Institutional Work in a Palliative Unit: "There is Less Time for Patient Contact"

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Abstract

The encounter between divergent institutional logics may be challenging for nurses, since they must balance different expectations in their daily institutional work. These challenges increase when new reforms are introduced. Our research question is: How do actors linked to a palliative care unit experience the consequences of the Coordination reform in their daily performance of care work? Our study is based on a qualitative study in a palliative care unit in a nursing home where we interviewed patients, their relatives, and nurses/department leaders. Our findings show that by downgrading the professional logic because of the Coordination reform, the focus is on efficiency and budget instead of proper healthcare. This is not satisfactory for any of the actors in our study. We contribute to the research on the reforming of the healthcare sector by focusing on how different actors experienced day-to-day activities in a context where different institutional logics were involved.

Keywords

Institutional logics, institutional work, professionalism, professional value, reforms, palliative care unit, case study

Introduction

New public management (NPM) reforms have led to an increase in collaborative arrangements in the healthcare sector (Hyndman & Lapsley, 2016; Pollitt, 2016), which has resulted in a restructuring of the sector. Healthcare organisations have undergone managerial and organisational reforms worldwide (Malmmose, 2019), focusing on making services more efficient and effective (Hood, 1995). Concern has been raised as to why we are being blinded by managerial reforms involving more focus on efficiency and strong top-down management that leave little room for discretion and reflection based on professional values (Martinsen & Eriksson, 2009; Raffnsøe-Møller, 2011; Svensson & Karlsson, 2008; Wackerhausen, 2008). These managerial reforms have challenged healthcare practices, as well as competencies and ethical considerations (Fimreite & Lægreid, 2005). Changing a practice also means that professionals are given new tasks (Doolin, 2001).

The implementation of managerial reforms challenges the professional thinking that has developed over time in the health sector. Consequently, healthcare organisations have been confronted with competing values (Van der Wal et al., 2011), and diverging institutional logic (Jay, 2013; Olsen & Solstad, 2020; Pettersen & Solstad, 2014; Van den Broek et al., 2014; Wilkesmann et al., 2020). Institutional logics are "the socially constructed historical patterns of cultural symbols and material practices, assumptions, values and beliefs by which individuals produce and reproduce their material subsistence, organise time and space, and provide meaning to their daily activity" (Thornton et al., 2012, p. 51), and they focus on the more intangible aspects of work. According to this definition, institutional logic will be a link between individual cognition and socially constructed institutional practice.

The health sector is thus a context where multiple institutional logics exist (Reay & Hinings, 2005, 2009). The encounter between divergent institutional logics may be difficult for leaders and employees in healthcare because they must balance different expectations of how they should perceive practices, values and norms of behaviour (Greenwood et al., 2010; Greenwood et al., 2011). Several studies have been conducted on how leaders balance different logics in their everyday work in the health sector (e.g. Pettersen & Solstad, 2014; Wilkesmann et al., 2020). This study focuses on nurses, including those who were leaders in the palliative care unit we explored. We go beyond studies that focus on leaders and staff in healthcare by including relatives of severely ill patients and the patients themselves (Mæhre, 2017). We argue that when patients and relatives are excluded from research, only health professionals' understanding of the situation will be elucidated, not the views of those who experience the care. In line with this, our research question is: How do actors linked to a palliative care unit experience the consequences of the Coordination

reform in their daily performance of care work? The actors in our study are department leaders, nurses, patients, and relatives.

The context for the study is the introduction of the Coordination Reform in Norway in January 2012 (Meld. St. 47., 2008-2009), which entailed a comprehensive reorientation of healthcare. Specialist health services were to be further specialised, and patients would more often be treated at primary level as the lowest effective level of healthcare in Norway. Because of the reform, local authorities were given increased responsibility to provide healthcare to patients discharged from specialist health services, which had an impact on nursing and care work. This again had implications for patients and their relatives. The present study is based on a qualitative study in a palliative care unit in which five severely ill patients, six of their relatives and eight nurses/department leaders were interviewed.

We contribute to the research on the reforming of the healthcare sector by focusing on how different actors experienced their institutional work in a palliative care unit where the tension between institutional logics has been intensified through a reform. By including the relatives and patients, we provide a more holistic view of the experience of important actors. We also contribute to the institutional logic perspective by studying actors at the micro-level, since we know little about "the way institutional logics are worked out on the ground, in day-to-day behaviours and experiences of actors" (Zilber, 2013, p. 82). In this way, we create a link between institutional logic as individual cognition and socially constructed institutional practice, and institutional work. Our results show that professional norms and values are in conflict with the managerial logic; this affects nurses' institutional work and patients' and relatives' experience of healthcare.

We structure this paper as follows: first, we discuss the theoretical underpinning of our study with a focus on institutional logics and institutional work. Second, we describe our research setting, the research methods and ethical considerations. Third, we present our data. Finally, we analyse and discuss our findings and draw conclusions.

Theoretical underpinning

During the last decades, healthcare organisations have experienced profound worldwide managerial and organisational reforms (Christensen & Lægreid, 2010; Hood, 1995; Malmmose, 2019). These reforms introduce a focus on managerialism which creates tensions to the profession-based logic in health practices (Pettersen & Solstad, 2014). We contribute to the research on healthcare by using an institutional logics perspective to understand how these tensions between institutional logics affect the work carried out in a palliative care unit.

An institutional logic perspective

Institutional logic guides department leaders' and nurses' work, which in turn affects the experience of those receiving care. An institutional logic is a set of thought and action

patterns that provides direction for what is appropriate and legitimate behaviour (Scott, 2014), and for the assessment of results (Jay, 2013). Logics are normally well rooted and therefore difficult to change. Institutional logics are powerful because they guide perceptions and behaviour in organisations and maintain or transform actors' assumptions and beliefs about practice (Coule & Patmore, 2013). We study the ways in which actors draw upon the competing institutional logics available to them to serve their own interests and to decide how to practise their everyday work.

When different logics meet in the same organisation, it can create challenges. In our study, nurses in the palliative care unit balance professional logic and managerial logic. A professional logic is based on values developed through education and practice in a profession (Exworthy & Halford, 1999; Freidson, 2001), such as by nurses and doctors. A professional logic affects actions taken by individuals, and is closely related to professional identity (Lok, 2010). Professional values, norms and history in public organisations such as hospitals and nursing homes are important frameworks for accountability and management practices (Modell et al., 2007). Clinical professionals may have institutional rights to exercise medical and ethical judgements, which are not necessarily included in contracts with top management.

On the other hand, a managerial logic is based on efficiency demands and often coexists with professional logics as in the healthcare sector (Arman et al., 2014; Kristiansen et al., 2015). The most important characteristics of the managerial logic are a competitive focus and clear performance targets, combined with local freedom of action and visible leaders with authority over employees. The Coordination Reform may be seen as part of the NPM reform trend. The aim of NPM is to implement management ideas from the private business sector into the public sector (Christensen & Lægreid, 2010; Hood, 1995). In this respect, the Coordination Reform could be linked to the managerial logic, which puts the professional logic under pressure.

Organisations are described as a meeting place for different institutional logics (Greenwood et al., 2010; Reay & Hinings, 2009). An organisation may experience institutional complexity when conflicting expectations, norms and values coexist (Greenwood et al., 2011). Multiple forms of logic can exist and be adapted by organisations in different patterns and may not necessarily conflict as they can be decoupled and sequential. Different forms of logic can also coexist in an organisation over time (Reay & Hinings, 2009).

Actions by healthcare leaders may be guided by managerial logic. However, professional norms and values are internalised into professionals' decisions in day-to-day clinical activities. These arguments support the proposition that healthcare professionals may adopt several types of logic sequentially or partially in their daily work (Llewellyn, 2001). This leads us to examine how healthcare professionals construct and resolve institutional complexity through institutional work (Lawrence & Suddaby, 2006). Zilber (2013, p. 78)

states: "While institutional logic is more interesting in the broad building block of institutions, examining in particular structures (including the structure of meaning and organisational practices), institutional work is more tuned to examining micro-practices." By articulating the micro-level of institutional logic, we can draw on the conceptualisation of institutional work (Lawrence & Suddaby, 2006; Lok, 2010; Tracey et al., 2011), and in doing so get new insight into how the tension between institutional logics unfolds in practice. Both perspectives offer a more complex and balanced view of institutional processes.

Institutional work

Although institutional work is connected to the processes of institutional maintenance or transformation of existing institutions (Lawrence & Suddaby, 2006), in this paper we will create a link between institutional logic as individual cognition and socially constructed institutional practice, and institutional work. Institutional work emphasises the individual as an active agent in institutions (Lawrence et al., 2013). Institutional work is defined as "the purposive action of individuals and organisations aimed at creating, maintaining and disrupting institutions" (Lawrence & Suddaby, 2006, p. 215). This definition captures the purposeful and reflective work done by individuals and organisations to create and maintain institutional logics, but this work can also break with the established. In other words, the actions actors take to create, maintain or reject values and beliefs in connection with an institutional logic may affect how they structure their practice. In other words, institutional work emphasises the work that takes place on the ground in the organisation (Zilber, 2013). More precisely, institutional work is about action in institutional processes, not outcomes. Lawrence, Suddaby and Leca (2011) highlighted that every act within the constituency of institutions is institutional work.

The term "institutional work" can also be understood as individuals as active thinking persons who make conscious choices as they reflect. To think institutionally is to take a point of view where one assesses what an institution (Heclo, 2008) or what the institutional logic stands for. Actors can contribute to maintaining or challenging the institutional logic by questioning what the logic represents. They can also choose to position themselves outside an institution or an institutional logic, and thus become more reflective of the framework in which they find themselves.

Lawrence and Suddaby (2006) argue that to focus on practice is to focus on the inner life of the process. Practice theory describes activities of individuals and organisations working to perform actions and achieve results. In a palliative care unit, professionals perform the practice. To explore the practice and processes, and how individuals deal with the institutional complexity, will create insight into how organisations cope with coexisting, contradictory logics (Dahlmann & Grosvold, 2017; Jarzabkowski et al., 2013). Professionals handle cases and clients by using knowledge and skills to make decisions, act and intervene. They have achieved autonomy to structure, evaluate and handle tasks related to their

profession. In other words, the professional group itself regulates knowledge, skills and expertise. Professional self-control is performed within the professional domain, where the work also involves protecting this domain from outside forces. The link between practice theory and institutional work is a significant factor, with the focus on intentional action when individuals and organisations seek to deal with the conditions and requirements that they encounter in their daily work. Lawrence and Suddaby (2006) view institutional work as intelligent, situated institutional action.

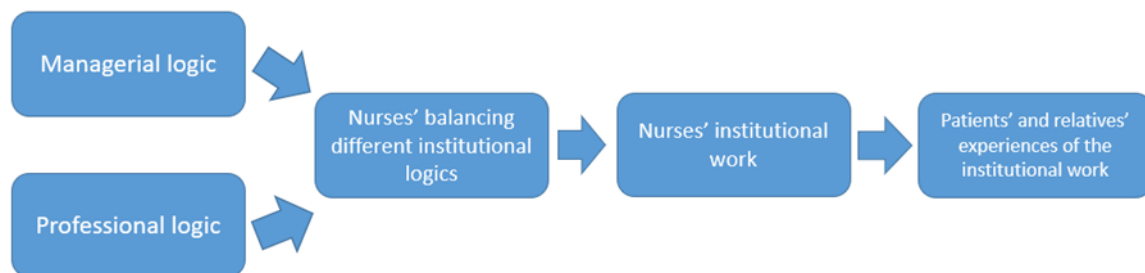Our research question is illustrated in Figure 1:

Figure 1: Experiences of different institutional logics and institutional work

In our study, we explore how nurses balance different institutional logics, and how this is expressed through their institutional work. We further describe how patients and relatives experience the nurses' institutional work and practice.

Empirical setting

Reforms in the healthcare sector have changed the way practice is carried out. The Coordination Reform changed practices in both specialist and primary healthcare services. The aims of the Coordination Reform (Meld. St. 47., 2008-2009) are that seriously ill patients who have a great need for care and nursing, and who previously were admitted to hospital, should receive further medical treatment, care and nursing in a primary palliative care unit known as an "enhanced" ward, in a nursing home. The greatest changes resulting from the reform are among primary care workers. Primary care receives a group of patients from a hospital who need different treatment and care than the previous groups of patients discharged from the hospital. Prior to the reform, specially trained nurses in intensive care units and palliative care units in hospitals treated this patient group. In other words, the Coordination Reform implies that primary palliative care units admit more and more severely ill patients without their resources and necessary competencies being increased significantly.

To understand how the tensions between institutional logic affect institutional work in an enhanced nursing home ward, a case study was conducted (Yin, 2014). The case was

selected because the ward was restructured because of the Coordination Reform, and the ward was an interesting place for studying the effects of the Coordination reform because the reform implied a restructuring of nursing homes and palliative care units with expected consequences for all involved parties (patients, relatives, nurses and leaders). Such wards are part of primary care in Norway and emerged after the Coordination Reform. They have more doctors and nurses than other nursing home wards. The ward in our study was organised partly as a "classical" nursing home ward consisting of units for people with cognitive failure, short-term units, and so-called somatic units, and partly consisting of rooms in the enhanced unit for more severely ill patients mainly transferred from specialist healthcare.

Methodology

Research design, participants and data collection

Data were collected from in-depth interviews with five severely ill patients, seven relatives and nine nurses, including two department leaders because they are the actors who experience the tension between diverging institutional logic in the practice in different ways. The purpose of the interviews was to gain knowledge of the everyday life of the patients, relatives, and nurses/department leaders and how the actors experienced the consequence of Coordination Reform. The patients who were interviewed had stayed at the palliative care unit for a while, and, therefore, had the possibility to witness the change in practice.

Subsequently, qualitative interviews were conducted. The aim was to explore opinions and experiences as well as different perspectives from the various actors. We carried out unstructured interviews by starting with an open question: How do you experience your everyday life in this department? Subsequent questions depended on how the informants had answered, and we had the opportunity to ask questions about before and after the reform. All informants in the study determined the time and place for the interviews. We conducted all interviews in rooms in the nursing care home. Interviews with each patient lasted for one hour, and two patients were interviewed twice because they requested this themselves. Although the time of the interview with the patients was agreed upon, we always consulted the responsible nurse and doctor before starting the interview with the patients. The patients' conditions could change abruptly.

In a staff meeting, nurses were informed about the study and had to send an e-mail to the first author of this article if they wanted to participate. The interviews with relatives, nurses and the two leaders in this unit lasted around 90 minutes.

Each interview was audio-recorded, transcribed verbatim and translated to English. The interviews were open, with just one introductory question

Data analysis

Both authors analysed the data, and the tension between institutional logics arises inductively from the empirical data. We were, for instance, inspired by Braun and Clarke's (2006; 2021) reflexive thematic analyses. We searched for patterns within and across each interview, but we also looked for a sense of continuity and contradictions within individual accounts. We did this first separately, and then together. First, we coded the data manually into broad thematic codes which we discussed in meetings and based on this we agreed the final codes.

We then analysed the themes across all interviews. During this process, the handling of the tension in institutional logics in their institutional work and how this was managed by department leaders and nurses was the main finding. Another finding was how those who received healthcare experienced the institutional work, both the patients and their relatives.

Ethical considerations

The project involved studies of people who were in particularly vulnerable situations in life. The patients were dependent on care to cope with their everyday life. The relatives were in a situation where their lives had been disrupted due to serious illness of a close family member. In such a situation, it is especially important to consider the researchers' ethical responsibility to ensure that participation in the research is voluntary. Such responsibility is connected to ensuring anonymity and confidentiality. In this paper, we have excluded the diagnoses, ages, medical treatment, residence, or gender of the participants.

The supervising physician gave us permission to distribute information to potential participants in the group of severely ill patients and their relatives. All were informed that they could refuse to participate without any consequences for their treatment and care. We then contacted the patients, distributed information letters, and read aloud the information to all patients. Severely ill patients may be given medication such as painkillers that may affect their alertness, which was undesirable. This was prevented by nurses ensuring that patients were not in a lethargic state due to painkillers when the interviews took place.

The Regional Committee for Medical and Health Research Ethics (REK) approved the project. The Norwegian Data Protection Authority/the Privacy Ombudsman for Research also endorsed the project. This approval allowed the researchers to be present in the palliative care unit to enable them to access information about the patients and their relatives that could not be achieved through qualitative interviews alone.

Empirical findings

Our focus in this study is on how department leaders, nurses, patients and relatives experience the conflict between different institutional logics, and how this is incorporated in

their institutional work. The following quote from a department leader illustrates how the Coordination Reform was introduced in the palliative care unit:

> At the start of this process, we had a larger budget than all the other units. Then they [the local authority management] started telling us that we had too many resources and too big a budget [...] When one seriously ill patient died, we had to remove several healthcare jobs, even though we had new patients who needed ventilation. We had more patients, and more seriously ill patients, admitted. In this situation, we had very tough discussions with the top management, where we had to explain why we had used more of the budget than we were allowed to. […] We got a few million more than the other nursing homes. Then there were even worse times. (Department leader)

This illustrates the situation for the unit in our study. Our main findings from the interviews are presented below.

The department leaders' and nurses' experience of the tension between the managerial logic and a professional logic

The informants' statements indicate a tension between managerial and professional logic, which the department leaders and nurses must balance in their everyday work. The managerial logic is expressed through the Coordination Reform, where the ward admitted more patients, and more severely ill patients with complex needs, without a higher budget or new resources being increased significantly. Here there is an assumption that the staff must work more efficiently. The professional logic is expressed through the professional background of the nurses where the well-being of the patients is the focal point. The department leaders are also professional nurses who experience the tension between institutional and professional logics as troublesome instead of being representatives of the managerial logic only. While they experience this tension as one between running the unit in an efficient and economically sound way, and the responsibility for ensuring person-centred care, the operative nurses experience other types of hands-on conflicts in patient related work. The tension of divergent institutional logic was in focus when we asked questions about their daily workday. This is expressed in the following way:

> The budget is of great importance… but at the same time I have to say what is best practice from a professional viewpoint. Otherwise, it will just be the budget. (Department leader)

> We're not allowed to make our own judgements, but everyone knows that a dying patient needs help. We have quality regulations that tell us how to treat terminal patients. (Department leader)

These quotes demonstrate that the budget took up considerable space in the department leaders' work. In other words, the work connected to the managerial logic (budget constraint) was in focus. The nurses, who work closely with the patients, experienced a hectic working day where they did not have time to provide adequate patient care:

> There have been cuts in the budget, and we are losing resources. We have more patients in the unit, and they are getting younger and younger. We are responsible, and we get less time for patients. (Nurse)

> The unit is full of seriously ill patients. It is a challenge when you know there are two or three patients who need your help at the same time. What is more, you know you have to say no to two of them. It is a very tough feeling. There is a lot that can go wrong, and we are the ones who are responsible. (Nurse)

These quotes show the nurses' challenges in their work, which also affect patient care. They also felt that the patients found that they were too busy:

> I have found that patients refuse to call for help. They apologise because they can see how busy we are. (Nurse)

These quotes illustrate how the nurses find that their professional work is under pressure from the managerial logic which is focused on efficient operation. The nurses also explain that their responsibility to the patients is sometimes a hard burden to bear because there are not enough nurses on the unit:

> There is a lot of responsibility on a nurse's shoulders some days. It would be a dream situation to have more nurses. [...] It is not much fun to apologise, apologise and apologise. We do not have the time we need. (Nurse)

> We try to be positive, but when you get ill, the house of cards collapses. Many of our staff have left because they cannot cope with things here. (Nurse)

Not only were there fewer nursing positions, but some nurses had also decided to resign because of the workload in the unit. The nurses also found that coordination with the hospital was inadequate in this situation:

> There is less time for patient contact. I do not think the Coordination Reform works. The hospital must ensure that patients receive good follow-up care. Now it is just about getting rid of the patients from the hospital. (Nurse)

> We often get patients admitted who die within 24 hours. That is so degrading. When they die, neither they nor their relatives have had time to get to know us. To find out what will help a person can take time. It's degrading to admit patients at such short

notice. The hospital does not see the patients. They just see that there will be a free room. (Nurse)

These quotes illustrate that patients are transferred from the hospital to the unit as soon as there is a free room in the ward. The nurses express that they do not have time to get to know the relatives before the patient dies. So, they feel they fail to give adequate healthcare. This indicates that the institutional work happens at the expense of their professional logic. The following quote tells us that the nurses have sent letters of concern about the conditions that they felt did not protect patients adequately:

We have sent many letters of concern, but nothing happens. (Nurse)

We all must behave according to the system. People are becoming more and more vulnerable in a way. We have no control over our work ... Now we are just storing patients here. We have nothing to offer them. (Nurse)

They teach us a lot of administrative work that goes beyond patient contact on the unit. (Nurse)

These findings illustrate the nurses' struggle with the new tension between managerial and professional logics. The findings also indicate that the managerial logic triumphs over the professional logic in everyday work priorities.

Patients' and relatives' experience of the conflict in the institutional work of the department leaders and nurses

The patients and relatives found that the nurses were struggling in their work. Yet they did not just accept that they had to cope with it:

I called for help. One nurse came and told me she would help me. An hour later a new nurse came and apologised that I had to wait so long. If I need some more intensive care, I hope they will move me back to the hospital. I am a bit scared now. .... It is not an excuse that they had too few staff. I understand them, but I cannot excuse them. (Patient)

The nurses on this unit are competent, but competent in different ways from the hospital nurses. These nurses do not have technical skills. Several of them could not use the pain pump. My mother does not feel safe in this unit because she has been transported to the hospital several times during the three weeks she has stayed here. She is too ill and needs more help than she can get in this unit. She is afraid. My aunt and I must be here with her day and night. (Relatives)

The quotes show that the patients and relatives are of the opinion that the nurses had neither the time, resources or skills to take care of palliative patients. The findings also show

that the efficiency focus involved in the managerial logic undermines nurses' institutional work, even though the nurses themselves considered the patients' well-being as the most important aspect of institutional work. As the quotes illustrate, the patients and their relatives experienced a lack of care, and some became afraid. The hectic working day where nurses had too little time for each patient also involved the relatives:

> There are lots of seriously ill patients on this unit. It is important that this unit has enough nurses and expertise. It is not good to discover that this is missing. I think the patients and relatives will feel more reassured if they find that patients are taken better care of. Now we had to do shifts. We want to help our father, and we hope this situation will not last very long. (Relative)

> There are not enough nurses. Yesterday one nurse told my mother there were not many nurses on duty that day and that my mother had to stay in bed all day. My mother needs more and more help, and we find that there are too few staff to give proper treatment and care. It is not okay. I feel sorry for the nurses too. (Relative)

The relatives were worried about the situation for their loved ones, but also for the nurses and themselves.

These quotes from a patient and relatives show how patients in a palliative phase felt that the professional work was under pressure. The nurses did not want this, but they had to adapt to the situation. The patients and their relatives observed that the nurses were busy, and express that the unit was not a good place for end-of-life care.

The patients also felt that they were becoming a burden to their relatives and the nurses:

> I hope I will die soon. It's not good to lie here and wait for death. I hope I will get the help I need. The nurses must help many patients, but I need help too. …. I want to die now. (Patient)

> Waiting for death is not a good situation. It is a burden for my loved one who has to visit me. I do not see the nurses much, and I hope it will not be long before I die. (Patient)

These quotes show the consequences for patients of the focus on efficiency (managerial logic). Relatives were also frustrated about the healthcare system and afraid that patients would feel like a burden:

> I do not think it is right that our mother must accept this. But I get ill thinking about our mother having difficulty breathing and waiting for help that does not come. I have told the leader of the unit and the nurses several times that our mother does not ask for help if it is not necessary. (Relative)

The relatives stated that limited resources had implications for the patients' need for the right treatment and care in the right place. Several relatives were confused about a health service that focused on what was most profitable in a cost-benefit system, not what was of most value for the human beings in this system. One of the relatives expressed this as follows:

> After several health reforms, nice words like patient involvement and the patient at the centre of care become more and more distant. I do not notice any talk about providing good care. No, it is all about the budget, how much things cost, how much we can get for the money, and how short the hospital stay should be. There's too little attention on the necessity of care. And I saw how they [nurses] rushed about. You dare not ask for help. (Relative)

The findings show the consequences of a shift in institutional work where human beings seem to be objects rather than individuals who need help to live a rewarding life and experience dignity and care until they die.

Discussion

Our data demonstrate that the Coordination Reform has changed everyday work in this palliative care unit. The data illustrate that department leaders, nurses, patients, and relatives struggled to find a balance between professional and managerial logic following the introduction of the reform. Reforms in the health sector are introduced to meet budget deficits and provide more efficient healthcare services. This is positive on the macro-level. But the experience can be different on the micro-level where the institutional work is carried out.

The balancing of institutional logics

An organisation is a meeting place for different institutional logics (Besharov & Smith, 2014; Greenwood et al., 2010; Reay & Hinings, 2009). To balance different logics implies a situation where conflicting expectations, norms and values coexist (Greenwood et al., 2011). In such a situation, different logics can exist and not necessarily conflict as they can be de-coupled and sequential (Reay & Hinings, 2009). Our data demonstrate that the Coordination Reform has had different consequences for the balancing of institutional logics in the enhanced nursing home ward, because the tension has been intensified because of the Coordination Reform.

Our data show top-down control characterised by efficiency goals rather than professional considerations. This is in line with a managerial logic (Arman et al., 2014; Kristiansen et al., 2015). Professional logic (Exworthy & Halford, 1999; Freidson, 2001) comes under pressure when professionalism is legitimised based on administrative objectives and budget criteria, as our study shows. We see a focus on a growing management control regime, which takes more and more time from nurses' focus on patient well-being. Professional values, norms

and history are central to professionals' accountability and management practices (Modell et al., 2007), and with the focus switching to managerialism, our findings illustrate that nurses have less time to get to know their patients. Getting to know patients require close contact. The findings show that the efficiency focus following the Coordination Reform contrasts with a political desire to have the "patient at the centre of care," which includes taking individual considerations into account. This illustrates that the objectives of reforms can be positive, while the practice is experienced differently.

The patients and relatives reported dissatisfaction with the service they were offered. This was ascribed to economic factors, but also a feeling of lack of care. According to the Coordination reform, the patient is entitled to be offered the right treatment at the right place at the right time. However, our study showed that this is not the case. Our study shows that the relatives and nurses were most critical of how external factors deprioritised the provision of care. The study illustrates that the patients were unable or unwilling to speak up about a practice that was not good for them, because they did not want to be perceived as demanding and troublesome. Limited resources caused discomfort for patients, relatives and nurses, and respect for the individual patient seemed to be threatened. These findings show that the professional logic (Exworthy & Halford, 1999; Freidson, 2001) was put under pressure.

Our findings show a new tension between professional and managerial logic in the unit. These two logics have coexisted (Arman et al., 2014; Kristiansen et al., 2015), but are now out of balance because of the Coordination Reform; the managerial logic has been strengthened at the expense of the professional logic. Since logic is a set of thought and action patterns that provide direction for what is appropriate and legitimate behaviour (Scott, 2014), and for 20, li assessment of results (Jay, 2013), the focus on efficiency and economic factors has prevailed—at the expense of professional values, which is not in line with the moral of professionals.

Our findings demonstrate that the new situation in which the managerial logic has been strengthened has given patients, relatives, department leaders and nurses a feeling of inadequacy. Patients found that they needed more help than they could be offered. The finding also reflected the relatives' worries. They experienced that their loved ones' health and wellbeing became their responsibility. They saw how nurses were in a hurry, leaving their loved ones to wait for help. This illustrates how nurses are required to change their focus, even if this takes place at the expense of their identity (Lok, 2010). The nurses felt that they were failing in their mandate regarding patient safety and security. They did not know how to cope with the tension that arose between the institutional logics because of the Coordination Reform and tried to do their best with the available resources.

Institutional work in the tension between different institutional logics

The new tension we see between different institutional logics in this case affected nurses' institutional work. Nurses have always worked in a situation where different institutional logics coexist. They are used to different types of logic sequentially or partially in their daily work (Llewellyn, 2001). The introduction of the Coordination Reform has changed the balance between the institutional logics in a way that affects the complexity of their institutional work (Lawrence & Suddaby, 2006; Lok, 2010; Tracey et al., 2011). This shows how institutional logic as individual cognition impacts the institutional practice. By adopting an institutional work perspective, we can study individual cognition and how institutional practice is socially constructed (Lawrence et al., 2013).

The strengthening of the managerial logic in a situation with coexisting logics (Dahlmann & Grosvold, 2017; Jarzabkowski et al., 2013) affected institutional work in the unit. Nurses want to focus on values that are important to them, their patients, ethical considerations (Fimreite & Lægreid, 2005) and patient well-being (Exworthy & Halford, 1999; Freidson, 2001), but as our study has demonstrated, conditions have changed. Department leaders and nurses who emphasise professional values in their institutional work are required to focus on efficiency and the budget in relation to managerial work. This creates challenges in their practice (Zilber, 2013). Nurses play a central role in the quality assurance of healthcare. Several of the nurses we interviewed found that administrative work took up much of their time. This work was assigned to them at the expense of their professional values and now characterises their institutional work. Against this background, the nurses experienced a conflict of loyalty. They were forced to focus on administrative tasks related to patients at the expense of close contact with them.

Their institutional work (Lawrence and Suddaby, 2006; Lawrence et al., 2011) became more difficult since they had to do work that did not directly address patient health and well-being. A nurse's work is also to protect the professional logic (Exworthy & Halforth, 1999; Freidson, 2001) from outside forces. This creates unpredictability in their everyday work. The nurses also found that poor interaction between the different levels of care was challenging and time-consuming. Several of the nurses in the study expressed a desire for more nurses on the unit, which was the case before the reform. They stated that they were understaffed, and they suggested that increasing the nurse-patient ratio and enhancing nurses' competencies might make their work less hectic.

The patients and relatives also noticed the shift towards institutional work based on the managerial logic. They did not feel properly looked after. The patients were seriously ill and knew they would soon die, and many felt that they were being left to themselves. They also did not want to interrupt the nurses who they saw were in a hurry. Patients need predictability and security in a palliative care unit when life is perceived as chaotic. If patients must wait for help because of a lack of resources, it may worsen their health

situation. Relatives feel insecure when they find that their loved ones are not receiving the care to which they are entitled. The relatives in this study were not happy to see that the nurses need to have more contact with patients, something the nurses want. The new focus on efficiency meant that the nurses had difficulty in knowing whether they should construct, maintain or change institutions (Heclo, 2008; Lawrence et al., 2011), beliefs and norms.

Conclusion

Our findings demonstrate challenges that arise in performing institutional work when a reform strengthens one of the institutional logics in the organisation. Our findings show that by downgrading the professional logic, the focus is on efficiency and the budget. This has consequences for all the actors in our study who are linked to the palliative care unit. The department leaders struggle with the tension between budget and healthcare in their institutional work. The nurses struggle with too few nurses at work at the same time, and a very busy working day where their professional work comes second. Patients are often left to themselves, feeling a lack of care. Relatives saw how nurses were in a hurry which meant that their loved ones were left to themselves and had to wait for help. Thus, the relatives had to spend more time with their loved ones.

By using an institutional work perspective, we enhance the understanding of the relationship between values and practice, and the balancing of institutional logics. By using a case study, we illustrate the experiences of several actors, including relatives and patients, of the same palliative care, and we contribute to the call for more studies on how institutional logics are worked out on the ground and in the day-to-day practices and experiences of actors (Zilber, 2013).

Our research contributes to the research on the reforming of the healthcare sector by focusing on the micro-level practice of institutional work, since we know little about "the way institutional logics are worked out on the ground, in day-to-day behaviours and experiences of actors" (Zilber, 2013, p. 82). Valuable research on reforming the health sector has focused less on the actors receiving healthcare. These actors are important in understanding the recipients' perspectives. By including the relatives and patients, we provide a more holistic view of the experience of the consequences of reforms inspired by a managerial logic.

Our research shows the need for policymakers to be more aware of the challenges resulting from the introduction of managerial reforms, and illustrates that politicians and primary care managers should be aware of the implications of managerial reforms on professional practice, since professional values come under pressure when managerial logics are implemented. We also highlight what primary care nurses find challenging, and what they need help with. This may improve cooperation between specialist and primary healthcare services (Haugen et al., 2006; Rigoli & Dussault, 2003; Tønnessen, 2011).

We argue that the inclusion of relatives and patients themselves provides us with a more holistic picture of practices in an enhanced nursing home ward, because we need more knowledge about the receivers of healthcare. The data show, as researchers have previously pointed out, that more attention should be paid to how patients and relatives experience healthcare services. This is of importance to enhance our understanding of treatment and care and of how to improve primary healthcare.

We recognise that our study is limited in context, time and scale. Therefore, we welcome further research involving comparative analyses with a focus on institutional work in balancing institutional logics. This will improve our insight into professional practice, and the difficulties facing professional managers and staff.

Article history

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