This involved that many employees worked harder to ensure quality of care according to their professional values. In line with Olsvold (2012), the one thing that made it possible for employees to work harder was the moral obligation they felt as female professionals and their loyalty to their immediate supervisor and colleagues.

On the other hand, in order to avoid becoming a flexible, almost invisible resource in daily care, clinical nurses used another strategy in response to overwhelming individual responsibilities followed by increased delegation in daily work. This strategy involved taking time to clarify individual tasks and workload with their nearest leader. As demonstrated in Article 2, many employees were not clear on which work tasks to complete and which to ignore, thus it made sense for them to clarify individual work tasks with their nearest leaders.

Although this new practice made sense as a way to demonstrate their individual professional standpoint in quality of care, it may result in a lack of trust in nurses' collegial professional autonomy. Responsibilities in daily care were seen as tasks that lay on the shoulders of the individuals and not as a shared responsibility among their colleagues. This finding is in line with Evetts (2009), who argued that increased self-discipline at work undermines the collegial form of professional competence to control work. In other words, with lack of trust in

collective action it might also become harder to change course and stand against implementation of new managerial tasks, as also demonstrated by Haukelien (2013).

7.2 From invisibility to professional visibility in daily work

The second movement is about increased adjustment to documentation requests in the organisation of daily work. As already shown in the first movement, daily practices were linked to external demands of standardisation and efficiency. Although documentation often is seen similar to standardisation, I chose to discuss it separately to show how documentation became a key element in negotiations about professional dispositions in care when it came to budgetary consequences. Increased use of steering information followed by performance management became important for further use in political decision making, as shown in Article 1. In addition, documentation appeared to be an important managerial tool to control both managerial and professional aspects of daily care.

Increased documentation involved use of more indicators for measuring economic costs, staffing, and quality of care that aimed to mirror daily work in order to provide a basis for assessing further financing and achievement. However, as also demonstrated in numerous other studies (Haukelien, 2013; Jacobsen, 2005; Vabø, 2007; Venturato et al., 2007), the challenge is that there are aspects of nursing work that by their nature are difficult to document and measure in a standardised manner. The danger is that increased adjustment to documentation might reduce the emphasis on essential, but less measurable quality aspects of health care in nursing homes. Therefore, it is a risk that increased monitoring of care provision downplays professional autonomy and constrains professional control in the organisation of daily work. This lack of professional autonomy might generate distrust in the logic of professionalism and turn into deprofessionalisation, as demonstrated by Evetts (2013).

However, the study findings showed that increased use of documentation was also used as a coping strategy that underpinned nurses' professional logic. When employees adhered to stronger documentation routines it was also with the aim to safeguard their professional autonomy and values in care. Increased use of documentation helped unit managers and front-line managers to advocate for professional values in negotiations for increased resources with central administration. In this setting, documentation was necessary to clarify consequences

of the misalignments between efficiency demands and quality of care. Therefore, in addition to reproducing managerial logic, I would argue that documentation was used as a mechanism to highlight professional aspects in care.

Such strategic adaption of documentation might be seen as in line with Freidson's (2001) description of professionalism as the third logic. Based on the fear that professional values would become invisible, documentation became a strategic instrument for fostering professional values in care which highlighted the logic of professionalism. Based in this understanding, increased use of documentation might be seen as a modified practice in linking professional values to the logic of managerialism. By translating traditionally silent aspects of care work into words, the professional and managerial logics can share a common language when negotiating what the work of care is and should be. By doing that, I would argue that increased use of steering information followed by performance management might also be seen as a professional management skill in the organisation of daily care. This point was also stated by Johnsen (2010), who disproved myths about performance management, arguing that increased documentation needed to be seen as a more pragmatic and useful tool, rather than a threat toward public services. This means that performance management enables both professional logic and managerial logic to co-exist in daily work.

Based in the study findings, such modified practices were played out in two different ways. First, documentation was used externally with aim to place the responsibility for quality issues back onto politicians with political liability. When political decisions were adopted on the basis of adequate information where the consequences of any downward adjustment in care were described, it became easier for the employees to support new management requirements that might lead to restriction in quality of care. Second, documentation was used internally to clarify situations in which quality issues were shifted back to the nursing home. For instance, documentation became a tool that employees used to legitimise decisions to apply additional staff even if it involved additional cost for the nursing home.

Based on these findings there is a tendency of a movement where employees shows willingness to articulate professional values through combining professional language and managerial language in work. Therefore, I would argue that professionalism was not ignored by the employees in response to increased standardisation in care. Instead professionalism was reproduced as part of the documentation of daily work. To be able to talk about

professional standards within a managerial language, the employees had to see themselves more as translators of care, as showed in article 2. Here, I agree with Allen (2014), who writes that anything that does not pass through the hands of nurses will neither come through. In other words, nurses must be seen as the system enablers where their ability to create new practices result into translational mobilisation. Therefore, I would argue that nurses' engagement in documentation in making professional aspects in work more visible, plays a critical role in the ability to relate to contradictory management requirements in daily work.

7.3 Direct toward indirect leadership in daily work

The third movement is about change in nursing leadership processes in daily work. As seen in Article 3, new managerial tasks challenged especially front-line managers' ability to concentrate on the clinical aspects of care. Front-line managers were occupied with maintaining control through monitoring systems and following-up steering information from a distance without having time to involve in direct patient care. Rather than seeing themselves as being able to enhance nursing and professional leadership, increased managerial tasks encouraged front-line managers to adopt a more administrative role. This finding is in line with the study of Rasmussen (2011) and Rankin and Campbell (2006), who demonstrated how the role of managers (middle leaders) changed from someone who worked side by side with their subordinates to a general manager with office-based duties. These new practices increased the distance between leadership and clinical aspects in work, which resulted in feelings of frustration and powerlessness among both front-line managers and clinical nurses at the wards.

Although front-line managers in this study saw themselves as the most qualified, they no longer had time to practice their clinical knowledge in daily work. Compared to traditional professional leadership, which says that those best qualified and with the most knowledge should carry out special tasks in work (Huber, 2014), the findings demonstrate how front-line managers had only a minor impact on how patient care was organised at the wards. In other words, daily work was mainly organised by clinical nurses at the wards without much direct influence from managers. This reshaping of nursing leadership processes involved maintaining control from a distance and encouraged more indirect, or 'hands-off' nursing leadership, as also demonstrated by Venturato et al. (2007). As response to NPM inspired managerial tasks, nursing home managers were rule-bound and forced to interact closely with

bureaucratic systems instead of interacting with their subordinates and patients. Or, as argued by Broadbent and Laughlin (2002), an increased managerial approach includes the application of “accounting logic”, with increased trust in administrative systems and financial goals.

However, the danger of this situation is that nursing home managers will lose first-hand information about the situation at the wards. And as long as nothing is reported by the subordinate staff, managers have no choice but to believe that care services are being provided in accordance with quality standards. This weakness became apparent in the dissertation findings. Especially unit managers showed a naive confidence in steering information based on reports from the employees. This had led to situations where unfortunate practices existed at the wards without those further up in the organisation being aware of it. Further, given the lack of manager involvement in decision-making, clinical nurses at the wards pointed out that they sometimes found it hard to handle colleagues’ deviations in care because they neither had the means nor the authority to address them. Therefore, many situations were seen as hard to improve because unit managers and front-line managers had neither a complete overview in daily care nor the time or capacity to support and motivate subordinate staff. Increased use of indirect leadership resulted into increased uncertainty among the staff about who was actually in charge of performing nursing leadership. Based on the study findings, I argue that change in leadership practices has significantly weakened nursing leadership in the organisation of daily care.

Lack in nursing leadership creates a situation that in the literature is often called the big paradox in health care (Kamp and Hvid, 2012; Vabø and Vabo, 2014). On the one hand, managers are seen as key actors in implementing and handling changes, and hold a vital role in safeguarding quality and efficiency in care. On the other hand, within their new administrative role, managers have lost some of their influence and control in coordinating and organising daily care. What complicates the situation further is that new managerial tasks do not consider professionals’ need to deal with unforeseen and boundless care requirements (Vabø and Vabo, 2014). This means that contradictory management requirements make manager functions even more demanding. To handle this paradox, the findings from the study show, as already described, that managers focused on problem-solving and encouraged clinical nurses to use professional flexibility in daily care.

By cooperating with clinical nurses, managers identified areas for improvement in practice where the message was clear; everyone was responsible for implementing the adopted requirements. I was surprised at how little protest that emerged among the employees at the nursing homes about efficiency demands. Although the clinical nurses expressed frustration, they also showed acceptance to follow new demands. This finding indicates that clinical nurses were able to show support and empathy, as well as loyalty to implementing new managerial tasks. However, this practice might also be a result of unit managers and front-line managers that had to be tough and operated as “executioners with tenderness” or “leading with an iron hand wearing velvet glove”, as expressed by Vabø and Vabo (2014). This means that managers were more or less forced to lead subordinate staff indirectly by taking on a tougher administrative role. I would argue that such lack of direct support from managers in daily work can create uncertainty in leadership processes, as showed in Article 3. In line with Venturato et al. (2007) and Haukelien (2013), I agree that without clear nursing leadership, the support of clinical nurses in their struggle to balance professionalism and managerialism becomes harder and makes the reproduction of managerial demands easier.

One explanation for this weakened leadership might lie in the lack of formal training that managers and nurses receive for their new role. As Kerridge and Ryder (2013) argue, without formal training for this role it is difficult to deal with new managerial tasks. Furthermore, Kerridge and Ryder (2013) argues, that all nurses in different positions require organisational skills such as communicating, planning, prioritisation, and documentation to develop nursing leadership. Therefore, to avoid confusion and uncertainty in care, I would argue that trained managers have turned out to be even more important to ensure nursing leadership in the face of contradictory management requirements in the organisation of daily work.

7.4 The co-existence of contradictory management requirements

As demonstrated through the three movements NPM requirements triggered a need to find new ways to organise daily care in nursing homes. The study shows that the tension between professionalism and managerialism is not unknown or immaterial, but emerges as an established perception and reality among nursing home employees. Facing tensions in daily work had become commonplace and seemed to be taken for granted. In other words, contradictory management requirements were not a surprise or something unexpected.

By demonstrating establishment of new and modified practices in the organisation of daily work, I argue that it is difficult to talk about a single reform change, by which professionalism is totally replaced or ignored by managerialism in care. Instead, NPM inspired reforms seems to provoke a combination between the past and the present, the old and the new, or, as Newman (2002) put it, different elements of new and old are packaged and repackaged in new ways in the organisation. In addition, organisational action is context related and a result of how actors construct their social reality, as pointed out within the institutional logic perspective (Thornton et al., 2012).

What is of interest here is that within different aspects of employees' daily work, establishment of new and modified practices were based on a different rationale. For instance, following stronger efficiency demands and increased standardisation might portray employees as rational actors in relating to NPM requirements. However, based on employees as professional actors, their actions could be seen as non-rational according to the logic of professionalism. Thus, by taking into consideration the structural-agency question from the institutional logic perspective I am able to explain how changing practices also are built from combining various institutional structures in daily work.

Another principle within the institutional logic perspective is that each institutional structure has both material and symbolic elements that are intertwined and constitutive of one and other (Thornton et al., 2012). In the study this point is clearly seen in how nursing home employees adjusted and adapted to NPM requirements through both coping strategies (change in routines and instructions) and sensemaking (social interactions). Here, I would argue that employees' sensemaking played a critical, but often invisible role in determining how contradictory management requirements influenced on daily work. Through sensemaking the employees were able to relate with duality in work, coping with new management tasks while still attempting to comply with professional values. In this manner, through sensemaking contradictory management requirements were given new form, content, and structure in the organisation of daily work. Sensemaking thus became the feedstock for institutionalisation as pointed out by Weick et. al.(2005).

By demonstrating how employees' sensemaking processes made it possible for contradictory management requirements to coexist in daily work, I would argue that the findings from this study contribute with new understanding in how contradicting logics might co-exist in

healthcare organisations. Compared to Reay and Hinings (2009) study, who demonstrated that the rivalry between professional and managerial logics in hospitals was managed by nurses and physicians through collaboration, sensemaking among the nursing home employees in this study might have the same function.

In addition to understanding formation of new and modified practices through sensemaking, I would argue that the three movements indicate a change in nurses' rationality and expectation that can be viewed as a prerequisite in their relationship to contradictory management requirements. According to Thornton et al. (2012) all action depends on how individuals are situated within and influenced by the sphere of different institutional logics, each of which present a unique view of rationality. Based on this understanding, how employees are able to balance between managerial and professional logics will be emerging in ways that both constrain and enable practices in daily work. In other words, nursing homes employees do not operate in a vacuum, but relate to the outside world when it comes to implementing NPM requirements. The issue here is not whether management tasks with a managerial logic are available or not, but whether there is a will to adopt them into the way in which daily work is organised (Newman, 2002).

Therefore, as the study demonstrates by directing the attention to actors inside the organisation, the findings from the study show acceptance among the nursing home employees to develop different solutions in daily care. These are acceptations that are more based on a NPM ideological argument of more stringent management requirements rather than employees' attention toward professional values. Without being aware of the key role employees at various positions possess in coping with contradictory management requirements, NPM inspired reforms might get unnecessarily negative and lead to unacceptable consequences in care.

8.0 Concluding remarks and possible implications for practice

The main goal in the dissertation has been to explore how employees at various positions in nursing homes relate to contradictory management requirements in the organisation of daily work. The last thirty years of expansion of NPM inspired reforms has spurred a need for more knowledge on this topic in health care organisations.

The present study demonstrate that NPM requirements in care are neither ignored nor rejected by nursing home employees, but rather integrated into their daily work. In order to implement rather strict managerial demands, it seems that the influence of managerial logic was adapted by taking elements from professional values. This was done by translating professional values into standards, making professional values more visible through the use of documentation, and changing nursing leadership processes in the organisation of daily care. Through new and modified practices these movements show that professional and managerial logics are able to co-exist in daily work. It is well known that healthcare employees operate from a professional view, but this study also highlight the massive influence from the logic of managerialism, and it is the synthesis of these two logics that characterises changing practices in nursing home.

Insights from this study could have implications both for leaders and clinical nurses in health care organisations, and for leaders at local and central administration. By highlighting individual practices and institutional structures (NPM requirements and professional values) as essential drivers for action and changes, the dissertation contributes with a greater awareness of how employees create the practices that enable contradictory management requirements to co-exist in nursing homes. It also contributes with greater awareness about internal governing processes. This is important knowledge in the further debate about the benefits of new steering ideologies in nursing homes. Furthermore, by using the perspective of institutional logic, the study demonstrates the importance of a new theoretical approach in studying the complexity of healthcare organisations.

Institutional structures and ideologies will always be in continuous change and although NPM inspired reforms sooner or later will be replaced with other ideologies, tensions and dilemmas in daily practices will always be part of employees' daily work in health care organisations. The study do not come up with a conclusion in how employees relate to contradictory

management requirements. However, it call attention to the fact that there is a tendency in which professional values are being renegotiated by considering NPM requirements a constructive improvements in organisation of daily work in nursing homes. Through the movements discussed in this study, we might see new and modified steering patterns that differ from and challenge traditional professional practices in nursing homes. Further research is needed in order to decide whether these new steering patterns are the most appropriate if better quality services in nursing home are to be attained.

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Appendix 1

Approval Regional Medical Research Ethics Committee (REK)

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK nord			14.09.2011	2011/1289/REK nord
			Deres dato:	Deres referanse:
			15.06.2011	

Vår referanse må oppgis ved alle henvendelser

Aud Obstfelder
Tromsø

2011/1289 Styring og styringsutfordringer ved offentlige sykehjem- i spenning mellom fag og økonomi

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk i møtet 25.08.2011.

Forskningsansvarlig: Lasse Lønnum
Prosjektleder: Aud Obstfelder

Prosjektomtale (original):

Fornyning av offentlig sektor stiller nye og strengere krav til måloppnåelse, styring og organisering av tjenesten. Helse- og omsorgstjenester er omfattende og sammensatte og i styringen av tjenestene har faglige og yrkesetiske prinsipper tradisjonelt stått sterkt. Helsepolitiske reformer og andre fornyingstiltak utfordrer en slik form for styring. Formålet med denne studien er å frembringe kunnskap om hvordan styring blir gjort i helse- og omsorgstjenesten og om de lokale styringspraksisenes virkemåter, muligheter og begrensninger. På hvilken måte markedsorienterte styringsprinsipper blir omformet og tilpasset helse- og omsorgstjenestens særegne karakter blir vektlagt spesielt.

Faller prosjektet innenfor helseforskningsloven?

De prosjekt som skal fremlegges for komiteen er prosjekt som dreier seg om ”medisinsk og helsefaglig forskning på mennesker, humant biologisk materiale eller helseopplysninger”, jf. § 2. ”Medisinsk og helsefaglig forskning” er i § 4 a) definert som ”virksomhet som utføres med vitenskapelig metodikk for å skaffe til veie ny kunnskap om helse og sykdom”. Det er altså formålet med studien som avgjør om et prosjekt skal anses som fremleggelsespliktig for REK eller ikke.

I dette prosjektet er formålet å frembringe kunnskap om hvordan styring blir gjort i helse og omsorgstjenesten.

Prosjektet er utenfor helseforskningsloven virkeområde.

Vedtak

Etter søknaden fremstår prosjektet ikke som et medisinsk og helsefaglig forskningsprosjekt som faller innenfor helseforskningsloven. Prosjektet er ikke fremleggingspliktig, jf. helseforskningslovens § 10, jf. forskningsetikkloven § 4, 2. ledd.

Komiteens vedtak kan påklages til Den nasjonale forskningsetiske komité for medisin og helsefag, jfr. helseforskningsloven § 10, 3 ledd og forvaltningsloven § 28. En eventuell klage sendes til REK nord. Klagefristen er tre uker fra mottak av dette brevet, jfr. forvaltningsloven § 29.

Vi ber om at tilbakemeldinger til komiteen og prosjektendringer sendes inn på skjema via vår saksportal: <http://helseforskning.etikkom.no>. Øvrige henvendelser sendes på e-post til post@helseforskning.etikkom.no.

Vennligst oppgi vårt referansenummer i korrespondansen.

Med vennlig hilsen,

May Britt Rossvoll
sekretariatsleder

Monika Rydland Gaare
førstekonsulent

Kopi til: postmottak@uit.no

Region:
REK nord

Saksbehandler:

Telefon:

Vår dato:

20.12.2011

Vår referanse:

2011/2340/REK nord

Deres dato:

01.11.2011

Deres referanse:

Vår referanse må oppgis ved alle henvendelser

Aud Obstfelder
Universitetet i Tromsø

2011/2340 Styring og styringsutfordringer ved offentlige sykehjem - i spenning mellom fag og økonomi

Vi viser til søknad om dispensasjon fra taushetsplikt, datert 01.11.2011 i henhold til prosjektet Styring og styringsutfordringer ved offentlige sykehjem - i spenning mellom fag og økonomi. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK nord) i møtet 01.12.2011. Søknaden er vurdert med hjemmel i forskrift av 2009.06.26 nr 0867. Helse- og omsorgsdepartementet har etter forskriften delegert kompetansen til å vurdere om det skal gis dispensasjon fra taushetsplikt for opplysninger til bruke i forskning til den regionale komiteen for medisinsk og helsefaglig forskningsetikk.

Forskningsansvarlig institusjon: Universitetet i Tromsø
Prosjektleder: Aud Obstfelder

Prosjektleders prosjektbeskrivelse

Prosjektets formål er å frembringe kunnskap om hva som styrer utøvelsen av omsorgstjenester i sykehjem og hvordan praksis tilpasser seg og omformer fornyingstiltak og endrede styringsbetingelser. Prosjektet skal gi økt kunnskap om styringspraksis i sykehjem, dens virkemåte, muligheter og begrensninger.

Komiteens merknader

Søknad om godkjenning av prosjektet ble behandlet i komiteen i møte 25.08.2011 som sak 2011/1289. Komiteen vedtok at prosjektet falt utenfor helseforskningslovens mandat fordi formålet var å frembringe kunnskap om hvordan styring blir gjort i helse- og omsorgstjenesten.

Det fremmes nå søknad om dispensasjon fra taushetsplikten. I studiens del en skal forsker bl.a. følge ledere og sykepleiere på vaktrom og møterom i sykehjem. Gjennom dette vil forsker kunne få kjennskap til informasjon om pasienter. Informasjonen skal ikke registreres eller på noen måte brukes i studien. Observasjonene er rettet mot arbeidsrutiner, prosedyrer, regler og beslutninger som på ulike måter bidrar til å forme og regulere de ansattes hverdag.

Komiteen vurderer at prosjektet er av vesentlig interesse for samfunnet og at hensynet til de indirekte deltakerne i prosjektet er ivarettatt.

Vedtak

Med hjemmel i helsepersonelloven § 29 første ledd og forvaltningslovens § 13 første ledd gis det dispensasjon fra taushetsplikten for Margrethe Kristiansen til det omsøkte prosjekt. Reglene om taushetsplikt etter helsepersonelloven gjelder også for Margrethe Kristiansen.

Dispensasjon er gitt under forutsetning av at prosjektet gjennomføres slik det er beskrevet i søknaden og protokollen.

Med vennlig hilsen,

May Britt Rossvoll
sekretariatsleder

Monika Rydland Gaare
seniorkonsulent

Kopi til:

postmottak@uit.no

Appendix 2

Approval Norwegian Social Science Data Service (NSD)



Margrethe Kristiansen
Institutt for helse- og omsorgsfag
Universitetet i Tromsø
MH-bygget
9037 TROMSØ

Vår dato: 31.10.2011

Vår ref: 28163 / 3 / MAB

Deres dato:

Deres ref:

KVITTERING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 26.09.2011. Meldingen gjelder prosjektet:

28163

Behandlingsansvarlig
Daglig ansvarlig

Styring og styringsutfordringer ved offentlige sykehjem - i spenning mellom fag og økonomi
Universitetet i Tromsø, ved institusjonens overste leder
Margrethe Kristiansen

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstillende kravene i personopplysningsloven.

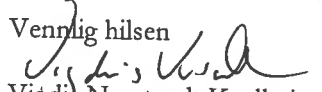
Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, eventuelle kommentarer samt personopplysningsloven/-helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/forsk_stud/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://www.nsd.uib.no/personvern/prosjektoversikt.jsp>.

Personvernombudet vil ved prosjektets avslutning, 01.03.2015, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen


Vigdis Namtvedt Kvalheim


Marte Bertelsen

Kontaktperson: Marte Bertelsen tlf: 55 58 33 48
Vedlegg: Prosjektvurdering

Appendix 3

Informational letter to unit managers of local nursing homes

Informasjon om forskningsprosjekt

Mitt navn er Margrethe Kristiansen og jeg er doktorgradsstudent ved Universitetet i Tromsø, IHO, Senter for Omsorgsforskning i Nord Norge.

Mitt doktorgradsarbeid omhandler *“styring og styringsutfordringer i sykehjem- i spenning mellom fag og økonomi”* og er et forskningsprosjekt som skal gjennomføres i sykehjem fra tre ulike kommuner i Midt Troms.

Hensikten med prosjektet er å frembringe en større forståelse om faktorer/elementer tilknyttet styring ved offentlige sykehjem i en tid preget av reformendring og modernisering av offentlig sektor. Spørsmål jeg ønsker å besvare er hva styrer organiseringen av arbeidet i sykehjem og hvordan utøves styring i praksis, samt hvilken betydning har styring for utøvelsen av omsorgstjenester i sykehjem?

Prosjektet skal gi økt kunnskap om styringspraksis i sykehjem, dens virkemåte, muligheter og begrensninger.

Gjennomføring av prosjektet er som følgende:

- I januar- februar 2012 gjennomføres intervju og observasjon av 3 ledere (enhetsleder, avdelingsleder) og 3 profesjonsutøvere (sykepleier, hjelpepleier, osv.) ved det største sykehjemmet fra tre kommuner i Midt Troms. *Se vedlagt informasjonsskriv med forespørsel om deltakelse i forskningsprosjekt.*

Deltakelse fra XXXX sykehjem innebærer at du som enhetsleder oppretter en kontaktperson mellom sykehjemmet og forsker som er;

- Behjelpelig med å formidle informasjon om prosjektet til sykehjemmets ansatte
- Behjelpelig med å rekruttere aktuelle forskningsdeltakere tilknyttet prosjektet, samt innhenting av samtykkeerklæring i tråd med vedlagt informasjonsskriv.
- Behjelpelig med koordinere avsetting av tid til intervju og observasjon

Håper at XXXX sykehjem finner prosjektet av interesse og stiller seg positiv for videre deltakelse.

Mvh

Margrethe Kristiansen

Universitetet i Tromsø

Tlf: 47234906

Appendix 4

Informational letter and consent form

Forespørsel om å delta i forskningsprosjektet

"Styring og styringsutfordringer ved offentlige sykehjem- i spenning mellom fag og økonomi"

I forbindelse med min doktorgrad gjennomfører jeg et prosjekt om styring og styringsutfordringer ved offentlige sykehjem. Prosjektets formål er å frembringe kunnskap om hva som styrer utøvelsen av omsorgstjenester i sykehjem og hvordan praksis tilpasser seg og omformer fornyingstiltak og endrede styringsbetingelser. Prosjektet skal gi økt kunnskap om styringspraksis i sykehjem og dens virkemåte, muligheter og begrensninger. Prosjektet vil bli utført av undertegnede. Prosjektleder og veileder er førsteamanuensis Aud Obstfelder ved Universitetet i Tromsø, institutt for Helse- og omsorgsfag.

Sammen med ca. 20 andre ledere og profesjonsutøvere ved tre sykehjem i Midt Troms får du denne forespørselen om deltagelse i forskningsprosjektet. Utvalget er rekruttert i samarbeid med enhetsleder ved ditt sykehjem og denne forespørselen blir formidlet via han/hun. Din identitet er ukjent for meg helt til du eventuelt samtykker i å delta i denne studien ved å returnere samtykkeerklæringen.

Deltagelse i prosjektet innebærer at jeg ber deg delta på et intervju og at du på en av dine arbeidsvakter (dag/kveld) er tilgjengelig for observasjon tilknyttet organisering av din arbeidshverdag. Intervjuet vil ta om lag en time og observasjonen gjennomføres kun på vaktrom/personalrom med fokus på planlegging og administrering av ditt arbeid. Jeg ønsker å få kunnskap om dine tanker og refleksjon rundt egen praksis og om styringsfaktorer som er med å fremme og forme din arbeidshverdag.

Det er helt frivillig å delta i prosjektet og du kan på hvilket som helst tidspunkt trekke deg og kreve personopplysningene som er gitt anonymisert, uten å måtte begrunne dette nærmere. Hvorvidt du velger å delta i prosjektet eller ikke, har ingen betydning for videre arbeid ved sykehjemmet. Det er ingen andre enn mine veiledere og jeg som vil få tilgang til personidentifiserbare opplysningene om deg. Alle opplysninger vil bli behandlet strengt konfidensielt.

Resultatene av studien vil bli publisert som artikler, uten at den enkelte deltaker kan gjenkjennes. Doktorgradsprosjektet forventes å være avsluttet mars 2015. Ved prosjektets slutt vil opplysningene bli anonymisert. Det er imidlertid mulig at det vil bli aktuelt med en oppfølgingsundersøkelse før utgangen av 2015. I så fall vil du motta ny informasjon og ny forespørsel om å delta.

Prosjektet er tilrådd av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste A/S (NSD), samt Regional komité for medisinsk og helsefaglig forskningsetikk (REK).

Dersom du ønsker å delta i undersøkelsen, er det fint om du signerer den vedlagte samtykkeerklæringen og returnerer den til nedenfor adresse så snart som mulig.

Har du spørsmål i forbindelse med denne henvendelsen, eller ønsker å bli informert om resultatene fra undersøkelsen når de foreligger, kan du gjerne ta kontakt med meg på adressen under.

Med vennlig hilsen

Margrethe Kristiansen

Universitetet i Tromsø, Institutt for Helse og omsorgsfag

9037 TROMSØ

Mail: margrethe.kristiansen@uit.no

Tlf. 47234906

Samtykkeerklæring:

Jeg har mottatt informasjon om prosjektet *"Styring og styringsutfordringer ved offentlige sykehjem- i spenning mellom fag og økonomi"* og er villig til å delta i studien.

Dato.....

Signatur Telefonnummer

Mailadresse.....

.....

Sendes til:

Margrethe Kristiansen

Universitetet i Tromsø, Institutt for Helse og omsorgsfag

9037 TROMSØ

Appendix 5

Interview guide

Intervjuguide

Dato: _____

Sykehjem: _____

- leder**
- profesjonsutøver**

Intervjuets innhold

Ønsker å vite mer om

- din oppfattelse og beskrivelse av innholdet i en typisk arbeidshverdag og hvordan den forløper.
- dine refleksjoner og erfaringer rundt hvorfor arbeidet utøves nettopp på den måten du beskriver.

Bakgrunn

Hvor lenge har du jobbet i sykehjem, ved dette sykehjemmet?
Stillingsstørrelse og hvilken utdanning har du?

Innhold i arbeidet

1. Om du skulle beskrive ditt arbeid for en utenforstående, hva har du da fortalt?

2. Hva er en typisk arbeidshverdag for deg?
 - a. hva gjør du når du kommer på jobb?
 - b. hva er typiske arbeidsoppgaver og ansvarsområder tilknyttet ditt arbeid og hvordan blir de utført? (gi eksempler.)
 - c. Hvordan blir disse arbeidsoppgaver og ansvarsområder dine?
 - d. Hvordan vet sykehjemmet (dine kolleger) at de arbeidsoppgaver du gjennomfører tilknyttet ditt arbeid faktisk blir gjort?
 - e. Hva ved ditt arbeid må du rapportere/dokumentere om?

3. Har innholdet i din arbeidshverdag **endret** seg slik du ser det?
 - a. Eventuelt hva er endret?
 - b. På hvilken måte gjennomføres endring?

- c. Hva opplever du kan være grunnlag til hvorfor endringer ved ditt arbeid oppstår?
- d. Hva er din erfaring på hva endringer bidrar til tilknyttet ditt arbeid?

Innretning av arbeidet

- 4. Kan du gi en nærmere beskrivelse på hva som bidrar til at du **vet du hva du skal gjøre** i ditt arbeid?
 - a. Beskriv og gi eksempel på hva som er viktig for deg i dine vurderinger og beslutninger tilknyttet ditt arbeid?
 - b. Hvorfor vektlegges de?
 - c. Hvem er ansvarlig for driften ved sykehjemmet?
 - d. Hva er sykehjemmets/avdelingens målsetning?
 - e. Hva er ditt kjennskap og erfaring med bruk av delegering tilknyttet ditt arbeid og hvordan blir det gjennomført?

Stabilitet/ motsetninger

- 5. Dersom du skulle oppgi sider ved din arbeidshverdag som for deg er viktig for å sikre **forutsigbarhet** i arbeidet, hva ville det være?
 - a. Hvorfor er det viktig for deg?
 - b. Hvilken betydning har det for utøvelsen av ditt arbeid?
- 6. Forklar hva som kan skape og bidra til **motsetninger og dilemma** tilknyttet ditt arbeid?
 - a. Hva er din oppfattelse for hvorfor dilemma oppstår?
 - b. Hvordan håndterer du dilemma i ditt arbeid
 - c. Hvilken betydning opplever du dilemma har for ditt arbeid?

Oppsummering

Har jeg forstått deg rett..... (kort oppsummering av meg)

Er det noe du vil legge til som er relevant for utøvelsen av ditt arbeid?

Appendix 6

List of keywords in observations

Feltnotater er konkrete beskrivelser av sosiale prosesser og den konteksten de foregår i. Målet er å gi en gjengivelse av ulike særtrekk og egenskaper av **tale** og **handlinger**:

Aktør	<i>Hvem</i> som var til stede?
Rom	<i>Hvor</i> det skjedde
Objekt	<i>Hvilke</i> fysiske gjenstander fremkommer
Tid	<i>Når</i> det skjedde
Handling	Enkelthandlinger av personer
Aktivitet	Serie sammen-hengende <u>handlinger</u> som personer gjør
Hendelser	Serie sammen- hengende <u>aktiviteter</u> som personer gjør
Formål	<i>Hva</i> forsøker man å oppnå (hvilke mål..)
Følelse	<i>Hva</i> føles og kommer til uttrykk

Styring gir retning, kontroll og koordinerer handlinger på vegne av andre.

Styring består av:

- Organisatorisk struktur
 - Administrerende prosesser
 - Ledelses beslutninger
 - System av regler og lover
 - Administrerende verdier og normer/
kultur
- Instrumentell- institusjonell styring*
- Formell- uformell styring*
- Overordnet- underordnet styring*