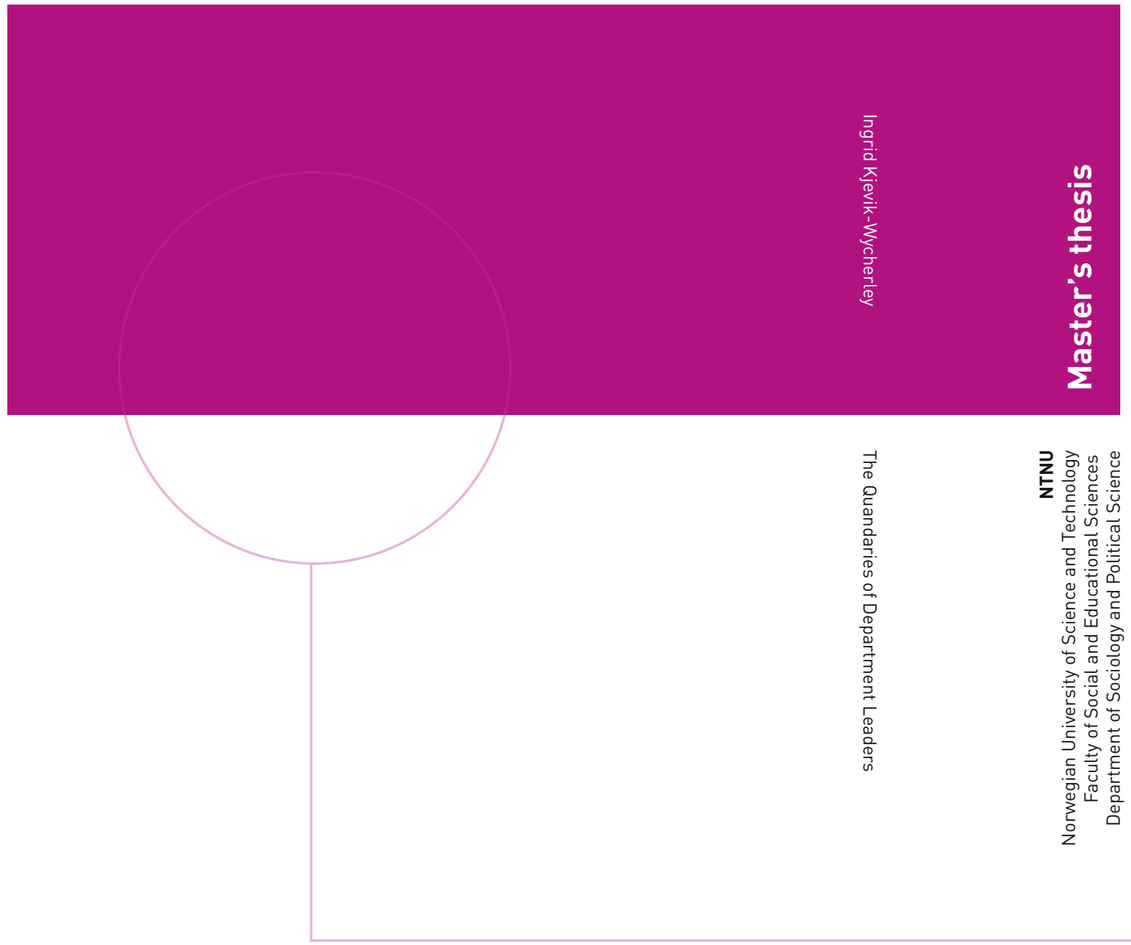

Ingrid Kjevik-Wycherley

The Quandaries of Department Leaders

A qualitative study of the dilemmas department leaders face when working to ensure good quality care in nursing homes

Master's thesis in Sociology
Supervisor: Bente Rasmussen
Trondheim, June 2017

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Abstract

This Masters Thesis is concerned with developments in Norwegian society which affect the way its nursing homes are organised. These developments are ones that department leaders of nursing homes must deal with. The research question is therefore: "What challenges do department leaders face when trying to motivate employees to do a good job, to give good care and create a quality care service?" The backdrop to this is the rapidly growing demands of an aging population and the reforms that have been introduced in accordance with New Public Management (NPM), with the goal of increasing productivity and efficiency, as well as decreasing financial cost. To investigate this, the qualitative research method has been used. Four department leaders have been interviewed, as well as two district leaders (who are 'above' the department leaders), and six care-workers (who are 'below' the department leaders). Through narratives obtained from care-workers, department leaders and district leaders, the dilemmas that department leaders faced when trying to ensure sufficient competence 'on the floor', came to light.

This research finds that the introduction of elements connected to NPM has resulted in certain mechanisms; including budget parameters becoming 'sacred', leading to department leaders organising the nursing home through 'budgetary and transactional lenses'. This resulted in them having a tendency to view employees as an expense to be economised with rather than a resource to be invested in, thereby creating an 'easy exit' for employees. In addition to this department leaders are removed from 'the floor', and are therefore unable to see the ramifications that decisions made through these 'budgetary and transactional lenses' have for employees' wellbeing, and the quality of the care service department leaders are responsible for.

The findings in this research can serve as an eye-opener for department leaders of nursing homes, making them actively aware of the dilemmas that can present themselves in nursing homes.

Foreword

Each summer when I return to work as a care-assistant in a nursing home, it takes approximately a week to get accustomed to the 'way of life' there. During this week a type of culture-shock takes place. I have gone from the busy student life of Trondheim, to an institution full of elderly people who need assistance with almost every aspect of their lives. I feel as though this unique position has contributed to giving me an 'outsider-in' perspective into the goings-on in nursing homes, and sparked my interest for nursing homes and New Public Management as a research area. At first, at the start of the employment period, one is sometimes shocked by the seeming lack of dignity for the residents, however after a week one becomes, to a certain degree, *hardened* to it. After all, what else can you do?

It has been my experience that the employees in nursing homes make the best of the situation. All my informants stated that they liked working in the nursing home because they like *helping* and *caring* for people; that care-giving is personally rewarding. In my opinion, the reason nursing homes in Norway are *still* functioning (albeit not optimally, as this research shows) is because of those dedicated employees who navigate through, and make the best out of the situation they have been handed. This is why I wanted to write about the dilemmas, conflicts and competing priorities that arise in nursing homes.

First and foremost I would like to profoundly thank all my informants who set aside time and took me into their confidence. I truly appreciate how open you have all been with me. If it had not been for you there would be no thesis. I would also like to warmly and sincerely thank my adviser, Bente Rasmussen. Every time I came away from your office I felt one hundred times 'lighter' and with a concise 'plan of action'. Thanks also to my supportive family and friends who have aided and encouraged me through the whole process.

Ingrid Kjevik-Wycherley, 6. June 2017, Trondheim

Contents

Abstract ..... **iii**

Foreword ..... **v**

INTRODUCTION **1**

THESIS COMPOSITION 3

THEORY – THE FRAMEWORK SURROUNDING NORWEGIAN NURSING HOMES **5**

SICKER PATIENTS AND GROWING DEMANDS 5

HOME AS LONG AS POSSIBLE 7

FROM PUBLIC ADMINISTRATION TO NEW PUBLIC MANAGEMENT 8

Decentralisation: governing at arms-length 12

MANAGERIALISM – THE 'ALMIGHTY' LEADER 14

Accountable leaders – governance by contractual management 14

The innovative and personal leader 15

DEPARTMENT LEADERS BACKDROP 16

RESEARCH METHODS USED TO GATHER INSIGHTS INTO THE CONTEXT OF NURSING HOMES **19**

ENSURNG ENOUGH COMPETENCE **23**

PROFESSIONAL MANAGEMENT 23

STRUCTUAL AND ORGANISATIONAL CHANGES IN NURSING HOMES 28

Lack of nurses leads to structural changes 29

Co-operation and flexibility 31

Upgrading care-workers 33

Accountable care-workers 35

Managing employees 36

Involving the employees in decisions 40

CREATING A GOOD WORKING ENVIRONMENT 43
Conflict and tensions among employees 44
The ideal nurse – perceptions surrounding the role of nurses 46
The desire for sociability 50
'LIFE IS PASSING US BY' 52
Young care-workers' experience of shift work 52
CONCLUDING DISCUSSION 55
THE SOCIAL ENVIRONMENT 'ON THE FLOOR' – REACTIVE RATHER THAN PROACTIVE DEPARTMENT LEADERS 56
THE RAMIFICATIONS OF 'BUDGETARY AND TRANSACTIONAL LENSES' VERSUS THE POSSIBLE POTENTIAL OF 'RELATIONAL AND RECIPROCITY LENSES'? 58
'Economic and transactional lenses' 59
What if department leaders wore 'relational and reciprocity lenses'? 61
TIME TO STEP OUT OF THIS ECONOMIC RATIONALITY CAGE? 63
LITERATURE 66
Attachment #1: Interview guide, Department leaders 71
Attachment # 2 : Interview guide, Care-workers 73

Introduction

Nursing homes are an institution where people who can no longer care for themselves in their own homes, are given a place where they can live and be cared for. This institution is often the final stage in a person's life. In Norway, around forty-seven percent of deaths occur in nursing homes (Ramm 2013, p.101). Figures from the 'individual based health and care statistics' (IPLOS) show that more than three-quarters of the people who died in Norway in 2011, were receiving elderly care service before they died (Ramm 2013, p.101). Hence, nursing homes have a vital place in many peoples' lives, and play an important role in the community.

A survey conducted in 2013, of 1700 employees, from 750 nursing homes in Norway, concluded that 2 out of 3 nursing home employees were of the opinion that patients received inhumane and unjustifiable care (VG 2013). This alludes to the fact that something has gone seriously amiss in Norwegian nursing homes.

It is well known that there are time pressures on staff in nursing homes (Ingstad & Kvande 2011,Wærness 1999). This is caused by patients who gain admittance being more ill than they were previously, coupled with tight budgets, as well as a low supply of nurses due to nurses shying away from working in nursing homes (Orupabo 2016). In the last few years there has been increasing attention to these time pressures in the media. One nurse employed in a nursing home told the national media, NRK, that "we are always working with our watch as our boss, and we are afraid to ask patients how they are doing, because we're afraid of getting a long reply" (Risberg 2012).

Patients' next of kin are also becoming increasingly vocal about their experiences and impressions of nursing homes. In particular, that what politicians promise is far from the reality. On the 2nd of March 2015, NRK published an article revealing how Frode Rise found it necessary to hire a private night nurse for his 91 year old mother, who was a patient in a nursing home, on the grounds that she was not receiving adequate ethical care. He explained that he didn't think it was ethically justifiable to have just one care-worker responsible for 19 patients, and one nurse responsible for over 100 patients divided between 6 departments (Omland 2015).

These reactions need to be seen in light of the situation in Norway today, consisting of an increased number of elderly people in need of care. To deal with this, Norway's policy is to help the elderly in their own homes, thereby keeping them at home as long as possible (Røste 2013, p.79). This results in people gaining access to institutions only when it is absolutely necessary. This, in turn, results in patients in nursing homes being much sicker than they were previously. Previous research shows that ninety-one percent of nurses employed in nursing homes state that the complexity of nursing tasks has increased (Gautun & Syse 2013, p.33). When budgets are not increased to match this demand, but rather reforms are introduced aimed at making these organisations run more efficiently, thereby being able to handle the increased workload, something must give way; sixty-seven percent state that there are too many tasks and sixty-one percent say that they do not have enough time to attend to the psychosocial aspect of patient care (Gautun & Syse 2013, p.33). This implies that prioritisation of tasks has become a central issue in nursing homes.

Although faced with these challenges, nursing homes are still responsible for providing a good quality care service for the people who live there. A central question therefore is: How do department leaders achieve this when they are faced with the conditions and challenges mentioned above?

Nursing homes are, in most cases, a final destination, or a place where people live out the final stages of their lives. Nursing homes therefore play an important role in the community; not only for the people who are admitted, but also for the people who have close relations with the patient; their daughters, sons, husbands, wives, grandchildren, friends and so on. It is also important for *their* wellbeing that they can trust, and have confidence in the nursing homes being able to provide the care and security that their relation or friend deserves. It is therefore possible to claim that the nursing home has to satisfy the patients, but also the nurses, care-workers, the patients' family – as well as the taxpayers. In other words nursing homes have a "plurality of constituencies" (Drucker 2007, p.137).

Therefore, developments, changes and reforms which occur in nursing homes are also of interest and importance to the general population. As one department leader I interviewed said, this is the reason why it is important for people to understand what is actually happening in nursing homes; gaining insight into the conditions nursing homes are under and not just how they are portrayed by the media, which is often as 'the big bad wolf'; not willing to look after the elderly people in a proper way.

Because the residents of nursing homes are completely dependent on others for help and care, it is crucial that we ask ourselves; how are current ideological hegemonies in the political sphere, influencing Norwegian nursing homes? It is important to gain an insight and understanding into what the realities of nursing homes are, which strategies department leaders use, and how they cope and navigate through the challenges and opportunities that present themselves.

Thesis Composition

In the theoretical chapter I have outlined the theories and developments which influence nursing homes, painting a picture of the framework that department leaders must work within. These theories and previous research also help provide the backdrop for my empirical research, as well as honing in on the research question which is presented at the end of the chapter. In the next chapter I account for my research design and how I went about gathering the empirical data, this chapter is therefore called; “Research methods used to gain insight into the context of nursing homes”. In the following chapter I present and discuss the empirical findings. Because the empirical findings were centered around which hurdles department leaders encountered and how they dealt with these when trying to ensure enough competence in their department, I have chosen to call the analysis chapter “Ensuring enough competence”. After this follows a brief concluding discussion where I attempt to draw out the most prominent aspects from the analysis by discussing what they mean for society.

Theory – the framework surrounding Norwegian nursing homes

Numerous developments have resulted in increased pressure on the elderly care sector, and its department leaders. Firstly, the growing numbers of elderly people dependent on care services. Secondly, the political focus on helping elderly people in their own homes leading to a change in the patient make-up in nursing homes; patients who do gain admittance are now much sicker than they were previously. This demands greater nursing skills in nursing homes. The fact that nursing homes are finding it difficult to attract and recruit nurses, presents a further challenge for them. Thirdly, there have been changes in the structural principles surrounding the running of, or organisation of, the public sector in Norway: The reforms in accordance with New Public Management (NPM). Which consist of the 'purchaser – provider' model which focuses on budget discipline, and an increased focus on, and reliance on, leaders and leadership, have resulted in significant changes in how department leaders can, and are expected to work. These structural changes in Norway make up a framework which department leaders of nursing homes must deal with, and work within.

Sicker patients and growing demands

In Norway, as well as in other OECD countries, there will, in the years to come, be an increased number of elderly people in proportion to the rest of the population (Eurostat 2015).

Consequently, we are in the middle of what we can call a 'social-welfare conundrum', made up of two central elements. Firstly, the changes in the needs of municipalities' populations. There is a growing demand for the elderly care services municipalities are required to provide. The main reason for this is the aging population. In addition to this, the growth of private wealth in the population, and increased expectations, results in the community expecting more from the elderly care service than it did previously (Ringholm 2013, p.104).

Secondly, nursing homes across the whole country, but particularly in the regional districts, are finding it increasingly difficult to attract and recruit nurses (Tjerbo, Aamodt, Stigen, Helgesen, Næss, Arnesen, Høst & Frølich 2012, Dahle 2016, p.169). Norway's regions found it either 'very difficult' or 'difficult' to recruit staff to the elderly care sector (Tjerbo et al. 2012, p.56). Orupabo (2016, p.90) interviewed nursing students and found that they did not want to work in nursing homes. They did not want to be limited to working in care and matters like personal hygiene, they wanted something *more* than that. This can be interpreted

as nursing students saying that nursing in the elderly care sector is not a sufficient challenge, nor of sufficient interest to them. In other words low status attaches to nursing in nursing homes.

In nursing homes there is a hierarchical structure in the workforce made up of nurses, care-workers, and unskilled care-assistants. Nurses have three years of formal higher education, and care-workers have a year, or a trade course (2 years of school and 2 years of placement) (Lysnes n.d). Care-assistants have no formal education. Traditionally the bulk of staff in nursing homes consisted of care-workers. They played the most important 'hands-on' role in providing the care service. However, the growing demands of the population, paired with a heightened threshold regarding which patients are able to be admitted to nursing homes (based on the severity of their illness/diagnosis), results in those patients occupying beds in nursing homes, having much more complicated diagnoses and often multiple illnesses, than previously was the case. Consequently, nursing skills in these nursing homes are becoming increasingly important, and are therefore now a major and central part in the care service that nursing homes need to provide (Grimsrud 2017).

In 2012 the co-operation reform ('*Samhandlingsreformen*') was introduced. This reform was aimed at getting municipalities to take a larger degree of care and responsibility for their constituents, by focusing more on preventive health measures, aimed at preventing illness and disease (St. meld. nr. 47 2008-2009). In the medium-sized municipality where I carried out my research, preventative health measures included, for example, increasing home based help. The goal was to do as much as possible for the patient or client in their own home, thereby avoiding hospitalisation. This resulted in those patients who did gain access to nursing homes, being much more ill than they were previously.

The second aspect to this reform was that after hospitalisation, patients' recovery and rehabilitation was to be a municipal responsibility, through nursing homes and home help. This resulted in patients being discharged earlier from hospital than previously. To ensure that this directive was followed up, the government introduced a 'fine' of 4000 kroner per day which municipalities had to pay to the hospitals. This covered the cost of the patients remaining in the hospital, for every 24 hours the municipalities were unable to receive patients who the hospitals adjudged were ready for discharge (Torjesen & Vabo 2014, p.139). In most areas this reform contributed to the fact that patients who gained admittance to nursing homes were sicker than before.

To summarise; nursing homes are experiencing an increase in demand due to the aging population and sicker patients, coupled with the fact that nurses do not find working in nursing homes attractive.

Home as long as possible

The publicly available social help for elderly people in Norway has undergone major change. From being mainly based on an institutional elderly care facility and nursing homes model, to more emphasis being put on home based care services. In 1992 'at home as long as possible' became an important political goal and a mantra of sorts. It was then believed, in light of a report from 1992, that the quality of life of elderly people was best ensured if they could stay at home as long as possible (NOU 1991:1). This idea manifested itself in a four-tiered model that was legislated on a national political level in 1997 (St.meld.nr.50 1996-97): "*Handlingsplan for eldreomsorgen: trygghet – respect – kvalitet*"). The model was developed with the aim of municipalities being best able to cater for elderly peoples' individual care needs, at the same time as ensuring that *everyone* was offered a service that suited their needs, as well as limiting the need for expensive rooms in nursing homes.

The four levels are based on how much assistance patients, or clients need. At Level 1 are elderly people who are healthy and self-sufficient. They are to receive 'help' in the form of an elderly center, and contact and security services. Level 2 relates to elderly people living at home, but who need *some* help. They should receive this in the form of 'home-help'. Those on level 3 are elderly people who are no longer able to live alone in their own homes, but who can manage most of their day-to-day tasks. These people are to be placed in a 'home-care department' (*omsorgsboliger*). Finally, at level 4 are elderly people who are completely dependent on 24 hour care, and are admitted to nursing homes (Røste 2013, p.79).

To be allocated to one of these service levels entails that the recipient must be assessed. There are certain requirements that patients, or clients, must fulfil in order to receive these services. Over recent years the requirements for being able to receive these services have become much more austere. The implementation of these service layers has meant that elderly people who were previously admitted to nursing homes, would now either receive help in their own homes, or in home-care departments. The result of these developments was that the patients who actually did gain admittance to nursing homes, (the final layer in four-tier care system), were now much sicker than they were previously.

From Public Administration to New Public Management

In the last few decades there has been a growing focus on cost efficiencies where health care is concerned, especially as these services are tax-payer funded. There are growing concerns about the increase in welfare costs, as well as the decrease in the tax revenue base (Dølvik, Flaten, Hippe & Jordfald 2014, p.86). We are staring into a future where there will be an overwhelming number of elderly people not participating in the labour market, compared to people participating in the labour market, and thereby contributing to the governments' 'money chest'.

Reforms in accordance with ideas connected to New Public Management (NPM), were recommended and introduced by central government, with this in mind (Vabø 2012, p.286). The overall goal was to "get more (health) out of every kroner" (Skorstad 2011, p.63). There have not been direct cuts in government funding for the elderly care sector, but rather an increase in patient numbers and those patients being sicker than previously. Consequently, the workload has increased. Strategies and reforms in accordance with NPM ideals have been introduced in the elderly care sector, in order to deal with the increased workload.

To understand the significant structural changes that were brought about in the spirit of NPM, it is helpful to compare it to the system it was supposed to replace, namely the Public Administration system (PA). The main difference between the two is that the PA system was characterised by mutual trust, principles of ethics and bureaucratic expertise. The NPM system is characterised by distrust, economic theory, governing 'at arms-length', (Hood 1991, p.5), and governance by contracts which included disciplining through budgets which are cemented into personal contracts (contractual management) (Vabø 2012, p.286).

Hood (1991, p.5) coins the PA system as being a "traditional military bureaucracy" which places significant importance on "good administration". The PA system was a system that placed great emphasis on the professional bureaucrats. In this system, politicians decided *which* goals were to be reached, and the bureaucrats, the experts, decided *how* to reach these goals. In other words the professional bureaucrats implemented; since they had the knowledge and expertise, implementation was their responsibility (Røiseland 2013, p.194). Trust was placed in the autonomous professional executers working in elderly care services to provide a good quality care service, by using their professional expertise guided by ethical norms. In the new system (NPM) the politicians, in addition to deciding *which* goals were to be reached,

now also decided *how* to reach them. The professional bureaucrats could offer advice which politicians could either *choose* to listen to, or dismiss.

The PA system was completely guided by rules and professional ethics, and was a just and fair system. However, it was also criticised for being inefficient, in other words too expensive, and static with little or no room for flexibility and experimentation (Bugge & Skålholt 2013, p.55-56). With the introduction of NPM it can be said that those elements of the PA system, such as 'rules of procedure', have been, to a certain degree, eroded (Hood 1991, p.16). The ideas that gained hegemony in the political atmosphere following the inauguration of NPM, included that the problem regarding the public sector was not a lack of resources, but rather that the public sector was poorly organised and inefficient.

By introducing techniques and ideas from the private market it was claimed that this would generate better results (Skorstad 2011, p.63). For businesses in a private market their value is defined by quantifiable measures, whereas the municipalities' care services value is mostly, or should be, defined by qualitative standards (Torsteinsen 2012, p.72). Nursing homes make a different contribution, and have a different role in society compared to businesses. They are fundamentally different. Nursing homes have different values, and must therefore also have different objectives. "Performance and results" are therefore significantly different in a nursing home from what they are in a business (Drucker 2007, p.134). By introducing aspects from the private market, by combining the qualitative with the quantitative, it is inevitable that conflicts between the two will surface.

One of these ideas was to promote the 'purchaser – provider' model. This model was based on economic theory (Vabø, 2014, p.70). This economic theory, with roots in utilitarianism and the idea of self-interest (Hume 1981 in Hood 1991, p.7), claimed that public service providers would always try to ensure their own wellbeing. That, for example, staff in nursing homes main priority would always be to ensure that they were 'well-off', and not ensuring that they were doing things in the best and most efficient way possible. This economic theory would claim that staff employed in nursing homes would try to maximise benefits for their own situation; that they, would, for example, attempt to have as much 'couch-time' as possible and take long breaks etc. According to this economic theory the outcome would be a system where one would never know whether staff could deliver the care service more efficiently. This way of thinking involves an underlying distrust towards the executers (providers) of the care service, as the purchaser will never have the same level of knowledge about the care

service which the provider has. Consequently, the purchaser's ability to control that the service is executed in the most efficient way possible, is limited. Without the intricate knowledge of what the care service really entails, then it cannot be said what might be done better. However, if the system is split into two separate and segregated entities and they are subjected to market competition, this will manage itself, because when providers are forced to compete, purchasers will always know which is the best service they can get - and which is the cheapest. This is because the purchaser can identify the differences in a competitive market. In the public sector, the market can be compared to the so-called 'best practice' aspect. This includes substantial performance reports enabling comparisons between the different providers. It also sanctions a situation where a purchaser can utter "if this provider can provide such cheap care, why can't these others do the same?" This way of thinking gives rise to the increased use of standardisations (Vabø 2012).

This was done by splitting up the 'old' (PA) form of organising the elderly care service, into one with a 'purchaser' (the municipality) and a 'provider' (the nursing homes executing the care). The basic idea being that the 'purchaser', the municipality, must put all services out to tender (Vabø 2014, p.71). This is because, as the economist will claim, it is only by competition that these 'providers' (nursing homes) will 'pull themselves together', and start to economise and operate efficiently in order to show that they are the best and cheapest option. This is based on the principle that 'providers' (nursing homes) will be forced to be more efficient because of the element of competition in the market (Hood 1991).

The NPM 'purchaser – provider' system is a system based on contracts in a market. So, where PA was based on trust and expertise, the NPM system is based on contracts in a market, albeit, this is not the 'real' market, but rather a pseudo-market (Torsteinsen 2012, p.71, Rasmussen 2016, p.203). In this pseudo-market the 'providers' (the executers of the service) are constantly mistrusted and must constantly be controlled and kept 'under the thumb' (Torsteinsen 2012, p.33). Because there is no competition in the municipality, the way this is done, (getting the 'best and cheapest' provider), is by delegating the economic responsibility with budget parameters, and implementing a detailed measuring and performance reporting system, which gives leaders 'above' the information they need to exert *governance* (Torsteinsen 2012, p.71-72). The 'purchaser' (the municipality) allocates a budget and assigns tasks, For example, nursing homes receive 'x' amount of funds, for 'y' amount of patients, and are expected to ensure certain goals by providing a good quality care service. When there is no market competition to discipline the executers into making them the best and the

cheapest, this is done through the budget. The budget is, in turn, cemented into the contract between the 'purchaser' and the 'provider', resulting in the executers of the care service working 'contract-based' (Rasmussen 2012, p.166, Vabø 2014, p.70). Thus, economic market theory comes through; the basic idea being that executers need to be disciplined through budgets which are cemented into contracts, in order to reach maximum potential, thereby getting the most 'health' out of the purchasers money.

A significant consequence of this type of 'contract work' entails that those who are working under the contract, in this case department leaders and district leaders, must now produce extensive documentation with details of the services they are providing (Rasmussen & Vabø 2014, p.107). That is, including how they spend funds allocated, as well as which tactics and methods they implement to effectivise and ensure quality care.

Nursing homes are exactly as the name implies; *a home*, with a *nursing* aspect. This means that as well as having to attend to the medical and practical aspects of patients' care (washing, medicines, etc.), employees also need to ensure the *homely* aspects (Vabø 2014). In helping to provide a suitable psychosocial environment, nursing home staff are, to a degree, responsible for patients feeling 'at home'. When tactics such as *lean* (Skorstad 2002, p.202) are implemented in nursing homes with the goal of achieving 'more care for every kroner', by prioritising tasks into so-called; 'must tasks', 'should tasks' and 'could tasks' it might be assumed that making patients feel at home, eg helping them keep their plants alive, would be downgraded to 'could tasks' thereby not receiving priority.

An example of one strategy implemented in many nursing homes in accordance with NPM, is the outsourcing of kitchen services, where a central kitchen produces and delivers ready-made meals to the nursing homes. This was with the objective of saving time and resources on cooking food on the premises. As Ringholm (2013) points out, even though the food is just as good, and just as nutritious, this new organisation can result in patients in nursing homes being less happy because there is no longer the smell of newly cooked food on the premises (Ringholm 2013, p.108). This can be connected to the *home* aspect of nursing homes. The point to be made is that while value had perhaps been created in economic terms, this did not necessarily mean that value is thereby equally created in terms of better services for patients, and improved working conditions for the employees (Ringholm 2013, p.108).

Decentralisation: governing at arms-length

With the breaking up of, and the segregation of the 'old' (PA system) way of structuring care service organisations, the new structure for organising elderly care services was based on a two-tiered organisation (Rasmussen 2012, p.166), which facilitated the implementation of the 'purchaser – provider' model. This two-tiered model is basically a system where the municipality governs by delegating responsibility to the separate economic units (Romøren 2006, p.8, Rasmussen 2011, p.59).

This decentralisation results in responsibilities and accountabilities being pushed, as far as possible, down to the lowest level in the health care system (Vabø 2009, p.347). The municipality must relate to the goals set by politicians, (central government), but can autonomously decide how to use the resources allocated to reach these goals (Rasmussen 2012, p.165, Vabø 2012, p.284). To reach these goals the municipality governs and delegates responsibility through personal contracts (Rasmussen 2011, p.61).

The figure (fig.1) below shows how responsibility is delegated from the municipality to the head of the 'economic unit', in this case, the district leader. The district leader then has the main responsibility for keeping to the allocated budget and providing a good quality care service. The district leader further delegates this responsibility down to their department leaders represented here by the circular figures. This results in each department leader, becoming responsible for an 'economic unit' and keeping to the allocated budget and providing a quality care service. The arrows pointing down represent the delegated responsibility which is formalised in personal contracts. The arrows going up represent the performance reports and documentation that department leaders and district leaders must produce to those 'above'.

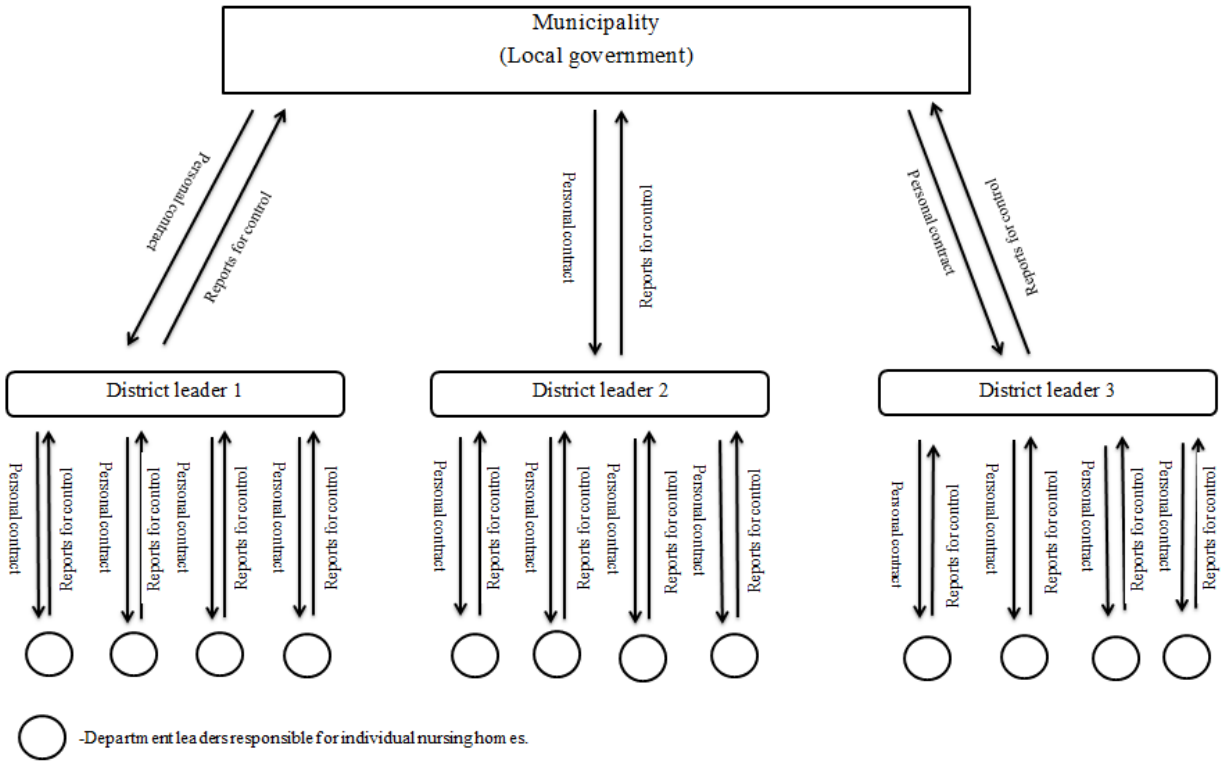

Fig. 1 The chain of governance.

In this system, founded on the principals of NPM, it can be said that the delegation of responsibility through personal contracts, leads to governance by contracts and control by documentation and performance reports. This 'documentation responsibility' has in fact grown. The PA system was characterised by *direct governance*, where central government explained what was to be done, and the executers were entrusted with the task. The 'new' (NPM) system was, on the other hand, characterised by 'governing at arms-length' (Hood 1991, p.5). With the 'purchaser – provider' model, there is an institutionalised distrust towards the executers which implies that the performance of executers needs to be controlled and disciplined. Hence the increase in the executers' documentation of their performance; proving and giving evidence that they are, in fact, doing their job, and providing a quality care service (Torsteinsen 2012, p.67). As Power (1994) puts it; "control for control". The new regulations implemented by central authorities, ie Quality Regulation (*kvalitetsforskriften*) of 1997, resulted in executers, the front-line staff of the care service, having to document everything which they previously, in the PA system, carried around in their heads (Vabø 2012, p.285). It might therefore be said, as Hood (1991, p.12) does, that in this kind of system the control emphasis is put on output instead of process. This means that the documentation of performance in quantifiable reports is put center stage, and not the actual care given.

Managerialism - The 'Almighty' leader

Managerialism is another element connected to NPM (Hood 1991, p.5-6). Managerialism centers around the *belief* or *faith* in leaders. That a good leader could lead anything they set out to lead, regardless of the nature of the business or service. The idea originated from private corporations and was that leadership was a 'profession' and a 'subject' in its own right, irrespective of the field being managed (Hood 1991, p.6). It would seem that the 'new' leader, and the corresponding re-structured role in nursing homes, also termed 'Professional Management' (Hood 1991, p.6), would be the solution to all the nursing homes' problems. The 'new' leader in accordance with NPM is composed of two elements that come from two different traditions. On the one hand, leaders are personally responsible for meeting budgets and the quality demanded through contracts, resulting in *governance* by contracts. Governance is therefore understood as steering, or directing; directives that come from 'above'. This aspect of the 'new' leader has its roots in economic theory. On the other hand, these leaders are supposed to exert *leadership*, which involves day-to-day leadership and how they influence their employees to do what they want. This aspect comes from a completely different, and perhaps contradictory tradition, namely from the cultural leadership tradition and the Human Relations (HR) tradition (Peters and Waterman 1982, Pedersen 2012).

Accountable leaders – governance by contractual management

Department leaders became personally responsible and accountable for providing a quality care service within the allocated budget, with the implementation of the 'two-tiered' system and the 'purchaser – provider' model. Instead of the state telling these institutions exactly what to do, faith is placed in the department leader, who would find the best solutions by "letting the managers manage" (Torsteinsen 2012, p.32). However, the greater the freedom, the greater is the need for control (Torsteinsen 2012, p.32). Municipalities are now governing through budgets which are cemented into personal contracts, a managerial tool termed 'contractual management', which is associated with NPM (Vabø 2012, p.286). These personal contracts have a disciplinary effect, requiring leaders to become self-controlling agents who 'willingly' seek to reach delegated goals and budget demands (Rasmussen 2011, p.60). Because of the department leaders' new 'freedom', they are subject to control by district leaders. This is in the form of documentation and the performance reporting responsibilities imposed on them. They are required to prove to the district leaders that they are spending their allocated budget in a rational manner (Rasmussen & Vabø 2014, p.107).

The reforms inspired by NPM resulted in the role of department leaders changing from one viewed as a type of buffer and support mechanism for the autonomous employee, to someone whose primary responsibility was to carry out strategic goals which came from 'above' (Rasmussen & Vabø 2014, p.98). This meant that the employees are, to a larger degree, increasingly alone when it comes to dealing with difficult situations 'on the floor' in the nursing homes. Employees are no longer given advice or feedback about their daily work, and do not report directly to a department leader every day. This, in turn, leads to the department leaders being disconnected from important information about what is happening 'on the floor' in their nursing home (Vabø 2014, p.43).

Prior to these changes the situation was different. One employee Vabø (2014) interviewed in the early 1990's, explained how the department leaders contributed to making the employees' jobs easier by listening to them, giving them advice, and making sure that there was good matching between employees and tasks. At the same time, this department leader trusted her employees, would delegate responsibility, and would support employees who felt powerless and unsure. Through daily conversations with employees about the day's experiences, this employer acted as a counsellor and facilitator (Rasmussen & Vabø 2014, p.100).

Department leaders interviewed in 2007 stated that in the restructured services they felt pressured to adhere to budget constraints, resulting in them having to become stricter and 'meaner' (Rasmussen & Vabø 2014, p.105). Some of those department leaders observed how they had changed as a result of this new form of management; they had forced matters through, things that they had previously been hesitant in implementing. Some explained how they found themselves using a much louder and commanding voice than they had formerly (Rasmussen & Vabø 2014, p.105). This would most definitely have an effect on employees, perhaps creating greater distance between staff and the department leader. Also, if department leaders felt pressured into accepting and implementing strategies they did not necessarily think would be beneficial to the nursing home, because of the personal responsibility they now had in adhering to budgets, this too could affect the employees and the organisation of the nursing home.

The innovative and personal leader

With the introduction of managerialism in Norway, emphasis was placed on leaders having the 'freedom to manage' (Rasmussen 2012, p.165). This included an empowerment of leaders who now had the freedom to use their own creativity to find solutions and methods of

ensuring a good quality care service. This aspect of the 'new' leader is based on the cultural leadership tradition. In this discourse, creative and resourceful leaders are thought of as being the key to achieving a good quality care service and satisfied 'clients' (patients). This 'new' leader needs to be able to mobilise and engage their employees in order to create 'excellence' (Peters & Waterman 1982).

When department leaders are governed by contractual management, becoming personally responsible for keeping within the allocated budget, one could assume that they might have a tendency to be focused on budget, and being able to report best possible performance results, and might therefore start to organise their 'production' (care services) based on this. This alludes to the fact of employees' wellbeing, and focus on building an organisation, ie the leadership aspect of professional management, becoming secondary to the budgetary and performance reporting demands, ie the governance aspect. Because of time pressures, prioritisations must be made between the two aspects that make up this 'new' leader. In most cases, this results in documentation and effectivisation being given ascendancy, ie the *governance* aspect. Thus, the economic tradition wins out (Rasmussen 2012).

Department leaders backdrop

The scene depicted here consists of three central developments: 1. The patients admitted to nursing homes being sicker than they used to be. This is a result of the demographic change in the population (aging population), Norway's policy of keeping the elderly at home as long as possible and the cooperation reform (*samhandlingsreform*). 2. Professional management being introduced in accordance with NPM ideals, resulting in department leaders becoming increasingly focused on their budgets and performance reporting obligations. 3. Limited budgets, as nursing homes are part of the publicly funded (from tax payers) welfare system that is offered to, and used by every citizen irrespective of social economic status (Vabø 2012, 2015). These three central issues are to be resolved in a situation where department leaders are finding it increasingly difficult to attract and recruit nurses to work in nursing homes (Tjerbo et.al 2012, Dahle 2016, Orupabo 2016).

This is the backdrop against which department leaders must work. My research question is therefore as follows: *What challenges do department leaders face when trying to motivate employees to do a good job, to give good care and create a quality care service?* As it is those employees who *are* the care, it is they who provide the service; essentially they *are* the nursing home. When looking into how department leaders confront this, it is also necessary to

look at the challenges they face and the hurdles they must overcome, to ensure a good quality care service.

Research methods used to gather insights into the context of the nursing homes

I conducted my research in a medium sized municipality. The nursing homes I visited and the staff I interviewed in connection with these, were all publicly run and publicly funded. The funding model in this municipality was based on ISF (*innsatsstyrt finansering*), which basically means that nursing homes receive a fixed amount for every 24 hours they have a patient occupying a room. Differently to home help, the nursing homes in this municipality received the same fixed rate for every patient irrespective of the patient's condition or diagnosis.

My main focus was on the department leaders in the nursing homes, as they are the leaders who are closest to what actually happens 'on the floor'. However, in addition to interviewing department leaders, I also chose to interview district leaders. This was to get a complete picture of how the different levels of management think, and their experiences in dealing with the conundrum posed, and how they manage and direct those under them. By interviewing district leaders my aim was for their stories to contribute to gaining a better understanding of the demands, expectations and instructions which department leaders receive from 'above'. I also chose to interview care-workers employed in nursing homes, as the staff narratives and experiences shed light on the problems and issues which department leaders face and have to resolve. The objective of interviewing care-workers and district leaders was to gain access to the narratives which help create the scene that department leaders are expected to work with.

I have, therefore, strategically chosen my informants; two districts leaders, four department leaders and six care-workers. The care-workers are from different nursing homes. This is also to further ensure their anonymity. All my informants' anonymity has been preserved, being referred to as care-worker 1, department leader 3 etc. According to NSD (Norwegian Social Science Data) my research was not subject for notification.

As an observing participant in this sector, I have acquired knowledge that has shaped and given form to this research design. I have done so through working in the sector as a care-assistant in study breaks. I have become familiar with nursing homes both as institutions and organisations. By working in this sector over several years, I have also acquired contacts amongst both employers and employees. When deciding where to carry out my research it was a natural choice to do so in the municipality where I had worked and had the greatest

background knowledge. My connections assisted me in making contact with the informants and winning their confidence and co-operation.

I established contact with department leaders by telephoning the central board for nursing homes in this municipality. They, in turn, gave me the telephone numbers of four department leaders. I spoke with each requesting their availability and interest levels at being interviewed. I explained what my research was about. All the department leaders I called upon were enthusiastic and willing. Following our conversations I sent each of them an email in which I was more specific about the research and arranged suitable times for the interviews.

In this municipality there were three district managers. I called each of them. One was not available; the other two responded and were positive towards being interviewed. They requested more information about my research, and what I would be asking them. I therefore sent a further email explaining the main intended topics. It should be noted that I was acquainted with these two district leaders through my time working in a nursing home. This was a major advantage. Both were very busy and would not have otherwise blocked out an hour of their schedules to be interviewed by a masters student, had we not been acquainted, (as they themselves told me).

The employees I made contact with were either referred to me through my acquaintances, or by ‘snowballing’ (acquaintances of acquaintances).

Three of the care-workers were interviewed at their workplace. This was of their choosing. This worked very well, as we were able to close off a separate room so that our conversation could not be overheard. This was a group interview. This format allowed them to discuss matters between themselves, something I experienced to be fruitful, as there were issues that came up for discussion which probably would not have otherwise, as a result of their own interactions. Conversely, one of the drawbacks of the group interview might have been that participants self-censored their opinions or thoughts, due to the presence of their colleagues and perceived pre-dispositions. The decision to undertake a group interview was one that I debated with my advisor. We agreed that the benefits outweighed the potential negatives. Since I was acquainted with these employees personally, I also knew that they were good friends and colleagues who got on well. This was also apparent during the interview. They spoke to each other often when difficult situations presented themselves at work. The interview lasted for an hour and half, and was recorded, as were all the interviews, in addition to being transcribed, after which the recordings were deleted. When reading through the

transcribed interview with the two younger care-workers, they talked about doing a course which would allow them to undertake 'nurse tasks'. I was interested to know whether this was something they had been offered, or whether they had themselves requested it. I therefore contacted them via messenger (facebook) and they replied that they themselves had taken the initiative to ask the department leader for this training.

I met with the other care-workers in their homes; one of the care-workers came to my house. These interviews lasted for between an hour and an hour and a half.

I met with the district leaders and department leaders at their workplace, in their offices. My experience was that the department leaders were very busy. One of my interviews commenced 15 minutes late because the department leader was busy in another meeting. Two of the other department leaders took phones calls during the interviews. In one instance the department leader needed to go up onto 'the floor' to talk to one of the nurses and did not return for 20 minutes. Although they were very busy they seemed happy to talk to me, and expressed their wish to raise awareness about developments in nursing homes and what was 'really' happening.

The analyses and findings of this work are based on the main themes that came through during the interviews. After categorising and extracting certain themes, I proceeded to find relevant theory. I consider that I have been quite inductive in my research process. However, it is also important to note that having read and worked with theories about each of NPM, organisational theories, and nursing homes, I did not go into the interviews completely 'blind', but rather these things shaped the focus of the interviews and the themes I had on my interview guide. My interview guide functioned more or less as a reminder of the topics I was interested in enquiring after, so that at the conclusion of our conversation I could say: "Just let me check that we've covered everything". By conducting the interviews more as conversations it allowed me to follow the informants' thought processes rather than my list of themes. This resulted in the conversation having a natural flow as opposed to a fractured question-and-answer session.

I have chosen to present my empirical findings by using 'thick descriptions' (Geertz 1973), where I let the informants tell their story as much as possible. I have done this by using, in some sections, long quotations where informants shared their experiences with me. Otherwise I have given detailed descriptions. I think it is advantageous to use 'thick descriptions' because it was my informants who were best able to get their points across in an emphatic

fashion when they told the story themselves. I have translated these quotations from Norwegian to English.

The purpose of this research was not to compare the different department leaders, but rather to gain insight into the framework within which they worked, to look at their experiences, and how they dealt with the problems that arose, due to being in a 'squeezed' position between the high and sometimes competing demands of providing quality care and operating within tight budgets.

An important aspect of my research was making sure I was able to get answers to the questions I wanted to investigate; how department leaders experienced and handled their squeezed position. It was, therefore, also important to gain insight into the conditions which district leaders (above) and staff (below) created for them. I chose to interview care-workers, as opposed to nurses, based on the fact that the greater bulk of staff consists of care-workers (Grimsrud 2017). Also, it is the care-workers who are, to a large degree, having to compensate for the lack of nurses, through taking on more tasks and greater responsibilities. In retrospect, and if time and the size of this project had permitted, it would have been interesting to do a 'in-depth' study looking at the four nursing homes where I interviewed department leaders, as 'cases', doing field work as well as interviews. Although this is a small research project, it can shine a light on the challenges that department leaders in nursing homes face, as a result of the changes that are occurring in Norwegian society.

When working with my empirical data the central issue was: How can department leaders ensure enough competence 'on the floor'. Through the interviews with care-workers, and district leaders' the challenges and situations that department leaders face when trying to ensure enough competence in their nursing homes, presented themselves clearly. The following chapter, where I present my empirical findings, is therefore called "*Ensuring enough competence*".

Ensuring enough competence

The main responsibility of the department leaders is ensuring a responsible and good quality care service for the patients who live in the nursing home. This basically entails being able to ensure enough competence in the department at all times and that the staff are able to work as a team. This must be achieved within the framework that department leaders are subjected to. These factors include budget, formal rules and regulations and employees. This chapter is divided into four sub-chapters: 'Professional management', 'Structural and organisational changes', 'Creating a good working environment' and 'Life is passing us by'.

Professional management

The department leaders felt that they had quite a bit of freedom in their roles, but always within the limitations of the budget allocated. A district leader explained the sorts of parameters she lays down;

> O*h very little, I don't have a need to control, the only thing I'm very strict on is that the report is to be sent on the 8th every month, not the 9th, the 8th, and then they can do almost whatever they want as long as they keep within budget and work towards bettering the quality of the service* (District leader 2).

Clearly 'the report' is of vital importance. The district leaders explained that it is this report (among other things) that allows them to report further, to those higher up. The state demands progress reports and statistics from the municipality; the district leaders being the representatives of the municipal elderly care department. The district leaders then demand information for the reports from their department leaders. However, the district leaders expressed that in their opinion there is too much focus on reporting and evaluating.

The department leaders explained that in their reports they gave details about budget, employee issues, whether there were any complaints, and progress reports on the patients - in other words 'performance reporting'. If they were exceeding their budget they also needed to explain in the report what tactics they would implement to get back on track, as well has the strategies they were implementing to better the quality of the service. One of the department leaders stated that keeping to budget can be challenging:

> *It can be challenging at times. The thing is we have a basic staffing level and that is supposed to be adequate to look after the people who live here, and at the same time*

deliver the service with the quality that is expected. But we're beginning to see, more and more, that the patients who come to us are much more ill than they used to be. This of course means that the demands on resources for following up these patients, are greater. So its always a kind of balancing act, where I need to continually consider; do we have enough staff, do we have enough competence on the floor at all times? In some cases the answer is 'no' and then I might need to put on extra staff, and then the money just starts rolling out. Naturally, I need to look at what I can afford basically (Department leader 1).

When, as this department leader said, budgetary demands gained such center-stage priority, it could most likely lead to department leaders *calculating* which employees could do what. This department leader had experienced times when she had exceeded her budget in trying to meet demands and provide quality of the service expected. She explained that one of her short term tactics to get back on track with budget, was to limit the amount of over-time she paid her employees. This meant being very careful with whom she gave extra shifts to. By making sure that no one exceeded five shifts in one week, over-time would be limited. This resulted in the need to use temporary employment, or employ staff in small part-time positions. This mirrors Dahle's (2016, p.182, 2011) argument that nursing homes are becoming increasingly dependent on part-time, temporary and agency employment. When the use of permanent staff becomes precarious, this will most likely have a negative impact on the care patients receive (Dahle 2011, p.1).

The department leaders are also in charge of deciding what should be done to improve the working environment in their departments. This is presumably why the different nursing homes had different ideas around this. Some had a collective lunch with salad on Fridays, others had international parties etc. However, there were certain strategies or tactics that department leaders were, to some extent, 'coerced' into using. For example, one district leader explained that they consulted about what they could do to create a positive working environment in the nursing homes, she said:

We talk about it when we have department leader meetings. When it comes to the summer party I'm very firm on the fact that this is something that all of my four nursing homes are to have together. Then there's the Christmas dinner; here they want do as they wish which I can understand. Of course on the things that I want them to do, I try and sell it as well as I can, so that they will take the bait. So I do try and

convince them sometimes. Of course there are some things that might not be that important to me, but are important to them, so I don't need to enforce everything I think is good. It's a good thing that they have a certain degree of freedom but I think they quickly understand that if I want them do to something, they can protest, but if there is just one department leader against it, well, put it this way, they have to follow the flock, but then they can have some time to think about how they are going to be positive about the intitiative (District leader 2).

This shows that although, through professional management, leaders are supposed to have the freedom to lead, in reality this is not always the case. While, the department leaders do have certain freedoms as this district leader says, they also have certain pressures from district leaders, which they are 'forced' to accept, thereby restricting their freedom.

When the department leaders and district leaders were asked what they would change about their jobs, they all specifically stated that they would prefer it if they had more time with their employees, to be able to work more 'hands-on' with them. They all felt that if they had time to do this, then their organisation would function better. They felt that they spent too much time reporting things for 'control'. As one department leader put it:

I think we have far too many administrative tasks. I think some of these could be delegated to a secretary. I really think that the department leaders should have more time to actually ***lead*** *not just sit in the office registering, and filling out all sorts of forms and things* (Department leader 2).

It would seem that this is, to some extent, contrary to the leadership aspect of the professional management ideal. That is, there was supposed to be a greater focus on leadership, which included leaders using their personal attributes to build relationships with employees, thereby influencing them in a personal way, to create a good service. However, when, as the informants said, there was so much administrative work, they had little time to be among their employees. It would therefore seem that this part of professional management does not happen in reality. There is no time and meetings, reporting and documentation are given priority.

The district leaders expressed that if they had more time with their employees (department leaders), they could follow up and see things through much better:

My authority and the opportunity to use my creative abilities, and to be solution-minded, have really been restricted over the last few years. This is my biggest regret in this line of work. The things we need to report have actually grown quite a lot over the last years; reports that need to be handed in for evaluation, statistics that need to be collected and sent higher up in the system, "action plans" and quality reports. It's a shame really because there isn't enough time to be very solution-focused because there are so many administrative things that need to be done (...) If I had more time to be hands-on I would be able to be on the spot more regarding the challenges that are present in my nursing homes, and together with the department leaders, come to solutions and then be able to follow those solutions through. I would be able to help the department leaders much more with these challenges, and other possibilities, instead of just being a part in the communication chain; receiving instructions from above and then just passing them on to the department leaders (...) For example, a few years ago I took over control of a nursing home that went over its budget by three million, and had a history of this in previous years too. Then I thought, if we are going to fix this we need to do this, and this, and this; we need to look at every little half hour and every 15 minutes. Then you have to stand in front of the employees and be prepared to be yelled at, and shouted at, and given dirty looks, but still be able to use that creativeness and find solutions .But now the programme is so packed, there are a lot of meetings, you're supposed to be involved in loads of decision processes, so you can get dragged into those arenas, instead of being able to focus on the actual running of the nursing homes (...) So sometimes I wish someone would just make the decisions (...) for example, with the dinner that was moved to three thirty, we didn't really need to spend a year going through different processes in every single nursing home, making sure that everyone was involved. If we didn't have to do all this, or as much of it, then I could spend more time actually working in a more hands-on way to improve my nursing homes (District leader 2).

The narrative from this district leader would indicate that department leaders are to a larger degree than these district leaders would like, expected to handle issues and implementations, single-handedly. That district leaders are also governed by those 'above', however, being in a middle position, must also take part in the governing by passing on directives to their department leaders so that a 'chain of governance' is created. District leaders need to prioritise meetings and administrative work, resulting in them being, to a certain extent

'removed' from their employees, which again results in department leaders being more alone in the department. The department leaders echoed this sentiment. One explained that she felt more and more removed from the day-to-day going-ons in her nursing home:

> *As a department leader today you're removed from the employees, removed from how they work, and specifically what they're doing (...) This is difficult for me, so sometimes I try to take some hours off and join them 'on the floor', to see how they work (...) I haven't actually had time to do this at this new nursing home but it's in the back of my mind all the time* (Department leader 1).

She explained that she wanted to do this because then she would be able to get a realistic view of what really went on and how things were done. She also pointed out that she thought this would help her build good relationships with her employees; showing that she cared and that she, herself, felt the pressures that her employees experienced. As she also said this could help her work on a strategy for improvement; "do we actually have the right people in the right places at the right times?" (Department leader 1). She also spoke about having more time to be a leader which would enable her to follow things through. Sometimes she felt as though they just had to jump from one thing to the next:

> *It would be so much better if I had time to work on implementing things properly, to really follow it through, make sure that the red-thread was there all along, instead of employees just trying to make the best out of it, and then someone thinks, ok now we need to work on care-plans, and then suddenly now let's work on hygiene in the kitchen* (Department leader 1).

It can be construed that what this department leader was experiencing, was not so much the 'freedom to manage', but rather the 'restriction' caused by having to implement certain measures, receiving instructions from 'above', and at the same time being unable to implement them, or to follow them through in a fashion she was satisfied with, because of time pressures.

Another department leader explained how she felt that the amount of 'office work' she had to do compromised her relationship with her employees to an extent:

> *We have the mandatory employer - employee conversations of course, but I think the most important conversations are the informal ones, so I try to have an open door policy. I try but don't always succeed. I try to chat to them (the employees) and say*

> *'hello', because I feel it is important that I'm down in the department and not just shut up in my office. But a lot has changed since we started here 7 years ago. Then I had much more time to, for example, join the employees in caring for the patients, but now you get swallowed up by all the administrative things that need to be done. Before we had a 'unit-leader' as well as a department leader, who did lots of what we now have to do. So now, we department leaders have become more and more removed from our departments* (Department leader 2).

Before this management reform, in accordance with NPM ideals, was introduced into the public sector, there was a 'unit leader' for every house, or every institution, with one or more department leaders under them. This meant that the 'unit leader' was partly responsible for the running of things, the formal administrative processes, and departments leaders' main tasks were in looking after employees and ensuring a good quality care service. The administrative work that these 'unit leaders' were responsible for, have now, with the reforms, fallen to the department leaders, in addition to their previous tasks of looking after employees and ensuring good working routines and a good working environment. As the department leaders state, there is not time for everything. They felt that they must prioritise the formal, administrative work. The likely reason for this is; that it is this documentation and performance reporting functions that department leaders are judged by. It is by this documentation, and these results, that quality of the nursing home is measured. In other words, the governance principal wins out, resulting in leaders not having enough time to be 'on the floor' among their employees.

Structural and organisational changes in nursing homes

Extenuating circumstances have resulted in structural and organisational changes in nursing homes. These circumstances comprise the increasingly elderly population which is in need of care. This results in sicker patients in nursing homes because now only the 'sickest' and 'neediest' of patients gain access to nursing homes. In addition to this, nursing homes have found it difficult to recruit nurses, and while demands from patients have increased, budgets remain the same. These circumstances have led to changes in how department leaders need to organise and run their nursing homes, including changes in staff routines, effectivisation methods, as well as strategies designed to deal with the increased demands of patients as a result of them being more ill. These were issues that came through clearly in the interviews with department leaders and district leaders, as well as the care-workers. Naturally the different professions had different and varying experiences, understandings and opinions

surrounding these developments. Both the districts leaders' opinions and care-workers' experiences, paint a picture of what department leaders must navigate through.

Lack of nurses leads to structural changes

The district leaders and department leaders all expressed their frustration at not being able to employ enough nurses. This resulted in changes in the way shifts and task allocations were organised. One of the department leaders explained how she had one daytime nursing position that was not yet filled, and two out of three night positions un-filled. She was struggling to find suitable candidates. This meant that she needed to use a care-worker, or a care-assistant, to 'fill the hole' in the roster, which she found difficult because, as she stated; "there needs to be a certain amount of competence 'on the floor' and when these positions remain unfilled it creates so much extra work for me, I always need to make sure that there is at least one nurse available. They don't have to be physically at the nursing home, but they at least need to be reachable" (Department leader 3). This experience was echoed by the district leaders. One stated that "we've seen throughout the years that there have been fewer and fewer nurses applying for positions" (District leader 1). This mirrors the general opinion many have of work as a nurse in a nursing home being of low status. Newly educated nurses say they want least of all to work in elderly care (Dolonen 2016, Orupabo 2016).

In particular, employing nurses for night work had proven ever more difficult, resulting in district leaders having to find new solutions for department leaders to implement in their nursing homes. As one of the district leaders stated; "some changes are just forced upon us, we can't do magic making nurses just appear" (District leader 2). Here, she was referring to how they have had to restructure the way night shifts were organised, no longer being able to have one nurse, physically, at each nursing home. The nurses must now be shared between several nursing homes. One of the district leaders explained:

> *We had some difficulties concerning nurses in two of the nursing homes in my area. When the nurses were sick, or absent, or on holidays, we couldn't just hire a substitute, it really wasn't that simple. So we decided that since these two nursing homes were located quite close geographically, they could share a nurse. So the nursing home where there wasn't a nurse physically present, could call the nurse at the other nursing home and ask advice, or, if it was necessary, the nurse would take a taxi to the other nursing home, and a care-worker from that nursing home would take a taxi in the opposite direction to fill the place of the 'missing' nurse, so that there*

> *were always the correct number of employees 'on the floor' at all times* (District leader 2).

As this district leader also explained, this did not go down too well with all the employees. Some of the care-workers interviewed echoed this sentiment, as there had been talk of this arrangement being introduced to their workplace also. One of them was quite sceptical, and thought it would mean that the quality of the care would be compromised:

> *Luckily this doesn't really concern me because I don't have night shifts but I'm very against having a nurse on some kind of emergency shift; someone who is located far away from our nursing home. It takes 20 minutes to drive from there to here! So what if something bad happens and it takes too long for the nurse to get here. No, it's just not good enough it really isn't* (Care-worker 1).

Basically, what was happening here was that there was a lack of nurses in this municipality who were willing to work in nursing homes, especially at night. As this was something which effected the whole municipality the district leaders had to restructure the way the night shifts were organised; giving care-workers more responsibilities, in the absence of a nurse being physically at the nursing home. District leaders told their department leaders that this is what needed to be done. The department leaders were then the ones who were actually going to implement this in their nursing home. It is therefore possible to assume that department leaders were forced into a 'squeezed' position. They must meet the requirements of the district leaders, especially in economic terms: Being able to share one nurse amongst several departments is cheaper than having one nurse in every department. However, department leaders are also responsible for their employees. They need to create a good working environment where employees are able to cope with the tasks that need to be done.

Department leaders need to mobilise and engage staff into creating a good care service. However, this task would be increasingly difficult when staff were under the impression that the care they were able to give patients in nursing homes had become, to a larger extent, irresponsible and unjustifiable. When employees experienced that their department leaders were no longer 'on their side', but rather represented demands from above, this had the potential to break down the trust between the department leader and their employees, and eventually lead to mistrust, thereby severely handicapping the department leader's ability to mobilise staff into providing good quality care.

The district leaders pointed out that this 'sharing of nurses' was something they also had to do, especially in small nursing homes during holidays and weekends, when ensuring nurse coverage was challenging. One department leader explained that since her department was linked with other departments, they were able to work together to solve the shortage of nurses problem:

> *We are a very large nursing home with different sections so I'm not the only department leader here, but yes, it can be challenging to ensure enough competence 'on the floor' especially on the weekends, but we make do, we're a large nursing home so we work together and are 'emergency backup' for each other, so I wouldn't say that we are irresponsible* (Department leader 2).

The conditions that these department leaders now found themselves in, with a short supply of nurses coupled with sicker, and therefore more demanding patients, meant that they must work co-operatively with other nursing homes and other department leaders in order to ensure enough competence 'on the floor'. In this case however, the term 'on the floor' is perhaps misleading, as it is exactly this aspect that this new re-structuring affects. That nurses were no longer *on* 'the floor', but rather could be *called to* 'the floor'.

Co-operation and flexibility

One of the consequences of the 'stay at home as long as possible' policy was that patients were now in nursing homes for shorter time periods than they used to be. One department leader explained:

> *Now that the patients live at home much longer than they used to because of the home help, when they do come to us, often via the short term nursing home, they are of course much sicker than the patients used to be, which means that they are much more 'needy', which, in turn, demands greater competence, especially nursing competence. Sometimes it is like we have become a sort of mini-hospital because this demands that we are able to be more flexible. For example, the average 'stay' here in the nursing home has become much shorter. We are witnessing more fluctuations; the patients come to us and stay with us for maybe six months before they die, and then straight away we get a new patient, so it demands a lot more. Before, the patients used to live at the nursing home for years and years and you could get to know them very well and have a good relationship with them. Now it demands a bit more, you have to constantly readjust yourself to new patients and everything that follows, so it really*

demands much more competence and knowledge than it did before (Department leader 1).

As this department leader pointed out, the government's policy of 'home as long as possible' has had profound consequences for nursing homes, as this policy is contributing to changing organisational structures in the nursing home. The department leaders also explained how this increased demand for competence has resulted in them wanting to change vacant 'care-worker' positions into 'nursing' positions, reflecting a national tendency, see Grimsrud (2017). However, recruiting nurses for these 'extra' nursing positions could prove challenging, as department leaders stated that they were already experiencing difficulty recruiting nurses for the *obligatory* nursing positions.

The new situation that these institutions found themselves in resulted in nursing homes and different departments having to co-operate. As one department leader said:

> *We have two departments here, the nursing home and the home-care department. Before, the home-care department used to belong to the home-help so the employees think of these two departments as two separate and very different things, so we are working on trying to get them to work together more and help each other. For example, in the evenings there's four in the nursing home and two in the care-home departments. With only two in the home-care department, they are very vulnerable, especially if something should happen. So we're hoping they can start to help each other* (Department leader 4).

In order to deal with the current situation, department leaders were trying to mobilise their employees to be better at working together, not just within one department but across departments. This idea of greater co-operation also came strongly from the district leaders who emphasised that as nursing homes will not be receiving any more funding, it is especially important that the employees can work together across departments, as well as across the different nursing homes. However, one of the district leaders explained that this can sometimes prove to be tricky, and that employees often resist:

> *Now nurses and care-workers in their contract... I say that they are employed in my area so I can move them here or there, but this isn't something that I do very lightly, but we need to be a bit more flexible, but then you've got the trade unions that come into the picture quite quickly to protect the employees. Sometimes I even think that the*

> *co-operation in one house seems to be difficult, like you've got one group there and one group here. For some of the employees just crossing the hall and working in the other group can be difficult. Some of them have even gotten a doctor's note for it. When this is what you're up against it can be very difficult to create a good problem-solving environment when employees are so focused on 'me, me, me'. It doesn't seem like it's always the clients that are the focus* (District leader 2).

This district leader emphasised that when they employed new nurses or care-workers, they specified that they were employed in 'her area' not at that one nursing home, which meant they could be expected to move locations if necessary. This new type of flexibility could perhaps make it even more difficult for department leaders to recruit and attract staff. By offering employment terms with a degree of insecurity connected to whether or not employees will need to change workplaces, could be seen as undesirable, resulting in potential staff seeking employment elsewhere.

Increased cooperation could prove to be a difficult task for department leaders to achieve if they did not have time to establish a good working and social environment 'on the floor' in their department.

Upgrading care-workers

The district leaders and department leaders were all very adamant about the need to concentrate on employee competence. They all point out that: "we now have to focus on employees' knowledge, we know we won't be getting any more funds, so we need to work with what we've got" (District leader 1).

All the department leaders explained that they were now focusing more and more on 'upgrading' their employees; that knowledge is central, and that they believe that by 'upgrading' care-workers (educating them, sending them on external courses, and internal courses often held by nurses employed at the nursing home) and giving them more responsibilities, that this could be a way of dealing with the growing number of patients who are significantly sicker than they used to be. One department leader talked about a dementia course, where employees learnt about dementia and how to behave amongst, and treat dementia patients. She pointed out that all her staff had taken this course. She was of the opinion that because they had managed to actively use this knowledge, it improved the quality of care. She explained:

> *We have seen great improvement after everyone finished the course about dementia. We now see the mistakes we used to make, for example; to start with, we had two kitchens next to each other with a sliding door in-between. This door was always open and we used to shout to each other and things, so yes we closed this door a couple of years ago so now the department is much more peaceful than it used to be. This also helps prevent patients becoming restless or agitated, thereby freeing time for other tasks* (Department leader 2).

One of the care-workers had a different take on the dementia course:

> *I like working here (in the nursing home) but sometimes it's very frustrating, for example, you learn how to do things, or how things should be done, but most of the time you don't actually have time to do it that way. For example, we had a dementia course were we learned how to shield a patient who was 'playing up'. These things that we learned sounded really great, but the fact is we don't have enough staff to be able to do it* (Care-worker 1).

It can be a difficult task for the department leaders to try to improve the quality of the care in their nursing homes, when those who are supposed to carry out that care, experience that they do not have enough time to be able to look after patients in the best possible way. That is, in the way they have learnt, through courses that department leaders have sent them on, with the goal of improving the quality of the care.

The fact that care-workers have been allowed, and given the responsibility for handing out patients' medicine (provided they have completed a medicine course) makes a real difference in the department. One department leader explained; "it makes everything a lot simpler and really takes pressure off the nurses, they have so many other things they need to be on top of" (Department leader 1). The care-workers interviewed, mostly stated that they did not mind handing out medicine. However, as some of the care-workers explained, that just because care-workers have done the medicine course it did not actually mean that everyone was prepared to use it. One of the care-workers explained that in her department, she was the only one of all of the care-workers who handed out medicine, even though the others used to do this and have done the medicine course. They said that they did not want to do it. This meant that when she was at work she was always the one who performed this task, otherwise it fell to the nurse on duty. The result being that nurses ended up with a task that the care-workers could have done.

It might be said that focusing on ‘upgrading’ employees could be rather pointless unless department leaders are able to *mobilise* them into using these ‘new’ skills.

Accountable care-workers

The fact that care-workers will have to start taking on more responsibility, is a fact that all the department leaders, and the district leaders, strongly pointed out. One department leader stated:

> *I think the care-workers need to be challenged a bit. Basically I think they need to take on a bit more responsibility because then you can get that feeling; it can feel very safe to just deal with the care side of things, but as soon as you are given some responsibilities, perhaps that now you need to keep track of something, or you are the one that needs to decide who should go where and do what. It can be all well and good to sit and discuss these things in a group but as soon as someone needs to take responsibility for the running of things so that the shift will go as well as possible… well I’m just saying we still have a lot of work left to do in this area* (Department leader 3).

Care-workers had also been given more documentation responsibility. The care-workers explained that they had been designated as the main contact person in regard to patients. Another change in responsibilities was that now there was one shift each day where a care-worker had extra responsibilities, the so-called ‘responsibility shift’. These responsibilities included administering medicine and the general oversight of the running of the nursing home on their shift. The older care-workers who were interviewed communicated that they did not particularly like having extra responsibility, as one care worker stated:

> *No I don’t like having more responsibility because if I, for example, work the evening shift and after I have gone home for the night, then I think about whether everyone has received their medicines, it’s a lot of responsibility. Sometimes when I am at home I need to call work. One time, for example, I had to call work at 2 am just to double check that one patient had received her medicine, so it’s actually a lot of responsibility. You are never really free from work. So I don’t want any more responsibility, no* (Care-worker 3).

The younger care-workers explained that they liked having more responsibility and having the 'responsibility shift', but that it depended on who you were working with that day; that if your co-workers were good at working together then it was much better.

The younger care-workers interviewed stated that they would welcome new tasks; that they would like to be able to do more than just hand out medicine; they would like to learn more. In fact, these care-workers liked to be able to 'shadow' nurses, when the nurses had the time, and were willing to learn how to do more 'complicated tasks': "Some of the nurses are really good at letting us tag along and watch, for example, if there is a wound that needs to be tended or changing catheters" (Care-worker 2), "the nurses want us to have more responsibilities too, like being able to tend to wounds and use Clexane" (Care-worker 4). These care-workers were waiting to do a course so that they would be able to give Clexane. This was something they have taken upon themselves and had asked the department leader if they could do this course.

It would seem that there was a different kind of attitude amongst the younger care-workers compared to the older ones. Where the older care-workers perhaps shied away from more responsibility, the younger ones welcomed it, and even sought it out. As the district leaders stated, there will not be resources for more staff in nursing homes, rather department leaders must use the staff they have in the best way possible to deal with the rising demands they face. Again, it is possible to claim that department leaders are squeezed between the demands of districts leaders (ie the municipality) and the feelings and experiences of their employees. The department leaders' task of engaging employees to take on more responsibilities could prove difficult, when employees are sceptical about being given more responsibility. However, having younger employees, such as those interviewed here, in the mix could perhaps help combat negative attitudes towards more responsibility, or help 'convince' other employees that learning new tasks can be exciting, as they (the young care-workers) themselves say. It would therefore seem important that department leaders were able to attract and keep employees such as these young care-workers.

Managing employees

Department leaders all stated that a tricky part of their job was in dealing with employees', constant 'nagging' about there not being enough staff 'on the floor'. The department leaders had to deal with this. All the care-workers interviewed explained that they felt like they did

not have enough time to get things done. They all spoke about their experience of the time pressures;

> *The most negative thing about working here is that we are always short staffed, too little staff and too little time(…)If we were better staffed then everyone could go home feeling that they had managed to do what they had set out to do. It would give a much better sense of satisfaction but that doesn't really happen any more. It's just like one of my colleagues said. I will always remember, it was quite funny, but quite sad too. She said that every afternoon when she gets in her car to drive home from work she needs to adjust the mirror down, because after a day of work she has become lower than she was when she got into her car that morning to come to work. I couldn't explain it any better. After work you feel completely drained of energy* (Care-worker 1).

The district leaders were, to a degree, on the opposite side of this position, communicating the policies that the municipality and central authority had decided upon, thereby putting department leaders in a tight position between employees experiencing staff shortages, and district leaders communicating that employees need to take on *more* responsibility and *more* tasks. The district leaders stated clearly that there would be no more resources, no more staff, but that department leaders would need to make do with the staff they had. The work tasks would, instead, need to be organised differently. The district leaders also stated that one of the most important qualities in a department leader was the ability to deal with employees; they especially focused on employees' demands for more staff. This was one of the main reasons department leaders resigned from their jobs, according to the district leaders. Sometimes department leaders were simply unable to deal with the pressure that employees put them under, concerning staffing levels. As one of the district leaders explained:

> *If you have a department leader who is unable to deal with his or her employees; if they have constant pressure from employees about being short-staffed, and the employees are not willing to change the way they work, or gain greater competence, and if the department leader is unable to stand up to them and push tactics or measures through, then they end up hiring extra staff. This leads to, firstly, the economy going 'overboard' and out of control. Then you end up with more dissatisfaction amongst the employees because staff cut-backs are necessary when the economy gets out of hand. This leads to a vicious cycle where some leaders think, 'I*

> *can't manage this'. So they give up, a new department leader comes in and the employees' demands are the same, saying; 'the last leader did this, added more staff etc'. So the vicious cycle continues… Now-a-days the employees have a lot of power* (District leader 2).

It would seem that department leaders also need to navigate through demands such as these. District leaders expect them to be strict with their employees, withstanding the pressure to increase staffing levels. Requiring them to push through other methods of organising the work, including finding 'time thieves' and effectivising tasks.

One of the department leaders explained that she found it difficult to deal with her employees at times. She pointed out that they tell her that they do not have enough time to do this and that and that they need extra staff. However, she said that she cannot know whether this is correct as she did not have time to be 'on the floor', to see for herself. So it was difficult for her to know the truth, and she needed to take the budget into consideration as well. To top it off she felt as though there were some issues with the culture and employees' attitudes, and therefore it was difficult for her to introduce changes and new ways of organising the work. She explained:

> *Employees can often get quite set in their ways; 'this is how we do it' kind of thing, and they aren't able to think differently, or consider that there may be other ways of doing things (…) For example I can come up with suggestions and it's like hitting a brick wall at times. In other places people's attitudes might be, for example, 'yes that sounds interesting', but here, sometimes I feel like some of them (the employees) are just against any sort of change. For example, when we started with the year rosters there was a lot of resistance to that, but that was a decision from above so there wasn't much I could do about it. So it's really not easy to manage all this sometimes* (Department leader 3).

This illustrates yet again the conflicting pressures that department leaders encounter. On one side there were directives from above that *must* be implemented, on the other side employees who were unwilling to change their routines.

Another department leader explained that her strategy for dealing with the employees was to have a firm grip on the budget. She had not used all of the money that was allocated. This meant that she was able to hire extra staff when she felt that it was most needed. However she

stressed the importance of making this a temporary measure and not putting on extra staff permanently:

> *For example I put on extra staff on the weekends, but I don't make this permanent on the roster, because then my employees will get used to it, and it's much more difficult to take something away than it is to give something. So that is why I do it like that. It is positive to be able to have control over your budget because then you can do things like that (...) In another department they have put extra staff on the roster, but because they then use more money than is allocated, they have had to cut back, which the staff are very opposed to, which then creates problems and dissatisfaction among the employees(...) So I think it is important to do exactly (the minimum of) what is required of us, and we can put on extra staff when we see fit* (Department leader 2).

This idea of only using the 'bare minimum' of obligatory staffing levels echoes the ideas of the 'just-in-time' principles from the private sector; "by avoiding tying up resources in storing what is not currently needed" (Hood 1991, p.12). This department leader is 'trimming fat' by only using the precise number of staff absolutely necessary to execute the care service. She explained that there was actually little talk about extra staffing in her department. She was of the opinion that this was because she held back, but when additional staff *really* were needed, she put on extra. She said that she trusted her employees, that when they said they needed more staff to deal with a patient, they actually meant it. It would seem that this department leader had managed to balance the demands from the district leader, ie keeping to budget, and at the same time she had maintained a certain status among her employees. By hiring extra staff when it was really needed she was showing that she was still on their (her employees) side, and listened to them when they explained that there was too much to do.

Another department leader felt that there was a constant 'nagging' about more staff amongst the employees. However, he explained that he had a few employees that he could trust to be able to differentiate between a 'constant' need for more staff, and when there were certain patients who demanded more staff. All the department leaders stated, however, that sometimes staffing numbers just really were inadequate. The budget did not always match the patients' needs. One of the department leaders explained that perhaps one patient needed a lot of care, for example, that two employees were required to get him, or her, ready in the morning, while another patient might only need looking in on. Yet these patients 'cost' the same. The department leaders received the same resources for all the patients. All the

department leaders explained that patients were getting more demanding in their care needs. There were fewer and fewer patients who were able to almost look after themselves. If budgets are not raised to match these developments, it is highly likely that department leaders will have greater difficulties when it comes to 'managing' their employees and their demands for more staff.

Involving the employees in decisions

One department leader in particular emphasised that she is working with lean tactics in order to improve the quality of care, and reduce expenditure:

> *At the other nursing home where I used to work I implemented a more long-term tactic in accordance with the lean principles. This is a special way of working with constantly improving things, the goal is to reduce, no, to increase the employees' wellbeing and connection or association to their workplace, as well as involving the employees to a larger degree, which can again result in lower sick absenteeism which can again contribute to being able to keep to budget. It's really a way of always looking for opportunities and possibilities of how one can best use the resources allocated in the most efficient way possible* (Department leader 1).

This means that as a department leader she was constantly in search of improvements, how to get the most care out of the resources she was given. She also said that she involved employees in analysing their own work routines, which got them on board with changing them. Her employees complained that patients did not get to eat breakfast until 11am; that they did not have enough staff to get everything done. Instead of 'giving' them extra staff, as the budget would not allow for this, she involved them in a process whereby they analysed everything they did in the mornings, found out how they spent their time and what were 'must' tasks, 'should' tasks and 'could' tasks.

This is in accordance with the lean ideals that one of the district leaders enthusiastically talked about. She explained that she visited another municipality where they had introduced these tactics to see how it was done. After this she had consultants from SINTEF (a research organisation) come in to explain and demonstrate how to do things. She stressed the importance of finding the 'time-thieves' and cutting out tasks that were not altogether necessary; explaining that employees needed to learn how to prioritise their time; to focus on 'sorting, systematisation, standardisation'. It might therefore be deduced that these lean methods were something that district leaders managed to 'sell', or convince their department

leaders of. When department leaders were faced with growing demands and tight budgets, lean methods could most definitely came across as an appealing strategy.

The department leader explained how it was much easier to get employees to change their routines when they themselves had been a part of the analysing process:

> *We found out that we wasted a lot of time on reports, and since the employees were involved in this process of analysing it was much easier to introduce changes when they themselves clearly saw that we spent too much time on reports. For example, reports from 7am till 7.30 am till 8 am which meant it was often 8.30 am when they actually started working. When they realised this we introduced a new way of doing the report* (Department leader 1).

The new way was that employees would use a white-board to go through the report. All the patients' names were on the board and next to them, either a 'zero' or a 'hook'. A zero meant that everything was normal, therefore there was no need to discuss this patient. A hook meant that something out of the ordinary had happened, and that this patient needed to be discussed. She explained:

> *It should be enough with five minutes for the report. The normal way of doing it is that everyone sits around the table and says things like: 'this patient was turned three times and the urine bag was emptied, there was 500ml', and this is repeated day in and day out, everything that's normal, or usual like this is repeated every day. So I said, ok lets not repeat all these things (…) so now we spend maybe two or three minutes on the report because this isn't some kind of emergency hospital, people live here over a longer period of time. Of course we need to be able to notice if someone becomes acutely ill or falls out of bed or something like that, but we can still notice that* (Department leader 1).

The conditions that department leaders faced demanded that they are able to 'create value'. When there were more tasks that needed to be done with the same numbers of staff, this required trying to create surplus value somehow, thereby freeing up time to be able to deal with the increase in tasks. This department leader chose to cut down on the report time, thereby freeing up time to be able to carry out the 'new' tasks that sicker patients demanded from nursing homes.

One care-worker explained how her department leader introduced lists that were to be given to the patients in the home-care department. On this list, it stated that staff were not to help patients with certain things like curling their hair, watering their plants etc. The department leader obviously deemed these things as unnecessary tasks which should not be prioritised. However as this care-worker explained; the employees often disregarded the list and tried not to let the patients see it, they did not have the heart to not help patients with their hair or make-up. As she explained:

> *Our department leader, I feel like he doesn't really support us, he doesn't listen to us; we say that we need to be more people at work, that we don't have enough time and the patients are not satisfied with the care, but he doesn't listen. Instead he just says that we shouldn't do this, or this, or this, but these are things that we have to do. When you work in the home-care department, we have to shower the patients and then put curlers in their hair. Well we don't have to, but we normally do it because there are patients who can't do it themselves. For example, make breakfast, shower, make the bed, water the plants and things we normally do if they ask us. How am I supposed to say that I don't have time? I don't dare to say that anyway. I just look at my watch and see that I have got 3 minutes and they ask me to do something and I just say ok, ok, yes that is fine, because maybe it's not so important for me, but it's important for the patient. But we don't have time to do everything. We are supposed to clean the floor too, but instead we prioritise the patient, but then their family comes and the floor is dirty and they say why isn't this being done? We are paying for this. We just don't have time to do it all. We tell the department leader but he does the opposite and cuts down on our tasks. If you come to a lady who has multiple sclerosis and can't do anything herself, and her family isn't able to come every week to help her, well then she is dependent on us, and if you put that list on the table in front of her, you feel really guilty. It makes you feel like a bad person. So we just put the list to one side and try not to let the patients see it. Of course to some patients we say, look you should try to do this yourself or perhaps your family could come and do this for you. But we can't say it to all patients and I think it is a real shame that our department leader won't listen to us. I hear about many other places where the department leaders and the employees work together to find solutions, but I feel at my workplace, it is kind of going in the other direction. Even though this is a home-care department, it is practically like a nursing home because the patients here actually need a lot of care. A*

> *lot of them can't go to the toilet without our help, and if you come to them and say sorry I can't help you because I don't have time, what kind of feeling does that give you? So I think it's a bit difficult. I wish that our department leader would listen to what we are saying instead of just saving, saving, saving. It is about human dignity, you know* (Care-worker 5).

The home-care department is the stage before patients are admitted to nursing homes, when they can no longer live alone in their own homes, but are not ill enough to be admitted to a nursing home. One could go so far as to claim that not prioritising, for example, patients hair, was in violation of the 'dignity guarantee' (*Verdighetsgarantien 2010*), a regulation aimed at ensuring a dignified and worthy 'old age' for patients in the municipalities care.

The care-workers disregard for this list is a clear example of a department leader not having the employees' support, resulting in a top-down management style and perhaps also, to a certain degree, a form of 'authoritarianism'. That, by 'forcing' tactics through without discussing these with employees, actually has no real effect on the way employees carry out their tasks. As this care-worker explained that she, and her colleagues did not have the heart to cut down on the tasks that they helped their patients with. It would seem that there was a mis-match between the department leaders goals and the goals of the care-workers. Arguably this mis-match can be construed as representing the inherit conflict between the budgetary demands (department leaders goals) and the patients' needs and demands (the care-workers goals).The department leader was focused on reaching economic and efficiency goals. The care-workers, the front-line workers, who execute the care, were focused on satisfying patients, as they are face to face with the patients, and it is they who must deal with misgivings or disappointment from the patients. It would seem that department leaders must be vigilant in gaining understanding into how their employees experience their work and what is important for them, otherwise situations such as this care-worker described, will most likely arise.

Creating a Good Working Environment

It is important that department leaders were able to handle conflict and tension amongst the staff. The district leaders stated this very clearly. When hiring department leaders they were, first of all, looking for people with good 'people skills' - other things can be learnt. According to them 'people skills' cannot be taught but are, rather, personal attributes: "It is so important that they (department leaders) are able to build good relationships with, and have a grip on

their employees. This is the most important quality in leaders" (District leader 1). This district leader explained that this is vital, especially in nursing homes because it is the employees that constitute the quality of care that the nursing home is able to provide. So, of course you want your employees to do the best that they can; "the employees are our main resource, if the employees are unable to work together, you might as well just forget the whole thing, it won't work" (District leader 1). And, it is the department leaders job to ensure that the employees *do* work well together.

Conflict and tensions among employees

All the department leaders had had their fair share of group conversations acting as negotiators, with employees coming to them with issues they had with other members of staff. One of them stated that it did not take much for a good working environment to go bad; "it only takes one rotten apple for the whole bunch to go bad! All it can take is one employee who is negative or something like that, who starts spreading bad vibes and then, when the damage is done, it is so much harder to un-do"(Department leader 3).

One of the care-workers explained that she experienced that her department was characterised by negativity. She spoke about one incident: "one time after I had been away sick for five weeks, I asked Mathilde if she could hand out the medicines tonight, since I hadn't been at work for such a long time, and she said: no, I can't be bothered, you have to do it" (Care-worker 2). This care-worker explained that she liked doing the medicine, but since she had been away from work for so long there could have been changes she was not aware of and wanted to 'get back into it' before having that responsibility again.

The care-workers explained that negativity in the workplace had an impact on their own attitudes towards working in the nursing homes:

> *If one of the others says something negative, and then you say something like: no worries we'll work it out and stuff like that, you know you try to be positive about it and then you just get back: no it won't work out. You just get more negativity thrown in your face (...) I mean I try to make the best out of a situation, but really it just makes you want to go down, take off your uniform, go home and wait for the day to be over. But now I've just tried to block it out so that I don't become negative too (...) When you're surrounded by people like that, you lose that spark, I feel like I lose a bit of life out of my body (...)it's really easy to become negative yourself when you're sitting with a group who are only negative (...) I've noticed that it's difficult to be that*

person that says; ok let's look at the positive side of things. It's really difficult when I feel like I'm the only one in the department that is able to see the positive side of things (Care-worker 2).

All the department leaders have had experience dealing with these kind of issues. One of the department leaders stated:

We have a challenge here with receiving clear messages about what the problem is. They (employees) often come to me and say 'this person and this person is difficult to work with' but this doesn't really tell me much. So for me to be able to do something about it, I need to get clear messages; what has happened and why, who is involved. It needs to be something a bit more concrete to be able to deal with the issue (Department leader 4).

It is clear that when department leaders were so far removed from the department or what actually goes on 'on the floor', it became difficult for them to get a grip on what had happened when conflicts and tension arose. When this is the case it could likely result in them being less able to deal with the situation in the best way possible.

Another department leader explained that she often had to act as mediator between employees who were in conflict. She stated that she tried to talk to her employees about gossiping, and that instead of gossiping it was better to go straight to the person and explain your misgivings in a nice way, instead of keeping it all bottled up inside. Or, as she had often experienced, employees had come to her and let out their frustrations about another employee but told her that 'she was not allowed to say anything'.

This then becomes a rather hopeless situation. However, they had been actively working on this in her department; being able to tell each other in a nice way if something was bothering them. Nevertheless, she explained that sometimes her negotiation did not really make things better, and that sometimes it was important to be firm: "I have to be very clear on the fact that I'm not siding with one over the other and I need to be a bit strict and say that 'you two have to work together, that means you need to find a way to solve this conflict, because you can't be shouting at each other in front of the patients, then you need to at least go out into the hall'"(Department leader 2).

While she laughed at this, she also explained that if she knew a conflict existed she would try to separate the concerned individuals into different groups so that they did not have to work

together, but underlined the fact that it was important that they understood that they needed to be civil towards each other. That while they would prefer to work in separate groups, they understood that they needed to be able to say 'hello' to each other:

> *It is extremely important that they are able to do so. If they can't do this, then they create a bad environment for the other employees too. So it's really important to be able to deal with these things as soon as possible. Obviously it's not all sunshine, but the most important thing is to take a hold of the problem at once* (Department leader 2).

Evidently, it was of vital importance that department leaders were able to pick up on, and deal with conflicts accordingly, before they spread and effected the entire department. However, this became increasingly difficult when the department leaders were absent from what went on 'on the floor'. One of the department leaders stated that she wished she had more time to be present in her department; then perhaps she would be able to deal with the issues before they became conflicts; "if I had more time out in the field I would be able to pick up on certain signals, how my employees were faring, whether there were tensions between employees that could cause conflict and thereby a bad working environment" (Department leader 2).

The ideal nurse – perceptions surrounding the role of nurses

The 'professional conflict' is a tension that department leaders have always had to deal with, as they themselves say; it is a classic dilemma. In the early 1990's, an attempt was made to combat the rigid hierarchical structure by the introduction of a flatter organisational structure in nursing homes and empowering the care-workers, and giving them more 'complicated' tasks (Rasmussen 2004, p.510). However, as both department leaders and district leaders stated: "we will be forced to organise the work differently in the future to use competencies in the most effective way" (District leader 2). They all stated that it was no longer affordable, for example, to have nurses washing the dishes. That even though there has been a political goal to have only skilled employees in nursing homes (Homme & Høst 2008, p.79), perhaps this is something that needs to be re-evaluated if nursing homes are going to continue to deliver quality care to the more sick patients, on the same budget. As one district leader pointed out:

> *There's always that old battle; which tasks nurses should do and which tasks care-workers should do. In the future I think this divide will become even sharper. We need to use the competence where it is most needed. This means that if you are lacking in*

> *nurses you can't use them to make sandwiches can you? No, obviously not, but we will also need to further develop care-workers. But they need to be willing, to take courses and take on more responsibilities. Also, I think we need to be able to dare to say that, actually, we do need care-assistants perhaps, to make the sandwiches and to do the dishes and these things* (District leader 2).

One department leader explained that previously nurses more or less had the oversight of everything happening in the department. He hoped that the care-workers would be able to take over this role in the future so that the nurses could concentrate on the growing amount of nursing tasks that needed doing (because of patients being more ill). This indicated that in the future the number of specialised nursing tasks that need to be performed in nursing homes would only increase.

Most of the care-workers interviewed explained that they preferred to work with other care-workers instead of nurses. They felt as though the nurses often just 'disappeared'. For example: "to be honest, in my department when we are three care-workers and one nurse, then in reality it's kind of like we are only three people at work, especially from ten o'clock to twelve o'clock, that's when the nurses are in the office ('*vaktrommet*') doing the stuff with the medicine" (Care-worker 4). The care-workers did acknowledge that the nurses have many responsibilities, but some of them felt as though they did not communicate with them well enough:

> *I think it really makes a difference that they say "now I'm going to do this, and this, and I'll be there, and there, because then you know, ok that's where they are. But in my department they don't do that. They just disappear out of the blue. Suddenly they are just gone and then you don't see them for two hours. Then you get annoyed because you can't find them, and they never come back, you know? It's really annoying (...) and then when you try to call them they don't pick up (...) it's almost a bit rude to say this but I think it's actually better for there to be only care-workers at work* (Care-worker 4).

Clearly these types of tensions were resulting in a bad working environment and obviously made co-operation between nurses and care workers difficult. This was something which department leaders had to actively deal with in order to prevent disharmony, and to try and ensure a good working environment, where teamwork and mutual support flourished.

The department leaders all confirmed that they experienced tension between nurses and care-workers around what nurses should be doing. As one of them explained:

> *There is a classic mentality, or attitude in nursing homes among care-workers, that the real work is the work that is done when you are with the patient preparing them for the day or putting them to bed etc. And that working in the office, writing reports or following up on certain things isn't… because it is a fact that now, more than before, there is a lot of documentation and administration work that the nurses need to do, which takes up a lot of time.. But I think there are many care-workers who perhaps don't acknowledge this as important work. That these are part of the nurses duties and will continue to be their responsibility. I think conflict is a very strong word but it's certainly something that is an issue which is discussed among the care-workers, like 'ooohhh they (the nurses) are sitting in the office again'* (Department leader 4).

This department leader explained that he tried to talk to the care-workers about their attitudes and thinking, explaining that preparing documentation is an important part of the job. He was however not certain that this had much effect; "mentalities are mentalities and not something that people can just change in a day" (Department leader 4).

Another department leader talked about a case in her nursing home where there had been quite a bit of gossip about one of the nurses, among the care-workers. Complaints that she did not do the dishes, or make the sandwiches. One of the care-workers thought she would tell the nurse that 'all' the other care-workers thought this. It resulted in this nurse not coming to work the next day and going on sick leave. The department leader explained:

> *So I drove straight to her (the nurses) house with flowers and called an emergency meeting a couple of days later and talked to the care-worker who had spoken to this nurse. In the end, the care-worker understood that she could not speak on behalf of others, but only on her own behalf. I also needed to clarify to my employees that, of course, Heidi (the nurse) wanted to do the laundry or make the sandwiches, as sometimes it can be nice, to take a break; to get away from the patients and do the laundry or to do cleaning. But she had other duties, and sometimes nurses have other things they need to do. I think it's really important that we dare to talk about the differences; that nurses and care-workers have different tasks, nurses have formal qualifications which they need to use sometimes. So I think most things can be*

resolved but it's very important to discuss things as soon as there is any gossip (Department leader 2).

It would seem that it was of vital importance for department leaders to be able to handle the tensions that arose between care-workers and nurses. Being able to provide a good care-service, especially with limited resources, department leaders would be completely dependent on having competent staff who work well together. Making sure that both care-workers and nurses are doing their tasks, and that both parties are able to understand each other, and the role the other plays, was vital. Department leaders had a key role in facilitating this. Again, this was dependent on the department leaders being aware of what was going on, which, with the principles of the governance aspect of professional management, was becoming increasingly difficult, as they were removed from the department 'floor'. Instead they were caught up in meetings and with administrative work. In the example above the department leader was not made aware of what had happened until after it was too late, until after the nurse had taken sick leave.

The tension between care-workers and nurses was perhaps heightened by the fact that now nursing homes were increasingly dependent on the skills of nurses. With patients being more ill than previously, more nurse skills were required. This was seen in how all of the department leaders interviewed, had either already converted positions from care-worker positions into nursing positions, or were waiting for a care-worker position to become available so they could convert it into a nursing position.

Previously, when nursing homes were perhaps more characterised as *homes*, as opposed to 'mini-hospitals' it was the care-workers who, overwhelmingly, made up the staff employed. With the new circumstances that Norway was facing; more elderly people, the policy of keeping them at home as long as possible, this was changing. The need for skilled nurses, and the importance of this competence, was becoming much clearer and more dominant in nursing homes. The way that department leaders deal with those changes and developments would have a considerable impact on their staffs' ability to work together as a united and coherent team.

It could be said that one way of doing this would be for department leaders to encourage, and facilitate sociability among employees at, and outside of work. This was something that all the interviewed employees were concerned with. That perhaps by meeting co-workers away from the stressful atmosphere at work, might help improve relations.

The desire for sociability

All of the care-workers interviewed expressed that they would like it if there was a bit more sociability at work, and outside of work. For example, occasionally having dinner together outside of work, or 'pay-day drinks' together. However, no one really took the initiative to start something like this, or to suggest it.

One of the care-workers explained that this sociability was very important to her when she was at work. She felt that when she was sociable at work and could chat with her co-workers, it put her in a good mood and that she worked better when she could meet the patients with a big smile. So, for her, the morning report where the employees drank a cup of coffee together for 15 minutes was very important. However, her employer had introduced a new way of doing the report which she meant took away a large part of the sociability at work. She explained that she felt that her employers often tried to 'cut out' the sociability. In one of the nursing homes where she used to work, her employer banned them from drinking coffee in the mornings *before* their shift started. She was absolutely confounded by this because they all had busy lives, with family obligations etc. so it was not easy to meet colleagues after work to socialise, so this cup of coffee before work was an important part in colleagues getting to know one another 'outside' of a working situation. She explained that these 'social moments' were important because then colleagues got to know and understand each other better, thereby creating a better social environment. She expressed her frustration with her current employer who had introduced a 'silent report':

> *Our department leader said that we shouldn't talk during the report! In the 7 years that I've been working here, we have always talked to each other about the patients for 15 minutes while we drink coffee. Our department leader introduced a silent report, so we would just read the report and pass it along without talking to each other. So everyone sits with a cup of coffee, completely silent, and reads. First one person then the next, then the next, and we just sit there looking at each other because we are not allowed to talk (...)I think this is really awful, the people here work so hard. Our job is mentally and physically challenging, and a coffee moment for 15 minutes doesn't take any time away from work. We still have enough time to do everything that needs to be done. We get to work at 7.30 am. You can't just run into the patient's rooms and drag them out of bed, so why do those 15 minutes matter so much for the department leader, where we sit and drink coffee for 15 minutes? It's almost like it's just to 'tick off' that we are saving money; that no one is to drink*

> *coffee; that we arrive at work and then run straight away to our departments and sit there and wait for the patients to wake up. What's the point? Why can't we use that time to drink coffee together and talk to each other? Then we can get a good start to the day. We get in a good mood. I think that is very important. (…) What is it that they are saving on? On coffee? On paper? What is it that they save by taking away that coffee moment? I think there is too little sociability at work. It's not because of this coffee moment that we don't have enough time to do everything. The reason why we don't have enough time occurs during the day, not in the mornings* (Care-worker 5).

Here it would seem that the department leader did not understand the employees' needs for sociability, or felt that he was unable to prioritise it. It would seem that the department leader was focused on reducing wasteful time or 'time-thieves', and viewed this sociability connected to the morning reports as a waste of time. Perhaps he was right, but at what cost? Perhaps it was this sociability in the mornings that contributed to the employees being able to work together and face the challenges ahead, in what we know, from previous research, is a stressful and time-pressured working environment; see Ingstad & Kvande (2011). Perhaps this coffee break helped employees cope with the stressful work situation. That it created a form of togetherness; that together they could manage the challenges that arose during the day, as opposed to thinking that they were on their own. In light of the fractiousness that often transpired between nurses and care-workers, one would think that this coherency was of vital importance, when trying to engage and motivate employees to create the best possible care service.

Again, there was a mis-match between the employees and the department leader. This mis-match could be caused by the department leaders' removal from 'the floor' of the department, as well as the pressures department leaders were under to stick to budget and report good results on tactics they implemented. When the budgets and performance reports gained priority it could seem that department leaders, to a certain degree, lost touch with what was important to their employees, what their employees appreciated, what made the work meaningful to them and what was happening in their lives. It could seem that department leaders were squeezed between employees' needs and budgetary demands.

‘Life is passing us by’

Young care-workers’ experience of shift work

This subchapter is based solely on the young care-workers I interviewed. What came across especially strongly were their thoughts, opinions and experiences concerning weekend-work; issues, it would seem, that department leaders were not aware of, as most attention concerning shift work was based on being adaptable to family life, not to the lives of young people.

The advantages and the disadvantages of shift work have been well documented. However, what came to light through my research was that the younger employees I interviewed, had other concerns regarding shift work, than the ‘typical’ family dilemma, see Bungum and Kvande (2002).

These care-workers explained how they had to work every second weekend. This was because they had positions that were only weekend positions, amounting to seventeen and sixteen percent, so that they were economically dependent on getting enough extra shifts. After a new law was passed, they were able to apply for (and claim) a larger permanent position, so that now they had a seventy percent position. They exclaimed that they had worked ‘their arses off’ for a year, saying ‘yes’ every time they were asked if they could work extra, and that they had practically no social life whatsoever that year. If they had made plans with friends and work called to ask if they could take an extra shift, they would always prioritise work in the hope of getting a larger position. Because they claimed the larger position (70 percent) based on their permanent weekend position they had to continue working every second weekend. Such unfavorable shift-work that these care-workers experienced is mirrored by Skoghaug (in Grimsrud 2017), the leader of the trade union, who states that it is care-workers and care-assistants that receive the majority of the undesirable shifts in nursing homes. This tendency is most likely due to the difficulties that department leaders are having in recruiting nurses, thereby offering nurses better employment terms in an effort to recruit them.

These young care-workers explained how this greatly affected their social life. As one of the care workers said:

> *Work actually really affects my social life, especially on the weekends when all my other friends are off work. It’s always the same; they ask me if I want to go out to eat, or go to a party, or something, and when I say I’m at work, they always say, ‘oh I thought so but I just wanted to ask to be polite’* (Care-worker 2).

They had tried hard to change their position to every third weekend, and had talked to their department leader about this. They had the impression, however, that they were not prioritised. For example, one of them found out that there was a position available for every third weekend. She had previously talked to the department leader about her situation, about wanting to change it, to which the department leader had told her that should a position become available, then she was at the top of the list. The position was, however, given to someone else, which was a great disappointment for this care-worker who felt that she was not being heard, or prioritised. One of them explained: "I actually think it is a bit too much to work seventy percent and work every second weekend as well. I feel like I'm practically living at work. I feel like work is my first home in a way" (Care-worker 4).

It would seem that the department leader did not understand these young care-workers' needs; what was important to them in their lives, or what gave their lives quality. There had been a lot of attention on parents and families, and how shift work can effect family life. This had perhaps resulted in employers having a greater understanding of, or perhaps prioritising those employees who were in a family situation, and had less understanding of young peoples' needs to, for example, go out partying (socialising) on a Saturday evening. As one of the care-workers said:

> *I feel like my weekends aren't taken into consideration at all. Before on my weekend shifts I would work during the day on Saturday then work the evening shift on Sunday. That meant that I could go out with my friends on Saturday night. But now I work either evening shift, then another evening shift, or a morning shift, then another morning shift. The evening shift finishes at around 10 or 11 pm so it's too late to go out then, and anyway I'm too exhausted after working that late. And I can't go out on Saturday if I have to be at work at 7.30 am on Sunday. So I don't really get to do anything fun at the weekends. It's like that for half of all the weekends in the entire year and that is actually quite a lot* (Care-worker 2).

Basically this meant that because of her every second weekend shift, she was only able to socialise half the amount that her other friends were, who did not work shift work. Both of the care-workers said that if something was not done about it they would resign; "it's not worth it".

For these young employees, going out and being social was an important part of their life. In Norwegian society there has been a large focus on families. Workplaces should be able to

prioritise and accommodate for employees to be able to have a family life. However, to put it bluntly, if these young care-workers were not able to socialise because their work shift would not allow for it, then perhaps they would never meet someone to have a family with!

These young care-workers were enthusiastic about their work and also eager to learn more and have greater responsibilities. They liked it when they got the chance to tag along with the nurses and learn how to do certain things, like putting in catheters. As one of the district leaders stated "we need freshly educated, young, enthusiastic care-workers working in our nursing homes. We need care-workers who are willing to learn new things and willing to take more responsibility" (District leader 2). However, if this was to be done successfully it would seem important that department leaders were able to understand young people's needs, and what was important to them, thereby making employment in nursing homes attractive to them. It seemed that in this case quite the opposite was happening. By not considering the young employees' wishes, it seemed there was a good chance of this department leader losing them as employees.

Concluding discussion

I have analysed this research as a case of NPM, and found that it resulted in two main mechanisms. Firstly, budget parameters became 'sacred' and produced department leaders who viewed and organised the nursing home through 'economic and budgetary lenses'. Secondly, due to the governance aspect of professional management, they were removed from 'the floor', and were therefore unable to see the ramifications decisions made through these lenses had for employees' wellbeing and the care service that department leaders were responsible for.

The narratives presented in the preceding chapter can be described as being a consequence of these 'lenses'. In addition, due to the increasing demands for the services that nursing homes provided, the increase in the elderly population. Also, because patients were in need of higher medical nursing care, which department leaders were having difficulty ensuring. However, the analysis perhaps also revealed potential solutions to the quandaries for department leaders, by highlighting opportunities for the improvement of their employees' working conditions and, thereby, perhaps also for the improvement of the organisation of nursing homes overall.

The structural changes consisting of reforms in accordance with NPM; governing at arms-length, the 'purchaser – provider' model and professional management, were aimed at combatting these increasing demands. Those measures have had a profound effect on the way nursing homes were organised, and the role of the department leaders who were responsible for them.

These effects meant that budget became the department leaders' first priority. That is, because the governance aspect of professional management, including contractual management, wherein department leaders became *personally* responsible for staying within budget parameters. In addition to this, department leaders are now fulltime managers with documentation responsibilities, and performance reporting duties to those above them, resulting in them being removed from 'the floor', and their employees, in the day to day working life of the nursing homes.

The structural changes and the re-structured role of the department leader, have also had a profound impact on personnel policies and the nursing home as an organisation (ie the working and social environment), which, in turn, affected employees 'on the floor', and

created issues and dilemmas which department leaders had to deal with. In the preceding chapter, examples of these issues, and how department leaders, dealt with, or failed to deal with, them came to light. For example, care-workers explained how the working environment was characterised by negativity and the tension which existed between care-workers and nurses, surrounding the role of the nurse.

The social environment 'on the floor' – reactive rather than proactive department leaders

The preceding chapter evidenced that care-workers experienced horizontal tensions and conflicts, ie between fellow care-workers, in addition to vertical tensions and conflicts up, towards nurses, as well as, in some cases, department leaders.

The quality of the service that the nursing home is able to offer, is completely dependent on having good staff. It would therefore seem, as one of the district leaders also pointed out, that an important part of the department leaders' job was to mobilise employees into one coherent and cooperative workforce. For an organisation to function optimally employees must be able to cooperate to reach *common* goals, as Drucker (1993, p.48) illustrates; "by itself the tuba doesn't make music; only the orchestra does (…) They (the musicians) all subordinate their speciality to a common task". However, when there are fundamental differences between employees, this cooperation might prove difficult. Nursing homes are staffed by a small number of nurses and many more care-workers (Grimsrud 2017). The *many* care-workers are all on the same level; they are equal to each other, and cooperate in performing the same tasks, whereas the *few* nurses are segregated and divergent from the *many*, as they are often away from 'the floor' carrying out other particular tasks.

This contrast affects the level of interaction and cooperation between them. Naturally the care-workers cannot liaise and consult with the nurses in the way they do with each other. Neither is this the objective. Nurses have superior qualifications which lead to them being responsible for tasks that care-workers do not have the competence for. There is then, a hierarchy where some employees (nurses) are 'more important' than others, and have better employment terms (eg full-time positions, limits on weekend work) and higher salaries than those of the care-workers. Yet at the same time, care-workers were expected to take over some of the nurses' nursing responsibilities, to deal with the increased demands nursing homes faced. When department leaders found it difficult to recruit nurses, the solution was to 'upgrade' care-workers to be able to do some nursing tasks. When department leaders kept

these groups to such different employment conditions, they were, perhaps, partly responsible for creating the divide between them, which certainly does not contribute to constructing a better organisation. When these structural differences were present, together with, as we have seen, tight budgets, the result was that department leaders kept staff numbers down to a minimum. Obviously, tensions and conflicts arise when there are too many tasks to be shared by too few, and insufficient time to get through the work. Inevitably this effects the social environment 'on the floor' in nursing homes.

From the preceding chapter it is seen that care-workers preferred not to work with nurses because they 'disappeared' from 'the floor', thereby creating extra tasks for the care-workers. As we have also seen, gossiping and 'tittle-tattle' among the *many* care-workers took place and grumblings about the *few* nurses; about their absence and unwillingness to carry out tasks 'on the floor'. The fact that it was not made abundantly clear that nurses have other tasks to perform, especially when those tasks are not necessarily visible, (to the same degree as 'direct' patient care, eg getting patients dressed in the morning) was detrimental to perceptions. It gave rise to the misperception among care-workers that nurses often sit in the office for hours on end, while they (the care-workers) are 'running around like headless chickens' trying to get through all of the day's tasks.

This conflict can be said to be rooted in the inherent conflict between the medical aspect and the homely aspect of nursing homes, where nurses represent the medical, and care-workers the homely side of things. Nursing homes are located at the intersection between being a hospital and a home for their residents/patients (Vabø 2014). With squeezed budgets and sicker patients, it would seem that in the conflict between the 'medical' and the 'homely', the 'medical' wins out because, as the previous chapter indicated, the 'homely' can be labelled as 'could' tasks (because patients would survive without them). When time pressures are a constant reality, basically these tasks can be marked down in prioritisation. This was exemplified by the department leader who wanted to 'ban' employees from doing patients' hair in the mornings, in the home-care department.

These tensions and conflicts point to the importance of there being a good working and social environment amongst the groupings of colleagues. However, with these two professional groups being so distant from each other this could prove difficult. It also suggests the importance of a vigorous leader who is present within the environment, 'on the floor' and

capable of mobilising and motivating staff to work together (in spite of the structural tensions between them).

When department leaders were so far removed from what transpired on 'the floor', it was problematic because, as the preceding chapter illustrates, while department leaders may have been aware of problems and tensions which existed, they were unaware of the specifics. Getting to the root of the issue could therefore prove challenging. When this persists, situations such as nurses taking sick leave due to bullying can occur. In that circumstance the department leader involved was so far removed from her employees that she was unaware of the situation until the nurse failed to attend for work (thereby complicating the department leader's task of ensuring enough competence 'on the floor'). Thereafter, the department leader attempted to 'douse the fire' by holding emergency meetings with the effected nurse and other staff.

It might be concluded that because department leaders were subject to the consequences of professional management, fulfilling their contractual obligations in regard to budget parameters and performance reports, this results in them being so removed from 'the floor', that they were only able to 'extinguish fires'. That is, react when it was already too late, and not pre-emptively, by working on creating a good social environment. It would seem that it was difficult for department leaders to deal with this quandary efficiently when they were removed from what transpired 'on the floor', often resulting in them being reactive instead of proactive.

The ramifications of 'budgetary and transactional lenses' versus the possible potential of 'relational and reciprocity lenses'

The supremacy of budgetary parameters in controlling all aspects of a nursing home's organisation is unequivocal. This results in the issues and dilemmas which came to light in the previous chapter. On the one hand, the governance aspect of the 'new' management structure; removing department leaders from 'the floor', results in difficulties in attaining the goal of a coherent and motivated staff group. On the other hand, this 'new' management structure made it 'easier' to keep to budgetary goals, because it was the budget that mandated what could be done, and how. Conflict exists between keeping within budget parameters, (delegated down to department leaders through contractual management), and building a good organisation by 'investing' in employees, which requires department leaders who are present 'on the floor'.

The ramifications of this were that the constraints of budget were put ahead of the needs and the wellbeing of the employees. This, in turn, produced the less than satisfactory employment terms and conditions that staff in nursing homes were subjected to. Department leaders became pre-occupied with keeping within the budgetary parameters. They tried to avoid paying staff overtime, and reduced hours so that care-workers were kept in part-time positions. For example seventy percent positions; working every second weekend, and taking on extra shifts to make up to one hundred percent (and being able to live on their salary). This reflects a national trend: In the ten largest municipalities in Norway there were, altogether, ten full-time positions and fifty-one part-time positions vacant for care-workers. For nurses these figures were respectively, seventy-two and forty-four (Grimsrud 2017). When kept in part-time positions employees are easier to manoeuvre and manipulate to fit into a roster which is made to conform to budgetary parameters.

It is possible to claim that when department leaders organised their nursing homes, and employees through these 'economic and budgetary lenses' it results in the relationship between care-workers and the department leaders being characterised by a *transactional* contract, as opposed to a *relational* contract (Rousseau 1995). Rousseau (1995, p.90) emphasises that a contract is not just a formal legal document, but that it goes beyond this. That the employment relationship should be viewed as a social contract, a mutual relationship, where there also exists an organisational, social and psychological aspect regarding contracts in organisations. Transactional contracts and relational contracts are located at opposite poles. Transactional contracts focus on aspects such as monetisable exchanges, the use of wages as employees' primary incentive, the use of employees' existing skills, ie not prioritising employees' development (Rousseua 1995, p.91). At the other end of the spectrum, relational contracts focus on a high degree of mutual investment between employer and employee, resulting in a high exit threshold for employees in addition to aspects such as emotional involvement, including personal support and concern for family well-being, and being attentive to 'whole person relations', as with the facilitation for personal growth and development (Rousseau 1995, p.92).

'Economic and transactional lenses'

When department leaders' view of their employees was increasingly characterised by a transactional contract form, as a consequence of the department leaders' re-structured roles and their increased focus on budget, making up the 'economic and transactional lenses' they were forced to wear, it results in them *calculating* which employees can do what: How large

their positions have to be, who can be offered extra shifts ('how much can I save by doing this'), and so on. Consequently, rosters were put together based on what was best for the economy, ie what the budget allowed, and the employees simply had to deal with what they were handed. As was seen in the preceding chapter, the young care-workers received shifts on the basis of what was best for the budget, not what was best for their *lives*. Through this 'economic and transactional' prism, there can be a tendency to view staff as an expense; an expense which can be saved on by cutting back, for example, by reducing over-time.

When wearing such 'lenses' employees will tend to be viewed as mere cogs in the machinery that can be replaced by new employees. Accordingly, it is possible to claim that these young care-workers were viewed as 'super flexible' employees because department leaders were perhaps under the impression that they had no other commitments, ie family commitments, and could therefore be used to solve the 'roster equation'. By taking an instrumental view of employees, in line with the transactional contract, they might have been seen as, 'usable' and 'disposable'. This creates an employment relationship where an 'easy exit'(Roussuea 1995, p.97), is likely, as exemplified by the young care-workers interviewed. If their employment terms were not improved, they would resign. Unless this became a significant concern for department leaders, they would perhaps miss the opportunity, which was right in front of them, to retain these employees and might, at the same time, improve the quality of care in their nursing homes.

The previous chapter illustrated how care-workers felt there was no, or very little sociability in their workplace. Instead of encouraging it, the care-workers had the impression that department leaders were trying to eliminate it to create more value, (more time). It could be that department leaders relied too heavily on rational economic incentives being motivation enough for employees. This is in accordance with the transactional contract and its reliance on 'incentive pay' (Roussuea 1995, p.90). That is, that employees being paid was enough motivation to do a good job, ("a fair day's work for a fair day's pay") (Rousseau 1995, p.90), such that focusing on building and maintaining a better organisation, is not prioritised.

This evidences that department leaders' attitudes or perceptions of employees was perhaps being more influenced by a transactional contract rather than the relational contract. The consequence of moving away from the relational contract could lead to the failure to focus on building and maintaining an organisation. This had repercussions, as we have seen in the previous chapter; complaints about too little sociability, employees who do not know each

other, conflicts and tensions arising between nurses and care-workers so that cooperation became difficult. A lesser collaborative and collective atmosphere or climate (or esprit du corps), where staff became more focused on themselves, as exemplified by an answer one of the care-workers received from another care-worker "no I won't do that, that's your job". It would seem that the quandary for department leaders was that they could almost expect to be unable to create a good organisation with satisfied employees, when they had to constantly prioritise the budget.

When department leaders were so focused on keeping to budget, the result was that employees' wellbeing was seen as secondary to budget demands. One example was where department leaders sought to economise on time by banning 'coffee-time' in the mornings before the day-shift commenced, and cutting down on the time that was spent on the morning reports. It is possible to pose the question then: What if it was this 'coffee-time' that had the effect of banding the staff together, so as to be able to talk and plan ('how are we going to solve this… how can we do this better'), so that together, mobilised by the department leader, they could find solutions to the problems they faced.

What if department leaders wore 'relational and reciprocity lenses'?

The 'relational and reciprocity lenses' are based on Rousseau's (1995) work regarding relational contracts and the psychological contract, as well as Gouldner's (1960) 'norm of reciprocity' theory. The relational contract theory is based around the fact that organisations take care of their employees (Rousseau & Tijoriwala 1998). Peter Drucker (1993, p.59) also advocates for the strategy of organisations 'investing' in their employees, which will in turn create employees who are loyal and dedicated to the organisation. This 'give and take' element is based on the idea of 'the norm of reciprocity' (Gouldner 1960). Two parts engage in an exchange which is mutually beneficial. That what the organisation demands of its employees should match and be linked to the career and personal development opportunities the employees have, through their employment situation (Rousseau & Tijoriwala 1998, p.680). By investing in employees, the organisation gains something in return, and vice versa.

When employees experience that the organisation appreciates them, invests in them, and prioritises them, they are, in return, willing to invest their loyalty and work *for* and *with* the organisation. However, it is important to remember that this is a reciprocal or mutual relationship and it is in this reciprocity that the employees' 'willingness' to participate is created. "The norm (of reciprocity) may lead individuals to establish relations only, or

primarily, with those who can reciprocate, thus inducing neglect of the needs of those unable to do so" (Gouldner 1960, p.178). This means that reciprocation can fracture if the mutuality in demands and rewards does not match up. They are broken if the organisation is unable to deliver the 'rewards' that the employees expect, and view as just and fair in accordance with the psychological contract (Rousseau & Tirjoriwala 1998, p.680). Perhaps if department leaders could wear 'relational and reciprocity lenses' it might enable them, to take employees' well-being and needs into consideration, to a greater extent thus creating loyal and invested employees. In turn, this could perhaps facilitate department leaders being able, to a greater degree, to utilize employees' motivation for the meaningful job of helping and caring for elderly people in the final stages of their lives, as dedicated employees working *for* and *with* the organisation.

To be able to enter into this 'norm of reciprocity', it would seem apparent that the reciprocating parts must have something to exchange, which the other part is willing to accept (Goulder 1960). It can also be assumed then, that a precondition for this is that the reciprocating parts *know* what the other part will accept. Translated to the situations illustrated in the preceding chapter, arguably the department leaders in the case of, for example, the young care-workers, had nothing to exchange because they did not know what these employees valued.

When interviewing these young care-workers it came to light that, for them, being social with their friends on a Saturday night, and going out partying, was an important part of their life, and what gave *their* life enjoyment and quality. Getting to really know their employees, however, was difficult when department leaders did not have enough time to spend amongst them. District leaders put substantial emphasis on the fact that when they recruited department leaders, they were looking for people with superior interpersonal skills. But as shown in the preceding chapter, when department leaders were forced to wear 'budgetary and transactional lenses' they were unable to utilize their interpersonal skills to their full potential.

When department leaders have too little time to be amongst their employees, due to the growing amount of control, documentation and performance reporting that is required to fulfil the governance aspect of professional management, building these relationships becomes difficult. Thus, the situation is one which contradicts the reciprocal model. It is therefore possible to claim that the current personnel policies evidenced in the preceding chapter, were perhaps preventing the 'norm of reciprocity' and the relational contract. Thus, department

leaders could lose these employees because of the personnel policies which were characterised by transactional contracts. The loss of these employees to the nursing home could mean the loss of a potential part of the solution to the welfare conundrum facing Norway. That potential solution perhaps being; young care-workers who were willing, and who sought opportunities to learn new 'nursing tasks' and take on new responsibilities.

With the competence dilemma that department leaders found themselves in, it would be of some importance to be able to retain these employees. Perhaps if department leaders were able to remove their 'budgetary and transactional lenses' and replace them with 'relational and reciprocity lenses', this might be achieved. Perhaps these new 'lenses' would enable department leaders to invest in their employees by viewing them as 'whole persons' and having time to be concerned for their wellbeing, rather than just using them and viewing them as an expense to be economised on. Perhaps these 'relational and reciprocity lenses' would enable department leaders to, for example, invest in their care-workers by giving them fulltime positions, and facilitating for their young care-workers having a functioning social life alongside their employment and career. Listening to their needs and *understanding* what is important to *them*. It might seem trivial and unimportant to the 'adult' department leaders, however it was not how these young people experienced them.

At the present time, it would seem that the ramifications of the structural changes introduced in accordance with NPM (governing at arms-length, purchaser-provider model and professional management) resulted in budget demands gaining priority over all else, thereby preventing department leaders from putting on 'relational and reciprocity lenses'. It would seem therefore that, the quandary department leaders found themselves in, is as to prioritising employees' needs, preferences, and wellbeing or, alternatively, adhering to budgetary demands and dictates. The outcome evidenced by this research was that the prioritisation of budget has won out.

Time to step out of this 'economic rationality cage'?

The conditions found in this research, can be described as being the result of the structural developments in society, the increasing demands on the elderly care service. The way society has chosen to deal with these developments has been to introduce tactics based on the ideas of NPM. In other words, this is a system that *we* have created. The 'purchaser – provider' model is, for example, not a 'god-given' law. It has not been *forced* upon us. Rather, it is a *means* we have chosen to reach the *goal* of a better elderly care service.

But does the 'purchaser – provider' model fulfil its goal of creating a better care service? According to this research the answer is 'no'. Paradoxically, it would seem that somewhere along the way the means has become more important than the goal, or the end itself. Thus, the means has become an end in itself, resulting in budget parameters becoming 'sacred', and 'untouchable'. This has caused department leaders to keep employees in part-time positions, as part of a strategy to ensure flexibility and attempting to produce services as cheaply as possible to keep within budgetary parameters. However 'as cheap as possible' does not translate to 'best as possible' but rather amounts to 'good enough'. It allows the nursing home to function but this practice has also had consequences, some of which came to light in this research.

We have created things this way. This also means that we can change it! For too long the economists have taken precedence over all else when it comes to commenting upon, and influencing aspects of society today – and telling us how things should be done. However, if everything is seen through 'economy-lenses', what kind of society will we end up living in? Norway is known for its egalitarian character and principles, for example, the social democratic welfare regime (Esping-Andersen 1990), of which the elderly care sector and nursing homes are a part. If it is only to be the economic perspective that wins out and shapes our society, how long will this egalitarianism last? Perhaps it is time the sociologists and kindred professions spoke out more loudly and clearly concerning developments in society.

Of course, having control over the economy is vital. It is, after all what *enables* us to provide a health care service in the first place. But if it is only the economic perspective that is given primacy, severe and undesirable consequences could follow, including, as we have seen in the research presented here, budgets gaining priority at the expense of patients and staff in nursing homes, economic and administrative tasks gaining priority over 'human' tasks, and deeming certain tasks which might add value to patients' lives as 'could' tasks.

In addition, department leaders who became too busy *proving* to central authorities that they were doing their job, of providing a quality care service, because central authorities did not *trust* them. Because of this department leaders, paradoxically, did not have time to do their job properly, having to downgrade their employees' wellbeing in their prioritisation. The work of documentation, performance reporting and administrative tasks are not required as some kind of 'universal law', but rather to fulfill a *need* that has been *created* through the implementation of the structural changes that occurred with the introduction of NPM.

Not only has economic rationality gained hegemony in the elderly care sector, but also in the education system. The fact that Norway is now, to a certain extent, *socialising* children into this economic rationality is a frightening thought, and perhaps makes the future appear bleak. It is high time that this economic perspective was nuanced by other perspectives. It is high time that we stepped out of this 'economic rationality cage' that economists and politicians have put us in.

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Attachment #1: Interview guide, Department leaders

Struktur

Hva er din rolle?

- Hvem er 'under' & 'over' deg?

Dine ansvarsområder?

- Økonomi → fordeling
- Hvem kan justere på budsjett?
- Hvem er det som fordeler økonomien, hvem er det som må passe på økonomien og holde igjen, hvem kan justere, og hvem er det som ansetter? Hvem er det som bestemmer hvem som skal ansettes? (økonomi er jo folk)

Endringene → helse sektoren har endret & er i endring

- Hva?
- Hvordan virker det?
- Påvirker din jobb?

Samhandlingsreformen (mini-sykehus; fordi sent ut tidligere)

- Hvordan er det her? Hva skjer når pasientene kommer ut av sykehuset?
- Hva tenker du om det?

Bemanning

Hvem er det som ansetter, deg? Regionssleder?

- Hva er din rolle i denne prosessen?

Hva gjør du får å klare å ha nok folk på jobb og nok kompetanse på jobb?

Hvem rekrutteres?

- Hva vil dere ha? Hvorfor?

Stillings størrelse

- Fast/løst
- Prosent

Sykepleier: vil ikke inn i sykehjem – hva gjør dere for å få tak i dem?

- Praksisplass, stipend + bindingstid, sommer jobb, ekstra ansvar m.m
- Hvilket signaler sender dette til hjelpepleierene?

Helsefagarbeidere

- Trondheim → introduksjonsprogrammet→ aktiv rekrutering av innvandrere til helse og sosial.

Personal politikk
Blir folk værende eller gjennomtrekk?

Hvordan beholder man de ansatte?

Innvandrere

- Jeg hadde egentlig tenkt å intervju innvandrere men da jeg kom tilbake til min gamle jobb, var det bare 4 igjen, alle de andre hadde sluttet. Hvordan er dette hos dere?

Avdelingsleder som personal leder

- Hva legger du i dette?
- Hvordan blir nyutdannede ansatte lært opp?

Videreutvikling? Slik at ansatte ikke går lei av jobben.

- Faglig veiledning?
- Helsefag arbeidere får lære nye ting, utvikle seg, eg medisinkurs

Forutsigbarhet/ekstra vakter? Helårsplan?

- Tar hensyn til ansattes liv utenfor jobb osv?

Helg → problematisk å få dekket med nok kompetanse?

- Hvorfor/hvorfor ikke? (sykepleier får mindre helg → må bli dekket av andre).

Sykepleiere vs hjelpepleiere → konflikt?

Hvor er du om 5 år?

Hvis du kunne bestemme hvordan denne jobben skulle vært hadde den vært annerledes da?

- Hvordan/hvorfor?

Kunne du tenkt deg å være regionsleder?

- Hvorfor/hvorfor ikke?

Attachment # 2 : Interview guide, Care-workers

Stilling

- Hvor lenge har du jobbet på sykehjem?
- Hvilken stilling har du?
- Utdanning?

Hvilken muligheter har du?

- Videreutdanning?
- Utfordrerne?
- Liker du å arbeide på dette sykehjemmet? Hvorfor/hvorfor ikke?
- Føler du at du får nok til å leve av?
- Trives du her? Hvorfor/hvorfor ikke?

Positive og negative aspekter ved å jobbe her?

Forholdene på arbeidsplassen?

Blir folk i denne jobben? Utskiftning/ gjennomtrekk

- Hva mener du burde bli gjort for at sykehjemmet skal klare å holde på folk?

Hvordan fungerer fellespausene?

Har du noen eksempler på positive tiltak som har gjort at du trives bedre med jobben?

Hvor er du om 5 år?

Hvis du kunne bestemme hvordan denne jobben skulle vært hadde den vært annerledes da?

- Hvordan/hvorfor?
- Mer eller mindre ansvar?