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'The night is for sleeping': how nurses care for conflicting temporal orders in older person care

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ABSTRACT

This paper examines the conflicting temporal orders of the regional nurse, a role which has been introduced to deal with the increasing demands of aged care and workforce shortages in regional settings. We build on ethnographic research in the Netherlands, in which we examine regional district nurses as a new professional role that attends to (sub)acute care needs, connecting and coordinating different places of care during out of office hours. We use the concept of 'temporal regional order' to reflect on the different ways caring practices are temporally structured by management and care practitioners, in close interaction with patients and informal care givers. In the results three types of disruptions of the regional temporal order are distinguished: interfering bodily rhythms and needs; (un)expected workings of technologies; and disrupting acts of patient and relatives. It was region nurses' prime responsibility to stabilise these interferences and prevent or soften a disruption of the regional order. In accomplishing this, we show how nurses craft their professional role in between various care settings, without getting involved too much in patient care, to be mobile as 'temporal caregivers'.

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Introduction

> The phone rings at the primary care center, it is 8 o'clock on a Thursday evening. The partner of an older woman with Parkinson's disease and dementia is on the line. His wife has just fallen on her back. She is at home, in pain and confused. He seems anxious, not knowing what to do. The GP calls the local hospital's geriatrician, but the geriatrician refers her to the neurologist who is familiar with the patient's health issues. The neurologist however states that the patient can only be brought in when there is a bed available at a nursing home, as she can't stay in the hospital. The local nursing home doesn't have any beds available. The GP contacts the region nurse on call; maybe the region nurse can visit the patient at home? (Weekend shift, January 2022, Fieldnotes)

This excerpt comes from our ethnographic study in which we observed region nurses in their work. The regional district nurse (from now on 'region nurse') is a new professional role in

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the Netherlands, introduced to provide (sub)acute care for older persons during out-of-office hours. Region nurses work in an ambulant team, travelling between nursing home locations, the primary care centre, and private homes, connecting these places of care. This new role aligns with a Dutch policy reform to keep people at home as long as possible and to prevent admission to an acute care hospital or long-term social care institutions (Dungen & Koesveld, 2018; VWS, 2020). This policy, under the slogan 'the right care at the right place', has been critiqued by sociologists as an austerity measure to deal with an ageing population, in addition to increasing health workforce shortages (Dungen & Koesveld, 2018; Klerk et al., 2019). Whilst the assumption that these policies result in efficiency gains has been questioned elsewhere in the literature (Schuurmans et al., 2023 Wittenberg et al., 2018), in this paper we focus on the consequences of the region nurse for the organisation of care. This policy shift ensures that issues surrounding care shortages, which mainly occur during out-of-office hours, must be solved by the providers and practitioners. As a consequence of these new policies, healthcare organisations have expanded regional collaboration and introduced new professional roles, such as a regional nursing teams to enhance care capacity (Van Pijkeren et al., 2021). We are interested in how this shift is accomplished and its consequences for patient care and professional work.

The promise of regional and home care provision as a place of appropriate care has become key to policy agendas in various countries in the global North in recent years. In these countries, governments seek to reshape healthcare provision and shift responsibility to patients and their relatives to contain costs and deal with workforce shortages (Evans et al., 2018; Jones et al., 2019; Lorne et al., 2019; Schuurmans et al., 2020). Sociologists studying this transition have focused on the policy and care infrastructures facilitating the rescaling and replacement in long-term care (Carstensen et al., 2022; Lorne et al., 2019; Oldenhof et al., 2016). This literature draws attention to the work that healthcare professionals, patients and their families do to replace care services and create a caring place at home (Langstrup, 2013).

Yet the regional organisation of care not only requires the remaking of policy, professional roles and care infrastructures, it also reconfigures care in time and space. Regional care provision, such as through the region nurse, stiches together various places of care with different 'temporal orders' (Blue, 2019). Temporal orders are a set of rhythms in time that shape the connections between practices. The timing, routines and sequences of events and practices in a nursing home are different from those in a patient's home, because of ossified organisational rhythms – e.g. the structuring of events in time like consultation rounds and multidisciplinary consultation, versus the more idiosyncratic rhythms of patients living at home to which nurses have to abide (Ward et al., 2022 White, 2022). In this paper we study the ways in which the new temporal order of the region becomes established and the work that region nurses do to sustain this temporal order.

In our analysis, we draw on a growing body of literature which seeks to understand the intersections of temporality, care and care work for older persons (Balkin et al., 2023; Hirvonen & Husso, 2012; Ihlebæk, 2021 Tufte & Dahl, 2016). This literature offers insight into the temporal (re)structuring of healthcare, elucidating how various logics have taken priority over the organisation and production of care for older persons. Much of this work has been concerned with studying the ways in which neoliberal policies of organising care impact the temporal orderings of healthcare work. They specifically focus on the 'objective' time (quantifiable and manageable) logics of new public management versus the

'experienced' time (embodied) of patients and healthcare professionals (Balkin et al., 2023; Hirvonen & Husso, 2012 Tufte & Dahl, 2016; Ward et al., 2022). This literature stresses the concern about a rationalisation and dehumanisation of care relationships through objectification and commodification. Such studies for example highlight the unpredictability and invisibility of body work that healthcare workers engage in, making it hard to standardise healthcare practices (Cohen, 2011; Davies, 2003). Further, these studies reveal the lack of time to perform caring work, as well as the agency of nurses in managing those tensions (Balkin et al., 2023; Kuijper et al., 2022).

In this paper, we aim to go beyond the distinction between 'objective' and 'experienced' time and study how time is constitutive of (nursing) practices (Blue, 2019). We will argue that time plays a crucial role in defining and shaping care practices, and in establishing a regional order of care. We determine how, spurred by health workforce shortages, a regional temporal order is constructed that reconfigures how caring practices, and hence care itself, are ordered in time. More specifically, we examine how the region nurse performs temporal work to make the regional temporal order possible. In accomplishing this, we show how region nurses struggle with crafting their professional role in between various care settings and their distinct temporal orders, without getting involved too much, in order to be mobile as 'temporal caregivers'. The following research question guides our research: *How do region nurses engage with different temporal orders in older person care when shaping regional care provision, and what are the consequences for how care is provided?*

Theoretical framework

In this section we elaborate on the concepts of temporal orders, institutionalised rhythms, and temporal work. Time as a term is understood and used differently across disciplines (Blue, 2019; Massey, 2001; Ringel, 2016). In this paper, we draw on a conception of time as 'a constitutive effect feature of practice' (Blue, 2019, p. 935). In other words, time is not a neutral background against which caring practices take place, nor something that is experienced within a specific practice, but rather a fundamental element that shapes those practices. In this paper, we analyse how organising care in a regional setting affects the temporal ordering of care and care work.

Temporal orders have been described as a 'set of temporal rhythms that shape connections between practices' (Blue, 2019, p. 934). They can be predefined and rationalised, for instance in the work routine and organisational time schedules. Yet temporal orders also exist more distinctly and fluently, such as the rhythm of a person's evening routine (Tufte & Dahl, 2016). One of the characteristics of temporal orders is that they influence each other, as practices and routines are connected and open-ended. Blue (2019, p. 934) gives the example of the working day in a hospital to illustrate how temporal orders can intersect. The activities during the day, such as consultant rounds, clinic appointments, surgeries, and other tasks, follow a specific sequence and are connected to one another. Such a daily temporal order is further affected by the temporal order of the week, as well as broader temporalities like seasons, or economic cycles. The institutionalisation of a regional temporal order thus includes the coordination of activities over different rhythms. Our focus in this paper is on how regional nurses perform temporal work to mediate between different temporal rhythms.

Temporal orders can be interrupted by events that disrupt routinised, or expected, sequences. These are what Blue (2019) refers to as 'rhythm disruptions', or as 'arrhythmia'.

Aligning various temporal orders and accounting for rhythm disruptions in various time-space(s) can be considered an intrinsic part of providing nursing care (Kuijper et al., 2022). Moroşanu and Ringel (2016), for example, coined the concept of 'time tricking' to show how practitioners enact time by, for example, speeding up death in a dying process or, on the contrary, delaying death to give people time to say goodbye to family and friends. Others have argued that time management appears to be easier to realise in a hospital setting than in long term care. These settings often require 24/7 attention with more unpredictable moments of care, for example, an older person wandering around (losing sense of time and place), fall incidents at home, or forgetting or taking the wrong medication (Balkin et al., 2023; Burns et al., 2023). Meldgaard Hansen (2016), for instance, shows how long-term and home care for older persons is mostly about finding and adapting care routines to life rhythms. Nurses, Ihlebæk (2021) argues, learn to enact a temporal reflexivity by knowing when particular temporal structures are required and how to use them in an ongoing and adaptive response to emerging care needs. These literatures particularly focus on a specific care setting, and not so much on the coordination of temporal rhythms at distinct and multiple places of care provision that must be brought together to create a new temporal order of (regional) care.

In relation to care, research has shown how patients' (bodily) needs, like in cases of sudden illness or emergencies, can disrupt organisational routines and schedules (Andersen & Bengtsson, 2019; Cohen, 2011; White, 2022). In healthcare institutions, increasing emphasis has been put on time-efficiency and task-predictability, stressing a neoliberal or 'managerial logic' of care (Tufte & Dahl, 2016). In this logic, tasks are understood as linear actions that can be counted and scheduled, suggesting a work environment that can be planned. This managerial logic has been critiqued by sociologists, who have argued that patient lives and care needs are often messy and unpredictable – for example, an older person becoming restless because of an emerging bladder infection or decreasing blood sugar level may require more continuous care than anticipated within such models (Mol, 2008). Performing care work is not linear, but is instead organised through variable and often unpredictable processes; care is infused with temporal orientations of enduring, waiting, prolonging, and hastening (Lemos Dekker, 2020 Tufte & Dahl, 2016).

Understanding how care practice is temporally managed and enacted requires us to go beyond the dualism of objective and experienced time by focusing on how different practices are temporally connected. According to Blue (2019), these connections may impact the entire nexus of practices, evoking a substantive (institutional) transition as new practices are reproduced and strengthened. We study how such a transition includes both routines and a valuation of what is considered (good) care (Ihlebæk, 2021; Schuurmans et al., 2023). Building on this literature, we explore how nurses engage with different temporal rhythms in older person care in the regional setting, how they (seek to) synchronise them and with what consequences for nursing work and care provision.

Ethnography of regional nursing care

Research setting

The ethnographic study was carried out in a long-term care region in the eastern part of the Netherlands between August 2021 and August 2022. Being part of an ongoing,

national research program (2018–25) on regional collaboration (Schuurmans et al., 2020; Van Pijkeren et al., 2021), this paper draws on one specific case study that was marked internally as a promising initiative by both policymakers and organisational actors from other regions, who framed it as 'best practice'.

In January 2020, a team of regional district nurses were introduced by six nursing care organisations. Sixteen nurses who previously worked for these single organisations were selected for this new role. They received additional training in nurse-technical procedures. The region nurse was introduced to find a solution for pressing workforce shortages in long-term care during out of office hours in the nursing homes, and eventually also home care. Home care was included, as the expertise of the region nurses was considered valuable for older persons living at home by both the management and general practitioners.

Region nurses are consulted in case of acute or urgent (yet not life threatening) situation, like patients with catheter or dripline problems, fall incidents, or restless behaviour. Nurses and nurse assistant working at the nursing home or in home care should consult the region nurse, instead of calling the physician. Region nurses, in turn, can consult a physician to discuss medical issues or to prescribe drugs – as this is legally preserved to medical doctors. The idea (and hope) is that the new role of region nurses will lower the pressure on both elderly care physicians and general practitioners, and that the region nurse can support care practitioners at different locations, leading to an outcome where more care can be given with less staff.

Data collection and analyses

Participants from the regional district nurse team were directly invited to participate in the study via one of the nurses, who frequently gave presentations about their work at conferences related to the research program. We shadowed care practitioners (i.e. region nurses, home care nurses, nurses in the technical team) during their shifts, allowing for informal conversations and reflections on their role and work. Additionally, the first author attended project meetings and conducted both formal and informal interviews with care practitioners and one regional care manager. We joined nurses in their cars, visiting a patient or picking up medication, and shadowed them in the nursing home, the primary care centre and at patients' homes, examining patients, talking to care workers and consulting a physician (amongst others). We observed eight region nurses, and two nurses were observed twice. Observation lasted an entire shift, usually eight hours or more (e.g. some shifts were longer because of an urgent call at the end of a shift).

Interviews and observations focused on the temporal work performed by the nurses, the choices they made, their rhythms and pace and the coordination of tasks between settings. In total, 10 shifts and 3 management meetings (60–90 min each) were observed, 120 h of observation in total. Also, we observed the technical nursing team twice. This team operates separately from the region nurse, focusing on technical clinical procedures at home, like adjusting a PICC line (peripherally inserted central catheter), starting sedation or administering chemotherapy at home. We aimed to get a better idea of their tasks and how those differ or overlap with the region nurse (32 h in total), as this appeared an important discussion in the region. Notes were made during observations and worked up in detailed observation transcripts shortly after. The interviews were recorded and

transcribed as well. All participants gave permission for the research. Ethical approval for the research was obtained through the wider project by [Erasmus University Rotterdam] in the Netherlands.

We used open coding at first with the research team engaging in discussions about the main codes for further analysis. Between coding sessions, we read various literatures related to our analytical focus on temporalities of care practice, which supported our iterative analysis of the data (Tavory & Timmermans, 2014). In our analysis we distinguish between the temporal order of the region, of day and night care, and the temporal order of patients and relatives. We analysed how these orders intersect and what factors disrupt the regional temporal order of care, leading to the following themes: bodily needs and rhythms, (un)predictable technologies, patient and relatives' routines.

The following section presents our results. Excerpts and quotes have been selected to illustrate the themes. The research was conducted in Dutch; quotes have been translated by the authors into English for the purpose of this paper.

Results

Our analysis shows how a 'new' regional temporal order in the evening, night and weekend shifts is enacted through a reorganisation of nursing work and the use of care technologies. However, long-term care is by nature unpredictable and during a shift, various events or 'crises' emerge, jeopardising the new regional temporal order in the making. Region nurses, as a new professional role, stabilise these situations and fosters the new temporal order. In doing so, they act as 'guardians' of the new regional order and institutionalise its rhythm in and through caring practices.

Making a new regional temporal order

With the scaling of care to a regional constellation, various sites and their specific spatial–temporal ordered practices are brought together. In what follows, we show how a temporal order of the region is constructed through various new approaches to care provision (a new professional role; a new care team), the use of specific technologies and the mobilisation of informal networks of care of patients. We argue that the logic behind this new regional temporal order is inspired by a managerial or efficiency logic, aiming to do the most with available scarce resources.

The temporal order of day and night care

Our respondents report that workforce problems are most acute in out of office hours shifts. To make care provision more efficient during these irregular hours, the management team aimed to distinguish between planned and unplanned care. Planned care refers to care that 'can be predicted, scheduled, or postponed'. As the regional care manager explained: 'non-acute [care] should be taking place during the day as much as possible and no longer during the night. The night is for sleeping' (March 2022, healthcare manager, interview). To establish this new temporal care order, organisations had to make sure that 'care is provided sufficiently during the day'. This, amongst others, was achieved through good care planning, anticipating and acting on possible swiftly deteriorating conditions of patients during regular hours. Furthermore, a technical team

provided planned care at daytime (e.g. parenteral nutrition, artificial respiration, administering morphine in terminal phase), meeting all the expected daily care needs of care recipients. One of the aims of the technical team was to make sure that no regular care activity had to be done during the evening, night or weekend. During the working day, nurses and physicians of the collaborating organisation took up unplanned care needs of patients. Managers of various collaborating healthcare organisations hoped to reduce the number of full time equivalent staff allocation of nurses and physicians working these shifts by reorganising care and cutting out, as much as possible, planned care from the evening, night or weekend. However, as managers were keenly aware that moments of unplanned care also happened during out of office hours, a new professional role of region nurse was created. The schedules of the region nurse left room for taking up the unexpected care demands of persons in the last life phase. The region nurses had no fixed appointments as they always wanted to be available for a possible urgent (and hence 'unplanned') care demand.

The new regional temporal order was also dependent on the way in which patients' informal care networks could be mobilised by care professionals to perform certain tasks. Informal caregivers helped to establish the new regional temporal order through various practices of care. Family members, for instance, were asked to pick up medication at the weekend pharmacy, or to provide a clean and dry environment at home to store or dispose medicine safely. The new temporal orders required patients and their relatives to be more self-reliant. In one of our conversations, a region manager explained:

> For three years we helped Mrs. Jansen to go to the toilet at night,' the region manager explained. 'We no longer do that. We try to prevent toilet visits [by making sure Ms. Jansen stops her routine of drinking tea before going to bed]. The patients really appreciate that they are no longer disturbed during the night.
>
> Are there situations where planned care is insurmountable? I [interviewer] ask.
>
> 'There are cases where it is medically necessary,' the manager explains. There is a patient, for example, who is bedridden at home and who must be turned over during the night to prevent bed ulcers, and this person has no adequate informal care support. But overall, there are fewer care moments at night and therefore there is less personnel needed.' (Fieldnotes)

This excerpt shows how patients and their families are encouraged to support and hence cocreate the new regional temporal order, one in which the night is for sleeping and professional care is mainly provided during regular working hours.

At the same time, technologies were introduced to help to establish the new regional temporal order. New technologies such as sensors, alarm buttons and fall floors aim to reduce crisis situations and to make care more predictable. We encountered various examples of technical interventions, for instance monitoring devices that enabled care providers, patients, and their relatives, to better manage care needs. For example, sensor technology was used to monitor patients remotely during the evening, reducing the need to visit patients for check-ups, particularly during evening, night and weekend shifts. These technologies, enabled a region nurse to have less contact moments.

It was the region nurses' primary task to attend to unforeseen care needs, instances that threatened to disrupt the new regional temporal order. In what follows, we tease out the temporal work that region nurses performed as guardians of this new temporal order 'in the making'.

Nurses' role as temporal caregivers

In our research, we witnessed various moments in which the new regional temporal order was disrupted by sudden bodily needs, malfunctioning technologies and uncooperative patients and their loved ones. At these moments nurses performed temporal work to stabilise these situations and prevent enduring disruptions of the new regional temporal order.

Moving fast, staying short

Bodies of older persons with complex care needs could not always be 'disciplined' into the new regional temporal order. Caring for psychogeriatric patients meant that disruptive situations occurred frequently, also during out of office hours. A patient, for instance, could become delirious and not only require instant attention of care professionals, but also possibly get restless and agitated, waking up other residents. During one of our observations, such a crisis emerged. The region nurse was called upon to assist at a nursing home where an older lady was wandering around, urgently demanding attention from the care staff:

> The patient does not physically resist but is not cooperative either. She moves like a dishcloth that must be unfolded again when putting on the bed. 'What have I done, she asks, I'm not guilty, am I?' The nurse tries to reassure her: 'You are not guilty, but the doctor [region nurse] is here to check on you.' The lady mutters about guilt, photos, her mother … She is obviously confused and anxious. The care worker explains that the patient has been restless all evening. She asks for tranquilisers to have a peaceful night. She states that she cannot keep an eye on this patient the whole night as she also must care for seven other patients: 'Something has to be done now!' she exclaims. (Evening shift, August 2021, fieldnote)

This situation occurred when nurse aides were getting their patients ready for bed. The delirium of the older lady disrupted the care rhythm of the nursing home. The nurse aide asked for immediate action (providing tranquilisers) to bring back quietness and rest on the ward – also for the sake of other patients who were getting increasingly agitated. At the same time, the caring process on the ward had to proceed on as other patients wanted to go to bed. Yet the region nurse must be available for other possible emergencies and requests in the region, and he could not stay long with the patient. After consulting a physician on call at home, the region nurse decided not to prescribe any tranquilisers:

> 'It is a skinny woman and she doesn't get much medication at all; if we give her something now, she'll drop down in no time,' the region nurse said. Instead, he suggested using a fall mattress and a sensor to monitor movement and respond to this. The care worker expresses her concerns. From 11pm onward, she would be alone with the group. The region nurse, however, stuck to his decision. 'This is more a problem of the care workers than the patient,' he argues back in the car. (Evening shift, August 2021, fieldnote)

During our observations, we regularly encountered similar situations. The preservation of the order in the facility was privileged above the patient state, at least from the perspective of the care worker. This was opposed by the region nurse's, who thought of it primarily as a problem of the care workers rather than of the patient. The temporal work carried out by region nurses focused on stabilising the situation and preventing serious disruptions of the regional temporal order, while also keeping up with quality care.

The temporal work of region nurses to sustain the new regional temporal order had implications for how they related to time, to care and to patients. Time to sit with patients was generally scarce, and region nurses deliberately did not engage in the care process, including when it was quiet. Instead, they preferred to spend these moments 'backstage', alone or with fellow care professionals behind a computer, at the coffee station or in the car. They explained that their role was to be flexible and to move around, and not to take over care work. Region nurses kept an eye on time and anticipated a (possible) visit to other places. They continuously contemplated how long they could stay in a situation and when to leave for the next visit. In doing so, region nurses made sure not to get involved too closely, for instance by postponing a phone call, delaying a visit, or leaving a care unit when it was obvious that 'more hands' were needed. Yet they deliberately did not consider this part of their work. They made sure not to become part of a local problem and to remain mobile in their role. Their primary concern was to stabilise a precarious situation – restoring the temporal order – so that the problem could be addressed at a later moment (during the next day, or after the weekend). As one of the region nurses explained: 'We solve an issue for the night or weekend'. In doing so, they 'cared for' a situation but kept emotional and social distance and did not take full responsibility for the care process (Milligan & Wiles, 2010).

Predictability versus flexibility

Although various technologies were introduced to foster the making of a new temporal order, they did not always play out as intended. Technologies sometimes had unintended effects, jeopardising the new regional temporal order and requiring work from region nurses to step in. The following excerpt illuminates how a technology to enable 24/7 care had unforeseen implications, requiring more and frequent care:

> We visit a woman who uses a device around her neck to administer a 'bolus' to increase the dose of apomorphine which goes through a drip line in her belly. The medication softens the symptoms of Parkinson's disease. However, her skin is infected due to high doses of the medication. The region nurse visits the patient to clean the wound and instruct the woman how to use the pump. The patient however denies that she gives herself a bolus too frequently. The region nurse suspects addiction to the medication. She concludes that they must visit more often, increasing the moments of care instead of replacing human care through technology. (Evening shift, May 2022, Fieldnotes)

Technologies that should facilitate a regional temporal order might result in new work and an increase of contact moments by region nurses. In this case, the technology of the bolus injection made it possible for the patient to administer medication in case of worsening pain. In theory, this would reduce the number of nursing visits, contributing to the temporal order of reduced and regular care provision. In practice, however, it also gave rise to (new) challenges such as addiction and skin problems that required more frequent care visits and hence time spent with the patient at home. In this case, the region nurse accepted that there was an immediate need for more frequent contact and hence the expansion of time as a response to bodily needs, and in the hope of preventing an addiction from escalating and potentially posing an even more serious threat to the new regional temporal order.

Beyond the unintended consequences of technologies, other threats to the regional temporal order included families. In some cases, patients as well as families, did not

want to settle into the new rhythm of collaborating care organisations. Struggling with a defect bladder catheter in the middle of the night, for instance, can make patients or their informal caregivers feel ignored and not cared for. Attending to these care demands helps to ameliorate such feelings. During one of the shifts, a region nurse explained that a lot of phone calls are about bladder problems (something seen as 'daytime care'). Ignoring these requests or finding a quick solution is not always possible. Instead, spending time and listening to the patient is important, it was argued:

> The patient must be taken seriously. What are the patterns? When does it bother them? Simply placing a catheter and 'flushing' or replacing it in case of a complaint is usually not the best solution. (Weekend shift, May 2022, Fieldnotes)

This excerpt depicts a situation in which the 'night is for sleeping' precept is interrupted by patient's immediate needs. Region nurses seek to attend to those needs and in doing so protect the regional temporal order by stepping in. These disruptions also emerge when informal care givers do not want to comply with the new organisation rhythm and expected actions from them, as is illustrated in the following excerpt:

> We are on our way back to the emergency post at the end of the shift. It is 11PM when the region nurse is phoned by the call centre. This family has called for the third time this night and urges the operator at the call centre to ask the region nurse to visit them. The region nurse has been there earlier today and is aware of the difficult family situation. When we enter the house, the patient is lying on a bed in the living room in front of a big television screen. In the corner of the room, his wife and daughter are sitting in front of another television smoking cigarettes. While checking upon the patient and flushing the catheter, the region nurse tries to speak with the daughter. The nurse explains that her father is doing fine, as was the case during her previous visits. She asks them what they are worried about. The daughter answers that whenever her father complains about pain, she will call. When we leave, the region nurse explains that she finds it hard to deal with situations like these, as it is not so much about the actual pain but more about the living conditions of this patient and how this family copes with the disease and the inconvenience that comes with it. (Evening shift, January 2022, fieldnotes)

This excerpt illustrates how patients and their relatives do not always settle neatly into an established organisational rhythm. In this case, the family insisted that the region nurse visits, while the condition of their loved one does not require immediate medical attention. However, the temporal work of the region nurse at the patient's home ensures that the patient and family situation is stabilised and does not escalate, not putting any pressure on acute care services.

Discussion

The aim of this paper is to develop an understanding of the spatio-temporal restructuring of older person care in a region with growing capacity problems. In our research, we have built on the notion that time is constituted with practices (Blue, 2019) This has turned our attention to the care provisions, technologies and care work performed by professionals, informal care givers and patients to enact a new regional temporal order. One in which enormous coordination and work is enacted to preserve the idea that night is a time for sleeping. We have particularly focused on the temporal work of region nurses to prevent and repair disruptions of this order, highlighting their role as

guardians of the night. We showed how their actions contributed to the institutionalisation of this new temporal order through caring practices.

The regional temporal order was produced through a reconfiguration of caring practices of various actors – care professionals, patients, informal caregivers – at various moments. The new regional order for instance required a reconfiguration of caring practices not only during the night, but also during at daytime. Specialised technical nursing teams were positioned to provide planned care during office hours, for example by using advance care planning to prevent potential care needs in the evening, night and weekends. We have empirically illustrated the dependencies between various temporal orders. For instance, the rhythms of the nighttime and daytime, rhythms of care in facilities vis-à-vis the temporal order of the region. In doing so, the spatial temporal restructuring of work requires a reconfiguration of work routines at various moments throughout the day (Blue, 2019).

We also illustrated how nursing work of region nurses and hence care itself were reconfigured. Various scholars have argued that values of good care are both constitutive of practices and produced by acts of care (Oldenhof et al., 2016; Schuurmans et al., 2023). In this research, nurses moved 'in and out of care', anticipating potential emerging crises. Even during a quiet shift, region nurses made sure not to stay long at a patient's bedside, only stabilising a situation to prevent any threats to the regional temporal order. They preferred lingering on the backstage, above hands-on caring for patients and frontline care workers, which was furthered by their urge to always be available for the next possible call. This analysis shows how the enactment of a new regional order required the repetition of certain acts that produces particular values of what good nursing care is. In this case, good care is 'just doing enough' to prevent an emerging crisis from escalating (Harrison et al., 2023; Waring & Bishop, 2020a).

Hence, various spatial–temporal orders intersect and at times resonate and/or disrupt one another. Building on Blue's (2019) conceptualisation of such disharmonious occurrences, as 'rhythm disruptions' and 'arrhythmia', we have distinguished three types of disruptions of the regional temporal order: interfering bodily rhythms and needs; (un)expected workings of technologies; and disrupting acts of patient and relatives. It was region nurses' prime responsibility to stabilise these interferences and prevent or soften a disruption of the regional order. Interestingly, with the professional role of the region nurse, unpredictability is anticipated as region nurses perform temporal work, dealing with and restoring the disruptions of the temporal order of the region. This differs from what is often described in the literature, where healthcare professionals' experience time clashes with (neoliberal) time regimes imposed on them by healthcare organisations. We showed that disruptions are actually a regular or 'normal' part of the sequencing of events in the regional temporal order (Hirvonen & Husso, 2012; Ihlebæk, 2021 Moroşanu & Ringel, 2016). Region nurses can be seen as guardians of the night, a function inscribed into the temporal order as far as the glitches in the order are already recognised and calculated in.

This research also has some limitations. We only followed a team of a limited number of nurses. More research on scaling up work, in other contexts and countries, is needed to learn more about the changing caring role of nurses in healthcare systems under pressure. In addition, we did not study how patients perceived the quality of care but only gained an insight into possible consequences from interactions during observations.

A focused study on patients, their relatives, and how they experience certain practices changing or disappearing is needed.

The configuration of the temporal order does have consequences for both the care and the role of professionals. Research on time and care has shown how efficiency paradigms increasingly are structuring time to care (Ihlebæk, 2021) and how the pace of performing care increases, causing time scarcity (Balkin et al., 2023). By focusing on how time *is* practice, we add to this literature by showing how, even if there is 'objectively' time to stay with a patient (such as in the case of the restless woman), region nurses must act flexibly and therefore distance themselves from situations. We found that certain practices that were previously part of normal routines of caring, such as guiding restless behaviour or not responding well to certain medication, are now seen as disrupting the organisation of care rather than intrinsically part of the process of caring. This can impact on how care is valued as it becomes increasingly debatable what 'essential' or 'good care' means (Felder et al., 2023; Harrison et al., 2023 Waring & Bishop, 2020b). These aspects of time and care should be studied further in future research.

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