Leading through constant change

What are the issues for front-line nurse managers arising from changes to the home care services?

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Preface

This thesis has been a long time in the making. I have learned a lot during this long process, and writing this as the final preparation before turning it in, is almost surreal, after having spent the last year completely absorbed in this work.

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Tittel og undertittel: Å lede gjennom kontinuerlig endring. Hvilke utfordringer møter førstelinjeledere som et resultat av endringer i hjemmetjenestene?

Sammendrag:
Formål: Tidligere forskning har vist at førstelinjeledere i helsetjenesten har vesentlig betydning for både utformingen av tjenesten og trivselen til de ansatte. Forskning har også vist at organisasjonsendringer fører til endrede arbeids- og ansvarsforhold for de ansatte.
De stadig økende utgiftene til helsetjenester har ført til en rekke forskjellige reformer og omorganiseringer i helsetjenestene. Kommunehelsetjenesten i Norge generelt og hjemmetjenestene spesielt har vært igjennom mange og vesentlige endringer det siste tiåret i et forsøk på å bremse utgiftsveksten i helsevesenet, og disse endringene påvirker arbeidsdagen til de som jobber i der.
Å rekruttere og beholde helsepersonell er vesentlig for å møte store utfordringer i kommunehelsetjenesten i årene som kommer. Førstelinjeledere er en viktig gruppe i dette arbeidet. Førstelinjelederne har ansvar for å lede og veilede personalet som jobber i førstelinjen – de som utfører hjemmetjenester til brukerne. Førstelinjelederne har formelt ansvar for kvaliteten på tjenesten, for arbeidsmiljøet til de ansatte og for å holde budsjettene. De er i en nøkkelposisjon mellom ledelse og tjenesteutøvingen. Disse sykepleierne er ansvarlig for at arbeidet blir utført, at kvaliteten på arbeidet er bra, at det blir gjort i tide, og at det utføres innenfor budsjetterte rammer.

Studiens formål er å beskrive, diskutere og analysere hvilke utfordringer som møter førstelinjeledere i hjemmetjenesten i deres daglige arbeid, og å belyse hvordan endringer i ansvarsområder og fullmakter påvirker førstelinjeledernes arbeidsdager. Vi trenger kunnskap om hvordan førstelinjeledernes rolle endres, og hva som må gjøres for å tilby optimale arbeidsforhold for å beholde denne viktige gruppen av arbeidstakere i tjenesten, og forsikre at de fortsatt er i stand til å holde hjulene i hjemmetjenestene i gang i tider med kontinuerlig og ofte hurtige endringer.

Teoretisk forankring: Studien er en kvalitativ studie hvor det benyttes etnografiske metoder. Den teoretiske forankringen er en bricolage av teori fra kvalitative forskingsmetoder, organisasjonsteori og teori om stress, etiske dilemmaer og moral distress som benyttes i alle steg av undersøkelsen. En bricolage av teori er brukt for på best mulig måte utforske den komplekse arbeidshverdagen til førstelinjelederne, og for å drive analysen videre.

Metode: Studien består av tre casestudier fra tre forskjellige norske kommuner og det er benyttet etnografiske metoder; observasjon, ”foucused conversations”; miniintervjuer knyttet til observasjonene og dokumentanalyse i datainnsamling og analyse. Hver enkelt casestudie er beskrevet og analysert, deretter er det gjort en crosscase-analyse.

Resultater: Studien viste at førstelinjeledere i hjemmetjenesten har svært hektiske arbeidsdager, og et mangfold av både arbeidsoppgaver og ansvarsområder. Arbeidet går ut på å holde hjulene i hjemmetjenesten i gang, og tre sentrale temaer ble funnet ; endrede relasjoner, å gjøre mer med mindre, og endrede ansvars- og fullmaktsområder. Et sentralt tema i alle de tre kommunene var stress og høyt tempo i hverdagen.

Førstelinjelederne var utsatt for stress, og opplevde at endringer i ansvars- og fullmaktsforhold endret arbeidsforholdene i tjenesten. Deltakerne i studien opplevde stress og høyt tempo både positivt og negativt – og det ble tatt for gitt av førstelinjelederne. Deltakerne satte pris på variasjonen i arbeidsdagene og følte at de gjorde en viktig jobb. De var imidlertid også utsatt for stort arbeidspress, etiske dilemmaer og moral distress i sitt arbeid. De opplevde forskjellige grader av stress, men opplevde alle at de hele tiden måtte løse flere oppgaver og gjøre mer med mindre ressurser for å kutte kostnader og holde trange budsjetter. Undersøkelsen viste også at det ble økende avstand mellom fullmakter og ansvar når kommunene implementerte NPM-prinsipper i sin organisering.

Konklusjon: Reformene i de norske kommunene har forandret jobbhverdagen for de ansatte i hjemmetjenesten. Det ser ut til å være en generell trend at førstelinjeledere opplever en økende avstand mellom fullmakter og ansvarsområder. Den økende avstanden fører til en økt opplevelse av stress, etiske dilemmaer og moral distress. Dette kan medføre alvorlige konsekvenser for de ansattes helse, og ikke minst sette kvaliteten på tjenestene til pasientene i fare. Dette kan igjen medføre problemer med å rekruttere, og ikke minst å beholde velkvalifiserte førstelinjeledere. Førstelinjelederne holder hjulene i hjemmetjenesten i gang, men prisen for dette kan være høy, både på det personlige plan og innenfor organisasjonene.

Nøkkelord: Hjemmesykepleie, New Public Management, kvalitativ metode, etnografiske teknikker, case-studier, førstelinjeledere, helsepolitikk, bestiller/utfører, rekruttering, jobbtilfredshet, stress, moral distress, etiske dilemmaer, bricolage.

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Title and subtitle: Leading through constant change. What are the issues for front-line nurse managers arising from changes to the Home Care Services?

Abstract: A growing body of research has shown that front-line managers play an important role in the job-satisfaction of employees, and ultimately the quality of care provided to the service users. Research has also shown that organizational changes led to changes in the working conditions and levels of authority for both front-line staff and front line managers.

Health care in Norway has been through major changes during the last decade. These changes affect and influence the working life of the employees in health care organizations. The spiraling cost of health care has led to a number of different reforms and organizational changes. These changes influence the people working within the organizations. Recruiting and importantly retaining health care personnel is of vital importance to meet the upcoming challenges in Norwegian health care in the future.
Community care nursing and home care nursing in particular has been the arena for multiple reforms and reorganizations, as an attempt to control the spiraling cost of health care. This has impacted on the staff working there. One group of workers that are interest are the front line nurse managers – the nurses who have responsibility for supervising front-line staff, for ensuring quality of the services provided and for keeping spending within budgets. The front-line managers are an important link between senior-management and the front-line. These nurses are important to ensure the work is done, done well and on time and within budget. But they also navigate tensions between doing more with less and advocating for their staff and clients while also trying to meet budget and other directives.

The purpose of this study is to describe, discuss and analyze the issues faced by front-line managers in home care nursing in Norway. In so doing it provides important information about how the role of these nurses is being changed and what might need to be done to provide optimal working conditions to both retain these staff and ensure that they are able to keep the wheels turning in times of continuous and often rapid change.

Theoretical framework: This is a qualitative study that draws on ethnographic principles to provide snapshots from the professional life of three front-line nurse managers. A bricolage of theory drawn from qualitative methodology, from organizational theory and from theory of stress and moral distress is utilized throughout the study to explore the complex reality of the working life of front-line nurse managers, and to drive the analysis further.

Method: The study comprises three case-studies employing ethnographic techniques to explore what goes on in a nurse managers' professional life. Observation, focused conversations related to the observations and document analysis were conducted to create the case-studies. Each of the three cases are described and analyzed. A cross-case analysis is then preformed.

Results: The study showed that front-line managers in home care nursing have very busy and sometimes very stressful days. Their job is about keeping the wheels turning. Three major issues arose; Issues related to altered relationships, issues related to doing more with less, and issues related to authority and responsibility. The busy days and stress were perceived as having both positive and negative effects – and it was taken for granted. The participants all valued the variations in their work, and felt that providing home care was rewarding. But they were also susceptible to stress and ethical dilemmas and moral distress, and they experienced different degrees of frustration about having to do more with less in an attempt to cut costs and adjust the services to the economic realities of their municipalities.

Conclusion: The reform to home care nursing in Norway has changed the professional lives of the people working within it. A general trend is an increasing gap between responsibility and authority for front line managers. This gap leads to increased perceptions of stress, ethical dilemmas and moral distress, which again can lead to health issues for nurses, and reduce the quality of care provided.
It can also lead to loss of expert workers and difficulties in recruiting people for the role. Keeping the wheels turning may be what these front line nurse managers do but it can be at high personal and organizational cost.

Key words: Front-line nurse managers, Home Care Nursing, New Public Management, ethnography, case studies, job-satisfaction, work-related stress, bricolage, moral distress, ethical dilemmas.

Contents

Background and introduction

1.1 Changes in health care.

Home care nursing is a vital part of health care in Norway. Home care nursing is viewed as a way to provide care at a lower cost, and a better and less expensive option that institutionalised care for people in need of long time care.

Home care is also an important political symbol – a symbol of freedom, focusing on providing care to people, while preserving the individuals' autonomy and continued right and possibility to live their lives as they choose – in their own homes. Home care nursing is a part of the services the municipalities offer to the public. The home care nursing services employ thousands of people, and hence, the services are not just an important part of the welfare system, they also provide work for thousands of people, predominantly women.

The last decade has seen major reforms, shaping and changing health care in Norway. Patients are discharged from hospitals sooner (Statistics Norway, 2009a), and a lot of the tasks that used to be performed in hospitals, like rehabilitation, medical treatments and various nursing services, are now the responsibility of the community care services (Abrahamsen Dag R & Svanlund Jørgen, 2005). The number of beds in nursing homes have been reduced (Statistics Norway 2009b), hospital stays are shorter than they used to be from an average of 7,5 days in 1997 to 5,0 days in 2007, (Statistics Norway 2009a), and an increasing number of tasks are preformed in the local communities, the municipalities.

Strict criteria for entry to nursing homes leave a high proportion of disabled people in need of services, in the community. All of these factors have lead to an increased demand for community health services, and home care nursing. There is an expected growth in demand for community health services in the years to come, both resulting from an expected rise in the population aged +80, but also because there is a new

health reform about to be launched, where more health care is supposed to be provided by the municipalities.

Every Norwegian municipality is required to provide home care nursing service to anyone permanently or temporarily residing in the municipality (HOD, 1984b). Each municipality must have a registered nurse in charge of professional quality in the home care nursing service (HOD, 1984a). This means that a vast majority of home care nursing services have nurses in the front-line manager's position.

The economical challenges and responsibilities for Norwegian municipalities have been widely described in the media. The spiralling cost of health care and the Norwegian hospital reform of 2002 seem to have put heavy pressure on the municipalities (Vike, Bakken, Kroken, Brinchman, Haukelien, 2002). There is a shortage of funds and an abundance of tasks to perform.

There are dilemmas when it comes to governing and running community health services. The government sets the long term goals and makes the acts and regulations guiding the health care services in Norway. They also provide the municipalities with money. The municipality is in the unenviable position of having to both make sure everyone gets the services they are entitled to, and at the same time making sure the cost of the same services does not exceed the limited funds. Each municipality is responsible for ensuring that both quality and quantity of the community health services are sufficient. At the same time, the municipalities have to limit the services – to fit with the lump sum-grants given to them by the government.

The spiralling cost of health care during the last two decades, has made the municipalities in general, and home care nursing specifically, a major arena for reorganizations – to ensure the best possible utilization of the limited funds available (Lian, Olaug S., 2007) The general trend in health care both internationally and in Norway has been a shift from a policy based on a social-democratic welfare policy to a market-driven approach – borrowing principles from market economy and applying

them in public services, in an attempt to cut costs (Vabø, Mia, 2007). These new policies have impacted on nurses' practice and nurses' work environment.

1.2 Modernizing health care – New Public Management

The term New Public Management (NPM) was first introduced by Hood in 1990. NPM has been introduced to a variety of public services all over the western world in order to create what are called more streamlined, efficient organizations (Lian, 2007). The term New Public Management is used to describe a general reform development. NPM is based on implementing tools and goals adopted from philosophies from market-economy into public services. (Vabø, 2007)

Although Hood described NPM as being more about results than about how the results are supposed to be achieved, it seems that the NPM-driven implementations that has been done to traditional welfare policy-arenas in Norway, has an increased focus on control (Lian, 2007) NPM focuses on transparency of organizations, and on increased power to senior management, as opposed to the profession-lead organizations of the past.

This study looks at the application of NPM-principles in Norwegian community health care, and in home care nursing. The implementation of NPM-principles in Norwegian municipalities is called the BUM-model, named after the Norwegian abbreviation for purchaser/provider-model. Implementing NPM-principles to municipality health care in Norway has been done by dividing municipality health care into purchaser-provider units.

Although the BUM-model is implemented in only 10% of Norwegian municipalities, more than 50% of the population in Norway lives in a BUM-municipality, because the majority of the largest municipalities have implemented the model (Vabø, 2007).

1.2.1 Tame and wicked problems

One of the basic ideas of NPM is the idea that "wicked problems" can be made into "tame" problems by standardisation (Vabø, 2007). A wicked problem is complex, and is characterised by not always beings solvable – just dealt with. A tame problem on the other hand, is a problem that can be solved once and for all. NPM is based on the belief that complex/wicked problems can be made manageable by standardising – by "taming" them (Vabø, 2007). However, one of the major criticisms of NPM is that it does not take into consideration that problems exist that simply cannot be tamed (Vabø, 2007). For example, when implementing NPM-principles in health care organizations, it seems like both the task of taming and solving the problems is delegated to the ground level of the organization, and that the answer is further standardizing until the problems have been "tamed"(Vike, et al., 2002).

It seems that NPM has been looked upon as a means to cut costs – even though the reform addresses issues of governing and increased power to the consumer. On of the intrinsic ideas of NPM-inspired organizational changes in Norway is that there is a reservoir of unused resources in any organization, waiting to be utilised (Vabø, 2007; Vike et al. 2002).

1.3 Care plan 2015

The Norwegians government's Care plan 2015 (Stortingsmelding 25, HOD, 2005) lists the challenges for community care nursing in Norway up until year 2015. It emphasizes the need for continued growth in the community health care, and in home care nursing in particular. It looks at the historical development of community health care in Norway, and how different groups of patients have become clients in the community health care during the last 15 years. Growing tasks for community health care, calls for new strategies when it comes to hiring and retaining staff in the community health services. The current Norwegian government plans to strengthen the workforce by the end of 2009, to ensure that the growing demands on the

community health care are met by an increase of the staffing in the community. The document reads as a long term plan for the community health services, and describes in detail how the Norwegian government visualizes community health care for the next 6 years.

The recruitment and retention of health care professionals are vital to meet the growing demand for community health services. The municipalities can not offer quality community care without health care professionals, and even though the need to recruit and retain health care personnel has been acknowledged, there seems to be some major challenges in the years to come in this respect.

Recruitment and retention of nurses in particular to the municipalities are vital. Several studies have shown that good management, and especially a well-functioning front-line manager plays a key-role in the job-satisfaction of nurses, and that ensuring job-satisfaction amongst nurse managers affects the job satisfaction of staff nurses in a positive way (Hertting A. Nilsson K., Theorell T. & Larson U. S., 2004; Lee, H. & Cummings G. G. 2008; Shirey, M. R., 2006).

This is what the Care plan 2015say about managers in community health care:

> *The sector has very few managers compared with other activities, but carries out its services around the clock, 365 days a year. Surveys show that close leadership with personal follow-up of the individual employee are vital to the working environment, professional development and good exploitation of resources, particularly in fields such as this. Strengthening the management function in the sector will therefore be a key task. (HOD, 2005, pg. 12)*

1.4 Research question

In light of NPM-inspired reforms, the need for strengthening the management function in community health care is a main goal for the Norwegian government. Central to this management are the nurse managers with day to day responsibility for the delivery of that care. This study is designed to look at issues for nurse managers' in home care nursing. The research question is:

What are the issues for nurse managers arising from change to the home nursing services?

The aim of the study is to describe, discuss and analyse the issues facing the nurse managers in their daily work. This is important because increasing the knowledge about these issues are vital when ensuring a working environment that is attractive – to ensure both recruitment and retention of health care personnel. The municipalities are already experiencing difficulties recruiting health care personnel (HOD, 2005). With the expected growth in demand for health care personnel to work in the community health care in the years to come, we need more knowledge about the factors that influence job-retention and recruitment in community health care..

There is a growing body of research emphasising the key role of the front-line managers when retaining health care personnel. (See chapter 2 for more detail.) How front-line managers perceive their working environment not only affect the retention and recruitment of front-line managers themselves, it also affects the recruitment and retention of the staff they supervise, and ultimately the quality of the care provided.

The front-line nurse manager plays a key-role when it comes to creating an attractive work-environment for health care personnel, as well as a key role in ensuring the quality of the services. This study seeks to identify and discuss some of the issues for front-line managers working in home care nursing, to increase the body of research-based knowledge about these issues, to help shape policies and ultimately help recruit and retain health care personnel in community health care, and ultimately inform practice and policy.

1.5 The scope of this study

This study draws on ethnographic principles to provide snapshots from the professional life of three front-line nurse managers – snapshots captured during a few winter days. I visited the nurse managers at their place of work for a few days, I talked to them, observed, watched what went on, took notes, talked some more, and then left.

My focus in this study is the front-line nurse managers themselves. The organizations, in which they work, provide a contextual framework that shapes the days, the tasks and the issues the nurse managers encounter while doing their work, to shed some light on what the issues they encounter are, and how they handle them.

1.6 My background.

My first encounter with the home care nursing services was during my final year of finishing my bachelor's degree in nursing. For the first time, I was practicing outside the hospital, in the ordinary, everyday world. I got to visit the patients in their own homes. It was one patient at a time, and I was completely fascinated by how doing procedures in the patients home, differed from doing them in the hospital. The creativity and pragmatic approach needed to provide good nursing care in the patient's home was a new experience. Meeting patients their homes outside the hospital wards, was quite different from meeting them in hospital. I got some glimpses of the lived lives of people, and I really enjoyed it.

Following my bachelor degree I worked for years in home nursing care services. Both as a registered nurse, as a front-line manager, setting up a purchaser/provider-unit in a municipality, and working as a consultant in the purchaser-unit in two different municipalities, assessing patients needs. I have been present during large organizational changes. I began thinking about doing a study like this in 2004, and got as far as recruiting 6 front-line managers to participate. When I returned to working on the project in the spring of 2008 after a break due to health reasons, all of

the participants I recruited four years previously, had left their jobs. And all of them had left their manager's jobs because of the strain and what they perceived as heavy workloads. Some because they felt it was too hard to combine the manager's position while having young children, two of them had been on long-term sick leave, directly caused by strain, stress and conflict, which they told me originated in the constant organizational changes, and ever growing demands on their time. Hearing their stories four years later, made me even more convinced I needed to do this study!

I am a nurse. I was educated almost 20 years ago, and I have worked in community health care since then. This has shaped my perception. It has undoubtedly shaped both the design and the analysis of this study.

1.7 Definitions used

1.7.1 Front-line nurse managers

The nurse managers in this study are at the first line, or front-line of the organization. The first line or front line of an organisation is where the actual services are provided. Both terms are used in the literature and I have chosen to use the term front-line managers in this study. Each Norwegian municipality y must have a registered nurse in charge of the quality of care in the home care nursing services (HOD, 1984a). This means that a great majority of the front-line managers in home care nursing are registered nurses.

The front-line managers are the link between senior management and the providers of care. They are responsible for the supervision of the providers of care, they are responsible for the quality and coordination of the care provided, for coordinating schedules, payroll, for decisions related to staff hiring and termination. There are some differences in authority and responsibilities of the nurse managers participating in this study, but their core responsibility is the supervision of staff and responsibility

for quality of care. Details about the authority and responsibilities are listed in the three cases described in this study.

1.7.2 Patients/clients

Throughout this study I have chosen to call the recipients of home care nursing "patients". The term "patient" is widely used by the people who work in home care, meaning the recipient of home care nursing. Although the terms "client" and "user" is gaining popularity, the term "patient" was used by all three participants in this study. The term client or user was mainly used when talking about the recipients of domiciliary services. When both terms are used in this study, it is done to differentiate between recipients of home care nursing and domiciliary care.

1.8 This study

This is an interpretive qualitative study that uses three case-studies employing ethnographic techniques to explore snapshots of a complex reality Based on the principles for ensuring rigour throughout a qualitative study, I have not only described the design of the study, the methods used to collect data and the stages of analysis, I have also included my own reflections about the methodical and analytical choices I have made, and reflections of my own role and of incidents during fieldwork that influenced and guided my choices and interpretations along the way.

> "Research design also involves a degree of reflexivity on the part of the researcher with respect to acknowledging the underlying theory and/or theoretical assumptions that have shaped his or her perspectives and understandings of the research focus and process." (Cheek, J., 2008)

I begin by giving an introduction to research about changes in community health care in Norway, and previous research done about issues for nurse managers in general in chapter 2.

In chapter 3 I describe the role of theory in this study

In the chapter 4, I describe the design of this study, the methods I used for data-collection, and a general description of the steps in the analytical process. Chapters 5, 6 and 7 contain descriptions and analysis of the three cases comprising this study. In chapter 8, I bring the cases together, and analyse the similarities and differences across my three cases using theories and literature relevant to the topic.

I then finish where I started – with my research question – and the answers and unanswered questions to my research question. I also identify some of the gaps and limitations in my study ending with suggestion about further research that is needed to further our knowledge about front-line managers in home care nursing.

In the next chapter I give an introduction to the literature that has informed this study.

2. Literature.

2.1 Organizational changes in community health care in Norway

Two important Norwegian studies have looked at the organizational changes in community health care in Norway.

Mia Vabø has conducted several studies about home care in Norway, and in the two studies comprising her 2007 doctoral thesis, she examined home nursing services, and how staff on the ground level of an organization dealt with the limited resources available, and the changes to the service over time(Vabø, 2007).

“Maktens samvittighet” (The Consciousness of Power - translated) (Vike, et al. 2002), is one of several research projects in the Norwegian Power and Democracy project. It is a research project designed to take a close look at local government, political processes, and the effect on health care (and other) services, both in Norwegian hospitals and municipalities. A team of researchers studied organizations in different municipalities and a hospital (before the hospital reform of 2002) from the inside, and from the ground level. In Norway, the responsibility to close the gap between the level of ambition for health care, and the actual resources available, lies with local government – in the municipalities. The study describes how and why these different goals within the municipalities conflict. The local government is responsible for carrying out ambitious goals and handling dissatisfaction in the public, continuously and at the same time.

Both studies reveal how the gap between a limited amount of resources and ambitious political goals for the services is looked upon and dealt with differently at different levels of an organization. Closing the gap between ambition and resources is viewed as an economic and administrative problem at the top level of an organization. At the ground level of the same organizations, closing this gap becomes a real life dilemma

and a moral problem that the staff feel obligated to solve. (Vabø, 2007; Vike et al., 2007)

In her first study, conducted in the mid-90s, Mia Vabø described how the provision of services and allocating of resources to a large extent was left to front-line managers and other employees of home care nursing. The responsibility for assessing needs and for providing services was placed at the ground level of the organization. Her study from 1994 revealed frustrations about the workloads, but also contained descriptions of how flexibility provided the staff with ample space to provide the services needed (Vabø, 2007).

Her next project, conducted in 2003, revealed a different home care nursing service. The home care nursing services had been through a number of reorganizations and administrative changes - where the main focus had been on shifting control and power to a higher level of administration. The municipalities (or boroughs) in the study had been through a major policy change. A purchaser/provider- model had been applied and the needs for home care nursing services were assessed by a separate organizational department (the purchaser unit) and the provision of the services was done by the home care nursing services. (Vabø, 2007)

Her 2003 study shows how the implementation of NPM-principles shaped and changed the home nursing services. She found an increased pressure on the municipalities to document both the quality of the services and spending of money. This pressure came from both politicians and the general public(Vabø, 2007).

Leaders and reformists, such as politicians, use general terms when describing the implementation of the new system of home care nursing. Their responsibility is to describe the general goals of the organization – in overview. They do not get into details of how the implementation is supposed to happen, but simply explain and clarify what the main principles of the system are. On the ground level of an organization, people are responsible for providing the actual services, and hence are focused on how new principles can be embedded in their practical, everyday working

life. This means that applying a new policy, and the consequences of applying it, look very different from different viewpoints – all depending on where you are in the organization (Vabø, 2007).

Vike et al. points to the same problem; what might be perceived as a practical problem from the view of the top management of the organization is at the same time perceived as a moral problem for the nurses and other staff working on the ground level in the community health services. At the top level of an organization, the obvious solution to cutting costs might be to put down boundaries for the service offer – while putting down boundaries and limiting services to patients with dire and valid needs might be perceived as a serious, moral dilemma for the nursing staff on ground level (Vike et al., 2002).

Both the studies by Vike and Vabø conclude that the staff on the ground level actually participates in obscuring some of the more serious shortcomings of the new system. Both studies claim is that the front-line staff‘s resistance to change and to cut services, is what sustains the quality of the services, not the staff adapting to change. (Vabø, 2007; Vike et al., 2002)

Personnel on ground level were not heard when complaining about working conditions – but seen by managers/administration on a higher level in the organizations as being resistant to change and as “slowing down reform processes” (Vike, et al., 2002).

Vike’s study looks at nurses in particular, and describes the nurses’ holistic view of their own professional duties, where they define themselves as responsible for the whole patient; the physical, psychological, social and spiritual needs of each patient shall be assessed, identified and dealt with by the nurse. Vike et al. argues that this leaves the RNs in the position where putting down boundaries for where their own responsibilities end, becomes almost impossible. Putting down boundaries conflict with the nurses’ training, and it conflicts with their code of ethics. He argues that nurses’ holistic approach to their own work provides good breeding ground for these

specific dilemmas. By defining their work and responsibilities as holistic, nurses take on a responsibility that is without boundaries, and hence, the nurses cannot put down these boundaries without experiencing moral dilemmas. The researchers question what happens when this (holistic) view has to be fitted into a system that promotes standardization and rationalization (Vike et al., 2007).

The findings of Vike's study are that nurses internalise the gap, they embody the dilemma, and hence they don't see the system they are working in as a failing system, but tend to view them selves as failing as professionals, instead. The authors' claim is that health care has been able to carry out reforms and keep the wheels rolling in spite of shortcomings, because the nurses (and other staff) at ground level, take on the responsibility to close, or at least decrease, the gap that exists between economical resources and the publics need for health care services. (Vike et al., 2002)

In the closing chapter of her dissertation, Mia Vabø concludes that there is potential conflict between the new system, based on NPM-principles and the existing health care legislation – and points to this as a topic in need of further research. The laws provide the patients with rights, and obligate health professionals to provide quality services. Taming "wicked" problems, standardising services, by trying to make it into one shoe designed to fit all, might conflict with both patients individual rights, and health care workers professional duties and codes of ethics(Vabø, 2007).

Both these studies points to the position of the front-line managers as being especially exposed to these dilemmas, because their positions link senior management and the providers of care on the front-line. Although both studies identify the position of the front-line managers as an especially difficult situation to be in when facing the dilemmas, none of them explore the front-line managers' situation in detail.

2.1.1 Organizational changes and their effect on nurses and nurse managers

A study comparing front-line managers in home care and nursing homes in a Norwegian municipality after implementing NPM-principles, found a striking

difference in regards to how the front-line managers perceived their work situations (Nessæther, Anne L., 2007). Although they all worked at the same level in the same organization, the managers in the nursing homes felt they had both influence and power/control in their daily work, the managers in the home care nursing services on the other hand, felt powerless, and overwhelmed by never ending tasks in their daily work (Nessæther, 2007)..

While a nursing home has a set number of beds, and therefore a maximum number of patients at all times, the home care nursing services has to deal with constant unpredictability; they have to provide whoever is in need with services, at all times. Their tasks are unpredictable, and without boundaries, but budgets are set. Nessæther's conclusion is that the perception of unpredictability and lack of control experienced by the nurse managers in the home care nursing was caused by the system, not by the individual nurse manager (Nessæther, Anne L., 2007).

Just like Vike (2002) and Vabø (2007) Nessæther (2007) concludes that there *is* a system failure – but this is not necessarily perceived as such by either management or the people working on the front-line. The system failure becomes evident at the ground level of the organization, and the nurses and other staff on the front-line feel a personal and internalised responsibility to close the gap between resources and needs. The nurse managers at the front-line of an organization are exposed to these dilemmas, because of their position in the organizations, where the reality of differing perspectives and goals surface and becomes real-life dilemmas. (Nessæther, 2007).

A study performed in a Swedish nursing home during a period of downsizing and reorganization showed how staff reacted and responded while going through a period of change (Flackman, G., Hansebo B. & Kihlgren A., 2009). The study was designed to look at the reactions of staff at three different points in time during the downsizing. The staff altered their relationships with colleagues, senior-management and also their patients during the downsizing. They struggled to adapt to change, but the altered relationships to both senior-management and patients still lasted a year after the process of downsizing was over. Staff lost a lot of their pride in their work, and

experienced an increasing distrust in senior-management. The loss of pride in work made the staff value the quality of their own work less – they felt the patients' quality of care was suffering (Flackman, et al., 2009).

2.2 Job-satisfaction and work-related stress

A systematic review of research done on nurse manager job satisfaction, finds that addressing span of control and workload, and strengthening front-line nurse managers participation in decision-making, is vital to increase job-satisfaction in nurse managers (Lee, & Cummings, 2008).

A systematic review on nurse managers and stress describes a shift over time in explaining and interpreting stress, from assigning it mainly to personality factors twenty years ago, to an explanation based on environmental factors in the more recent years (Shirey, 2006).

There seems to be a growing acknowledgement of the influence of stress on nurse managers' job-satisfaction, and on how organizational factors influence front-line nurse managers' professional life and their perceptions of stress.

When examining junior nurse managers' perceptions of stress, Rodham & Bell (2002) showed that not only were the nurse managers generally unaware of work stressors and their potential health effects –the study also showed that there was a culture of acceptance and expectations of work stress amongst the nurse managers in their study, coupled with a lack of awareness to how to effectively manage stress.

Studies about front-line nurse managers and burnout, identifies high levels of stress and low levels of control as a major factor (Laschinger H.K.S. & Finnegan, J., 2008; Lee & Cummings2008; Mackoff, B.L. & Triolo, P.K., 2008). It seems that stress, heavy workloads and decreased control are important issues to address for nurse managers.

This study is designed to take a closer look at the nurse managers in home care nursing, and their daily work. How does it feel to be in a front-line management position? How does changes in the organizations in which they work and the increase in work-load influence them? What is a day – or a week in their working life, like?

3. Theory

Authors writing about qualitative research, offer very different views on the role and the use of theory, and for a novice researcher, this can be confusing. Anfara (Anfara T., 2008) describes how there is not absolute consensus amongst qualitative researchers as to what extent, how and where theory plays a role in qualitative research. He goes on to say that both students and experienced researcher frequently have trouble both identifying and using theoretical frameworks.

According to John Cresswell (2003), theory has increasingly been used as a lens to guide researchers both as to what issues are important to examine and what people need to be studied. My initial interest to do this study was shaped by my own prior experience, literature on the topic of changes in health care organizations, the introduction of New Public Management-principles and its effect on nurses and nurses' working conditions. I found plenty of interesting research that strengthened my resolve to do a study about front-line nurse managers in community health care. These topics then provided a lens to guide me when deciding on what kind of issues I wanted to study and what people I wanted to observe.

In the following discussion I present my thinking and decisions about the underlying theory and theoretical assumptions that shaped my study:

3.1 The qualitative researcher as bricloeur

Denzin and Lincoln (Denzin, Norman K. & Lincoln, Yvonna S., 2005) introduce the idea or concept of the qualitative researcher as a bricoleur. Such a bricoleur is a quilt-maker, drawing on a variety of different parts and contributions to put together a quilt or picture (a bricolage) of what is going on. The metaphor of bricoleur reflects the way that I used theory throughout this study. The study brings together and weaves

into a text various theoretical perspectives. I have identified three main threads that have been woven together to form the theoretical bricolage. These are theory framing the study, theory informing the methodology and methods and theoretical concepts to drive emerging themes.

Bricoleurs realize the limitations of one single method or one single theory, and realize the inseparability of the knower and the known, and the complexity of all human experience.

> Appreciating research as a power-driven act, the
>
> Researcher-as-bricoleur abandons the quest for some naïve concept of realism,
>
> focusing instead on the clarification of his or her position in the web of
>
> reality and the social locations of other researchers and the ways they shape
>
> the production and interpretation of knowledge. (Kincheloe, J.L. 2005,pg. 324)

Kincheloe's (2005) position is that recognizing and using bricolage will then lead to new, ontological insights, based on the argument that any object of inquiry is inseparable from its context and from the language used to describe it. He goes on to say that bricoleurs understand that the ways these dynamics are addressed have profound influence on the knowledge produced, and thus influences and shapes the way we come to view the world, and ultimately, operate within it (Kincheloe, 2005).

My study is designed to look at issues arising from change in a complex world. I find the term bricolage very useful when describing how theory is applied and used in this study, and my choices for theories to drive the analysis part of this study.

While Denzin and Lincoln (2005) look upon the use of a bricoleur approach as a way to ensure rigour when doing qualitative research, it must be acknowledged that some

researchers have questioned its value. Hammersley refers to the bricoleur as a Jack-of-all-trades, with a little bit of knowledge about a lot of different disciplines, and as an expert of nothing (Hammersley, Martyn, 1999).

Kincheloe (2005), on the other hand, has another view. Bricoleurs realize the limitations of one single method, or one single theory, and realize the inseparability of the knower and the known, and the complexity of all human experience. My study is designed to look at issues arising from change in a complex world. Despite the debate around its use, I find the term bricolage very useful when describing how theory is applied and used in this study, and my choices for theories to drive the analytical part of this study. I turn now to discuss each of the three threads that have been woven into this study's theoretical bricolage.

3.2 Thread one –Theory framing the study

The overarching theoretical frame for this study draws on interpretive views of the world. By this I mean that the study is preformed in a naturalistic setting and is designed to explore a complex reality. This is why qualitative approaches were suitable. I wanted to go out and find out what was going on in the world of the participants of this study.

From my initial literature review and my past experience, I knew quite a lot about was going on in the field I wanted to study. I did not, however, have a clear picture of the various theoretical approaches and emphases of the studies I had read addressing similar areas as in my study. I needed to read the literature again, and this time, look for the theory that informed the studies that had triggered my interest. To help me I turned to the writings of Vabø (2007) and Vike (2002) to identify the underlying theoretical frames of their work.

The organizational theory that lies behind both Vabø (2007) and Vike's (2002) works, made a lot of sense. Viewing an organization as a dynamic entity with different actors and different goals and looking quite different depending on one's

position in the organization, was suited to describe the some of the issues I was looking at in my study. I wanted to know how the frame of the organizations shaped the world of the people working within.

Within the broad interpretive frame, reflexivity played an important part.

Reflexivity refers to self-awareness, and acknowledgement of the researcher's voice in qualitative research. In a qualitative study, the researcher is the instrument; the researcher designs the study, makes the observations, writes the field-notes, asks the questions to the participants of the study, makes choices when analysing the data collected and makes the choices on how the findings are to be represented. The researcher is in a key position all through the research process, and needs to be acutely aware of this throughout the research process (Patton, Michael Q., 2002).

To be reflexive is to examine "what I know and how I know it" taking into consideration the cultural, political, social and ideological origins of one own perspective of the world, as well as the perspectives of the participants of the study (Patton, 2002).

I wanted to go out there and find out what the issues for the nurse managers were without being too influenced by my own preconceived notion of what was going on. My inexperience as a researcher, and a strong wish to be rigorous doing this study, called for some reflexivity as to how my own background and experiences had shaped my perspective.

The need to be acutely aware of one's own role in doing this kind of research is stressed by all of the authors of the literature on qualitative methods that I have used when designing and performing this study (Haavind, Hanne, 2000; Patton, 2002 Silverman, David, 2006). Reflexivity on the part of the researcher is a vital part of ensuring rigour in a qualitative study. The reason the term rigour is used in qualitative research, is because rigour addresses the dynamic between the researcher and the researched, and how ignoring addressing this is a major flaw in qualitative research.

(Liamputtong, Pranee & Ezzy, Douglas, 2005). Rigour in qualitative research is described in chapter 4.1.1.

I have described my incentives for doing this study in chapter 1. I know the field. I have been in the front-line managers' position, and I found it hard, stressful and at times quite exhausting. But I also found it profoundly rewarding, and sometimes it was hard for me to separate the stressors from what gave me lots of joy and caused rewarding personal growth.

My main concern was that I did *not* want to go out in the field thinking that the every day work of a nurse manager is filled with issues and impossible dilemmas and nothing much else. Although I had been in this position, and found it very hard at times I did not want my own perceptions to get in the way of my participant's. But at the same time – if I had not experienced first hand what it can be like to be between a rock and a hard place trying to ensure the quality of services while going through major organizational changes, I don't think I would ever have performed this study. I had read a lot about organizations, about change in organizations, about stress and coping for nurses and nurse managers, and about shifts in health care policy changing the reality of the people who work in health care. But having an open mind and using an inductive approach was very important to me. I did not want to go out into the field looking for stress and burnout or dysfunctional organizations – I wanted to know what was going on.

A broad interpretive view of the world interwoven with reflexivity at every point is what forms the first thread of the bricolage of theory in this study.

3.3 Thread 2 - Theory informing the methodology and methods

Theory informing the methodology and methods was an important part of the bricolage. Sometimes this is overlooked in studies but methodology and methods are theoretical choices and draw on particular theoretical assumptions about the world and research.(Cheek, 2008). The theory of this study is therefore closely related to methodology all the way through. I have followed the guidelines for designing a qualitative study in line with the study drawing on an interpretive view of research. I have tried to make explicit these theoretical frames as a way to ensure rigour throughout the process – by going through the design of the method stage by stage, and using various literature when designing the study, trying to make sure that the decisions I have made throughout, ensures a rigorous and theoretically sound approach.

An example of this, is how I used focused conversations (Street, Annette,1995), where my observations provided initial areas for taped (focused) conversations with the participants. What I observed during my stays at each municipality, decided what topics were discussed during these conversations. For example, after spending three days running to keep up with the tempo of one of the managers in this study, my question to her was: “Do you have enough time to do everything you are supposed to do? “

Theory informed activities of planning the study, gaining entry to the field, recording observations, and analysing the data collected. Theoretical influences on the methodology and the methods employed (they are detailed in chapter 4), were derived from ethnography.

3.3.1 Ethnography as drawing on interpretive views of the world (Often described as both theory and method).

Ethnography means writing about what people do. (Ethno – people, and graphos – writing.) The terms ethnography, observational studies and fieldwork are used

interchangeably (Silverman, 2006) – but they all mean spending periods of time watching people, combined with talking to people about what they are doing – and they are all designed to see how the participants in a study understand the/their world (Silverman, 2006).

Observing in social science is all about looking at what goes on in a social setting. It's about observing mundane, everyday routine, putting great emphasis on detail, to be able to describe what goes on. The essential question to ask (and answer) is "What goes on here?" The researcher goes into the field with an open mind to find out about the world of the people observed (Silverman, 2006).

When doing a study using observational methods, Silverman stresses the importance of avoiding early use of theories and concepts the process of analysis, because "this might exhibit a poor fit with participant perspectives." (Silverman, 2006, pg. 68). Using ethnographical methods then did not only influence how the data was collected, it also influenced when theoretical concepts were introduced during the process of analysis.

3.4 Thread 3 - Theoretical concepts to drive emerging themes

Even though I collected data and did the initial stages of analysis using an open, inductive approach, when I got further into the analysis, it was time to reread the literature that shaped the study – to look for lenses through which I could view my data and analyse my findings. Using a bricoleur approach through the final stages of analysis, several various theoretical concepts provide different lenses that enhance and explain the researchers' understanding of the findings.

This is in keeping with Creswell's (2003) model of the inductive logic of research in a qualitative study . Theoretical concepts are used in the research project after the researcher has analysed data and identified different themes and patterns. In the next stage of analysis, the researcher looks for theoretical concepts from the identified

themes and categories, and then adds theory to drive the analysis further. The researcher adds meaning and new understanding to the data by adding theoretical concepts to act as lenses through which to view the findings.

The use of theory at this stage in the analysis, drives the analysis further, and takes the study from a descriptory level, to a level where the findings of a study are understood by applying theory and past experiences to provide new understandings of the themes and patterns (Creswell, 2003).

When I got into the analysis, adding different theories to different parts of the data was what drove the analysis further. Using different theory depending on what kind of issue I was addressing, gave me good tools when analysing. I asked the question: "what are the issues…" and different issues might require different tools or theories or "lenses" to best describe them. That is why I have used what might best be described as a bricoleur's approach when adding theory to the final stages of analysis in this study. Some of the findings are viewed through the lens of organizational theory, some through the lens of stress and moral distress and the various effects stress have on nurses and nurse managers work environment. Some of the findings are examined in view of the existing legislation regulating patient's rights (HOD, 2001) and health care professionals' duties and The Norwegian Nurses' code of ethics (NSF, 2007).

Using a bricolage approach, applying different theories to understand different things, seemed like the logical and most pragmatic thing to do in a study like this. What I have observed, are complex realities, with a lot of different things going on during a day, and often even simultaneously. To understand this, one single theory does not suffice.

4. Design

Research design refers to the way a research idea is transformed into a research project. There are several things that must be taken into consideration and reflected upon when deciding on a method design for a qualitative study

The method and the reasons why the study is being done are closely linked; the research question and the aim of the study guides the methodology utilised in the project (Cheek, 2008). The method must be described as a dynamic process – not a static "how-to"-manual, and the description of the methodology in a study on a level between a "how-to"-manual and general theoretical reasoning (Haavind, 2000).

4.1 Reflections about the choice of method

The aim of this study is to describe, discuss and analyse the issues (arising from change) facing nurse managers in the home care nursing services in their daily work.

My aim in this study was to take a closer look at three nurse managers working within a system that is under constant change. I wanted to know more about the people in these positions, and how they dealt with the issues at hand, while keeping the wheels of the home nursing services turning on a day to day basis.

After some soul searching, some major confusion and at last, some very gentle and very competent guidance in the right direction, I decided that doing snapshot case-studies using ethnographic methods, would be a good way to get answers to my research question. By choosing this method I would be able to go out to the world of the front-line managers in home care nursing and observe for my self what was going on there, and get my participants view of what was going on at the same time. I would be able to find out what goes on in the professional lives of the nurse managers in the three case-studies. By collecting data from different sources, I would be able to triangulate both the data collection and later, my analysis.

Triangulation is vital in ensuring rigour in a qualitative study. Triangulation refers to collecting data from different sources, to be able to view findings from different perspectives. (Patton, 2002.) A common misconception of triangulation is that it is supposed to confirm a viewpoint or finding by yielding the same result from different sources of data, or different methods of collecting data. The real point is to test for consistency. Finding inconsistencies in data yielded from different sources should not be viewed as weakening the credibility of results, but as an opportunity for deeper insight into the relationship between inquiry approach and the topic under study. (Patton, 2002.)

In the second municipality of this study, there were major differences in how the re-organization process was described in documents from senior-management, and how the re-organization was described by the nurse manager. Although the two sources yielded different data, triangulation in this case confirmed that there were conflicting views about the process at different levels of the organisation – which proved to be a vital finding in the case.

4.1.1 Rigour

In qualitative research, the researcher is part and parcel of the whole research process. (Liamputtong & Ezzy, 2005). The researcher is deeply involved in every part of the research process, from designing the study, to collecting the data, to the final analysis and description of the findings. The human factor is both the great strength and the great weakness of a qualitative study; it is the double edged sword of qualitative research (Patton, 2002). In qualitative research, there are no rules for sample size, for which method to employ or for what choices to make during the process of designing a study. There are guidelines, but no rules (Patton, 2002) .

Rigour tames the unpredictability of qualitative research by the researcher's careful reporting of why and how choices were made during the whole process of a research process, from the designing of the study, to how sampling was done, how data was collected and how the data was analysed (Patton, 2002). Rigour is the thorough

description of the logic behind any choice made throughout the research process. Reflexivity is an important part of a rigorous approach as it addresses the researchers' role in doing qualitative research (Patton, 2002). I have written about reflexivity in chapter 3.1. Throughout this chapter, the logic behind the design of this study, -the collection of data and the logic behind the analytical choices have been described in detail to ensure rigour when performing this study.

4.2 Ethics

There are two main dimensions in the ethical aspects of a qualitative study. The fist dimension is procedural. The project must be approved by an ethics committee, in the case of my study, the Norwegian Social Science Data Services (NSD). After finishing the initial design of this study, I applied for approval by NSD, and the study was approved in November 2008 (Appendix 2). After the sampling and recruiting was completed, a letter with information about the study, complete with an informed consent-form, was sent to the participants (Appendix 1). The data collected in this study and the signed consent-forms have been stored according to NSD-rules.

But addressing the procedural dimension of a project is not the only ethical aspect that needs consideration when performing a research project. Some authors have been critical to ethical issues sometimes being reduced to an approval process, and losing sight of the actual ethical issues at hand when doing qualitative research(Liamputtong & Ezzy, 2005; Patton, 2002). The political and social consequences of participating in a research project for the participants must also be addressed throughout a study. The ethical considerations of a research project do not end when the study is approved by an ethics committee. They begin there. Taking into consideration the personal, political and social consequences for the participants throughout a study is what constitutes the most important part of the ethical aspects of a qualitative study.

4.2.1 Ethical considerations and choices when writing the case-studies.

I have chosen not to identify the any of the municipalities in this study by name. This is because revealing the names of the municipality might jeopardise the confidentiality of my participants, especially in the small municipalities. I have given some of the geographical data about the municipalities, because there are several municipalities in Norway with much of the same characteristics as the municipalities in my study. The number of municipalities that fit the general description is large enough to avoid disclosure of my participants' identity. The size of the municipalities on the other hand, means that if the municipality is identified, the nurse managers can also be identified as being one of only a handful of people. For this reason, I decided not to write down specific data about the nurse managers in the case descriptions.

Some of the observations were done in settings with other people besides my participants present. When describing the setting and attendees of a meeting in my field-notes, I have only suggested the positions of the others – and given the approximate number of people present; I have divided them only into staff, colleagues and collaborative partners, without any further details about them. When someone said something during a meeting that I felt was worth quoting, I asked the person directly after the meeting whether I could quote him/her. When I have used quotations from others in field-notes, I have only identified them as coming form a colleague or staff member, to emphasise that it was said by someone other that the participant of my study. I have included very few details about the nurse managers in the case descriptions.

4.3 Sampling

One of the major differences between quantitative and qualitative methods, is the sampling approaches (Patton, 2002). Qualitative inquiry focuses on in-depth studies of relatively small samples - selected purposefully. Purposeful sampling means

sampling information-rich cases; cases that can illuminate issues important to the purpose of the inquiry (Patton, 2002).

4.3.1 Maximum variation sampling

There are several different sampling strategies used in qualitative methods, and for this study I have chosen a maximum variation sampling strategy. Maximum variation sampling aims at capturing central themes that cut across a great deal of variation. The logic behind maximum variation sampling is that any common pattern emerging from a great deal of variation are of particular interest and value in capturing core experiences and shared dimensions of a setting (Patton, 2002). Even through home care nursing are provided according to the same act (HOD, 1984b) in all Norwegian municipalities, the context in which the services are provided, differs greatly. My choice of maximum variation sampling is therefore preformed on the contextual frame in which the services are provided, as both home care nursing and its front-line managers have already been singled out as the topic for this study. The two contextual factors that were employed for the maximum variation sampling strategy were; level of community and level of way work is organised.

4.3.2 Level of community

Norway is a country with both metropolitan/urban areas, and sparsely populated regions. We have big cities and tiny communities surrounded by vast areas of woodland and mountain terrain, and a long coastline of fjords and islands, with small coastal communities.

Providing home nursing in a borough in a big city and in a sparsely populated municipality in the rural district, might consist of the same core tasks, but while the staff in a metropolitan area are able to reach their patients on foot or car, the staff in the rural areas depend upon using cars (and boats), and having to travel long distances in dire driving conditions, to reach their patients. A lot of the time of the staff is spent travelling between patients. A home nursing service that covers a large

area will have to spend more time travelling, leaving less time for direct interaction with the patients. The geographical location of a municipality influences the work of the home nursing service. The cost of transport might differ greatly between the municipalities.

The distance from the nearest hospital/emergency services might influence the work and the priorities of the nursing staff.

For the reasons listed above, I wanted to select municipalities that offered maximum geographical variation, when sampling for this study. More detailed descriptions of the geography of each municipality are included in chapters 5, 6 and 7.

4.3.3 Level of way work is organised

Although organizational changes and in many cases; the implementation of some NPM-principles, in health care and home nursing have happened nationally in Norway, there is great variation as to how and to which degree they have been applied (Vabø, 2007).

When sampling participants for my study, I wanted to choose municipalities that are organised differently, to reflect the differences in the organization of home nursing work in Norwegian municipalities. According to Vabø (2007), the degree to which Norwegian municipalities have implemented NPM-principles varies. In 2005, 51% of Norwegian municipalities had implemented the BUM (purchaser/provider)-model. Almost all of the municipalities in Norway with more than 10.000 inhabitants have implemented NPM-inspired purchaser/provider-model. Most of the smaller municipalities have not.

One of the municipalities/boroughs in my study has implemented NPM-principles. They have a purchaser/provider unit. They have launched a consumer's choice-model

in the providing of domiciliary-services, and are looking into a consumer-choice model for the home care nursing services as well.

One of the municipalities were going through major organizational and downsizing project at the time of this study, and had not yet decided on what kind of organizational model they would end up with.

One municipality has taken a pragmatic approach to organizational changes over time, which means that they have introduced routines to ensure that all patients' rights were taken care of by issuing formal letters granting services to each client/patient. But they had still kept the "old fashioned" welfare model, where patients' needs are assessed and services provided by the same organizational unit.

A more detailed description of the way each municipality is organized is included in chapters 5, 6 and 7.

4.3.4 Finding municipalities that fit the criteria

To find the municipalities that fit my geographical sampling criteria, I used Statistics Norway - SSB (http//www.ssb.no). SSB provides statistics on all Norwegian municipalities.

Information as to which municipalities use what model of organization is not as easily accessible as geographical data. I had some prior knowledge about this, both from personal contacts and from the media. By accessing some municipalities' web-pages and using my own personal experiences and network I ended up choosing three municipalities.

4.3.5 Sampling grid

I have called the municipalities M1, M2, and M3 in the grid.

Table 1 – sampling grid

	M1	M2	M3
Population	<*00.000/40.000	>6.000	>2.500
Location	Metropolitan	Small town/rural	Rural/remote
Organizational model	Provider/purchaser	In process of change	Welfare-political model

4.3.6 The participants

Maximum variation sampling was used to find municipalities for this study. The actual participants for the study, the three front-line managers, were then recruited from the municipalities that fit the criteria. To make sure the participants had the necessary experience, I had decided on two inclusion criteria for my participants;

- They had to be front-line managers, as defined in chapter 1.7
- To insure that the participants had experience in managing the home nursing services, I wanted participants that had a minimum of 6 months actual manager experience.

After I identified possible municipalities that fit my sampling criteria, I contacted the home care services department in each municipality, and got the names of potential participants for my study. I contacted them by e-mail and phone, and all of my first choices agreed to participate in the study.

The nurse managers in this study are all registered nurses, and they have all worked in home care nursing for more than 10 years. Two of them were relatively new to their current managers' positions, but they both had prior experience as nurse managers in different units of home nursing care. Their ages ranged from the mid-thirties to mid-fifties. The span of control of all three units was 15-20 full-time-positions. Part-time employment is common in home care nursing, and the actual

numbers of people the nurse managers are responsible for supervising were a lot higher – closer to about thirty people at each site.

The participants were all female. More than 90% of the employees in the community health care services in Norway are female (Vike, et al., 2002).

4.4 Method – a dynamic process

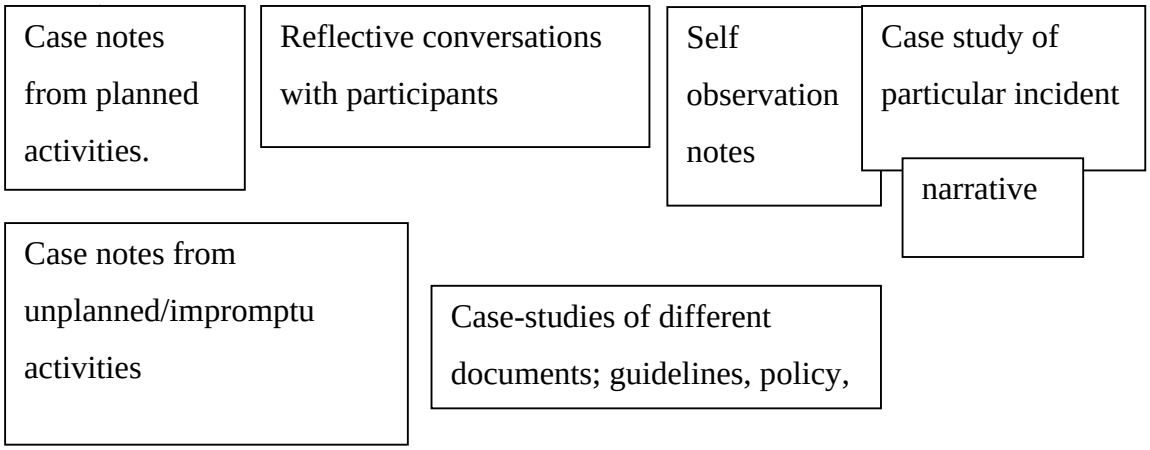
Both Patton (2002), Silvermann (2006) and Haavind (2000), stresses that the method in a qualitative approach to a research question needs to be dynamic. The data generated during fieldwork (or any kind of qualitative approach), needs to be reflected upon, and used to guide both further observations/data-collection and the analysis of data.

The method should therefore be presented within its overall framework focused on the aim and purpose of the study, as a dynamic process, where the data one collects, directs the work of the researcher further.

4.4.1 Nested and layered case-studies

Fieldwork might consist of many mini-case-studies, even when it ends up as one single case study at the end of the project (Patton, 2002).

Model 1. Examples of "mini-case-studies" constructed at each site of my study



All of the boxes above illustrate the various kinds of data collected during my field observations. Following is an example of what my case study from one of the municipalities consists of:

Data collected at municipality x – January 2009:

- Field-notes from conversation with nurse manager.
- Field-notes from meeting 1.
- Field-notes from meeting 2
- Field-notes from lunch break with NM and staff
- Field-notes from morning meeting
- Interview/focused conversation with nurse manager
- General observations
- Reflections about my part in this.

Documents from the municipality:

- Organizational chart
- Service-offer declaration for the home care services.

The other two case-studies are very similar, but the themes for the focused conversations, documents and particular incidents were different in each of the three case-studies.

4.4.2 Observing

To help me map out what I needed and wanted to observe, I made a list of sensitising concepts to guide my case-studies/field work – inspired by the writings of Patton

(2002) on constructing case-studies. Being a novice researcher entering into a study that by definition had no set formula, I felt a strong need for guidelines when designing the study and deciding how my data was to be collected.

4.4.3 Sensitising concepts

Sensitising concepts serve as a reminder that no researcher goes out into the field as a blank slate (Patton, Michael, Q.,2002). Even when doing an open investigation; going out into a field and asking the question of "what goes on here?", the researcher needs some guidance to make sense of the complex world under study. A list of sensitising concepts serves as a check-list of multiple ways to collect data, and to where and when to look for a variety of data that might give insight to the research question(s) (Patton, 2002). I have gone through the theoretical threads that shaped and informed this study in chapter 3. To help me guide my observations, I made a list of sensitising concepts before venturing into the field. Patton's recommendation (2002) is that less experienced researchers need to make a formal list of sensitising concepts in advance of field-work. The list will both help guide observations while out in the field and the organizing of the field-notes later.

In this study, the sensitising concepts included:

- **Geographical setting.** Where are the offices placed?? How does the staff access their patients?
- **Working environment:** Are the offices crowded? Does the nurse manager have her own office, or does she share her workspace with others?
- **Social environment.** Who are present? What is going on? When is this happening?
- **Historical perspectives**. The history of the home care nursing services in each municipality. Number, nature and result of organizational changes

- **History of recruiting staff**. Is it easy or difficult to recruit staff? Do people stay in their jobs when recruited or is the turn-over of staff high?

- **Description of planned activities and structured interaction.** What kind of formal meetings are held? Who are present? What is happening?

- **Observing and describing unplanned activities and informal/impromptu interaction.** Describe situations that arise during the day. What does the nurse manager do?

- **Observe and describe interactions with others.** Who does the nurse manager meet during a day? Are there drop in visitors? When does she meet her staff? When does she meet senior management?

- **Comment on non-occurences – what does not happen?** "What does not happen?" or rather, what was not talked about, turned out to be a vital finding of this study.

- **Record special language.** Identify insider language – explain terms used.

- **Observe non-verbal communication.** Observe NM in interaction with others in both planned and unplanned activities.

- **Analyse documents.**

When I first started this project, my intention was to do in-depth, open-ended interviews with my participants, guided by a theme-guide. At this early stage of the process I made a theme-guide, based on the findings in Vabø(2007) and Vike's (2002) studies and on my own experience from the field. This theme-guide, and Patton's (2002) list of sensitising concepts was used when I wrote down my own list of sensitising concepts. This list later proved vital when trying to get a sense of the whole by looking at parts when I started my observations. It helped me focus my observations during field-work.

4.4.4 Preparing for the field observations – doing pilot-studies.

Before I started my field observations, I spent quite a lot of time reading about other field observations and how they were done. Although I was going into a field I knew quite well, I have never done a research project before, and I needed to prepare myself! I put great emphasis on training, and I did a number of small observational "studies" in different situations – to train myself in observing people in different settings.

I was invited to join a friend, a nurse manager in an institution, during the change of shift in the morning. I observed, made notes and then typed up my first field-notes. I was amazed to see how much was actually going on in a setting with a large number of people present, even during a relatively short period of time (40 minutes.) After I finished the typing of my first field-notes, I presented them to my friend, and she told me that she was quite amazed about how much was really going on during that hectic meeting at the change of shifts. This pilot study made me aware of the need to focus or funnel, as Silverman (2006) calls it, when observing in an environment with lots of different things going on at the same time. When I focused on the nurse manager, my observations were quite hectic, and the data collected was extensive, but they were manageable.

When I spent some time abroad, in a country where I don't speak the language, I spent an afternoon in a restaurant, having coffee and reading Silverman's writings about ethnography. I spent an hour observing what was going on in the restaurant.

Not being able to understand what people were talking about; I had to rely on my eyes. This impromptu pilot study taught me that I actually could observe a lot of interaction between people, even when I don't understand a word of what they are saying.

4.5 Making observations

Before going out to make observations, the researcher has to make some decisions about her role while out in the field (Patton, 2002).

4.5.1 Insider or outsider perspective

Although I was not familiar with the organizations I was observing, I am familiar with home care nursing from several years of working in this field. This meant that I had some knowledge of what went on, although I was not familiar with the culture of the particular organizations included in this study. I knew some of the "language used". This gave me both advantages and disadvantages. The advantages were that my prior experiences made me able to watch and understand what was going on, to ask the "right" questions to my participants. A disadvantage might be that I might be taking things for granted – and assume that even the people reading my work, will understand what is going on. I tried to minimize this disadvantage by being vigilant in ensuring that any insider terms were described and explained in my work, and by being vigilant in describing what I saw and heard and read before I started my interpretation of what I had observed.

4.5.2 Overt versus covert observation

I wanted to do a fully overt observation. I applied the principle: "Being vigilant in fully informing and protecting the people who honour us by agreeing to participate in our research."(Patton, 2002, pg 271). My participants knew my research question, and what I was observing. They received a letter describing my project before I arrived, and I went through my plans and the scope of my study with each of the participants when I arrived for my observational period. The staff was informed briefly about my arrival before I got there, and I gave a short run-through of my project during the first day of my stay, at all three sites. When asked about my study during the observational periods, I answered all questions as best I could.

4.5.3 Duration of fieldwork:

I spent three days during one week (Monday though Friday) at each place of study. I observed for up to 4 hours at a time, depending on what kind of situations I was observing. Nurse Managers are usually present during the day shift, and that means that all my observations were done between 7:30 am – 4 pm.

Below is an example of the time-schedule for my observations at one of the sites:

Table 2 – Example of time-schedule for observations

Time	Tuesday	Wednesday	Thursday
07.30-09.00			Morning meeting – change of shifts
09.00 – 11.30	10.00 – 11.00 Introductory meeting with nurse manager		
11.30 – 12.30	Working lunch with NM and staff	Working lunch with NM and staff	Working lunch with NM and staff
12.30 – 14.00	13.00 – 14.00 Formal meeting awarding short-term nursing home stays		12.30 – 13.00 Focused conversation with NM
14.00 – 15.30	14.00 – 14.45 Formal meeting – awarding long term nursing home stays	15.00 – 15.30 Change of shifts – NM and staff	14.00 Informal closing conversation with NM

4.5.4 Focus of observations:

My focus was the same as my research question. I wanted to observe how issues arising from change affected the Nurse Managers' daily work. The focus was narrow – but my observations were wide. I was observing and looking for my topic of interest in a number of different places and situations. Silverman (2006) stresses the need to both funnel and overview at the same time while observing, and as hard as it

might sound, I really tried to do just that, by observing an array of different situations, but focusing on the nurse managers the whole time.

4.5.5 Field-notes

Patton (2002) recommends writing descriptive notes, and dividing the descriptions from the reflections in a way that can easily be transcribed later. He recommends using brackets or * *when inserting interpretations into the field-notes. Following Patton's advice on this, I took extensive notes during my field-observations, and wrote out the field-notes the same day as I did the observations. My field-notes are thick, rich descriptions, and I chose a form in which the field-notes read as a narrative of my entire study period, where the events are listed chronologically, – with subtitles providing information as to what kind of activity I was observing. The field-notes also contain narratives of incidents that occurred during the observations. I inserted my own thoughts and reflections using ** in which I inserted my own thoughts and reflections *in italics.* Excerpts from my field-notes are included in chapter 4.5.2

During my weeks of field-observations, I took part in both planned and unplanned activities – and I took notes all of the time. I had a small spiral-backed note book with me, and made my observational notes on the right side of the pad, and my own thoughts, reflections and initial interpretations of what was going on, on the left side.

4.5.6 Focused conversations

In "Nursing Replay"(Street, 1995) focused conversations was used as a way to enhance data collected during an observational study. In the original study the author describes how she struggled with developing a questionnaire to probe the observations in her study, and how she discovered that doing focused conversations, asking her participants to tell her more about a topic of interest or the observation she had just made, generated the data she was looking for. Street's idea of doing focused

conversations, sounded like a good way for me to probe and deepen what I had already observed during field observations. I made the decision to use focused conversations based on the fact that I did not yet know what I was going to observe during the field observations.

When I entered the field, I told my participants that I would like to finish off my observational period by having focused conversations with them, giving me an opportunity to ask questions about themes or incidences that happened during the observations.

During my observations, I picked up on topics that I wanted to know more about, and made notes in my ever present notebook. The taped conversations became a way for me to probe some of the data or themes I had picked up on during the observations, and collect more information about certain topics.

Although my three participants were working in organizations that were organised very differently, they all had very busy days. In the three focused conversations I had with my participants, I asked them different questions, based on what had happened during the observational period. There was one question, however, that I ended up asking all my participants. It was: “Do you have enough time to do all the things you are supposed to do/want to do?”

Other topics discussed during the focused conversations were collaboration with the hospital, being nurse manager in a period of change, and one of the nurse manager’s thoughts on outsourcing home care nursing. In chapter 8.2.1 there are citations from all three focused conversations.

All three conversations took place in the nurse managers’ office, I used an audio recorder, and I transcribed the focused conversations on the same day or the day after the conversations took place. The conversations lasted for about 20 minutes at all three sites and they were transcribed word by word.

4.5.7 Documents

Silverman: “Texts are words and images recorded without the intervention of the researcher.” (Silverman, 2006, pg. 154.) (As opposed to field-notes and transcriptions of interviews/focused conversations, who are written by the researcher.)

I collected different documents from each site, raging from organizational charts, visions for the home care nursing services, and at the one site going through organizational changes, I collected documents about the restructuring/downsizing project the ongoing organizational changes. The documents collected in this study were mainly used as contextual background. Information from the documents was used in the focused conversations and when writing the case-studies.

4.6 Venturing into the field

After designing the method, getting approval from the NSD and finishing the sampling and recruiting, and doing my small pilot studies, I was finally ready to go out and collect my data. All of the field observations were done during January. Before I entered the field, I had several conversations with the nurse managers – and they had all been given the introductory letter (appendix 2).

When I arrived at each municipality, I had an initial meeting with each nurse manager. During this first meeting, I was given a presentation of the municipality and its Home Care Nursing services, its history and present day challenges. I told the participants a little bit more about my project – based on what I had already written in my introductory letter, and asked them if they had any question about the study and my observations. We then went through the agenda of the nurse manager for the duration of my stay, and planned what events/meetings I should attend while I was there. I was present anywhere from 1 – 4 hours each day, for three days at all sites. Silverman (2006) emphasises that doing ethnography is all about watching mundane activities. That is exactly what I did. I observed meetings, I was present during the

change of shifts, during lunches; I spent the time watching people doing their every day work.

4.6.1 Amount of data collected

When I entered the first site of my studies, I was really afraid I would miss vital data – my first day in the first municipality was busy and a bit stressful – I kept taking notes and writing everything that happened down until my right wrist was aching.

Observing in the field got a lot easier after a while. It was still hard, very intense and concentrated work, but after a while I was able to relax a little bit more – and I gradually became more confident that I was getting the essence of what was going on, although I never felt quite sure. The double-edged-sword of qualitative research again; one can never be quite sure that one is finding the right answers, or even asking the right questions. But as I was observing and watching and got more of an overview of what was going on in the field of my study, I became more confident that I was on the right track.

4.6.2 Learning research by doing research

After reading several authors' writings about the role of the observer, I really thought I was as aware of my own role when going out to do my studies (Briggs, K., Askham J., Norman I & Redfern S., 2003; Patton, 2002; Silverman, 2006; Street, 1995). I understood and appreciated the impact my presence would have on my participants, and how I needed to keep this in mind both when I did the observations, and when I was interpreting the data.

During field-work, my role was varying between taking a passive, observing role in the background while attending formal meetings, to actively communicating with the nurse manager when we were in her office, or moving from place to place. When I was present during more informal situations, like lunch-breaks, I kept my focus on

the nurse manager, but part-took in the informal conversations along with the others present.

I was in the middle of the second week of observations, at the second site of my study, getting quite comfortable in my role as the tag-along-act – following the nurse manager around, taking notes and observing, when my role was challenged in a major way during a meeting.

The following is taken from the field-notes at one of my sites, and it tells the story of what happened when I had to do a rapid re-evaluation of my role as a researcher in this field: (This is a copy of my field-notes. The *italic parts* of the text, are my reflections, the rest is descriptive.)

> ” When the formal part of the meeting is finished, most of the people leave the meeting, but the four nurse managers from the home nursing care service stay behind, and they continue discussing the down-sizing. One of the nurse managers is part of a group whose task it is to figure out pros and con’s of reorganization as a tool to downsize the organization. She expresses insecurity, doubt and ambivalence about whether they should implement at purchaser/provider model in the municipality or not.
>
> Suddenly, something happens that I am not prepared for, even though I realize I really should have been prepared for this… “My” nurse manager tells the others that my project is about change, and what happens during periods of change, and she asks me to tell the group a little bit about my project and my own experiences with processes of change and down-sizing. I have first hand experience from implementing the purchaser/provider-model, and the nurse manager knows this from our introductory conversations.
>
> *At first, I don’t know how to respond to this. This calls for a rapid change of role on my part – I’m being asked to take active part in this meeting, and step out of my ”comfort zone” sitting silently next to the nurse manager, ”hiding” behind my note-book. For a few (short) moments, I struggle with doubt and*

confusion, asking myself how this sudden change of role will affect the rigour and ethics of my study. Then the words of Silverman and Patton come to mind, and I realize that I am experiencing exactly what they have been talking about. This is a moment when my role will have to change; this is typical example of what they have been writing about.

These people are struggling with processes and issues that I know a lot about. This has been my area of professional focus for years, and I feel a strong ethical inclination to contribute whatever I can to help them deal with these issues. They invited me in spite of this being a very difficult time for the whole organization, and I realize that I know a lot about what they are struggling with. The literature I based my method design on, say very clearly that the researcher has to be open for change during the observational period – and that my approach to method design and my own role in the process needs to be dynamic. When one seeks to observe and describe someone's world, one needs to be aware that the nature of a study like this is that it changes continually, and the researchers approach needs to change with it. The researcher cannot be fully prepared and know beforehand what kind of situations he/she will encounter before she is in the situation. After a very a short period of time, when I go through this in my head, I realize that this is a moment when I need to step forward. I need to put my note- pad down, and actually participate actively.

I start by telling them a little bit about my project. I recommend some of the literature I based this study on – both Vabø and Vike. Both these studies are about major changes in organizations seen from the ground level of organizations. …"

This incident made it very clear to me what all the authors I have used to help design this study, actually **meant** by putting so much emphasis on how the researcher needs to be aware of one's own role. This was a light-bulb moment for me. It seems that the image of the objective and distanced researcher still was alive in my mind at this

point, even though I had been reading and reflecting a lot on how I could and should have a dynamic approach to my own role while out in the field.

Haavind (2000, pg. 11) - translated: "When experienced researchers enter the field, they take into consideration not only what goes on in the field, but also the effects of their [the researchers] own actions."

This incident transported me from novice student researcher, to a student researcher with a little bit more experience and knowledge than I had before this happened. For the rest of my observations, I kept this incident in mind, and kept recording my thoughts and actions with an increased understanding of what reflexivity meant, and how it was vital. Both Silverman (2006) and Patton (2002) says that all case-studies needs to change and develop over time. The data collected as one goes along should be used to redesign and guide the study further. I finally understood the meaning of this. I realized that planning in detail what to do and how to do it, and how my own role would be before entering the field, is not possible when doing a study designed like this one.

The fieldwork stage if this work was very exciting and rewarding and I came back from the field loaded with my thick, rich field-notes, my interview transcripts and documents, feeling that I had seen and done something that was really worth while. But then the really hard work began.

4.7 Analysis

According to Patton's alter ego, the wise Halcom, "the complete analysis isn't". (Patton, 2002, pg. 431). These words can offer comfort, but also add to the confusion of a novice researcher, desperately searching for "how-to" manuals and rules to confirm that one's work is on track, and done the right way. Halcomb goes on to state that: "Analysis brings moments of terror that nothing sensible will emerge and times of exhilaration fro the certainty of having discovered the ultimate truth. In between

are long periods of hard work, deep thinking and weight-lifting volumes of material." (Patton, 2002, pg. 431).

In Hesse-Biber & Leavy, the authors claim "There is no one right way to go about analysis." (Hesse-Biber, Sharlene Nagy & Leavy, Patricia, 2006, pg. 344)

At this stage in the process, I had gotten more used to the "No formula – just guidance"-approach of the qualitative research literature I had spent so much time reading. I did not feel quite as confused and discouraged as I had when I encountered the same "no formula – just guidance"-advice when deciding on a method and designing the study. But the fact that I had accepted this at this point does not mean that the analysis-stage of this study was an easy process. In qualitative research, every study is unique, every set of data is unique, and therefore the analysis must also be unique. (Hesse-Biber, & Leavy, 2006) This all sounded reasonable to me, but when it came to actually doing the analysis, I struggled. And the statements about every study being unique and needing a unique approach, contributed to my bewilderment. I desperately needed a "how-to-manual" to tell me how to do this – but the authors of all the literature on qualitative research and analysis could only offer me guidance.

To guide me though the analysis, I used the six stages of analysis described by Creswell (2003) and Patton's (2002) writings about cross-case analysis.

4.7.1 Getting organised for analysis – step 1

I had turned my nested cases into case-notes that could be read from beginning to end – as three stories about my visits to the three municipalities. Both Creswell(2003), Hesse-Biber & Leavy (2006), Patton (2002), and Silverman (2006), identify the transcription of data as the first stage of analysis. When transcribing my field-notes, I chose to include everything from the observation notes into my transcripts. I included my descriptions of the setting, what people were present, and so on. The main reason for doing this was my own inexperience in doing this kind of work. I did not feel I had the necessary overview at this point to decide what parts of my data were vital,

and what parts were not. I typed the field-notes while still out in the field, usually at the end of each day. When I finished the observations, I had my snapshot case-notes, complete with field-notes, transcripts of the focused conversations and the documents from each municipality, and I was all ready to go.

4.7.2 Step 2 and 3: The essential question; "What goes on here?"

Although my research question was at the back of my mind the whole time I collected the data, my inexperience in data collection had me acutely aware that I needed to keep an open mind throughout the process.

Some of the data, like the constant interruptions to the nurse manager's work, which at times seemed almost too obvious and too frequent to even record, turned out to be quite essential. Other kinds of data, though used as contextual data, turned out to not be of equal importance. My descriptions of the décor and location of the staff room at the home nursing services of the municipalities were not vital to this study. But a comment of how the room was crowded and noisy during lunch was made in the case-description. This observation was important during the analysis, as it emphasised the continuous variation of the every-day work of the nurse manager

The open, inductive approach to data-collection also guided my approach for the analysis. I read and re-read my snapshot case-studies with the same question in mind – "What goes on here?" Focusing on this question brought me to the next stage of the analysis.

4.7.3 Identifying themes from the field-notes and focused conversations – stages 3 - 4

After I had read the field-notes and the transcripts from the focused conversations numerous times, I reformatted the field-notes/nested case-studies, and divided the document into two columns, with the original text from the nested cases on the left side. When I identified themes as I was reading through my field-notes, I wrote short notes in the right hand columns of the documents.

These themes were often the same as the ones I had already made in italics during the typing of the field-notes. Sometimes during the analysis, there were more themes that emerged from the data as I went along, but it seems that when I wrote my first interpretations of what was going on while out observing, I really *did* start the analysis – just like Patton (2002) and Silverman (2006) say . I just didn't really realize that I had until I started grouping my findings.

I started with one case, read it, re-read it, made notes of themes I felt emerged from my data, and then wrote short comments or memos about the themes I had identified, and I went back and forth between the cases. Although the analysis is described in steps in this monograph, it is not how the actual work was done.

Silverman (2006) makes a point of the analysis being a dialectic process – which means that one does not start at one point, with reading the data and start grouping it, find themes and patterns and then write it up – ending with the final steps of analysis and description of the findings. It means going back and forth between the stages of analysis during the whole process. Just like the wise Halcomb had predicted (Patton, 2002). But the core activity was reading the data for a long period of time, combined with some really hard thinking.

4.7.4 Identifying change

I use the words issues and change in my research question. During the initial stages of the analysis, I kept looking for issues when I was reading through my data. The real break-through came when I stopped searching for issues, and started looking for change. When I started the planning of this project, I used *change* as having the meaning of large, organizational changes, like going from the traditional welfare model when awarding health care to patients, to a NMP-inspired model of running services. These changes in organizations, in politics and policies, all influence the working lives of the people working in the home nursing services.

As I was struggling to find a way to arrange the findings of my data, I realized that change was an essential part of a lot of the things that saw during my field observations. Not only changes on the organizational level, but change on different levels and in different ways than I first thought. Change really *is* a major theme in these nurse managers' working lives. There are changes in workloads of both nurse manager and staff, caused by changes and fluctuations in individual patients' needs. There are changes in staff; people are out sick, quitting their jobs or taking out vacation time. The home care nursing services are open for business 24/7 – all year. All three nurse managers in this study spent most of their time accommodating these changes during my visits.

Many of these changes are not specific to home nursing, but apply to nursing (and other kinds of work) in various organizations as well. But there are some characteristics that are unique to the home nursing services. The nurses work in other people's homes. They have to go out, no matter what the weather conditions are, to provide services to the people who need them. They have to live with unpredictable changes in number of patients, and this adds to the unpredictability of workload. The home care nursing services don't have a set number of beds available – but has to provide services to whoever is assessed to have a need for them at any given point of time (HOD, 1984b).

In the two rural municipalities especially, changes in weather and driving conditions was an issue they had to deal with daily.

I finally realised that when I could pinpoint the various changes captured in my data – then I could identify the issues arising from them, as well.

4.7.5 Issues arising from change

I then grouped my findings into three major themes:

- Issues related to authority and responsibility for the nurse manager

- Issues related to doing more with less
- Issues related to altered relationships

Although they were of a different nature in the individual cases, these three themes were central in describing what went on in the nurse managers' professional lives. They described different issues the nurse managers had to deal with when keeping the wheels of the Home care nursing services turning.

4.7.6 Writing the case-studies.

After I had identified the major themes and how they emerged in different ways in my three cases, I started out to write the cases down. The major themes and the way they emerged were used as subheadings in all three cases, to illuminate my findings. In addition to grouping the themes, I also included one narrative in each case. The first snapshot-case contains a story about a cat, the second a story of an ailing patient, and in the last case, I included a story about a key. These three narrative passages in the cases are included to illustrate the nature of my observations, and to give the reader an insight to what I saw when I was in the field.

Chapters 5, 6 and 7 describe the three cases comprising this study. I start off by describing each municipality; its history and organization, before I go on to further describe the findings of each snapshot case.

At the end of each chapter describing the cases, I made a summary of each case. I made a chart listing the three major themes in each case, and how they emerged in the individual cases.

4.7.7 The final step – cross-case analysis

When using a maximum variation-strategy when sampling for a qualitative study, shared patterns and findings that emerge from heterogeneity, have special

significance (Patton, 2002). Chapter 8 focuses on the shared patterns of this study. In this chapter the findings and themes from my three case-studies are brought together. The findings from the case-studies were used as data for the cross-case-analysis.

Cross-case analysis consists of two major parts; First, detailed description of each single case, and second, the common themes that occur across the cases (Patton, 2002). Although the cross-case analysis is presented as the final stage of analysis, it began during steps 3 and 4 of the process of analysis. When I was moving back and forth between the individual cases to identify themes, shared patterns began to emerge. I wrote memos about these themes. After describing each case in detail, I used these memos when starting the cross-case analysis along with the isues identified at each site. I then added different sets of theory to drive the analysis further, to shed new light on the findings.

In chapters 5, 6 and 7 I give detailed descriptions of each case. In chapter 8, I bring the three cases together.

5. Case 1 - River deep, mountain high

5.1 The municipality

This was the sparsest populated municipality in this study, but the largest one in terms of square kilometres. Transport was a major challenge here – it cost a lot of money, and took up a lot of time. Some of the inhabitants in this municipality live in remote places – not easily accessible. The staff of the home care services spent a lot of time driving to the patients, the distance between the southern and northern border of the municipality, is almost 200 kilometres. The climate offers long, cold winters with lots of snow, and difficult driving conditions for long periods of time.

The municipality is situated in a valley. It has a river running right through it; it has mountain terrain, vast woodlands, and agricultural areas. A main road between two large cities goes through the municipality, and the administrative centre of the municipality lies just off this main road, near the geographical centre of the municipality. The municipality's administrative centre is a small town – and the home care services office is located in the centre of the village, in the same building as the nursing home, and right next to several different types of community care housing facilities.

Demographic data

The population is aging, and there is an expected increase in population aged 80+ for the next few years. The municipality has a lower than average number of inhabitants with higher education. The municipality is a relatively mono-ethnic community.

Working in a small community

This municipality was very small in population. Despite the long distances, everybody knew everybody else here. If someone observed a neighbour behaving

differently, or if they hadn't seen the neighbour for a while, they contacted the home nursing services.

One of the realities of working in a small community was that everyone knew who the employees of the home nursing services were. This made it hard to keep confidentiality for the patients, because people in the community knew both who the employees of the services was, and recognised their cars when they were parked outside peoples' homes.

It could also be hard to separate professional life from personal life for the employees, as they were sometimes asked about professional issues while off duty. This blurred the boundaries between the professional and personal lives of the people working in the home care nursing services, as most of the staff lived in the municipality, and they meet patients and their families both when they are on and off duty.

5.2 Responsibilities and decision-making authority for the nurse manager

The front-line nurse manager had formal responsibility for supervising the staff. The staff comprised registered nurses, nurses' aides and domiciliary staff. The staff provided services to people in their own homes, and in community-care housing.

The nurse manager was responsible for ensuring the quality of the services provided. She was responsible for the staffing schedule and making sure there were enough people at work at any given time. The nurse manager had formal authority to assign home nursing care, domiciliary care, all types of community care housing and both short- and long-term nursing home stays. She was the leader of a team of peers/colleagues that meet every other week to discuss changes in patients' needs, and how they best could be accommodated. Even though the nurse manager had the formal decision-making-authority, she exercised this authority in close collaboration

with her team of colleagues. During my visit to the municipality I was present at two meetings where different services were assigned to patients.

There was emphasis on taking into account individual circumstances when decisions were made in both these meetings. The routines for working cooperatively within the team seemed well-established, and participants of the meetings discussed each case, and came up with tailored solutions for each patient. As the nurse manager had the ability to make decisions it was possible to follow through on these tailored solutions. For example, one of the cases required discussion because a patient had applied for a special service, for which there were no funds left in budget, even though it was still January when I was there. The nurse manager made the decision that despite the lack of funds, the service had to be provided.

When this happened, the nurse manager turned to me and said: “It’s all about finding solutions. I am sure we’ll be able to find the money somewhere.” She told me that in a municipality this small, costs for one patient with extensive needs are very visible in the budget. But at the same time, in a municipality this small, even senior-management knows most of the people living there, and recognises people’s need for services.

The responsibility for the formal hiring and firing of employees and the follow up and evaluation of staff lay with the unit manager, the senior manager of the nurse manager. The unit manager also had the formal responsibility for the budget. These responsibilities were interlinked with the daily supervision of the staff and schedules, and the nurse manager worked very closely with the unit manager. They hade their offices right across the hall from each other, and collaborated very closely.

5.3 Knowing the patient

The nurse manager described her vision of the home care nursing services as being the provision of services to enable, “a good life at home”. She and her staff really made an effort to provide very flexible services. The NM felt that the small

population of the municipality helped them provide these flexible services. She worked very closely with the manager of the nursing home and other services, and everyone knew most of the patients. *"If there is a will, there is a way"* – she told me. They tried to accommodate patients wanting to stay in their homes, even when they were in need of extensive home nursing care. She told me how the patients receiving home nursing services had different and varied needs and that their needs often changed from day to day, and sometimes even from hour to hour. The need to accommodate these changes and perform nursing care accordingly was perceived as a core task for the home care nursing services and a core responsibility for the nurse manager. There were enough beds assigned for short term stays in the nursing home and in the community care housing facilities. This made her job easier in that she was able to accommodate needs whenever they arose.

The importance of knowing the patient was exemplified by the following incident.

A story about a cat

The staff of the home care services had a working lunch. The nurse manager encouraged everyone to come in to the offices for lunch every day, even if it meant spending extra time in the car. She told me that she felt that it was of vital importance for people who work on their own for most of the day, to be able to come in to the offices and spent time with their colleagues. The room was crowded during lunch, and the room buzzed with talk, as the staff was telling each other stories about what they had experienced during the day while they had their lunch. The atmosphere in the staff room was relaxed and informal during the lunch-break, and people were eating and talking.

One of the nurses expressed great concern for at patient's cat – the cat was very thin and had a skin disease, and the staff exchanged observations they had made of this cat while visiting the patient. The conversation about the cat continued and engaged everyone, but at the end, the concerns about the cat gradually became concerns about the cat's owner. One worker noted: "She really can't be feeling well at all when she

does nothing when her animal is in obvious discomfort – because she has always taken very good care of her animals." The others agreed, and they continued to discuss the patient, and decided to help her make a doctor's appointment.

This snapshot from my field-notes about a lunchtime conversation illustrates how what started out at small talk, turned out to be an important concern about a patient's health. It highlights the effect that knowing the patient over time had in that changes such as the lack of care for a once well cared pet revealed deeper issues around the older person's health.

5.4 Doing more with less

During my first meeting with the nurse manager, she told me the story of the home nursing services, and how the funding and priorities of the services have changed gradually over the past decade.

"The gradual reduction of services provided has happened in close cooperation with the users/patients."

Gradual change in funding – reduction over time.

During the last decade, there had been a gradual reduction of available funds for the municipality as a whole, and for the home care services specifically. In the home care services the cuts to services had mainly been in the area of domiciliary services. In earlier days, the staff of the home care nursing or the domiciliary services did the clients' laundry in the clients' homes – free of charge. Clients now had to pay for having their laundry done in the nursing home laundry. Shopping for groceries was another service that is no longer provided by the home nursing services. The local grocery-store delivered groceries to people's homes for a fee. Some of the clients resisted having to pay for these services, but most had agreed to the changes.

Gradual change in priorities.

The home nursing service had a vision for its services; “A good life at home.” This vision was printed in big letters and hangs in a frame on the wall of the offices of the home care nursing services.

The priorities of the home care nursing services had gradually changed. Ten years ago, the goal was to keep everyone living at home for as long as possible, no matter where they lived. In 2009 there was still an effort made to provide sufficient services to patients with a strong wish to remain in their homes, but people living in the most remote areas were given priority when applying for nursing home stays. The reason for this was both to limit the number of visits required to the most remote places of the municipality for economic (cost of transportation) and safety (avoiding long, hazardous drives on deserted, mountain roads during winter) reasons. Further, the last decade had seen a trend for the oldest patients to move closer to other people and the service facilities that were placed in the central town. Consequently, during the past ten years the municipality had established several different kinds of community care housing facilities in the central village.

Further changes had been made to the home service organization during the last decade, to make it more “modern”. All patients receive formal letters granting services. Rules for deciding on who is qualified for different services had been established, and implemented guidelines to ensure a just distribution of services had been implemented. This system had been introduces to give each patient formal, individually tailored grants of services, and transparency. The nurse manager told me that they have reflected upon whether they should formally divide the organization into provider and purchaser, but had decided against it, because they felt it would mean too much bureaucracy, and more importantly; it would mean having to give up some of the flexibility and ability to deal with changes as they occurred, because they would have to assign one of the nurses working with patients to do this job. This would mean less manpower to do the direct patient work.

Putting the needs of others first

The nurse manager spent a lot of time trying to lessen the effect of unpredictability and heavy workloads for her staff. She was available by phone when the staff were out working in the patients homes, to answer questions and help solve emerging problems. The only time she turned off her phone, was during a formal meeting. There was little or no down-time. For example, when the nurse manager met her staff for the change of shifts or for lunch, she always brought a notepad and pen with her. The notes she made during meetings with staff, usually contained some tasks for the nurse manager to perform.

She spent a lot of time informing staff about changes to the schedule, about patients, giving messages or listening to staff concerns, supervising staff, and assisting staff when necessary. Being readily available to staff, colleagues, patients and patients' families like this, often meant that she didn't have enough time to do some of the tasks that were part of her job, especially tasks like writing letters, controlling time sheets and other activities demanding of peace and quiet to perform. When I asked her if she had enough time to do everything, she answered "NO". She had to prioritise all the time, and whatever was most urgent, had priority. Other tasks were postponed to times when there were less things for her to do. During busy periods, work piled up for her, and she needed to put in some extra time after office-hours to catch up.

Collaboration

The nurse manager commented that the routines for collaborating with the nursing home, the rehab-unit and the day-care centre were very good, and the lines of communication were open and functioning very well; there was a good and continuous flow of information. The manager of the nursing home has her office just a few steps from the offices of the home care nursing services, and they often met for informal conversations and to exchange information about patients. The nursing home and the home care nursing services were gaining increasing respect for each

others tasks and goals, and this mutual feeling of respect had made communication and collaboration both easy and rewarding.

Collaborating with the regions hospitals was something of an issue, though. The nurse manager told me how the routines for collaboration had gotten a lot better than they used to be, but that there were still some difficulties. Her main concerns were that the hospitals did not contact the municipalities before they promised a service offer to a patient ready for discharge, and sometimes this could become an issue – especially if the patients felt that the hospital had promised them something, and this was something that the municipality could not then offer. Although the municipality is formally responsible for formulating the service offer, the hospital sometimes made promises to a patient that the municipality could not keep.

Constant change

The nurse manager had busy days and whenever she met with her colleagues or staff, she was bombarded with information and questions. She was dealing with complex problems, patients with different, complex needs that change from day to day, and staff being out sick or needing to change shifts. She handled loose ends, picked up pieces and solved practical problems. Although she was sometimes stressed out by this ("*sometimes there are just too many things going on at the same time*"), she also appreciated the fact that no two days were alike in her job, and she liked the tempo and felt that they were making a difference by working the way they did.

The nurse manager about her job

The nurse manager really enjoyed working in the home care nursing services, because of the need to be practical, creative, flexible and pragmatic. She enjoyed the fact that by being flexible, creative and pragmatic, they were able to find good ways of adjusting the services to fit the individual needs of each patient. This flexibility in provision of services and tailoring services to meet every patient's needs was something that was referred to many times during my stay. The flexible approach was something the nurse manager talked about – and it was also something I witnessed on

several occasions while observing. She felt she could handle the complexity and unpredictability because of a flexible system with enough room for change.

5.5 Keeping the wheels turning

The nurse manager was almost always available for both staff, clients, patients and their families. She was willing and able to accept the constant change of which her work-days comprised, and dealt with the stress and the multitude of different tasks her job consists of as they happened. Although she appreciated the fact that no two days were alike, she sometimes needed to work late to catch up. The flexibility that was a priority when providing the services also meant that the nurse manager had to be flexible when doing her tasks.

The nurse manager was responsible for keeping the wheels turning. In keeping the wheels turning the following themes, illustrated in the chart below, developed around issues identified as important by the nurse manager for her work.

Table 3 – Case 1

Case 1	Themes	Categories	Subcategories
	Theme 1: Issues related to altered relationships	Knowing the patient	Pride in flexible solutions Possibility to intervene when patients' needs change Small community – people know each other.
	Theme 2: Issues related to doing more with less	Gradual cuts in funding	Changes in the service offer for clients and patients
		Putting the needs of the other first	Working late Working though lunch Prioritising patients living in remote areas for nursing home stays.
		Gradual change in priorities	
	Theme 3: Issues related to authority and responsibility for the nurse manager	Authority to accommodate changes in patients' needs	Authority to assign all kinds of services. Authority an possibility to change the service offer when needed

5.5.1 Theme 1 - issues related to responsibility and authority

The flexible way services were preformed in this municipality was praised highly by the nurse manager. She identified it as one of the main reasons that she liked and got satisfaction from her job. This flexibility was created in part by the fact that she could decide and assign what services she felt were needed and when. In our focused conversation, her last comment to me was: *Flexibility is key* (to be able to solve problems the way they do here), and I think that was a very appropriate way to end my observations at this municipality because flexibility and a pragmatic approach to everything really were key to how they worked here. The nurse manager having the formal authority to assign different services when the needs of patients were changing provided her with important tools to provide this flexibility. She also had enough resources to provide tailor-made, flexible services. This was important to her feeling valued and respected in her role.

5.5.2 Theme 2 – issues related to doing more with less

There had been cuts in funding in this municipality. The cuts had been done gradually, and the nurse manager felt that they had been able to implement the cuts without causing too much of a quality reduction. They did not stop doing things such as laundry and grocery-shopping for the clients until they had other systems in place.

Helping in doing more with less was the fact that the staff was well educated, they had a lot of experience and were very resourceful when it came to finding tailored solutions to complex problems. They knew the patients and clients, and they knew the area.

However, doing more with less came with a price. When experiencing heavy workloads, the nurse manager was putting the needs of others first, by being available and trying to lessen the load for everyone else. This meant that she often had to work late to catch up, and that lunch had become part of work. There was virtually no downtime for the nurse manager while I was there.

5.5.3 Theme 3 - altered relationships – knowing the patients.

Providing home care nursing services in this municipality was all about knowing the patient. Tailoring, flexibility and acceptance of patients needs as being forever changing, was intrinsic in a lot of things that were said and done by the people I met here. The nurse manager felt that the best part of her job was that it gave her a unique insight to the lives of people – they were people, not just names. The respect for people's lived lives, and a willingness to provide the necessary help for people to be able to continue living these lives, was the priority of the home care nursing services.

6. Case 2 - On the coast

6.1 The municipality

This municipality is a typical coastal municipality in the south of Norway. It consists of one small town; the community centre, and is surrounded by woodlands and agricultural areas. It has a long coast line, and there are several islands only accessible by boat in this municipality, and several of the patients and clients the home care services live on these islands.

This is a popular tourist destination in Norway during the summer, and there are lots of summer houses/second homes here. During the summer months, the population of the municipality increases by thousands of people. This also means that the number of patients in the home care services increase during summer, because vacationers are entitled to receive home care nursing services, if needed, while staying in the municipality (HOD, 1984 b). My visit here was in January, though, so there are not a lot of tourists around. On my first day, it was snowing heavily in the morning, and the roads had not yet been ploughed when I drove in to the home care services' offices.

The municipality is quite large in size, and a majority of the inhabitants live in the rural parts of the municipality. It's not unusual for an employee in the home care services to spend hours in the car during a shift.

The topography of the municipality is varied, and most of the roads are narrow, steep and curvy. To reach the clients and patients living on the islands, the staff depends on transportation by boat.

The municipality has a nursing home in the main town of the municipality, and several different kinds of community care housing, both in the town, and in rural locations. Some of them are permanently staffed, while others have regular visits

from the home care nursing services. The staff of the community care housing are part of the home care services.

Demographical data

The population of the municipality is aging, and they can expect a rise in the 80+ population in the years to come. Like the other rural municipality, the level of education of the inhabitants here is lower than the national average. This is also a relatively mono-ethnic community, but there has been a slow increase in people from non-western cultures here.

6.2 Responsibility and authority for the nurse manager

There were three levels of management in this municipality – the front-line nurse manager, the unit-manager for the home care services and the senior-management of the municipality.

The nurse manager had formal responsibility for supervising the staff. The staff comprised registered nurses, nurses' aides and domiciliary staff. The nurse manager was also responsible for the quality of the care provided, and for the staffing schedule.

She shared the responsibility for hiring and termination of staff with her next-in-line-manager, and they worked really close and had their offices in the same building. She did not have formal responsibility for keeping the budgets, but worked closely with her unit-manager, who has the formal responsibility for the budget.

The authority to assign home nursing care, domiciliary care, community care housing and short- and long-term nursing home stays was shared with a group of peers/colleagues. The group consisted of the nurse managers in the home care services, the unit manager of the home care services, nurse managers from the nursing home, the manager of the rehabilitation unit, and one of the municipality's MDs. They met every other week to discuss cases and assign services. Although the

meeting was held only once every fortnight, the assessing and assigning of home care nursing was done continuously. No one had to wait for the formal assignment of services; they just had to wait until after the bi-monthly meeting to receive the formal letter granting the service.

6.3 Doing more with less

Sudden drop in funding

This municipality was in the middle of a big reorganization and downsizing project. They had to cut costs by more than 25% during the next four years, due to a dramatic drop in income for the municipality. The first major part of the down-sizing-project; the implementation of a new shift-plan; was scheduled for six weeks after my visit there. In relation to this change, there had been cut-backs in the staffing. Up until the week before my arrival, the employees of the home care services did not know whether they would be able to keep their jobs in the home care services or not. This had caused a lot of unrest and anxiety amongst staff. The week before my visit, they had been told that all staff with regular employment would be keeping their jobs, but that temporary staff, some of whom had been working there for years, were not. Arranging the new shift-plan meant a cut back in funds for hiring temps during sick-leave and vacation time, which meant that they would have to do more with less during times when members of staff were out sick or taking out vacation time.

Down-sizing the organization

The need to downsize the municipality's service offer had been known for 18 months when I visited. The nurse manager told me how they were tired and that it was actually a relief when the new shift plan was launched and it was clear who would keep their jobs. During the days I spent there I made a lot of observations about what being in the midst of organizational change can do to the people working on the front-line.

The front-line nurse managers in the home care nursing services had been put in charge of cuts, and at the same time been told to keep the quality. There seemed to be a belief by the senior-management of the municipality that there was an unused reserve somewhere in this organization.

Conflicting views and contradictory messages.

The message from the administration was to reduce activity, but preserve quality. The nurse manager got quite agitated when she talked about this. She told me how their organization has been praised in the past for providing quality services at low cost, but now, they have been told that they have been *too* generous in the past, and that they need to change their practice. The nurse manager had been proud of the services they provided, but now they were told that what they had been doing before, was not good enough anymore.

Tasks like bringing in fire wood and shovelling snow were no longer to be the responsibility of the home care nursing or the domiciliary care staff. The manager said that she could see that this might not be a thing that the home care service should be responsible for doing, but on the other hand, there was no other department in the municipality offering these kinds of services.*" If we are no longer supposed to do this – then who will?",* she said.

It was still a major goal for the municipality that people were able to stay in their own homes for as long as possible. And for the patients, having fire-wood brought in, and snow removed in the winter, were vital for them to be able to stay in their homes. My participant said: *"Where is the common sense in that? People are supposed to stay at home for as long as possible, but we are no longer supposed to do things for them that are of vital importance for them to be able to stay in their homes? We haven't been doing things like this because we have nothing better to do – we have been doing it because it needs to be done, and no one else does it. There is no one else to do this, if we don't."*

The nurse manager and her staff were held responsible for reducing the service offer, but had no authority to assign the tasks they were no longer supposed to do, to someone else. In the documents describing the down sizing-project, great emphasis was put on the down sizing being a joint project for the whole municipality from top to bottom. On several different occasions, both the need for change and the need for loyalty from all employees were stressed. Reading the documents about the down-sizing-project, one of the subheadings was "Resistance to change". In the document, great emphasis was put in the process being viewed as a joint effort for the joint staff of the municipality, with one single goal. The documents stated that it was of vital importance that everyone from top to bottom in the organization joined forces, to make the process a joint effort. Resistance to change was listed as the main danger to the down-sizing-project. Thus, not only were the front-line managers responsible for making cuts. They had also been told that objecting to the process was not an option.

6.4 Altered relationsships

The front-line nurse manager had been part of a group responsible for deciding whether implementing a purchaser/provider-model in the municipality was something they should do to reduce costs. During a meeting, she was expressing doubt and confusion about what decision to make, and needed to talk to her colleagues about this. The management of their municipality had used a neighbour municipality as an example of a successful reorganization; complete with the implementation of a purchaser/provider-model. "*But when we talk to our colleagues there, they tell a totally different story. The top management say it's a huge success, but the nurse managers and the RN's of the home care services say quite the opposite.*"

The nurse manager's primary concerns about implementing a purchaser/provider department were that a purchaser would not know the patient well enough to be able to assess the services needed correctly. She put great emphasis on how knowing the patient was vital when assessing and assigning needs. The variations in patients' needs were something she worried would no longer be taken into consideration.

She felt that assessing and assigning the (changing) needs of the patients were core parts of the nursing job. The first-time visits to a patient's home to assess needs could also be a welcome variation in the busy work-days of the staff. The personnel in the front-line of the neighbour municipality had told the nurse manager and her colleagues that their system had become much more bureaucratic after the implementation of the purchaser-unit, and that it took "forever" to have a service offer changed. In practice, they changed the offer when they observed the need and did not wait until the formal grant was done. Consequently, they felt the reporting back and forth between purchaser and provider was just a waste of time and money.

Altered relationship to other levels of the organization

The nurse managers here had been told to cut down costs, but preserve quality. When I visited it was very unclear for them how they were supposed to do this.

One of the managers said that she was in serious doubt as to whether some of the changes that had been suggested, actually were effective when it came to saving money, but that she was afraid that voicing these concerns would have her labelled as being resistant to change, and thus not participating in the project as she should.

Imposed change and growing distrust

The document from the municipality addressing the down-sizing stresses the importance of the process being perceived as a joint project from top to bottom in the organization. The senior-management wanted the down-sizing project to be a joint effort. The documents describing the downsizing emphasised that managers on all levels have a responsibility to make sure the effort was joint at all stages of the process. The need to avoid resistance to change were stressed multiple times in the documents, but documents did not offer any suggestions as to how to achieve this, except from stressing the need for the managers to inform and include staff in the process. Although the down-sizing was a joint project for the whole municipality, each department had been put in charge of cutting their own costs. For the home care

services this had already resulted in them having to take on tasks that other departments had decided to stop doing in an effort to downsize.

My participant described this very eloquently during our focused conversation: "*An organization like this (the municipality) is all about wheels within wheels. When you remove one wheel, things don't run smoothly anymore. We have been put in a position where others have cut down on their tasks, leaving new tasks for us to perform – and to me that makes no sense! Why is it that they (other departments) can decide to just stop doing important tasks, and leave it to us? Where is the joint effort in that? This makes us angry. Angry because we have to cut back just as much as anyone else – but then we also have to pick up the pieces left by somebody else. And turning down someone in need is not an option for me."*

The nurse manager had spotted a discrepancy between the suggested methods for cutting costs, and the actual methods being used. The managers in home care were voicing a growing distrust towards the senior-management – they felt they were not told the whole truth, and didn't know what to believe. "*We feel that the outcome of this project is already decided upon and that we are given information that does not tell the truth about what we are about to launch*."

So – it seemed like the effort to create a loyal, streamlined down sizing project had somehow failed – at least at the time I was there. Although one of the main goals for the ongoing process had been to create a united organization, where everyone were pulling together to create the necessary change – something had seemingly gone wrong. Instead of joining forces to reach the main goal, people were cutting down their own sections to meet new targets whilst at the same time shifting costs and responsibilities to others.

Business as usual

Although the down sizing took up a lot of the nurse manager's time, and was the main topic of most of our conversations, it was business as usual in this municipality

most of the time I was there. I partook in several different meetings between the nurse manager and her staff. Two of these situations were staff meetings– one to inform the staff in a community care housing facility about the new schedule, the other to prepare for the discharge from hospital patient. Both of these meetings were of a quite different nature than the meeting where the nurse managers were discussing the down-sizing. It was business as usual, and keeping the wheels turning, in spite of the down-sizing taking up both time and energy.

The story about the ailing patient

My last observation in this municipality was a meeting set up to plan the nursing care for a patient being discharged from hospital. This patient had been a patient in the home care nursing services for years, and had major physical and psychiatric problems, and was coming back to the municipality after having spent a week in hospital. Caring for this patient was time consuming and very hard for the staff – the patient had a long history of being violent to staff, but also of being scared and depressed and deeply afflicted by the serious condition. Taking care of this patient meant that the staff needed to be supported; they needed to be able to put down boundaries and to be mentally and physically strong.

I had heard a lot about this patient during my observations, because the nurse manager got several phone-calls from the patient's family and from the hospital during my stay. The nurse manager had told me about the patient, and added that she felt the hospital stay had been a welcome break for the staff, because of the patient having such extensive needs that required constant and complex interventions.

But when the meeting to plan the discharge from hospital started, the focus was not on how hard it was to take care of the patient – the focus was on getting the patient back to the municipality as soon as possible. This reaction from the staff was prompted by the nurse manager telling them that the hospital-staff had had to use force to perform tests and even provide care for the patient. The staff reacted by expressing a lot of concern and empathy. They were in agreement that the best

solution for the patient was to be released from hospital as soon as possible. The level of empathy and compassion expressed by the staff was very touching. With the level of uncertainty and unrest the staff was going through, I was truly impressed by how they were putting the patient's needs for security and being in a familiar environment before their own needs for some down-time.

I include this little story in the description of this case, because although the down-sizing took up a lot of time for everyone working in the home care nursing services, and especially for the nurse manager, they were also keeping the wheels turning and taking care of patients despite the unrest and uncertainty about what their place of employment would be changed into. The story serves as a wonderful illustration of the core activities of the home care nursing services. It tells the story about how staff and nurse manager dealt with and coped with the variety of very different patients, with different diagnosis and ever changing needs. It gives a description of how the nurse manager and the staff kept the wheels turning, and provided quality care even in times of organizational change, uncertainty and unrest.

6.5 Keeping the wheels turning

The nurse manager was almost always available for both staff, clients, patients and their families. She was willing and able to accept the constant change of which her work-days comprised, and dealt with the stress and the multitude of different tasks her job consists of as they happened. In addition to keeping the wheels of the home care nursing services turning, she also had an even heavier workload that usual because of the downsizing. Her staff needed information, they needed to talk to the nurse manager, and she needed to take care of these needs in addition to the regular tasks of providing home care nursing to the patients. The nurse managers spent a lot of time lessening the effect of change and unpredictability for the staff. She made sure she was available to staff when they came into the office before the end of the work days. With the downsizing going on, she felt it was vital to make sure everyone

was getting information as soon as possible, informing staff, listening to the staffs concerns, supervising staff, but also assisting the staff when necessary.

What follows is a summary of the themes that developed around issues identified as important by the nurse manager for her work in this municipality.

Table 4 – Case 2

Case 2	Themes	Categories	Subcategories
	Issues related to altered relationships	Knowing the patient	Insecurity as to whether possibility to intervene when patients' needs change will be preserved in new organization
		Imposed changes to organization	Feelings of distrust towards management Feelings of distrust towards colleagues in other departments Loss of pride in her work
		Resisting purchaser/provider-model	Fears decreased knowledge about patients' might affect quality
	Issues related to doing more with less	Sudden cuts in funding	Changes in the service offer for clients and patients
		Told to keep quality but cut costs	Confusion and bewilderment about how to do the cuts
		Putting the needs of the other first	Working hard to keep staff informed Taking care of staff's worries
		Busy days	Working late
	Issues related to responsibility and authority for the nurse manager	Organization is changing Change in priorities	Has had authority and possibility to change the service offer when needed – but has been told she has been too generous in the past Feels powerless

6.5.1 Theme 1 - issues related to responsibility and authority

This organization was in the middle of a down-sizing-project. Although they had been had been told that the organizational model for the home care nursing services was to stay the same during the first implementations of the new organization, there were concerns about the future. They didn't know what the future would bring, and they were at a loss as to how they were supposed to cut costs. Although the authority had not changed for the nurse manager, she was experiencing feelings of uncertainty and felt that assigning services had become difficult, because she really did not know where to cut down. She had been told they had to change their practice and become stricter when awarding services, but she felt that cutting down in the way suggested by senior-management, was not compatible with providing quality services. This left her and her colleagues feeling bewildered and powerless.

6.5.2 Theme 2 – issues related to doing more with less

This municipality was supposed to cut spending by more than 25% during the next four years. The downsizing had just started, and the nurse manager was confused as to how to achieve the cuts. Both the nurse manager and her colleagues were feeling quite powerless. She had been told to do something she had no idea how to do.

The example of the home care services no longer being responsible or actually being allowed to bring in firewood to the patients, serves as a good example of how changes to this organization were changing the lives of the staff on the front-line and of the patients. The nurse manager knew that having firewood brought in and steps cleared of snow, was of vital importance when the goal was to keep the patient living at home for as long as possible. She felt strongly that putting down new boundaries for what kind of services to perform, was incompatible with preserving quality. But she was afraid that voicing her concerns would have her labeled as being resistant to change.

Doing more with less came with a huge price here. The down-sizing project had created a lot of unrest and ambiguity. The nurse manager did not know how to cut the costs, but she knew she had to. She was putting the needs of others first, by being available and trying to lessen the load for everyone else. Being in the middle of the down-sizing, there was a lot of extra work for her. She had to keep the staff informed about the down-sizing, attend several meetings about the downsizing, leaving less time for supervising staff and taking care of the home care nursing service. At the same time she had to struggle with her own issues of grief for losing something she had been proud of, and not knowing what the future would bring. And to top it off, she (and her colleagues) felt that they could not question the process they were in, because they had been told that it was their responsibility to make sure the staff did no resist the changes – and that made them feel that they were certainly not allowed to voice any resistance to the changes themselves.

This put them in an impossible situation, where they felt they were lacking of options. My participant, although fully accepting the need to down-size, felt that it was both unfair and very hard to make decisions that she felt were not compatible with taking care of the patients needs.

6.5.3 Theme 3 – issues related to altered relationships

Providing home care nursing services in this municipality used to be all about knowing the patient. Just like the first municipality, tailoring, flexibility and acceptance of patients needs as being forever changing, had been what guided their work. "*You know – sometimes when people are frail, and living alone is getting harder for them, we try increasing the help, and that makes them feel safe…and able to cope. It's really exciting! We are making a difference for people, and that is really rewarding.",* the nurse manager told me during our focused conversation. But now they were unsure about how the future of home care nursing would be. They were resisting the implementation of a purchaser/provider-model in the municipality, and

they were resisting too much standardisation, because they felt that would reduce the quality of care. However, they were unsure whether what they said would be taken into consideration –suspecting that these changes would be implemented despite their protests. And they worried that their concerns would not be taken seriously, and labelled as resistance to change.

7. City life – municipality 3

7.1 The borough

The third venue for my study was a borough in one of the major cities in Norway. Its population was more than five times larger than the other municipalities combined. Most lot of the patients lived within walking distance from each other, and from the offices of the home care nursing services. The borough had almost a dozen units of home nursing care – and two of these units shared offices and administrative functions. There was community-care housing facility across the road from the home nursing services, and the nurse manager was in charge of the staff there. The borough is densely populated and is surrounded by large recreational areas.

Demographical data

The population is aging and the rise in the population aged 80+ is expected to increase in the years to come. There has been a rapid increase of people from non-western cultures in the borough.

The organiziation

The organization had been through a series of changes during the last 10-15 years, the latest less than a year ago, when the unit led by the nurse manager of this study had been established. The municipality, of which the borough is a part, utilised a lot of NPM-principles. The borough had a purchaser/provider unit, and both assessing needs and assigning services were done by the purchaser -unit. The borough practiced consumers-choice for their domiciliary services, which meant that the patient/consumer could choose between having their domiciliary services from the municipality or from a private provider. The borough was also planning to implement consumers' choice for home care nursing.

Like in the other two municipalities, there was one level of management between the nurse manager and the senior-management in the municipality. The nurse manager was in charge of the quality of care, in charge of hiring staff, in charge of the schedule, and had the full formal responsibility for keeping spending within budgets. Her staff consisted of registered nurses, nurses' aides and domiciliary staff. She did not have the authority to assign any services, but there were systems in place for reporting changes in patients' needs to the purchaser-unit of the municipality.

7.2 Doing more with less

The nurse manager was head of a new department of the home care nursing services. The new unit was established about a year previously because of increased needs for home care nursing in the borough. A year later, all positions in the unit had not been filled, and five members of staff were on maternity-leave. This meant that the nurse manager spent quite a lot of time working on the staffing-schedule, to make sure there were enough people at work at any given time. The nurse manager had a coordinator in a 100% position working in her group. The coordinator was responsible for coordinating the work-lists and the staffing-schedule, and the nurse manager's work-load had been reduced after the coordinator-position had been established.

Staff were quite difficult to recruit at the time of my visit, but the services still had to keep running 24/7. The nurse manager was responsible for the follow-up of staff who were sick, and told me that it sometimes felt wrong that she has to spend so much time on people who were absent because it left her with less time for the people who were present.

The story about the key.

During our initial conversation on my first day at this municipality, the nurse manager got a phone call. When she finished the conversation, she looked at me, and said: "*Sometimes small changes can make a big stir*."

She was referring to how moving a tiny object, a key, was causing a lot of unrest, uneasiness amongst the staff and a lot of extra work for her.

Her use of the smallness of a key metaphorically to illustrate how seemingly small changes could cause a big stir and a lot of extra work, was very poignant, and the story is well suited to illustrate the multi-faceted nature of the work of the nurse manager in this borough.

The story started the week before my field observations. A patient in one of the community care housing facilities had some items missing from her apartment. The key to all apartments in the building had been kept in the same place for years, and after the items were discovered missing, the nurse manager moved the key to a place where it had to be signed out each time it was used. The nurse manager told me this as we were hurrying off to meet the staff of the assisted care facility after our initial meeting in her office on the first day of my observations.

During my observations, this tiny key was the only topic of one staff meeting, and the main topic of another. It caused several phone calls and several one-on-one meetings with staff. The nurse manager had to deal with the staff being upset and even angry that their work had become more complicated because of the removal of the key. She had to deal with staff feelings of distrust towards their colleagues, and with staff needing to know that they were not suspected of stealing from a patient's apartment. She had to deal with the patient that had been robbed, the patient's family, the police and the insurance company. And she had to do all of this of this while she still had to keep the wheels of home care nursing turning.

Putting the needs of others first

One of the first things the nurse manager told me during my visit was that one *had* to be able to let go of control of everything to be able to survive as a manager in the home care nursing services. Managing staff that spent most of their time away from the offices and away from the managers' and colleagues' gaze meant one had to be

comfortable with not knowing what went on everywhere. Being the nurse manager involved a great deal of ability to trust the staff.

Just like at the other two municipalities, the nurse manager here spent a lot of time being available, lessening the effect of change and unpredictability for her staff, by keeping staff informed. Although she was delegating tasks to her staff all the time, she still had to take on tasks to help create free time for the staff to use on patient care. A coordinator had taken over a lot of the tasks connected to coordinating the work lists and the staffing schedule, but there were still a million things for the nurse manager to do. The nurse manager had spent quite a lot of time learning how the systems worked, because she needed to be able to step in and do this task if her coordinator was absent. The position of coordinator was vital for the home care nursing services to run smoothly, but at the same time, the nurse manager felt she could not assign one of her staff to do this task when the coordinator was absent, because that would mean that she would not have enough people available to give the patients the help needed.

The nurse manager about her job

Although she never once (except when asked) talked about being busy, her story of her job is all about being busy, having a lot to do, and trying to keep ahead – and trying to keep informed. She was relatively new to this job, she is was in a management education program, and she struggled to find the time to do all the things she needed to do.

Just like the other two nurse managers in this study, the nurse manager brought her notepad and pen with her when she met her staff. Every meeting with staff resulted in notes containing messages and tasks that needed doing. The nurse manager told me that she always tried to give as many tasks as she could back to the staff for them to take care of themselves, but when the workloads were heavy and the staff were running, she helped them out. "*They can not be two places at once*", she said.

7.3 From knowing the patient to preforming tasks

This case was also a story about routines. This municipality had formalised routines for reporting needs for reassessing a service offer, for handling fluctuations in workloads, for measuring workloads, and pre-designated time-estimates for the tasks performed.

The provider-units of home care nursing did not have regular meetings with the purchaser-unit. When a new patient was registered, a service-offer was made by the purchaser-unit, it was registered using the electronic report-system, and updates were sent to the purchaser-unit twice a day.

The routines established for re-evaluating patients needs, were of the same nature. The staff of the provider-unit reported changes in patients' needs to the purchaser office electronically.

There were standard time-estimates for all kinds of different patient tasks. The estimated time was used to document workload, but patients were not given a time estimate in the service-offer. The estimated time calculated for the tasks of each provider-unit were used to control work-load and generate job-lists for the staff. When the work-load exceeded a pre-estimated limit, extra staff might be allocated to the provider-unit with the most pressing need.

There were guidelines for approximate % of time spent by staff doing patient-work. During the dayshift 55% of time was to be spent on direct patient care, and 65% of the time during evening-shift was to be spent with patients. 80% of domiciliary staff's time was to be spent with clients.

Studies of the amount of time the staff spent with patients were done at regular intervals. The studies were used to control amount of time spent in direct patient/client care, and to document increased need for staff.

7.4 Responsibility but no authority

The nurse manager wondered whether they had lost something important during the multiple organizational changes they had been through. While the nurse manager was still formally in charge of keeping the wheels turning, and for providing quality services to the public, the formal authority to assign services was placed somewhere else, with the purchaser unit.

And while there were routines in place for reporting changes to the purchaser-unit, she worried that her staff did not always evaluate and assess the patients. Someone else decided what they were supposed to do – and the staff had to follow their list of tasks, even when things changed. The individual adaptation and customisation of services that was a core part of the professional lives of the other two nurse managers were not possible here. The nurse managers and her staff were "doers" not "knowers". That does not mean that the staff did not know their patients. But it means that the focus in this municipality was on performing tasks, knowing that even when they observed changes, they could not always act accordingly. They had to report the changes, not change the task. The nurse manager told me during one of our conversations that she wondered if they had lost something important. Her concern was "*I worry that the staff just go in (to the patient,) do whatever is on the list, and then leave. They don't always observe and report change – because that is no longer their job.*"

The nurse manager in this municipality, although being ahead and in front when it comes to "modern" organizing, worried that they might have lost something on the way. They had a strict division between domiciliary care and home nursing care, to enable outsourcing of the domiciliary care part of the services, and there were plans to introduce consumer-choice principles for home nursing care.

The nurse manager told me how several things about implementing consumers-choice principles to home care nursing, worried her. Her experiences from

implementing consumer's choice for domiciliary care had her really worried about what would happen to the quality of care in home nursing after outsourcing.

When asked why the borough had decided to implement consumer-choice for home care nursing, her answer was:

Consumer-choice? I think that is a political decision. That the consumer has a right to decide who gives you services… it is a political principle. …We have consumer's choice for domiciliary services already, and have had it for some time now. We (the municipality) do domiciliary services, but we have several other companies who provide them, as well. …and we don't collaborate with them. We have weekly meetings with the staff who perform the domiciliary services (employed by the municipality) – and they also have the opportunity to come by here and ask…And people come to me with concerns like …..''When I clean her house, I find pills on the floor all the time…Do you think she is taking her medication as she is supposed to do?''

We work much closer with them - it's easy for them (domiciliary staff) to come by the office and address things they are unsure or worried about. We never hear concerns like this from the staff in the other companies.''

The nurse manager was responsible for the quality of the services and depended on having changes and concerns reported to be able to act accordingly, but feared that outsourcing would mean she would no longer have the necessary overview.

The nurse manager commented on how she felt something (important) has been lost. They could no longer shape their own days and be flexible. "*I wish we had the opportunity to be little bit more flexible at times…''*

7.5 Keeping the wheels turning

The nurse manager spent her time keeping the wheels turning. She was running from one place to the other, trying to keep up, keep informed, keep her staff informed, keep her boss informed, and doing a lot of things almost simultaneously. The systems that had been implemented to increase transparency and standardise the services, could provide her with extra staff when needed. But it also increased the nurse managers' workload. She had to spend more time documenting changes and making sure her staff were documenting changes. The outsourcing of the domiciliary services had meant an increased workload when it was implemented, and it had made it harder for her to have an overview of all the clients for whom she was in charge. As in the two other municipalities, phones were ringing, people were coming by for unannounced visits, and the work-days of the nurse manager seemed pretty chaotic most of the time.

The following are themes developed around issues identified as important by the nurse manager for her work in this municipality.

Table 5 – Case 3

Case 3	Themes	Categories	Subcategories
	Issues related to altered relationships	Doing tasks instead of knowing the patients	Fears staff does not observe changes in patients
		Outsourcing of domiciliary services	Lost knowledge about clients – lack of control of services but responsible for quality
		Plans to implement outsourcing of home nursing services exist	Fears reduced knowledge about patients
		Don't always agree with assessments from purchaser unit	Potential/real conflict

	Issues related to doing more with less	Gaps between needs and available resources	Changes in the service offer for clients and patients
		Busy days	Works late to catch up
		Hard to recruit staff	High use of temporary staff Spends time recruiting
		High percentage of staff out sick or on leave	Takes on tasks to free time for staff to do patient work
		Putting the needs of the other first	Works hard to keep staff informed Working late
	Issues related to responsibility and authority	Purchaser/provider-model	Changes in patients' conditions must be reported to other unit before they can be reassessed. NM has no authority to change service-offer.
		Bureaucratic routines	Not possible to change lists when needed
		Responsible for keeping budget	No decision making

7.5.1 Theme 1 – issuesrelated to responsibility and authority

The nurse manager here could not assign services. She depended on reporting changes in a patients' needs to the purchaser office, who them made the changes – or not, depending on their assessment of the patient and the situation. When the workloads were heavy, there might be extra staff assigned to the unit. But this was not something the nurse manager was in control of. Her responsibility was to document the changes, and then she depended on other departments viewing her needs as vital, before she could have the extra help assigned.

The nurse manager here had less power to act. She also had a reduced overview of the patients/clients of which she was in charge of providing sufficient quality care for.

7.5.2 Theme 2 – issues relating to doing more with less

Just like the two other municipalities, there was a perceived increase of the workload here. The unit led by the nurse manager had been established because of an increase in the need for home care nursing in the municipality. One of the major issues with doing more with less here was the fact that all positions had not yet been filled, and several of the staff were on leave. This meant a lot of extra work for both the nurse manager and her coordinator during this time. There were interviews of new staff-members to perform and temps to be hired to fill the vacant positions on the schedule.

7.5.3 Theme 3 – issues relating to altered relationships

In this municipality the focus had shifted from knowing the patient to doing redesigned tasks. Parts of the domiciliary services had been outsourced, and there were plans to outsource the nursing care as well. The staff here had become “doers”. They performed pre-designated tasks from a list they had no authority to change. The relationship to the individual patient had changed, and so had the nature of their work. This did not mean that the staff did not know their patients, though. What it meant was that the staff here had become a link in the chain of providing services to patients, instead of providing most of the link, as in the two other municipalities.

The borough had designed a system for allocating extra staff when the workload became heavier than the set standards, but this was people coming in only for short periods of time, and they didn’t know either patients or their colleagues very well. In addition to this, there had been some recruitment-issues here, with staff being out sick

or on maternity leave, leaving vacancies on the schedule, which again, meant more work for the nurse manager.

Sometimes the nurse manager and her staff disagreed with the purchaser-unit's assessments of the patients' needs. The nurse manager's perception was that the purchase-unit often assessed the patient's as needing more services than what turned out to be the case after the provider started the service offer. She felt that this conflict might be avoided if the purchaser and provider-units cooperated more closely.

8. Bringing the study together

In this chapter, I will take a closer look at some of the findings from my observations and add theory and quotes from the literature to further understand the issues arising from the constant change in the professional lives of the front-line managers of this study.

The following table is an overview of the issues in keeping the wheels of home care nursing for the three nurse managers:

Table 6 – Keeping the wheels turning

Themes	Categories	Subcategories
Issues related to altered relationships	Knowing the patient	Pride in flexible solutions Possibility to intervene when patients' needs change Small community – people know each other. Insecurity as to whether possibility to intervene when patients' needs change will be preserved in new organization.
	Imposed changes to organization	Feelings of distrust towards management Feelings of distrust towards colleagues in other departments Loss of pride in her work
	Resisting purchaser/provider-model	Fears decreased knowledge about patient's might affect quality
	Doing tasks instead of knowing the patients	Fears staff does not observe changes in patients
	Outsourcing of domiciliary services	Lost knowledge about clients – lack of control of services but responsible for quality.
	Plans exist to implement outsourcing of home nursing services exist.	Fears reduced knowledge about patients
	Don't always agree with assessments from	Potential/real conflict

	purchaser unit	
Issues related to doing more with less	Gaps between needs and available resources	Changes in the service offer for clients and patients
	Hard to recruit staff	High use of temporary staff Spends time recruiting
	High percentage of staff out sick or on leave	Takes on extra tasks to free time for staff to do patient work
	Sudden cuts in funding	Changes in the service offer for clients and patients
	Told to keep quality but cut costs	Confusion and bewilderment about how to do the cuts
	Putting the needs of the other first	Working hard to keep staff informed Takes on tasks to free time for staff
	Busy days	Working late to catch up Coming in early to catch up Working though lunch Taking care of staff's worries Working late
	Gradual cuts in funding	Changes in the service offer for clients and patients
	Gradual change in priorities	Prioritising patients living in remote areas for nursing home stays.
Issues related to authority and responsibility for the nurse manager	Authority to accommodate changes in patients' needs	Authority to assign all kinds of services. Authority and possibility to change the service offer when needed
	Change in priorities	Has had authority and possibility to change the service offer when needed – but has been told she has been too generous in the past Feels powerless
	Purchaser/provider-model	Changes in patients' conditions must be reported to other unit before they can be reassessed.
	Bureaucratic routines	NM has no authority to change service-offer. Not possible to change lists when needed No decision making
	Responsible for keeping budget	

8.1 Issues relating to responsibility and authority

Although there were a lot of similarities between the three municipalities and in the professional lives of the nurse managers, there was one marked difference. At the two first municipalities, the NMs frequently talked about how the constant fluctuations in patients needs were something they had to deal with, and at the two first municipalities, one of the nurse managers had the full authority to assign all kinds of services, at the second one, the nurse manager shared this responsibility with her colleagues.

At the last municipality, where the purchase/provider model had been implemented 8 years ago, this was not an issue anymore. That is – the fluctuations were still there, but the way this municipality is organised, the responsibility for adjusting help when needed did no longer lie with the nurse manager, but with the purchaser unit. This meant that when someone (usually the staff of the home care nursing provider unit) observed changes, the changes were reported to the purchaser unit, the purchaser unit re-assessed the needs, and a new, revised service offer for the provider to perform, was issued. At the other two municipalities, when a change in needs of a patient was observed, the change of the service offer was done right away, and a new service grant was issued. All three nurse managers were responsible for documenting changes, but only two of them had the authority to makes changes accordingly. A review of studies on nurse managers' job satisfaction (Lee &Cummings, 2008), showed that empowering nurse managers in decision-making, is pivotal to a higher level of job-satisfaction which again leads to positive outcomes with respect to both the quality of care and staff's job satisfaction. A review on two decades on research on stress and coping for nurse managers (Shirey, 2006), showed that while nurse managers had gained an increasing span of responsibility, they were lacking in power and opportunity to influence policy guiding the care in their organizations. Viewing the three participants of my study as belonging to organizations that have implemented modern management principles to different degrees, the same trend seems to apply. In the third municipality, the nurse manager had less power/authority

than the other two participants, but at the same time she had more responsibility than the others. The gap between level of responsibility and level of authority had become wider here. At the second municipality, the insecurity as to whether the nurse managers would be able to keep their authority to assign services, was causing unrest, but it had not yet changed during my visit there.

Both Norwegian studies about change in Norwegian organizations point to this increasing gap between levels of authority and responsibility (Vabø, 2007; Vike, et al. 2002). The increased authority for management that is a core ideology in New Public management, does not apply to front-line managers. The power has been moved from the front-line to a higher level of management.

The studies on stress and job-satisfaction among nurses and nurse managers all point to the balancing of responsibility and authority as an important factor to decrease perception of stress (Brown, H., Zijlstra, F., & Lyons, E., 2006; Hertting et al. 2004; Lee & Cummings, 2008; Mackoff & Triolo, 2008; Pijl-Zieber, E. et al., 2008; Shirey, 2006). Heavy workloads coupled with reduced authority and increased span of control and responsibilities were coherent with a high occurrence of perceived stress.

8.2 Doing more with less

Maximum variation sampling strategy aims at capturing and describing shared patterns that cut across cases. These shared patterns and themes are especially significant from having emerged from heterogeneity (Patton, 2002). Doing more with less was an issue that arose at all three sites.

All three municipalities had a history of constantly trying to do more with less. There had been selective cuts at all three sites. It seemed like all three nurse managers had taken the cuts onboard themselves, as they all showed a readiness to work harder in order to provide their staff with the time and information they needed to perform care for the patients and clients. They were putting the needs of both their staff and the

patients before their own need for predictability and down-time. They were available almost all of the time, trying to lessen the load for everyone else.

8.2.1 Management by running around

I was attending a management program in the nineties, when I was first introduced to the term “management by walking around”. This is a term used to describe a management-model where the manager makes him-/herself visible and available for the staff by “walking around”, and was first introduced in 1982 by Peters &Waterman (1982). When I was looking for a way to describe the workdays of all three participants of my study, the term “management by *running* around” felt very appropriate. Both because all three nurse managers were very much involved in the daily work of their units, and because all three of them actually at times literary had to run to keep up with everything that was going on.

Earlier in this study I have described how I struggled to find out how I could present the constant interruptions that occurred during my earliest observations without disturbing the flow of my field-notes.

The constant interruptions turned out to be a common and frequent finding during all three field observations. These women were busy. They were juggling, shifting focus from one moment to the next and except for a few meetings when their phones were turned off, they were always available to staff, co-workers and patients. An ever emerging theme in my field-notes and transcripts of the focused conversations are the comments on interruptions.

Stress is a common theme in the literature about front-line nurse managers and their work environment. Both studies that look at nurse managers’ job satisfaction (Lee & Cummings, 2008), and studies about stress amongst nurse managers found stress and heavy workloads to have major impact on nurse managers(Shirey, 2006; Rodham & Bell, 2002). The heavy workloads led to a perceived and real lack of control, feelings of stress and of not being able to cope, and even to self-blame. In these studies, the

nurse managers explain their lack of coping skills by internalising the blame. They blame their inability to cope with the constant change and steady growth of work-load on themselves.

During my observations, the nurse managers told me about their patients, their organizations' history and its present state. They told me about staff, and about what went on, but the fact that they were extremely busy all the time, was not mentioned once by any of them.

That is, not until I launched the subject – then they all had plenty to say about it. During the taped conversations I asked all of them the same question; "*Do you have enough time to do all the things that needs doing?*", and they all said "*NO*!" And they all gave a little laugh – actually, when listening to the recordings afterwards, their reactions are very similar – right up to the little laugh following the "NO!" One of the managers said to me: *I guess you already know the answer to that question, don't you?* She was referring, of course, to the fact that I had been following her for three days, and had had plenty of opportunity to observe this phenomenon for myself.

This excerpt from the focused conversation, right up to the interrupting phone call, gives a typical example of how the days of the Nurse Managers were:

Me: Do you have enough time for everything you need to do?

NM: No! (Smiles, and looks at me.) My priorities are on the patients – and on the staff…And right now, the downsizing takes up a lot of time…

Me: Hm – (I nod and smile)

NM: ..and that means that casework and formal grants have to wait... This downsizing really takes up a lot of time. I have two places… (Referring to the home nursing care unit and the xxxxx – a community housing facility xx kilometres from the offices)….and I am responsible for keeping the staff informed about everything that goes on. I pass on the information continuously when the staff comes in. Between 2:00 and 3:00 pm I make sure I talk to everyone. I pass on written information. Even

though the information is on the intranet, some of the staff don't always access the intranet, and I need to make sure everyone knows what is happening as soon as possible.

(Her phone rings, and I turn off the recorder.)

One of the nurse managers told me: … *leaving at three is not something you get to do very often. This is a 24/7business, and you just can't leave things until the next day – or until you have time to deal with it .We are dealing with people in need, and that means that there are some things that just can't wait.*

The fluctuations in workload, although an obvious cause for stress and having to prioritise all the time, was also something they all told me that they appreciated. They said:

"*You know – sometimes when people are frail, and living alone is getting harder for them, we try increasing the help, and that makes them feel safe…and able to cope. It's really exiting! We are making a difference for people, and that is really rewarding."*

"*We are in the unique position where we get insight into a lot of aspects of the lived lives of people. I love that about my job, and it is very important to me!"*

"*You know – this is a kind of job where you just have to accept that you cannot control everything that goes on. You have to trust people (the staff) to do what they are supposed to do. It's great to manage like that. These are grown-up people, and it gives me great joy to see and hear from others that they are doing a good job."*

The very fact that the days were all different, and that they never knew what each new day at work would bring, was held by all as an exciting and rewarding aspect of the job – but at the same time they all recognised this as the cause of a lot of stress:

"*This is not a job easily combined with having very young children."*

"Sometimes the work just piles up. Sometimes some things just have to wait. And sometimes I just get here really early in the morning, before the staff comes in. An hour or two of peace and quiet before the phone starts ringing can make a lot of difference, because I get a lot of work done when I am not interrupted all the time."

"I prioritise all the time. Whatever is most urgent gets done first. And when the pile on my desk gets too big, I spend an hour or two in my office after people go home"

None of the three questioned this. They spent most of the working days during my visit always on the move. Their phones were ringing all the time, people were calling, the staff dropped by with questions. They all said their priorities were patients and staff. Their actions were consistent with what they said. They all made sure to be present when the staff came in for lunch, and at the end of shifts. They were available at almost all times, for calls and questions and discussions and talks.

At first, I did not reflect much on the tempo and the interruptions either. Actually, it made me feel like an insider when I first encountered it – it was something I immediately recognised and identified with from my own experience of being a nurse manager.

It seemed like the participants in my study all demonstrated a readiness to accept the stress and constant interruptions and changes of focus as an intrinsic part of the job. This acceptance of stress is also a major finding in Rodham's study of junior front-line managers (Rodham, & Bell, 2002). The participants of my study talked a lot (when asked) about different ways of dealing with the stress; making pockets of time before or after office-hours to finish whatever they hadn't had time for during the busy days, they talked about how one could not be a nurse manager if one could not deal with constant interruptions and changes in focus. But none of them talked about the possibility of alleviating some of the stressors. None of them questioned whether they should have to accept the constant interruptions, they just did. They were dealing with the stress, but never mentioned ways to alleviate the stressors. The stress was perceived as normal.

In Rodham & Bell (2002), the authors concluded that the junior nurse managers in their study contributed to the perpetuation of a culture of individual responsibility. Job related stress and work overload were individualised and internalised, and not seen as a system flaw, but as an intrinsic part of the job. The way the participants of this study talked about their work, indicated that they saw their jobs in the same way.

There is an established relationship between job stress/heavy work loads and emotional exhaustion and burn-out. Excessive workloads have been found to be a significant predictor of stress. (Burke R.J. & Greenglass E.R., 2001). All three nurse managers in this study had very busy days and virtually no down-time during working hours.

8.2.2 Putting the needs of the other first

When asked, all three nurse managers said that the needs of the patients were the number one priority. It became rather obvious to me after observing and analysing the data, that the needs of the staff was also put before the nurse managers own need for pockets of uninterrupted time. All three nurse managers made a point of being available by phone for the staff while they were out working in the patients' homes, and being available for staff when they came in to the offices of the home care nursing services during the day.

It seemed like the nurse managers in this study were ready and able to try and do more with less. They did it by internalising gaps and trying to be available for both their staff and the patients and clients whenever they were needed. They all delegated tasks to staff, but during busy times, they took on a lot of work, to free time for the staff to do the core tasks; to provide sufficient quality care for the patients. But who takes care of the nurse managers? All three managers in this study felt they had support from their next-in-line-manager. But having support did not mean they could unload the work – it meant they had a place to unload their frustrations and worries, not the actual tasks. In chapter 1.4 I included a quote from the Care Plan 2015 (HOD, 2005). The need to decrease the span of control for managers in community care is

recognised in the document, but there were no plans to reduce the span of control for front-line managers in any of the municipalities when I visited them.

8.3 Altered relationships

This study has found issues related to altered relationships as a result of change on many levels. There were altered relationships between patients and staff – between different departments in the municipalities, and between levels of management.

In municipality 2, the managers were expressing a growing distrust towards the senior-management of the municipality. They were given conflicting information about the down-sizing and did not know what to believe anymore. They were angry and sad and confused as how to achieve the senior-management's goal; to save money but preserve quality.

This distrust in management was also found by Flackman et al. (2009), after reorganization, and the study identified issues related to imposed change, like distrust in management and altered feelings about their jobs, was still evident 12 moths after the reorganization. Not only is reorganization and down-sizing a source of stress and ambiguity, the effect lasts for a long period of time (Hertting et al. 2004; Lee &Cummings, 2008).

The nurse manager in municipality 3 recognised this as the major reason that she wanted to avoid yet another reorganization; she felt the cost was just too high.

8.3.1 How resitance to change makes change possible

Both Mia Vabø (2007) and Halvard Vike et al. (2002) points to how resistance to change actually keep wheels rolling during processes like this. The paradox is that when viewed from top level of an organization, the fact that the wheels are kept rolling throughout a process of change, might be interpreted as the process being successful, when both Vike (2002) and Vabø (2007) concludes that it is the (dreaded)

resistance to change that actually keeps the organization going. The staff on the front-line adapt to the changes to lessen the effects of the changes on their clients, and by doing so, obscure the shortcomings of the system (Vabø, 2007; Vike et al., 2002). But this comes at a price.

8.3.2 From knowers to doers.

In the first two municipalities, the staff and the nurse manager were part of the whole chain of taking care of the patient. This chain consisted of the first meeting assessing patients' needs, the regular visits, occurring changes of needs and subsequently, the change of the service-offer. Both of the two nurse managers in the smaller municipalities held this chain as an important factor that they dealt with from day to day. In the second municipality, the signals from senior-management were that this practice would have to change. Even though thee changes had yet to be implemented, it created frustrations and worries on the front-line. In the third municipality, this *had* changed. The focus was on doing pre-designed tasks defined by the purchaser unit, not on dealing with changing needs. I am not suggesting that the staff in the third municipality did not know their patients. But the responsibility for taking care of the patients' constantly changing needs were split between different departments, making changes a slower process. The nurse manager feared that the divided responsibility for observing and assessing the need for change to a service offer might make her staff oblivious to subtle changes in the patients' needs, which again could reduce the quality of care.

Whether a model that divides the responsibility for assessing needs and doing tasks really takes care of the patients' interests or is actually designed for the management to have increased control of what happens on the front-line, is a vital question. In the third municipality, the nurse manager's perception was that it made it harder for her to be responsible for the quality of care. Her perception is in line with the findings in Vabø's dissertation (2007). The increasing gap between responsibility and authority

made her work harder. She was responsible but did not have the necessary authority to make changes when needed.

At all three sites, there were lists of tasks that needed doing everyday. The idea of a just distribution of services was vital at all municipalities, but the way it was practiced, differed. The staff in the two small municipalities could not just decide to spend their whole workday with one patient, leaving the others to take care of them selves. But they had more of an opportunity to be flexible. They could spend more time with one patient when needed, and make up for it, by spending more time with other patients at a later point. The flexibility served all of the patients, but was depending on the needs of patients fluctuating both ways. If all patients experienced increased needs at the same time, the staff would be in trouble. At municipality 3, documenting a heavier work-load, *could* result in extra resources being allocated to the unit. But only if the increased work-load was found to be the most pressing in the borough at that given time.

8.4 Keeping the wheels turning

Although all three of the nurse managers were delegating tasks to their staff all the time, they were also taking on tasks to help free time for the staff to use on patient care.

NPM has been seen as a tool to ensure consumer's rights, by introducing a purchaser unit who does not take into account aspects like capacity in the provider unit, when granting services.

Mia Vabø (2007) discusses the trilemma of public services in her thesis. In providing public services three different issues arise. Her comparisons of the welfare political model and the NPM-model points to an important issue; By viewing the welfare-policy-model and NPM-model as different discourses, she shows how the welfare-policy model actually recognises the competing pressures between different normative demands. It recognises both frugality (control of spending) rectitude

(justice in allocating services) and resilience (the service-offer being relatively stable over time) as separate parts of the conflicting demands of providing public health care services, and recognises all three parts as important to address. The welfare policy discourse, recognises that the dilemmas or trilemma arise as a result of the complex nature of providing public health care (Vabø, 2007).

A NPM-discourse on the other hand, does not recognise this dilemma, or trilemma, and define the conflicting demands as resulting from not having done a good enough job of standardising the service-offer. It does not recognise provision of care as a "wicked problem", and hence does not recognise the left-over-tasks as real problems, but results of poor defining. When interpreted thorough a NPM-discourse lens, the dilemmas arise because the organization has not done a proper job when defining responsibilities and standards (Vabø, 2007).

One can imagine that the time lag between the initial report of a patient needing a change in services, until the actual change can be launched, must be longer when there are more people involved, and there are formalised routines for collaboration and information-exchange between purchaser and provider unit. Although this might reduce some of the stress for the staff in the home care nursing unit, it does not take into consideration the need for a rapid change of the service-offer to the patient. So although a NPM-model might address issues of transparency, it does not recognise that the needs of patients can change quite suddenly. It does not recognise the provision of care as a wicked problem. And as long as it is not recognised, dealing with the left-over-tasks becomes an invisible job.

8.4.1 Moral distress and ethical dilemmas

When exercised rigidly, a division between assessing and assigning needs, might jeopardize not only a flexible system, but also the quality of care for the patient. In addition, having responsibility for quality, but no authority to decide what measures to take to ensure this quality, is a difficult situation to be in. This might be in conflict with both the Code of ethics (NSF, 2007) and the Health Personnel Act (HOD, 2001).

Both the Code of ethics and the Health care personnel-act places the responsibility for providing sufficient care for patients, on the individual nurse. This means that when the system in which she works, does not provide her with sufficient resources to provide quality care, she is still responsible. This responsibility includes addressing issues that compromise the quality of care with the management of her organization.

Moral distress

Moral distress occurs when a nurse is conscious of the morally or ethically appropriate action a situation requires but cannot carry out that action because of institutionalized obstacles. (Corley, M. C., Minick, P., Elswick, R. K., & Jacobs, M., 2005).

In municipality 2, the nurse manager felt that she could not address the issues arising from the changes to the organization, in fear that they would be interpreted as resistance to change. She was experiencing a serious dilemma, and voiced this then she told me: "*I am not going to turn down someone in need"*. The nurse manager in the third municipality was voicing concerns about whether she had sufficient overview to be able to spot the changes in their patients needs. The nurse managers in municipality 2 and 3 might both be at risk for developing moral distress in their attempts to keep the wheels of the home care nursing services rolling. The nurse manager in municipality 2 feared that the suggested changes to her organization might compromise the quality of the services they provided. In municipality 3 the nurse manager though that a more flexible system might have been better for both staff and patients. *"I wonder if we lost something…"* was her comment. Research on moral distress experienced by nurses found that a perceived lack of authority contributed to moral distress, and that nurses that experienced a lack of authority was reporting a higher frequency of moral distress (Corley et al, 2005; Pijl-Zieber et al., 2008).

8.5 What are the issues for front-line nurse managers arising from changes to the home care services?

Dealing with the constant changes in the home care nursing arises from issues regarding doing more with less, altered relationships and differences in authority and responsibility for front-line managers. The workdays of the three participants of this study was spent keeping the wheels of the home care nursing turning. But keeping the wheels turning, came at a price for all three of them. They all had heavy workloads, even if the degree of authority to deal with the heavy workloads and the constant changes varied. How their work was organised influenced both the authority and responsibility of the nurse managers. The issues for all three nurse managers showed that they were susceptible to stress. The way in which their work was organised, differed though. Research on stress and nurse managers, shows that there is a much higher likelihood for the ones experiencing lack of power and authority to develop symptoms of stress and burn-out.(Laschinger & Finegan, 2008).

This means that when experiencing lessened authority, the probability to develop stress and burn-out, increases. This study has shown that the gap between responsibility and authority increases when a NPM-inspired organisational model is utilised. This is in keeping with the findings of the studies of Vabø (2007), and Vike (2002).

8.5.1 Recruiting and retaining nurses

To recruit nurses, creating attractive jobs is pivotal. In chapter 1, I have given an introduction as to why recruiting and retaining nursing staff is vital for the municipalities in the years to come. This study confirms how increased pressure on the municipalities increases the pressure on the people working in the front-line. The stress, burnout and moral distress that might result from this, will have consequences on different levels. Stress and burn-out causes health-problems for the nurses. It causes reduced efficiency. Ultimately, and most importantly, the quality of care for the patients is reduced. .All three nurse managers in this study were susceptible to

stress, and the way their work was organised and the work-load, presents a real danger for all three of them in terms of being at risk for developing symptoms of stress and burn-out, although perhaps at different degrees. The great and growing need for qualified health care workers in community health care means that the need to address these issues will be pivotal to increase recruiting and retention of nurses.

8.6 Where to from here?

This is a small study. Although it explores themes and issues related to health care policy, it is not an organizational study, nor is it an evaluation of the organizational models described. What it does, is to provide snap-shots of an ordinary week in three nurse managers' working lives, by bringing together different sets of theory to explore and explain the complexity of the issues arising and of nurse managers' professional lives.

It seems like the wheels of home care nursing to a great extent really *are* kept going by the staff on the front-line, who answer the demand for more cost-efficient services by internalising this demand by trying to run faster, do more and lessen the burden of the patients' helplessness and their own moral convictions by working even harder. This study emphasise some of the issues related to keeping the wheels of Home Care turning. It combines existing knowledge about organizations and individual perceptions of stress, moral distress and burn-out.

8.6.1 Further research

Evaluation whether quality of care has been improved by introducing NPM-principles is long overdue. The evaluations that have been preformed, has been inconclusive. That is – none of them have shown increased efficiency as a result of reform. Some have shown increased bureaucracy, others points to there being no significant difference in cost or quality of the services (Vabø, 2007, appendix). These studies need to focus on not only whether the patients are getting what the

formal letter granting the service-offer states, but also to examine whether they are actually receiving what they *need*.

Moral distress is an issue in need of addressing Research on how moral distress affects health care personnel and ultimately how health care personnel manage moral distress and how this affects the quality of care is sorely needed. We already know that moral distress is a problem. We need to know more about its effects.

There is a growing body of research on work-satisfaction among nurses. To help recruit and retain nurses in community health care in Norway, we need to know more about what makes people resign from their jobs in the services. A qualitative study to examine the reasons why staff decide to resign from their jobs in municipality health care, could give additional and important information on how to make health care workers stay once they are recruited.

8.6.2 A new generation of reform?

It is time the optimistic belief that there are huge reserves of resources available in health care if only the organizations find a way to utilise them, is revised. Assigning perceptions of stress and lacking ability to cope with both increased work-loads and a decrease in power to deal with the workloads, to individual traits in nurses and nurse managers, might work on a short term basis. On a long term basis however, trying to deal with these issues without looking for reasons within the organizations, might seriously affect both the recruitment and retention of nurses.

Change in itself is not a negative thing. The nurse managers in this study all emphasise how the constant change can be a source of joy – the unpredictability does not only cause stress, it is also perceived as a positive thing. They all emphasise how dealing with change and making a difference for people, is a valued part of their professional lives. It makes them feel valued and that their work is worth while.

Before I started to prepare for this study, I had the naïve idea that when major, new reforms are launched the basis for the decision to launch reforms of this multitude,

lies in research. I must say that what has surprised me the most about this study is the lack of empirical evidence that NPM works (Vabø, 2007). To realize that NPM was not in any way empirically tested before major reforms were launched all over the western world, is one issue. Another issue is that Norwegian municipalities continue to implement NPM-principles to their services without taking into account the growing body of evaluation and research out there. It seems like implementing NPM-principles does not create more effective organizations. In many cases, it seems like implementing NPM-principles has created organizations that are increasingly bureaucratic, leaving less time for the actual service-offer (Vabø, 2007; (Marstein, Egil, 2008). There is a growing body of research that shows that the apparent success of NPM *is* caused by the front-line workers' reluctance to change, and feelings of obligation to their patients. (Vabø, 2007 appendix), (Vike, 2002).

The nurse managers in my study did this. The story of the municipality that was going through a major organisational change, illustrated this. They adapted to the new reality of their working life by working harder, by resisting changes they felt would compromise quality. They did not address this with the senior-management, because they were afraid of being labelled resistant to change. They *were* hiding the negative consequences of the new organisations from senior-management. But they were not doing this just because of their sense of duty, as listed by Vike (2002) as a reason for reform to be able to continue in spite of shortcomings. They were doing it because they were told by senior-management that they couldn't. They felt they had no choice.

Perhaps it's time to use the growing body of research-based knowledge and implement a new generation of reform?

We need to secure the rights for the often frail patients. We need rules and standards and transparency for our services. The necessity of trying to slow down the spiralling cost of health care is obvious. The nurse managers in my study all recognise all of these factors as a part of their realities. I think that a main reason for their constant running and putting the needs of the others first, is closely connected to them trying

to accommodate all of these three factors at the same time. Working in the front-line of municipality health care, means running faster, trying to do more and having decreasing power. Are we on the right track?

The code of ethics for health care personnel (NSF, 2007) and the acts that secures an individual's right to quality care(HOD, 2001, HOD 1984b) already provide guidelines that take into consideration both the patients need for quality care, and health care personnel's responsibility and duty to provide this care.

My firm belief is that to be able to provide good quality services, like stated by the Norwegian government in the Care plan 2015 (HOD, 2005), we need to acknowledge and take into account the complexity of providing health care, and recognise the presence of "wicked problems"; problems that cannot be solved, just handled, in the provision of health care.

A good quality health care system relies heavily on the people who work on the front-line. Ensuring a good working environment, and an acceptable workload, to prevent burnout, moral distress and high turn over, is essential. The need for growth in community health care, rely heavily on recruiting qualified personnel to do the work, and on keeping the qualified and dedicated workers once they are recruited. We already know a great deal about this topic. I think it's time the body of research that already exist to shape a new generation of reform.

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Appendix 1

Invitasjon til deltakelse i prosjekt om førstelinjeledere i hjemmesykepleiens arbeidsbetingelser og utfordringer.

Som et ledd i min masteroppgave i sykepleievitenskap ved Universitetet i Oslo, vil jeg gjerne invitere til deltakelse i min studie.

Den norske tittelen er:

I endring – Hvilke utfordringer møter førstelinjeledere i hjemmesykepleien i sitt daglig arbeid?

Oppgaven skal skrivers på engelsk, og den engelske tittelen er:

Leading the home nursing services through changes; what are the issues for nurse managers arising from changes to the home nursing services?

Tidligere forskning om hjemmesykepleien i Norge, har bekreftet at dette er en tjeneste som i stadig endring, og er utsatt for mange forskjellige krav og forventninger. Disse kravene og forventningene er av en slik karakter at de kan komme i konflikt med hverandre.

På grunnlag av denne tidligere forskningen, ønsker jeg å gjøre en studie om førstelinjeledere i hjemmesykepleien, og håper at du vil være med i denne studien.

Fokus for studien blir de utfordringer man møter som førstelinjeleder; hvordan man balanserer kravet om å yte forsvarlige tjenester til en hver tid, men stramme budsjettrammer; og hvordan man opplever å lede en tjeneste som på mange måter karakteriseres av å være ganske uforutsigbar fordi både antall brukere og den enkelte brukers behov, endres hele tiden.

Studien planlegges som en observasjonsstudie, der jeg følger 4 utvalgte førstelinjeledere i det daglige arbeidet i 3 – 5 dager. Jeg vil gjerne delta som observatør i ditt daglige arbeid – og vil gjerne være med på diverse møter som rapporter, personalmøter, møter med samarbeidspartnere (bestiller/utfører etc.). Jeg vil også gjerne se de dokumentene som styrer tjenesten; slik som plan- og budsjettdokumenter og dokumenter som knyttes til kvalitetsarbeid(rutinebeskrivelser). Dessuten vil jeg gjerne ha samtaler med den enkelte av dere underveis, om dilemmaer og utfordringer man møter i sitt daglige arbeid, og hvordan det oppleves å lede en tjeneste som er i endring, og hvor krav

og muligheter til å løse lovbestemte oppgaver ikke alltid er lett å få til innenfor de rammene som eksisterer.

Jeg har selv arbeidet i hjemmetjenesten i flere kommuner gjennom mange år, både som soneleder/avdelingssykepleier og både som leder og fagkonsulent i bestillerkontor. Det var mine egne erfaringer som i sin tid vekket interessen for de temaene jeg nå tar for meg i studien min.

Deltakelsen i studien er frivillig, og du dersom du ønsker det, kan du trekke deg fra studien når som helst i prosessen, uten nærmere begrunnelse. Du har også rett til innsyn i de opplysninger jeg samler i observasjonsperioden på ditt arbeidssted.

Det vil ikke være mulig å identifisere hvem som har deltatt i studien. Data om hvilken kommune du arbeider i og hvem du er, vil bli anonymisert, og vil ikke være gjenkjennelige for andre i det ferdige arbeidet.

Jeg vil før oppstart av observasjonsuken, presentere et samtykkeskjema for underskrift, som sikrer din anonymitet, og forklarer hvilke rettigheter du har som deltaker i denne studien. Jeg vil også ha en grundig muntlig gjennomgang med deg ved oppstart av observasjonsuken, og informerer også gjerne personalet om hvorfor jeg er tilstede, og hva jeg skal se på i løpet av den uken jeg er på besøk i din organisasjon.

Arbeidet med studien vil foregå fra 30.10.08 – 30.10.09. Etter at studien er ferdig, vil alle personopplysninger slettes.

Jeg håper du vil delta i min studie, og svarer gjerne på spørsmål om prosjektet! Ta kontakt på tlf. 947 88033 eller på e-post helene@aksoyfalch.eu.

Kontaktinformasjon:

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Appendix 1

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Med vennlig hilsen

Helene Aksøy

:

Appendix 1

Samtykke

Undertegnede har sagt seg villig til å være med i studien:

What are the issues for nurse managers arising from changes to the home nursing services?

Deltakelse i studien er frivillig, og du kan trekke deg når som helst i prosessen uten begrunnelse.

Dataene som samles inn om deg og din arbeidsdag, vil anonymiseres i den ferdige undersøkelsen, og data som kan identifisere deg, vil i prosjektperioden oppbevares på forsvarlig måte ved Institutt for sykepleievitenskap og helsefag, Universitetet i Oslo. Du har rett til innsyn i alle data samlet om deg.

Opplysninger om hvilke kommuner jeg utført observasjonsarbeidene i, og hvilke tjenesteledere jeg har vært i kontakt med, vil anonymiseres i det ferdige prosjektet, slik at du ikke vil kunne identifiseres.

Disse dataene vil slettes etter undersøkelsens slutt – senest 30.10.09.

Jeg har lest informasjonen om prosjektet, og samtykker i å delta i studien:

Navn Sted Dato

App. 2

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Harald Hårfagres gate 29
N-5007 Bergen
Norway
Tel: +47-55 58 21 17
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Julianne Cheek
Institutt for sykepleievitenskap og helsefag
Universitetet i Oslo
Postboks 1153 Blindern
0318 OSLO

Vår dato: 09.12.2008 Vår ref :20413 / 2 / IBH Deres dato: Deres ref:

KVITTERING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 06.11.2008. Meldingen gjelder prosjektet:

20413	*Hvilke utfordinger møter førstelinjeledere i hjemmetjenesten som følge av organisasjonsendringer?*
Behandlingsansvarlig	*Universitetet i Oslo, ved institusjonens øverste leder*
Daglig ansvarlig	*Julianne Cheek*
Student	*Helene Aksøy*

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller 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, 31.10.2009, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Vigdis Namtvedt Kvalheim

Ingvild Bergan Hordvik

Kontaktperson: Ingvild Bergan Hordvik tlf: 55 58 32 32
Vedlegg: Prosjektvurdering
Kopi: Helene Aksøy, Markalléen 90 A, 1363 HØVIK