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Nurses' professional discretion in the purchaser-provider split in home care in Norway

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Abstract

Aim: To explore how nurses' professional discretion is operationalized in home care services that follow a purchaser–provider organization in Norway.

Design: A qualitative descriptive study.

Methods: Semi-structured interviews with open-ended questions were used, and data were collected from in-depth interviews with 15 registered nurses working in home care in four Norwegian local authority areas between April and November 2020. Braun and Clark's six-step analysis was used to analyse the empirical data.

Results: The analysis yielded two main themes, namely 'The purchaser's instructions: facilitating and constraining care' and 'Professional discretion meets the purchaser–provider organisation of healthcare,' with five associated codes.

Conclusion: Nurses are dependent on an organizational framework due to the complexity of health care services and the number of tasks involved. At the same time, they perform considerable compensatory work and need the ability to be flexible to enable this work and to perform actions related to the unforeseen needs of individual patients or those involving professional discretion.

Impact: The purchaser–provider model both facilitates and constrains nursing practice and professional responsibility in home nursing. Home nursing services need to be well organized because of their complexity and the wide variety of tasks they involve. In this context, the element of constraint is associated with the need for flexibility and professional discretion. Despite a strict framework, the nurses perform additional and compensatory tasks. Reforms inspired by 'New Public Management,' such as the purchaser–provider split, limit the workload for nurses; however, there is still a need to exercise discretion. The findings of this study may help home care managers and health policy-makers understand the interaction between management logic and health care logic, leading to a more appropriate organization of health care services where the nurses, as actors, gain more trust.

Implications: This study highlights home care nurses' opportunities to exercise discretion in an organizational framework that strives towards standardization. The nurses' ability to exercise discretion is important for individual and holistic patient care. At the same time, an organizational framework is needed because nurses cannot attend

to all the needs the patients may have, as this will overload both home health services and the nurses.

KEYWORDS
discretion, health services administration, home care services, home health care, home health nursing, nurses' role, nursing, professional competence, standardisation

1 | INTRODUCTION

Health- and social-care authorities around the world are focusing on how to organize health and social services in a highly sustainable manner (Sogstad et al., 2020; WHO, 2017), while increased longevity and greater numbers of people with complex needs result in an ever-growing health care sector (Pot et al., 2018; Van Eenoo et al., 2018).

Home care is central to meeting these challenges (Andrade et al., 2017; Ellner & Phillips, 2017), and home nursing has become a multifaceted and complex health care service that involves an ever-increasing number of tasks (Andrade et al., 2017; Martinsen et al., 2018; Saeterstrand et al., 2015). In this study, home care is regarded as a part of local public and primary health care services and includes home nursing as a specific service.

1.1 | Home health care and the purchaser–provider-split model in a Norwegian context

Home care systems differ between and within countries (Genet et al., 2011). The Norwegian health care system is founded on the principles of universal access and the decentralization of providers. The municipalities organize primary health care, while the national government is responsible for specialty care, including hospital services, through the state-owned regional health authorities (Ringard et al., 2013). Primary care, care services and rehabilitation, in addition to social services, are organized locally by the municipality and under the same legislation (Health and Care Services Act, 2011; Nakrem & Kvanneid, 2022). While health care policies are centrally controlled, the responsibility for the provision of health care is decentralized. The municipalities organize and finance primary health care services according to local demand. Primary care functions according to the principles of holistic and integrated care. Municipalities are also responsible for providing long-term care, which is not in hospitals and is included in universal health insurance.

The purchaser–provider split (PPS) has been the prevalent model used in Norway since the 1990s (Eide et al., 2022). Since then, the PPS model has replaced the traditional organizational model that did not distinguish between providing and administering home care and nursing; now, the provider fulfils the duties that were previously performed by the purchaser (Deloitte, 2012; Vabo, 2014). Most municipalities in Norway organize home health care according to the PPS model (Martinussen & Magnussen, 2009; Nakrem & Kvanneid, 2022), and the provision of care is carried out under the 'National Regulation of Quality of Care' (Ministry of Social Affairs and Health, 2003). The main arguments for implementing the PPS model were cost efficiency, reduced bureaucracy and greater legal protection for care recipients (Hood, 1991; NOU, 2006; Nylenna, 2014; RO, 2004; Vabø, 2012). In the context of municipal health care, the PPS model distinguishes between the responsibilities and duties of the care manager (the purchaser) and those of the health- care personnel (the provider) (Tønnessen et al., 2017). The care managers are professionals (usually nurses) working in purchaser units in community health care who are not involved in taking care of patients. They are responsible for the public administration of individual decisions and for deciding which care services are allocated to patients in the municipality and need to strike a balance with regard to allocating the available resources fairly. The manager does not provide any formal instruction for the services apart from deciding the content and the number of hours needed to fulfil the tasks considered necessary to meet the patients' needs for home health care and home nursing. The PPS model is based on market-inspired management principles, and a business-oriented economic rationale (Busch & Vanebo, 2011; Rasmussen & Vabø, 2014; Siverbo, 2004).

Home health nursing includes services that range from practical help and psychosocial support to more advanced medical treatment, such as the administration of medication and wound care. Social home care is regulated rather loosely and regarded as an embedded part of health home care (Schönfelder et al., 2020). Most patients are elderly individuals with varying, often chronic, illnesses, disabilities or frailty. The staff includes registered nurses, auxiliary nurses and nurse assistants (Holm, 2017; Nylenna, 2014). Significant geographical distances between patients (Seljemo et al., 2023) generally require that the same nurse performs all the tasks on the route even if said tasks do not require the skillset of a registered nurse. However, registered nurses are trained to handle medications safely and monitor their effects. Health care workers may assist with medication administration, but they do not have the same authority to administer certain medications independently. In Norway, registered nurses require a bachelor's degree to be allowed to practice nursing. They generally work in hospitals and primary care. Some nurses in primary care have completed specialized education, and a few have master's degrees in nursing. All home care staff are regarded as health care workers and serve under the same legislation (Health and Care Services Act, 2011; Healthcare Personnel Act, 1999).

Effective collaboration among the staff is necessary to complete the increasing number of care tasks, although registered nurses play a key role in providing professional home nursing

based on the principles of high-quality care and a holistic approach to patient care and treatment. To practise home nursing involves the complexity of working in another person's home and requires considerable competence (Allen, 2014; Armstrong, 1983; Fjørtoft, Oksholm, Førland, et al., 2021; May, 1992). National legislation regulates the work of nurses and other health care personnel and the rights of the patients (Health and Care Services Act, 2011; Healthcare Personnel Act, 1999; Patient Rights Act, 1999). In the Norwegian welfare model, holistic and person-centred care is a key element, and the model is considered to be comprehensive and generous (Vabø, 2012). Equity in health care is stipulated in the Patient Rights Act, and patients receive free home nursing in primary care. The care provided is based on formal instructions that prescribe the nurses' duties, such as the amount of time to be spent with each patient.

2 | BACKGROUND

Previous research on management using the PPS model indicates that it is a good tool for achieving the goal of better resource utilization in home care services; however, it does not address how the purchaser's instructions are understood and implemented (Holm, 2017; Saeterstrand et al., 2015). At the same time, research has also shown that organizational forms inspired by NPM did not deliver on their own goals and that there were significant undesirable side effects (Siltala, 2013; Simonet, 2013). Further, the PPS form of organization puts great pressure on home care as the lowest level in the health care system to ensure efficient service allocation within a tight budget (Vabø, 2012). Health care professionals, as care providers, work according to electronic work lists that describe the care tasks for each patient and the estimated number of minutes required for these tasks. They are required to document the tasks using digital devices or desktop computers in their office and report any deviations (Holm, 2017).

Sometimes, it could be difficult to combine the prescribed tasks with the patients' actual needs (Ponnert & Svensson, 2016; Strandås et al., 2019a; Vabø, 2014). In such cases, the purchaser decides on which work tasks are completed for the patients based on home visits, where the patients' care needs are verified and planned. However, the purchaser does not execute the care services during their home visits, and these are left to the care provider to perform. In real-world settings, wicked problems that are not described in the task instructions may arise due to ambiguous causes; each problem is unique and can be linked to a long chain of causes related to a person's unique life situation, such as the patient having urgent or more acute needs than previously described or needs that could not have been predicted in advance due to their nature (Head & Alford, 2015; Vabo & Vabø, 2014). The organization of the PPS model frames the work of home nursing both indirectly and directly. Nurses work as care providers in the homes of patients, but the care tasks are strictly regulated, which means that the prescribed care may be task-oriented and less flexible, may lack continuity and may require increased documentation by the nurses and detailed goal management, leaving less time for conversations and the provision of basic care (Fjørtoft, Oksholm, Delmar, et al., 2021; Haukelien et al., 2015; Strandås et al., 2019a). Past studies have highlighted the need for adequate nursing staffing and the development of interprofessional interaction models that describe the roles and responsibilities of the various actors involved to meet the needs of individual patients (Matthys et al., 2017; Melby et al., 2018).

Home health nursing involves complex issues that are difficult to standardize (Hansen, 2022; Vabø, 2012). In addition, home health nurses are required to provide frontline services in home care and, thereby, implement policies for good home health care as street-level bureaucrats. Thus, they find themselves stuck between politics and the population, often with conflicting demands (Lipsky, 2010). They are expected to adhere to the PPS model. As frontline public-service providers or street-level bureaucrats, nurses encounter certain dilemmas. Their work must fulfil the expectations associated with providing sufficient quality in the home service in addition to adhering to the allocated time frames for the needed care. This may constrain their professional discretion (Lipsky, 2010; Vabø, 2012). Here, professional discretion refers to the nurses' performance of the prescribed tasks, which include considerations about the relevant ethics and legislation and the patients' best interests, while seeking to provide high-quality care (Grimen & Molander, 2013; Schön, 2001). We know from past research that nurses' prioritization of patients' care needs is based on their professional judgement and discretion, which include tacit knowledge, and that prioritization in different patient situations is an advanced skill in nursing practice (Lake et al., 2009). In this article, we focus on one of the most important service providers in the local health care system, the home health nurses and analyse their dilemmas and experience in the context of health services regulated within the framework of PPS and as frontline service providers in home care services.

There is a need to learn more about how nurses who provide home care services experience and reflect on their decision making with regard to their discretion, actions and role as service providers in health care in patients' homes when these services are framed by the PPS model.

The nature of the tasks and needs in the service sector implies that professional practitioners understand them the best and will act according to their professional standards (Mintzberg, 1993). It is difficult to measure performance in this sector (Busch & Vanebo, 2011). A key question here is related to how much discretion professional practitioners should have and to what extent should they use their clinical assessment and judgement. The purchaser may tend towards standardization, while the provider may want as much freedom as possible based on their professional discretion and the ideals of holistic care (Busch & Vanebo, 2011; Strandås, 2021). Home health nursing requires nurses with adequate competence (Bing-Jonsson et al., 2015; Nakrem & Kvanneid, 2022), and they are required to combine different ideologies in their work, such as professional autonomy and discretion, provide comprehensive and individual care to patients and legitimize an organizational

framework of standardization—all of which may involve conflicting expectations (Tønnessen et al., 2017).

Although nurses play a key role in primary health care, the content and contribution of home nursing seem to be unclear or unacknowledged in Norwegian policy documents (Fjørtoft, Oksholm, Førland, et al., 2021). Past findings indicate a need to draw attention to and empower home care nurses and their practice (Kassah & Tønnessen, 2016), and there is also a need to uncover more knowledge about the role and practice of nursing with regard to nurses' professional discretion related to home care services guided by the PPS model.

This study can be considered important because there currently is an increasing need for and pressure on the municipality's health services, which will likely grow in the future, as well as limited resources. Therefore, it becomes important to find a balance between the needs and requirements for health services and the available resources. In this context, the exercising of professional discretion is considered important.

3 | THE STUDY

3.1 | Aims

The purpose of this study was to examine nursing practice in home-based care and explore how nurses' professional discretion is operationalized in health care services that follow a purchaser–provider structure.

The research question is as follows: *How do home health nurses experience professional discretion in a PPS organization in the Norwegian context?*

3.2 | Design

A qualitative descriptive study design was employed (Bradshaw et al., 2017; Patton, 2015). Qualitative descriptions possess the characteristics of qualitative research (Bradshaw et al., 2017) and were chosen because they provided a way to describe and explore the nurses' perceptions and experiences (Doyle et al., 2020). The descriptive design used includes an interpretation as a part of the analysis (Sandelowski, 2010), where the description comes first, followed by the interpretation (Patton, 2015).

3.3 | Participants

The data were collected from in-depth interviews with 15 nurses working in home care between April and November 2020 in four municipalities (two rural municipalities, one small urban municipality and one large urban municipality). These municipalities were chosen to achieve variety in the sample through different experiences on the participant (Sandelowski, 2010) and to identify shared patterns that emerge from heterogeneity (Doyle et al., 2020).

Only registered nurses were recruited for this study, as they bear overall responsibility in home nursing. The study participants were recruited by the first author, who first contacted primary health care management teams before reaching out to local health care unit managers who assisted with the recruitment process, and the participant information sheet was sent by email to nurses who met the inclusion criteria with an invitation to participate. Nurses who were interested in participating in the study contacted the first author directly or through the health care unit managers. The inclusion criteria were that the participant had to have at least a bachelor's degree (had to be a registered nurse) and at least 1 year of experience in home nursing. Informed consent was obtained from all the participants. The recruited participants had an average of 14 years of experience in home nursing (range: 1–36 years). Recruitment continued until data saturation was achieved, which occurred when new codes or themes stopped emerging (Saunders et al., 2018). Everyone who wished to participate in this research was included, and no one withdrew from the study. The demographics of the participants are presented in Table 1.

3.4 | Data collection

A semi-structured interview guide with open questions based on the overall aim of the study was piloted and adjusted as necessary (see Table 2; Kvale & Brinkmann, 2015). The questions focused on the nature and content of the nurses' everyday work and the factors that affected their practice. It was crucial to allow the participants to speak freely about their concerns and what they considered important to communicate about their everyday work in home nursing. The first author conducted the interviews. Five of the interviews were carried out online due to COVID-19 restrictions, while 10 took place in suitable rooms at the nurses' workplaces. The interviews lasted between 58 and 100 minutes (80 minutes on average) and were audio-recorded. In addition, field notes and reflection notes were written immediately after the interviews to support the analysis. The amount of data was not defined in advance. The authors discussed the possibility of saturation during data collection and ended the process when they gathered rich and robust data and saturation for the initial and preliminary themes, where the areas of saturation fulfilled the study's aim (Braun & Clarke, 2021b; Patton, 2015; Saunders et al., 2018).

3.5 | Ethical considerations

The national research data authority approved the study through its ethics committee, which complied with the National Guidelines for Research Ethics in the Social Sciences, Humanities, Law and Theology (NESH, 2021). The study was conducted according to the Declaration of Helsinki (World Medical Association, 2022). Potential participants were informed orally and in writing about the study's aim, data collection and data confidentiality. Further, participants were allowed to withdraw from the study at any time without providing a reason. Those who wished to participate provided written

TABLE 1 Participant characteristics total no. of participants: 15.

	Type of local authority	Gender	Age (years)	Experience as a home care nurse	Percentage of full-time work	Bachelor's degree in nursing/specialization	Area of special responsibility
Nurse 1	Large urban	Female	20–30	4 years	100%	Bachelor	Infection control
Nurse 2	Large urban	Male	20–30	4 years	100%	Bachelor	Systematic clinical examination and assessment
Nurse 3	Large urban	Female	20–30	1 year	100%	Bachelor	Medicine room, partial responsibility
Nurse 4	Large urban	Female	30–40	9 years	100%	Bachelor	Medicine room, main responsibility
Nurse 5	Rural	Female	30–40	12 years	85%	Bachelor + specialization in psychiatry	
Nurse 6	Rural	Female	60–70	30 years	100%	Bacheor + specialization in cancer care	Palliative care, cancer care
Nurse 7	Rural	Male	50–60	10 years	100%	Bachelor + specialization in geriatrics	Dementia
Nurse 8	Small urban	Female	50–60	8 years	100%	Bachelor	Multi-dose medication
Nurse 9	Small urban	Female	40–50	16 years	100%	Bachelor	Health care coordinator
Nurse 10	Small urban	Female	50–60	22 years	100%	Bachelor	
Nurse 11	Small urban	Female	60–70	36 years	100%	Bachelor + specialization in cancer care + specialization in counselling	Cancer care
Nurse 12	Small urban	Female	50–60	26 years	100%	Bachelor + specialization in counselling	Multi-dose medication, student supervision
Nurse 13	Small urban	Female	30–40	5 years	100%	Bachelor	Employee representative
Nurse 14	Rural	Female	40–50	20 years	92%	Bachelor	Dementia care coordinator
Nurse 15	Rural	Female	50–60	14 years	100%	Bachelor	Deputy general manager. Responsibility for analgesics

consent, and participation was voluntary. All data were treated confidentially, with only the research team having access to them. The Consolidated Criteria for Reporting Qualitative Research (COREQ) were fulfilled (Tong et al., 2007).

3.6 | Data analysis

The data were analysed using a reflexive thematic analysis (TA; Braun & Clarke, 2019)—a data-driven analysis that enabled the discovery and generation of themes and codes from the study's qualitative data (Patton, 2015, pp. 541–552). A TA is a common technique used in qualitative studies and allows for design flexibility (Braun et al., 2022). At the same time, different perspectives on how to use this approach can be a limitation in this study (Braun & Clarke, 2006, 2013; Vaismoradi et al., 2013). However, a reflexive TA emphasizes the researchers' role and awareness as active components of the analysis through reflexive and thoughtful engagement with the data and during the analytic process (Braun & Clarke, 2019). The researchers discussed how their professional background and experiences might interfere with the analysis processes and adopted a reflexive attitude throughout the research process (Braun & Clarke, 2021a). A checklist of the criteria for a good TA was also used (Braun & Clarke, 2006).

The six phases of a TA described by Braun and Clarke (2006, 2013) and Braun et al. (2022) were utilized. The audio-recorded interviews were transcribed into 371 pages of text by the first author. NVivo was used in Phase 1 of the analysis to obtain a clearer overview of a large amount of text. The data were then converted into Microsoft Word documents for further analysis. All authors read the transcribed material to familiarize themselves with it. In Phase 2, the first author performed an initial and open coding throughout the dataset. This was a pre-analytical process in which interesting features of the data and both similarities and differences were coded. Phase 3 was performed by the first and last author and concluded with codes that belonged together being arranged into code clusters. During this phase, the analysis moved from emic to more epic labels and themes (Patton, 2015, p. 544). The code map (Figure 1) illustrated this as three themes, namely 'The patient' (in the centre), 'The nurse' and 'The organization', with eight associated labels. In Phase 4, the analysis continued with the identification of themes. Throughout this process, all the authors reflected on the

TABLE 2 Interview guide: Overview of themes and key questions.

Theme	Key questions
Opening questions	What is your educational background, and do you shoulder any special professional responsibility for any area in the department?
	For how long have you been a nurse in home health nursing, and what is your full or part time?
	What are your immediate thoughts, understandings or reflections about the topic of this study?
	What is important to you as a nurse?
The nature of the work	What characterizes a typical working day for you?
	For example, describe your last day/evening shift, e.g. your tasks.
	What do you think is important to tell me about from your nursing practice?
	What do you do in your nursing practice, and what are your responsibilities in your opinion?
	Who do you collaborate with in home nursing practice?
	Report: if I sat in a report meeting, what would I hear?
Decisions regarding health services/ planning of nursing care	How much of what happens during a shift is known to you at the start of the shift?
	Is there harmony between the decisions related to health care services and what you actually do?
	Does the structure of the health services affect the practice of nursing in any way, and what do you think about this?
	Do you carry out additional work, i.e. work and tasks other than carrying out the health services that are defined in advance? Tell me about your thoughts and experiences on this topic.
Professional competence and development	Do you believe that you have the competence required to do your work?
	Where do you acquire new knowledge from when you need it?
	To what extent are courses, professional meetings, professional reflection and/or guidance available to you?
Closing questions	How has it been to talk to me about these topics?
	Is there anything you would like me to ask you that I have not already talked about?
	Clarifying and complementary questions were also asked during the conversation based on what came up in the individual interviews

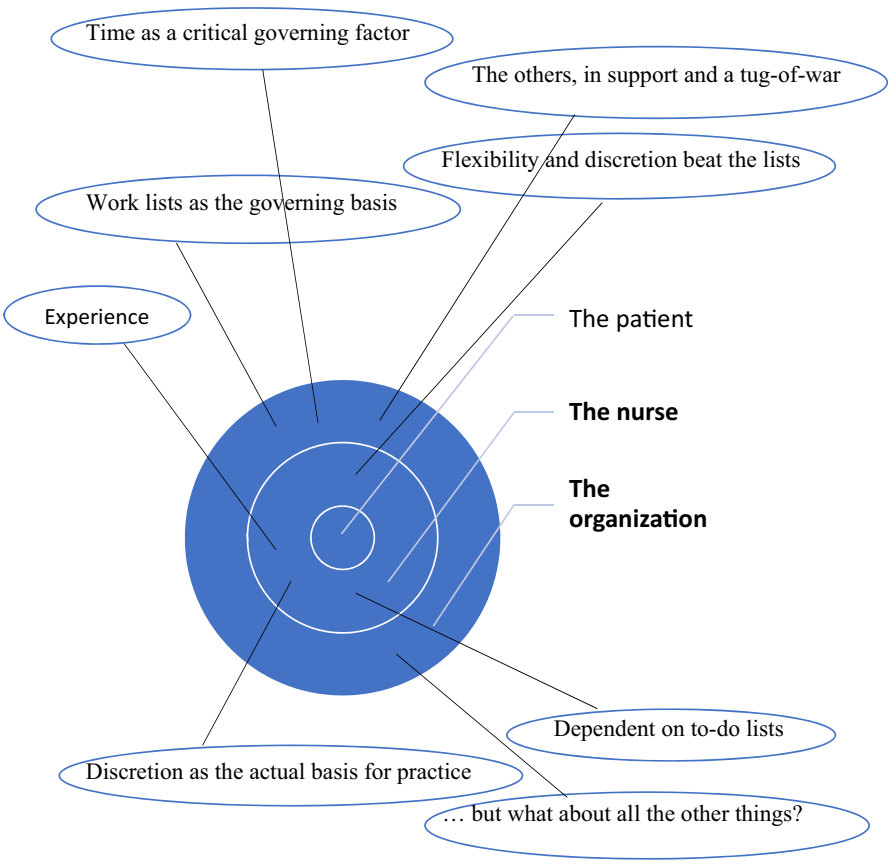

FIGURE 1 Codemap thematic analysis.

TABLE 3 Research question, themes and codes.

Research question	*How do home health nurses experience professional discretion in a purchaser-provider split organization in the Norwegian context?*	
Themes	The purchaser's instructions: Facilitating and constraining care	Professional discretion meets the purchaser-provider organization of health care
Codes	Formal lists—the starting point	Performing additional work - the nurse's compensatory activity
	Informal lists—the crucial support	Flexibility and discretion complement the lists
	To have time or not—busy days and less busy days	

relevant codes and on what should or should not be included in the analysis (Braun & Clarke, 2013). As there was a relatively large amount of data, the authors had several discussions during the process regarding which direction the analysis should follow (Braun & Clarke, 2013). Further, the field and reflection notes were used to contribute to the researchers' reflexivity (Doyle et al., 2020). The themes evolved through continuous interpretation and abstraction. The preliminary themes and codes obtained during this phase are presented in Figure 1. In Phase 5, reflection and discussion led to new processing and new themes and codes. Ultimately, the themes were reviewed to determine their fit with the codes and the dataset, and the final themes were defined. Phase 6 of the analysis consisted of writing the article. In this phase, the discussion and reflection between the authors resulted in four themes with four associated codes being reorganized into two themes with five associated codes.

3.7 | Rigour

The rigour and trustworthiness of the study were established by asking questions regarding dependability, credibility, confirmability and transferability (Lincoln & Guba, 1985). The use of verbatim quotes strengthens the validity of the data generation (Whittemore et al., 2001). During the analysis and the writing process, Braun and Clarke's (Braun & Clarke, 2013) 15-point checklist of the criteria for a good TA was used, which included the whole research process and phases—from the transcription of the data, coding and analysis to the writing of the manuscript. The research team reflected on and assessed various aspects during the analysis (Braun et al., 2022; Patton, 2015), including their role in the research process. Reflection notes were taken throughout the course of the study (Vaismoradi et al., 2013) to support the analysis process and its validity (Whittemore et al., 2001).

4 | FINDINGS

The analysis resulted in two main themes:

- The purchaser's instructions: facilitating and constraining care.
- Professional discretion meets the purchaser–provider organization of health care.

The five codes associated with these themes are further described below with selected interview excerpts to illustrate them. The research question, codes and themes are presented in Table 3.

4.1 | The purchaser's instructions: Facilitating and constraining care

The first main theme deals with how the organizational framework facilitates and constrains home nursing, especially with regard to the formal instructions that define the duties of home care nurses. The three codes under this main theme are 'Formal lists: the starting point', 'Informal lists: the crucial support' and 'To have time or not: busy days and less busy days'.

4.1.1 | Formal lists: The starting point

According to the respondents, work lists form the basis of home nursing and are crucial for ensuring that the work is done given the huge volume of home care services.

At the start of each shift, work lists are distributed to all staff members on duty: nurses, health care workers and others. Most of the lists include home visits to clients who receive various services ranging from simple tasks to more extensive care and treatments or more advanced nursing. Aligning with the respondents, this organization of services can result in poor continuity of care from 1 day to the next.

> We have different zones, and then we're given lists in the morning, and we follow them. Like today, I'll be there, and, tomorrow, I'll be somewhere else. So then, we organise the work in the shift, and we try to distribute it as evenly as possible. And the person who's got a list is responsible for everything on the list that day: writing a report, booking things like taxis and doctor's appointments, all kinds of things like that, and following up tasks on the computer.
>
> (Nurse 6)

How specific the descriptions of the duties in the work lists vary between the considered municipalities. The nurses state that they want lists that describe duties in more general terms to give them

greater flexibility with respect to planning them: '… so we can influence the content of the work, because patient needs might vary a bit' (Nurse 1).

A key factor that governs the organization of home nursing is the use of the right expertise in the right place and the distribution of the work as evenly as possible. The geography of Norway, with considerable distances to and between patients, means that the work cannot always be distributed according to the need for expertise. Due to the significant distances and the available resources, in some areas, it is not feasible to send both a nurse and a health worker to the same place. This can mean that nurses have to perform tasks that other home care providers can do.

The work lists are dynamic and are often altered during a shift if an unexpected event occurs or a task takes longer than expected. The lists can also vary from day to day depending on the available resources. Patients may be moved between lists for optimal workload distribution and use of time by the nurses themselves, the nurses' managers or administrative personnel, and the nurses are also switched between the lists that they are responsible from shift to shift.

> … you're put on a route … you never know where you'll end up next time you come to work because other people are in charge. But then, there are changes as well, and you have to go everywhere because they want to use you everywhere. We're like a parcel being passed around all the time …. The lists are always changing because it all depends on the needs and time. Things are added on, and things are taken off, and there are people whose job it is sit and make these assessments. We tell them about the needs and changes, and if, for example, there's a route with less on it, other patients are moved to that list. So, patients move around between the lists.
>
> (Nurse 11)

The work lists specify the work to be done and are crucial for ensuring that all the tasks are performed. Nevertheless, nurses change the stipulated order of and time to spend on home visits when they consider it appropriate.

> Sometimes, I swap visits. If I think it's better to go to one patient before another one, well, then, I do. So, I sort of do what I want, even though I have a list to follow.
>
> (Nurse 6)

The nurses organize their workdays according to their work lists. In addition to the work lists, informal lists are vital for home nursing.

4.1.2 | Informal lists: The crucial support

Given the complexity of the work, the formal work lists are usually inadequate, and nurses regularly draw up informal lists to ensure that the work is done at the right time and place. Various to-do lists or entries in their diaries are essential for continuity. Informal lists often contain elements that deviate from or supplement the formal lists. Examples include messages from doctors, pharmacies or relatives or patient information provided by experienced nurses that need to be followed up on. The combination of formal and informal lists helps nurses provide high-quality, continuous care.

> When visiting patients, nurses often write reminders in the medical record for themselves and for the person who will take over. Reminders are a key part of their everyday work, and they're crucial to getting the work done.
>
> (Nurse 1)

Home nursing tasks are often complex and require a clear overview and follow-up over time. As nurses have different work lists in each shift and, therefore, do not know who will take over a patient or problem on the next shift, informal notes and reminders are important for the continuity of care. This is how various decisions, changes or other messages are communicated.

4.1.3 | To have time or not: Busy days and less busy days

The work lists include time slots, the order of the tasks to be performed and the stipulated time for each task. Although nurses attempt to adhere to the stipulated schedule, this can be difficult. Too little time may have been set aside for the prescribed task, and it is possible that unforeseen events may occur.

> We get fixed times, but we can't promise we'll arrive then. Things can happen, like alarms or extra work.
>
> (Nurse 7)

If a nurse is behind schedule, they can ask a colleague to help them out by doing some of the work on their list. However, sometimes, the other nurses are equally busy, and the nurse has to do everything themself.

> I try to keep up and follow the timetable, but it gets to a point when I'm so far behind that I don't think about the time for the rest of my shift.
>
> (Nurse 2)

The nurses generally expect some overtime because their lists can be completely full of tasks and have no leeway for any unforeseen events. They do not want to push the work to their next shift, and an important point in this context is that fragmented work can more easily lead to mistakes. To ensure continuity, they prefer to complete their tasks before they end their shift.

> Maybe no one expects me to work overtime, but I'm not going to pass on a whole load of work to the next shift. I finish what I've started, because I've got into it, and it's also best for the patients. If I stop doing something in the middle of it because I didn't have enough time, it can more easily go wrong. It isn't easy to jump in and take over, maybe straight after a day off, and do stuff that's already been started.
>
> (Nurse 13)

The nurses reported that there is often a tug of war between those who provide health care and those who provide formal instructions: 'The ideal practice we read about in books isn't feasible in reality due to the time pressure and a shortage of nurses' (Nurse 5). Nurses spend the amount of time that they consider necessary even if it puts them behind schedule, and they often experience busy and stressful working days.

> … I think I'd like a bit more time sometimes. The days go by incredibly fast, and I feel like I've never got enough time … sometimes, it's just a bit too much. Just now, we're having a fairly quiet period; but, at times, it's so busy that you ….
>
> (Nurse 12)

This comment suggests that the work is generally hectic. This additional work is related to nurses' professional ideals, such as holistic and patient-centred care, and their exercise of discretion.

4.2 | Professional discretion meets the purchaser–provider organization of health care

The second main theme deals with the nurses' professional ideals in their encounter with the PPS as a way of organizing home care services. It has two codes: 'Performing additional work: the nurse's compensatory activity' and 'Flexibility and discretion complement the lists'.

The nurses' observations, experience and professional assessments form the basis of their discretion in deciding what should be done. Thus, their additional work is based on not only their flexible attitude but also on their professional judgement and discretion.

4.2.1 | Performing additional work: The nurse's compensatory activity

The first code is related to the work that the nurses perform in addition to their instructions and work lists. The prioritization and provision of health care requires good organization and interaction both by the nurses and the administration. The nurses perform considerable administrative work in addition to the work lists.

> It's all part of our everyday work, and it sounds easy to arrange for a medication record form for someone coming home from hospital and set up a dispenser. But there's a lot in between—telephone calls, disruptions—so you have to deal with them first before what you just started doing; there are colleagues who need help with something …
>
> (Nurse 15)

The nurses often take responsibility for coordinating the work around patients and interact with other actors. Further, strict documentation requirements are assigned, and, often, there are short response deadlines for various reports on acute events or when making inquiries to different partners. The content thereof neither can nor is described as the nurses' tasks in advance but is, according to the nurses' competence, crucial to do for continuity and, therefore, becomes unseen and unacknowledged work.

> But they don't always see the invisible work we do, like when you get a phone call. It's not just those phone calls; you have to document that you've answered the calls, and you have to do something about the message you got; and it's not just about sending a message, but you have to write and organise and arrange things … The results are visible. But all the steps you take to get there may not be as visible. There are so many steps.
>
> (Nurse 13)

This work falls under the nurses' areas of responsibility and professional standards; it involves considerable tacit knowledge and is not easily noticed by others. It can include administration and coordination or work based on the nurses' assessments of patients' additional care and treatment needs.

While the provision of health care is based on formal instructions, there is a need for services beyond this. Such tasks are not necessarily the responsibility of nurses or included in the home care services but, nevertheless, seem to 'end up in nurses' laps because of their discretionary actions and flexibility.

4.2.2 | Flexibility and discretion complement the lists

The nurses consider formal instructions to be necessary for providing appropriate patient care. However, they also argue for the use of professional discretion and a flexible attitude to ensure person-centred care:

> We have to use common sense and be flexible so that patients feel that things are going well for them. 'No, I can't bring in a bag of firewood because it's not on my work list'—that's not how things work, you know.
>
> (Nurse 5)

The tasks performed during home visits are quite often not on the work lists; some of them are based on the nurses' professional assessment, while some are performed for personal reasons.

> Well, we have our lists to keep to; they're what we're supposed to follow. But then, you realise that today 'Agnes' is having a difficult day and she needs a bit more help than it says on the list.
>
> (Nurse 6)

Observation and assessment are components of the function and methodology of nursing. A nurse's job is to take action based on their observations. This study shows that several actions taken on the basis of observations are not a part of the formal instructions or work lists.

> We do much more than what it says in the instructions, and a lot of it couldn't be written there anyway. Observations that are a part of a nurse's job, like weight loss, skin colour. Different observations that you document, report and must be followed up on. That's much more than what it says you have to do.
>
> (Nurse 6)

The tasks may look simple on the work list, but the patient situation may require the nurses to carry out additional work. For example, checking a patient's blood glucose level as stated in the work list will also involve documentation and follow-up monitoring. Further, the patient's condition may deteriorate, their relatives may call to ask about something or colleagues may need help. Nurses must react with various measures, such as sending messages to the patient's doctor, or different care and treatment approaches based on their latest observations and professional discretion. Such work is not stipulated but is a kind of invisible compensatory task that is vital for high-quality care and continuity. Further, it is entirely up to each individual nurse whether to perform a certain task. Experienced nurses know the consequences of not carrying out such tasks; hence, even if it means having to do invisible, extra work in an otherwise busy working day, they carry out these tasks.

> No one records this work, and my assessments and readings are completely invisible to the system.
>
> (Nurse 8)

The work list governs parts of home nursing; but when nurses visit patients, further work emerges from their assessments.

> It's the patients who control my work. Definitely. I think I do a lot that's not written down. But I do what I have to, what I find important for their day regardless of what it says. I don't talk about it much. I have the impression that we all do it that way.
>
> (Nurse 13)

There is a culture of doing extra work, but there is no culture of openly talking about it. The additional work can be divided into four main types: (1) Work that cannot be included in formal instructions or work lists because it arises at the moment and cannot be predicted, (2) extensive administrative work that follows various events and needs, (3) following professional ideals and using professional discretion and judgement and (4) work required to compensate for the patient needs that are not met by the formal instructions.

5 | DISCUSSION

The purpose of this study was to explore nursing practice in home-based care and examine how nurses' professional discretion is operationalized in health care services that follow a purchaser–provider structure.

The findings resulted in two main themes: 'The purchaser's instructions: facilitating and constraining care' and 'Professional discretion meets the purchaser–provider organisation of health care'.

Our findings indicate that the nurses regard the organization of health care services, which was described according to the PPS model, as necessary because this limits and clarifies the work that is to be done. At the same time, several authors have pointed out the negative consequences of the PPS model, which are partially related to the fact that the model shifts the focus from a person-centred approach to a production approach (Hood & Dixon, 2016; Siltala, 2013; Simonet, 2013; Strandås et al., 2019b; Vabø, 2012). The PPS model entails that any changes in terms of health care provision can take place only after the administration (the purchaser) has altered the instructions, which is not based on the provider's assessment by default. In such settings, the organization of care could be insensitive to the actual needs of patients, especially those that belong to vulnerable groups (Vabø, 2011). The nurses in this study perform work outside the instructions given to them to provide care that is adapted to patients' needs, which can, as other studies have emphasized, be considered a manipulation of the system (Melby et al., 2018; Strandås et al., 2019a; Vabø, 2012). According to our analysis, this work seems to be a practice that is a part of the nurses' professional autonomy, discretion and sphere of responsibility; furthermore, even though they call it extra work, it seems to be extremely vital for comprehensive and qualitative care (Allen, 2015). However, this manipulation and extra work, which stems from good intentions, can perpetuate a dysfunctional organization rather than challenge it.

5.1 | More general instructions

The nurses emphasize the necessity of being able to exercise professional discretion. More general instructions could be a way to allow for this. Unforeseen events can occur during encounters with patients, and many of these, such as those involving acute illnesses, must be addressed immediately. Such events cannot

usually be covered in advance by written instructions. According to Lipsky (2010), professionals who make decisions about others must exercise discretion, as the nature of service provision requires human judgement, which cannot be programmed or completely predetermined, such as in decisions regarding health care services. The so-called 'tame problems' are health care needs that can be included in advance instructions. However, care work will also involve 'wicked problems' (Rittel & Webber, 1973; Vabø, 2014), which are understood as problems or needs that arise at the moment; they may be acute or impossible to predict. In addition, the criteria for formulating health care instructions seem unclear (Vabø, 2012). An ethnographic study demonstrated that institutional guidelines govern the practices of case managers (purchasers) and determine which services will be available to patients. Therefore, case managers play an active role in making assessments to adapt patients' needs to the existing hierarchy of needs (Oydgard, 2018). If the purchaser formulates more general instructions and includes time for additional tasks by recognizing that unforeseen needs can arise, nurses' use of discretion will be acknowledged, and they will be able to address acute and unforeseen events.

5.2 | Nurses' exercise of discretion

The exercise of discretion and judgement is a core element of nursing competence that guides the nurses' practice in addition to their work lists. We find that the concepts of discretion and judgement overlap in that they both include the readiness to act (Alvsvåg & Martinsen, 2018; Grimen & Molander, 2013). Technical and instrumental principles, such as formal instructions, are inadequate in the increasingly complex and unpredictable reality of professional practice; this implies that 'knowing'—such as by establishing a list of tasks to be done—is not enough (Schön, 2001). For many practitioners, reflection is the cornerstone of their professional practice, although this is not always accepted as a legitimate form of expertise (Grimen & Molander, 2013); reflection during action and on action is a key element in the exercise of discretion and good practice (Schön, 2001). Our study illustrates that nurses use observation as a method, such as observing a patient's weight loss, skin colour and bad days and exercise discretion in their work by adapting the individual care they provide as necessary. Thus, they are operating both within and outside their prescribed care framework. The reasons behind why they choose to work outside the framework may be altered patient needs or the fact that their assessment differs from that of the purchaser. Although, Norway has a comprehensive welfare model, well-developed health care services and a less pronounced shortage of health workers than most other countries (Vabo & Vabø, 2014; WHO, 2022). These may be the reasons why nurses can find the time and space to exercise their professional discretion and go beyond their prescribed duties.

Discretion is based on first-hand experience and is thus a personal quality (Polanyi, 1967, 2000). Hence, the discretionary assessments and practices of practitioners within the same profession may vary, although one can expect similar practices from the same profession (Grimen & Molander, 2013). While the exercising of discretion and judgement can lead to more personalized health care, it can also create differences in practice. In a PPS-based structure, the provider's practice is linked to and described in health care instructions and translated into work lists. If the lists contain a large number of tasks in a tight time frame, this will affect the time available to the provider to perform additional work or act on the basis of their professional judgement. The nurses in our study find room to exercise discretion and address the needs or problems that arise, although this leeway is experienced differently. They try to identify priorities or take shortcuts to perform the tasks that they consider important, especially on busy days. If they are very busy, they use their lunch break, work overtime or contact their colleagues directly instead of following the prescribed path.

Professional competence is a personal quality, and it can be difficult to gauge a person's professional discretion due to its very nature. Enhancing nurses' self-confidence by acknowledging their assessments and judgement, which are often based on tacit knowledge, is a sign of developing expertise and advanced skill in nursing practice (Lake et al., 2009; Polanyi, 1967, 2000). As Allen (2018) points out, nurses have no authority to perform this part of their role, but studies have shown that their skills and competence are unique in leading and coordinating care work (Smolowitz et al., 2015). They use their professional discretion and judgement when following their instructions and when performing tasks that are beyond the instructions. It is important to recognize that both these aspects are central to nursing practice.

5.3 | Nurses' administrative function

Nurses' administrative work and coordination are key to the provision of high-quality health care (Fjørtoft, Oksholm, Delmar, et al., 2021), and they ensure that care tasks and services are carried out at the right time and in the right order (Allen, 2019; Bardram, 2000). They monitor patients and anticipate the next treatment step, thus ensuring timely care. They are also usually the first to discover patients' needs and address them. Nurses become the 'eyes and ears' of the organization, and other actors depend on their assessments and discretion to guide their actions (Allen, 1997, 2019). In our study, the home care nurses describe this as extra work because it is not usually included in their instructions. It is undocumented additional work that is carried out based on the nurses' assessments or at the request of other health care personnel. This study demonstrates that such work is vital for the continuity of care and patient safety. It must, therefore, be recognized to a greater extent to prevent it from remaining an undocumented additional practice. Due to nurses' competence, their function as the organization's 'eyes and ears' and their use of discretion, other actors come to depend on their assessments and discretion.

Nurses play a key role in home care; given the complexity of home care needs, their tasks cannot be solved with simple solutions based on rules and formal instructions, as seen in this study and others (Larsen et al., 2017). Nurses' administrative work involves considerable discretion and judgement and consists of complex processes that require high levels of professional and personal competence as well as organizational and business acumen. This highlights the requirement of experience to understand the health care services that patients receive at different levels from different providers (Grimen & Molander, 2013). It also highlights the need for a specific professional logic, as opposed to the management logic of the PPS, due to contradictions between nursing ideologies, professional ideologies and ideologies that stem from NPM (Olsen et al., 2021; Waerness, 1984; Wollscheid et al., 2013). The nurses in our study had an average of over 14 years of home nursing experience. Other findings also indicate that work experience has a direct influence on the exercising of professional discretion and affects whether care managers deviate from the defined guidelines to increase freedom of action in health care (Olaison et al., 2018). Further, other findings from home-based nursing suggest that the verbalisation of skills is enabled through the mobilization of competencies through work experience and reflection (Andrade et al., 2017). Competencies are derived from an ongoing process of knowledge, experience and reflection. All these factors suggest that the nature and complexity of home nursing necessitate experienced nurses (Allen, 2019), which implies sound knowledge about patients and the anticipation of the next step to ensure that the right treatment is provided at the right time and in the right order. Furthermore, other actors will be entirely dependent on these nurses, as they are the eyes and ears of the organization.

5.4 | Organization, professional discretion and the mixed blessing of flexibility

This study indicates the desirability of the proper organization of health care services. In addition to nurses' considerable administrative work, they need flexibility, which can provide them with the time and opportunities required to perform the care tasks that arise from acute events or needs or are based on their professional discretion and assessments at the moment. Discretion has been explained as a relative concept that can only exist in relation to something else: 'Discretion under which standards? … discretion as an area left open by a surrounding belt of restrictions' (Dworkin, 1978, p. 31). In an organization that follows the PPS model, these restrictions will be formal instructions, resources and legislation in addition to the standards of professional expertise and ethical guidelines. Discretion can thus be exercised in relation to these frames. Hence, according to this understanding, the freedom to exercise discretion is relative and can be strong or weak depending on the leeway provided and the strictness of the rules or standards (Grimen & Molander, 2013). One can, therefore, argue that professional discretion can be exercised within organizational frameworks such as the PPS and formal health care instructions, resulting in two complementary sides of the same process.

Our study illustrates that home care nurses are dependent on a certain organizational structure to enable them to provide health care services due to the complexity and diversity of care provision. The PPS also enhances control over resource distribution. However, our findings show that the complexity means that formal instructions (from the purchaser) are inadequate for providing quality health care. Ironically, in provider units where the 'rules were undermined', the team leaders seemed to be the most satisfied with the quality of the home care that they delivered (Wollscheid et al., 2013). In addition to unanticipated needs and events, not everything in nurses' assessments can be articulated or described in the instructions or work lists. The core of professional practice is the practitioner who exercises discretion (Freidson, 2001); this calls for flexibility to allow nurses' discretion to unfold, and a trust-based innovation of municipal home care with a 'trust model' instead of a PPS could be a solution for this (Eide et al., 2022; Schön, 2001).

In clinical practice, care providers generally do 'whatever it takes' to provide quality care and maintain a trusting and respectful relationship with patients (Young et al., 2018), and nurses are the professionals who often take responsibility for rectifying the situation when something does not work (Danielsen & Fjær, 2010; Olsvold, 2010). However, such flexibility can be a mixed blessing. When nurses have flexibility in their work, they may overburden themselves, and some may expect overtime due to the additional tasks that are created through their professional discretion or urgent needs. The ideals of care and a holistic approach, in the face of seemingly never-ending patient needs, can lead to a practice where nurses go beyond their sphere of responsibility, leading to them having excessive workloads. Although health care needs may be limitless, care work still requires limits. Legislation, formal instructions, specifically allocated resources, professional competence and professional ethics form the framework for nurses' work. On the one hand, these factors set limits for their work; but, on the other hand, nurses also need to exercise professional discretion, and there is tension as well as conflicting interests and logics related to their professional discretion, the number of tasks to be completed and the organization of the services. However, nurses' use of discretion entails additional work within the prevailing organizational framework. Different types of logic play a part in such frameworks, such as the management logic of the organization and nurses' autonomy, professional competence and caring logics. Further, the top-down control limits the nurses' scope to exercise discretion and, thereby, provide person-centred care.

5.5 | Limitations

One limitation of this study is related to the transferability of the findings, as this study only considered a single country and its way of organizing health services, which may differ in other contexts. It

is also considered a relatively small sample, which may affect the validity of its findings. Further, we did not have information regarding when the PPS was implemented in the individual municipalities, which could be a limitation as well. Finally, a different study design could provide insights into the differences that could be identified from the nurses' experience regarding the PPS model.

6 | CONCLUSION

Our research shows that nurses are dependent on an organizational framework due to the complexity of health care services and the amount of work involved. In addition, nurses need the ability to be flexible to enable them to respond to unforeseen patient needs or events and use their discretion to maintain professional standards in situations that may arise. More general instructions for health care provision could be a solution for this challenge. Further, the purchasers and providers could be employed within the same entity through an organization based on trust so that the nurses can influence the formal health care services provided to a greater degree.

Home care nurses perform many tasks in addition to their formal instructions, including considerable administrative work and the coordination of care. They have a holistic perspective and perform additional work that is invisible in the sense that it is not included in their instructions or formal work lists. This aspect of the nurses' compensatory practice, their role and their competence is central meeting the demands of the home care service and the nurses' professional quality, and must be acknowledged by home care managers and health policy-makers.

AUTHOR CONTRIBUTIONS

All authors made substantial contributions to conception and design, and acquisition of data. First and third authors analysed and interpreted the data. All authors were involved in drafting the manuscript and revising it critically for important intellectual content. All authors gave final approval of the version to be published. All authors agreed to all aspects of the work.

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DATA AVAILABILITY STATEMENT

The data used in this study are available from the corresponding author on request.

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