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Paper for the 8th International Conference in Critical Management Studies:

Continuity and change in Norwegian Nursing homes: an example from a long-term study in an urban home.

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Introduction

This paper discusses to what extent continuity or change characterizes recent development of Norwegian nursing homes, focusing on organizational and architectural development of these institutions. While home-based care is increasingly developed in the municipalities, nursing homes play a more significant role in the care for the elderly sick in Norway than in most other European countries (Statistics Norway 2007). Care for elderly sick in medically specialized hospital settings, though, is less pronounced in Norway than in the rest of Europe. Hence the care for elderly sick may be said to be less a part of high-tech medical surroundings and more decentralized in Norway than in the bulk of European countries, with most nursing homes close to the home communities of the patients. This is a challenge both economically and in terms of infrastructure with regard to the sparse and dispersed population of Norway. How this challenge is met, has been changing during the latest two decades. To some extent, governmental responses at state and municipal level seem to be affiliated with trends linked to New public management (NPM) (Christensen & Syltevik 1999), aimed at making the long-term residential care more cost efficient. Other changes, like changes in the architecture and physical outline in the facilities, are rather costly and may be driven by other forces (Jacobsen & Mekki 2011).

Care in nursing homes takes place within the frames of architectural and physical surroundings where these surrounding constitute an important dimension in how care is realized and practiced each and every day. Even though the internal and external physical surroundings, routines linked to place and physical space and staff culture varies somewhat between individual nursing homes in Norway, there also exist marked similarities between the nursing homes. Moreover, although some important changes have taken place with regard to architectural outline and financial and organizational models in the latter decades in Norway,

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still pronounced continuities exist. Based on ethnographic fieldwork, this presentation in particular focuses on continuity and changes in one urban nursing home throughout more than 20 years since 1988, a time span which includes a rebuilding of the institution in 2003.

Architecture and physical surroundings

Ward architecture

The architecture and physical outline of the bulk of Norwegian nursing homes have changed substantially toward an architecture less based on traditional hospital architecture than before, a more familiar physical outline for the elderly, from wards of 20-30 beds to smaller wards of 7-10 beds, and from double or triple occupancies to singular occupancies and more use of patients' own furniture in their rooms (Jacobsen 2005, 2010). Presently, most nursing home wards are small and around 95% of the resident rooms are singular occupancies (Statistics Norway 2012). Routines, resident-staff interaction and social life in general seem to have changed in line with those changes, for good and for worse.

The nursing home in focus in this paper used to have two larger wards on two different floors, both with 29 residents. The resident rooms, several of them double occupancies, were situated along two longer hospital-like white corridors with the one perpendicular on the other. Where they met, the nurses' station was situated, with two larger windows facing both corridors. After the rebuilding of the institution in 2003, three new wards have been constructed out of each of the old wards, with eight, nine and ten residents in each.

During the fieldwork period in 2004, staff members with more than 10 years length of service now and then commented on the differences between the "old" environment and routines and the changed environment and practices after the rebuilding in 2003. In their view, more changes have been for the good than for the worse (Jacobsen 2005, 2008a). Interestingly, views on changes for the good were frequently expressed though admitting being ashamed of earlier practices related to the previous physical environment, like not knocking on the doors of the residents before entering their private rooms. The doors to the residents' rooms at that time were all similar in color and way of function, being impossible to lock and possible to open without turning a handle. This meant that when staff members with a lapful of clothes and equipment aimed to enter a resident room, they were able to open the door by a kick by the foot, a practice which was frequently observed during the first period of fieldwork during

1988-1989. This practice is not possible any longer with new doors which have proper door handles and are also possible to lock with a key. Moreover, during fieldworks after the rebuilding, in 2003 and 2012-13, it was observed that knocking the door before entering a resident room seems the common practice, where some staff members even take pains to wait for some seconds after knocking on a resident door before entering the room.

The change in use and outline of private spaces of the residents, even including the shape of the doors, seem to have enhanced a behavior where residents' personal space is more respected. Besides every room now being a singular occupancy and inclusion of private furniture and personal belongings being encouraged, each resident room also features an important trait of Norwegians homes, whether houses or apartments, namely a proper hallway. Territorial exclusivity and control in the Norwegian society, like in several (but not all) societies, seem very much linked to controlling the hallway (Jacobsen 2008b).

Another visible change in staff routines relates to the organization of care work. Prior to the rebuilding of the facility, the long corridors made possible quite apparent physical signs of how care work was planned for. Light signals outside each resident room were of two main kinds, with white light signaling that a staff member was helping a resident inside the room, and a red light being a sign that the resident was in need of assistance. In order to indicate to the general staff that a staff member was busy inside a given resident room, a white light visible from the nurses' station and along the whole corridor was one way of making this clear.

Another means of achieving the same aim, in the case that the resident was using a wheelchair, which was the case of more than 70% of the residents during first period of fieldwork, was to put the resident and the wheelchair adjacent to the door of the resident's room prior to helping the resident to bed in the evening (Jacobsen 2005). As an example, if one staff member had the responsibility to help five residents to go to bed, the staff member could place all five residents nearby their respective rooms and turn on the white light in each room. In this way the staff member provided a strong signal toward his or her co-workers of the willingness to work as least as hard as the other colleagues. This practice, which was frequently observed during the first period of fieldwork, was naturally posed quite a strain on the residents having to wait longest for help. After the rebuilding of the facility, with smaller wards and shorter and in some cases corridors with a curved shape, this practice was neither functional nor possible. This previous practice is a typical example of a practice which staff

members who have served for some years remember with a feeling of shame, a practice which earlier served as a clear sign of reliability and inter-staff loyalty in the face of severe lack of personnel resources (ibid.).

Obviously, the new architectural trend, where singular occupancies and small wards are the rule, may enhance staff routines more beneficial to nursing home residents. Still, there may also be downsides to this development. While “small is beautiful” in terms of ward size relates to modern concepts like “dementia friendly wards” (Ministry of Health and Care Services 2012-2013), this development could also have some disadvantages. As an example, provided that the assumption that around 80 % of the Norwegian nursing home residents are living with dementia (Selbæk et al. 2007), a resident with no cognitive impairment will meet a challenge trying to find another resident in the same situation to talk to in a ward of 8-10 residents. Two assistant occupational therapists at the nursing home pointed out, during interviews in 2004, that the social life of the residents has become more impoverished since the 2003 rebuilding. Several staff members voiced the same opinion with regard to staff social life, that the size of the staff community present at any given time was too small for meaningful staff socialization and that exclusive territories for staff, not the least the nurses’ station, have been reduced to almost nothing (Jacobsen 2008).

Neighborhood and physical surroundings

There has moreover been an increasing stress on the qualities of the near surrounding of the nursing home (Akre & Hauan 2009), not the least related to establishment of so-called sensory gardens, representing a type of green environment easily accessible to people with disabilities and stimulating for persons with dementia and other frail elderly persons. There is a growing public awareness as to the importance of the aesthetic and social qualities of built and natural and build environment of nursing homes, including the accessibility of shopping malls, cultural centers, restaurants, parks and more. Seemingly there has been a development toward an “opening up” of the previously somewhat isolated health institutions like nursing homes towards the wider society, although it is highly relevant to ask to what extent such a development has really taken place.

A study of 34 nursing homes in Western Norway in 2012 revealed a steadily increasing distance to public space and facilities by increasing year of construction since 1950. The distance is expressed both in absolute terms, as measured distance in km to a range of public facilities and spaces, and in terms of accessibility across physical and psychological barriers

like walls, stairways, roads carrying a lot of traffic and video supervised entrances (Jacobsen, unpublished paper). This finding supports the stance that despite the increasing consciousness with regard to the importance of public space and the near physical surroundings for the care of the frail institutionalized elderly, evident in governmental White papers (Ministry of Health and Care Services 2012-2013) and discourses in the Norwegian mass media, nursing homes seem to a decreasing extent well integrated into meaningful social and physical surroundings. Increasingly sensory gardens are part of the new constructions, or added to older ones. However, the sensory gardens are mostly secluded from the near surroundings of the nursing home by being walled in by parts of the building, fences and hedges.

The development of nursing homes in Norway is paradoxical in relation to how they interact with their neighborhoods and near surroundings. During the 50ies and 60ies the ideal nursing home was situated in areas characterized by “peace and quietness” (Hauge 2004). Still, nursing homes built in that period seem more well placed with regard to public and private services and access to public spaces. During the latter two decades, the official policy has been more in favor of integrating nursing homes into live and vibrant surroundings, event to the extent of combining shops, cinema, library, swimming pool and the like in the same building as the nursing home (Akre & Hauan 2009). Despite of this new ideological development, nursing homes seem increasingly isolated from a pulsating public life.

The nursing home mainly focused in this paper was initially constructed in 1977. Its relationship with the near surroundings is typical of nursing homes build in the 70ies, where public facilities and places are potentially more available to residents than in facilities built in more recent times, typically situated where land is not too expensive, frequently implying areas not centrally located with regard to public and commercial services. In some instances new nursing homes are even placed nearby areas of industrial wasteland. Still, the nursing home in case is less well situated relative to public facilities than nursing homes built in the 50ies and 60ies. This fact contributes to making the nursing homes more isolated from the society in general than before and hence possibly strengthening traits which may be related to what Erving Goffman (1962) labels “total institutions”, characterized by limited interaction between the “inside” and the “outside” of the institutions and by the related breakdown of spheres of residents’ daily life normally kept separate in so-called Western societies, where work activities, leisure activities and eating and sleeping are kept socially and territorially separate.

Change of routines, organization and management ideas

Several administrative NPM-inspired changes seemingly relate to all Norwegian public institutions, altering systems of reporting and accountability practices, and changing how actors tend to think about “quality”, “local influence”, “workplace democracy” and “empowerment” (Jacobsen 2007; James 1999). In nursing homes, the reorganization of staff routines has for some years followed an explicit aim of “decentralization”, where the rights and duties of each staff member is to be more specified and more authority and responsibility is to be achieved at the lowest possible administrative level in the institution. Part of this reorganizing concerns resident reports, where previous report meetings involving all care staff involved in overlapping works shifts are to be substituted by so-called “silent reports” where each individual health worker writes an electronic report on “her” or “his” residents, to be reviewed by the staff member taking over on the next working shift. Paradoxically such processes of decentralization seem to create a situation with more political influence from the top administration and the health authorities (Hamran 1996; Jacobsen 2005, 2007; Vike 2003). In line with this some of the staff members complain about the present administration both becoming increasingly powerful and larger, in share number of personnel, at the same time as the municipal authorities obtain more control over the administration of the institution.

Regarding systems of reporting, the decentralized responsibilities involve filling out a broad range of forms, with the professed aim of ensuring the quality of the care work (Vike 2003). During the fieldwork in 2004, courses were arranged for all personnel in permanent positions. The label of the courses was “quality enhancement” (“kvalitetsforbedring”) and was led by a private consultant, a nurse with a background in law and business administration, hired by the administration. The consultant introduced the course by presenting an account of how Japanese and, later, American car producers increased the amount and quality of their production by developing systems of “total quality management”, a system she wanted to implement in a somewhat modified version in the nursing home. A booklet of forms to fill out, on everything from deviation measurement (primarily focusing on administration of medication) to fire safety routines, was presented as tools for enhancing quality by systematically documenting all relevant dimensions of care, and as a management tool whereby achieved “quality points” translate into economic rewards for each ward and for the nursing home as a whole. The course took place over a period of several months, totaling approximately 20 hours of attendance for each staff members, an attendance not compensated

for economically. The completion of a course was a requirement for all staff members for continued employment.

The forms presented had illuminating names like “flow diagrams”, “fishbone diagrams”, “control diagrams” and “deviation measurements”. The consultant stressed the importance of starting out with forms where quality points were easiest to obtain, like the forms related to fire safety and medication security, providing statements like “ten out of twenty [possible points] means 50% quality”. She stressed repeatedly how the “customers”, the patients and their next-of-kin, increasingly expect quality and that a near foreseeable future will involve full “transparency” and informed choices whereby potential residents or a close relative may choose the nursing home with the better quality.

An important question to ask is of course, to what extent is the description of a new model of public governance a description of the reality in Norway, particularly in the care sector? Do health personnel do as expected? Are the new incentives working? At least so far, there are reasons for doubting at least that the health staff acts primarily according to the theories inherent in the new reform. The physicians, for example, still seem to act more (or at least as much) on the basis of a professional ethics meeting the greatest needs first and delivering just health care services (Lian 1996, 2003). And, to what extent and how are NPM inspired reforms in nursing homes reflected in the daily practices of the homes? There seems to be a significant degree of reluctance among nursing staff in nursing homes (Jacobsen 2005) (and in hospitals, see Bø 2007) with regard to following up on new reporting routines and new forms of work organization. This does not mean that the reform process do not show any significant results, to the contrary, an increased market for pro-profit organizations within the elderly care and public economic support of nursing homes based on results they can report (including so-called “quality points” based on specific new measurements) are two of several clear signs that the new policy is in some sense also working. Looking to countries like New Zealand, who started a similar reform process of the public health care system prior to Norway and where most of the elderly care sector is presently managed by for-profit, and mostly international, organizations (Harding & Lerdal 2005), there may still be other changes to expect in Norway in the long run which are not pronounced in the short run (Kuhnle 1994; Kildal & Kuhnle 2005). The point here is that health professionals and semi-professionals do not seem to fit the NPM theories, since their trade is also governed by a professional ethics and since they are continuously in close contact and hence influenced by their patients and their needs (Jacobsen 2008a; Lian 1996). Besides, they may as well be influenced by the very

nature of their work, in nursing homes much dominated by “bed and body work” (Jacobsen 2005). For this reason, the organization of care for the residents may have quite “old fashioned” qualities connected the dominantly non-specialized work and the rhythm of frail bodies (Hamran 1996) and the old established notions among professionals as well as the general public of what a nursing home is and ought to be (Jacobsen 2010).

In the case of the nursing home presented here, the positive and optimistic attitude of the consultant stood in stark contrast to the silence and the general lack of enthusiasm of the staff attending the course. Signs of resistance from staff were abundant, both at the course and afterwards, as staff members shared thoughts and experiences from the course with each other at the workplace. As one example, one auxiliary nurse once interrupted the consultant, asking her whether a form existed measuring the satisfaction of the residents with their meals. Her question provoked laughter from colleagues as it was plain and clear to everyone present that no such form existed and that the content of several of the available forms was in rather far removed from the major concerns in daily care work. The consultant, who showed signs of discomfort by the question, admitted that no such form existed. The auxiliary nurse did not give in and followed up by asking whether one or two items in one of the forms dealt with meals. Following another negative response, she added that to the further torment of the consultant that “you know, our ward is just like a scout camp, the meals are the most important happening of the day”. She added: “I don’t think that routines to prevent residents escaping and fire routines are on the top of the list of what preoccupies the next-of-kin. Such a resident [with such a priority] I have so far yet to meet”.

Among the staff at the wards, the quality enhancement program underwent a “quiet boycott”. Staff members were frequently voicing opinions like, “the more we fill in forms the less we have time for caring for the residents”, and, “if we fill in a vast pile of forms each day, who is to sort out the information? We know that the charge nurse is supposed to do that, but how can she? She hardly gets by with the workload she already has”. While one of the charge nurses was more optimistic with regard to the new management system and stated opinions like “finally we have the opportunity to render visible all the work we do to our top management and to our politicians”, the general staff doubted that the information would reach people in power.

There is a possibility that the daily reporting routines were implemented to a larger degree in some other nursing homes. In the nursing home portrayed in this paper, however,

there were few signs of the attempted reform being successful. The electronic work shift report was implemented though, but with a certain twitch. The staff combined making the nursing home administrators happy by adopting to electronic work shift reporting, at the same time as the “old” system of oral report meetings was continued.

Much more striking and pronounced than changes brought about by the new administrative changes were old established routines related to helping residents to raise in the morning and going to bed in the evening or late afternoon. Despite some observed changes in routines, some of them clearly to the benefit of the residents like knocking on the residents’ doors before entering, more generally most staff routines were easily recognizable at the institution focused in this paper throughout a period of 25 years. Some “old” routines appeared slightly transformed, like manners in which the staff related to visiting next-of-kin. While two decades ago strict visiting hours was the rule at the nursing home, there is more flexibility now where staff and next-of-kin negotiate time for visiting residents. Still, visits by next-of-kind is only to a limited extent links the nursing home environment to the wider society, as visitors are orally and in written form, by way of posters on the ward entrances, asked to not enter the common room out of respect for the staff and the other residents and to restrict their visit to the room of “their” resident (Jacobsen, unpublished paper).

Continuity and change in Norwegian nursing homes: some concluding remarks

As already mentioned, the organization of care for the residents seem to entail some “old fashioned” qualities related to human body rhythms, the predominantly non-specialized care work and ruling old established notions among professionals and lay people alike concerning the nature of nursing homes. Nursing homes appear as a “bracket” in the ordinary society where, as a most natural thing, the lives of the residents are administered by people not living at the institutions and where there is a need to maintain a, at the best semi-permeable, barrier between the institutions and the wider society. The same old die-hard notions of what a nursing home is may contribute to continuities in daily practices of the staff and administration, at different levels, which counteract both NPM reforms, on the one hand, and efforts toward the opening up of the institution to the wider society by conscious efforts in making the institution more home-like and by efforts aimed at integration with the built and natural surroundings of the nursing home, on the other hand. The barrier, physical, social and psychological, created between the institution and its surroundings, is mirrored by the strict routinization of the lives of the residents, a routinization neither in line with an ideology

stressing the homelike qualities of nursing homes nor with professional aims of care staff and medical staff. A logic of the “total institution” (Goffman 1962) seem to characterize the nursing home as much now, after architectural and managerial reforms, as before the reforms. By way of conclusion, although some important and notable changes in social life and daily care have been taking place in Norwegian nursing homes during the latter two decades, due to architectural and NPM inspired administrative changes, still continuities may be more important and pronounced than changes. This presentation focus on one particular nursing home followed up through several years. Other studies of Norwegian homes taking place after the introduction of architectural changes and the new management reforms and hence of more short-term duration, also in different ways point to the old-fashioned qualities of the organization and care work of the nursing homes (see e.g. Hauge 2004; Larsen 1999; Sandvoll 2012).

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