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Job crafting as retention strategy: An ethnographic account of the challenges faced in crafting new nursing roles in care practice

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Abstract

Nursing shortages in the global north are soaring. Of particular concern is the high turnover among bachelor-trained nurses. Nurses tend to leave the profession shortly after graduating, often citing a lack of appreciation and voice in clinical and organisational decision-making. Healthcare organisations seek to increase the sustainability of the nursing workforce by enhancing nursing roles and nurses' organisational positions. In the Netherlands, hospitals have introduced pilots in which nurses craft new roles. We followed two pilots ethnographically and examined how nurses and managers shaped new nursing roles and made sense of their (expected) impact on workforce resilience. Informed by the literature on professional ecologies and job crafting, we show how managers and nurses defined new roles by differentiating between training levels and the uptake of care-related organisational responsibilities beyond the traditional nursing role. We also show how, when embedding such new roles, nurses needed to negotiate specific challenges associated with everyday nursing practice, manifested in distinct modes of organising, work rhythms, embodied expertise,

Members of RN2Blend consortium will be listed in the Appendix section. www.rn2blend.nl.

socio-material arrangements, interprofessional relationships, and conventions about what is considered important in nursing. We argue that our in-depth case study provides a relational and socio-material understanding of the organisational politics implicated in organising care work in the face of workforce shortages.

KEYWORDS
ethnography, job crafting, nurse differentiation, retention strategies, workforce shortages

Highlights

- Contributes to an understanding of current workforce issues in nursing;
- Presents an ethnographic study into job crafting as nurse retention strategy;
- Provides an ecological analysis of challenges faced in crafting new nursing roles;
- Calls for more structural investments in the political position of nurses.

1 | INTRODUCTION

Covid-19 has revealed the importance of a strong and engaged nursing profession. Yet nursing shortages in the global north have been soaring for years, specifically as a consequence of demographic changes, growing healthcare demands, and increasingly complex caseloads.[1] The pandemic further exacerbated the rift between nurse capacity and healthcare demand because it generated large amounts of catch-up care and an increase in sick leave rates among nurses, who felt worn out after facing heavy and emotionally charged care loads both during and immediately after the pandemic.[2] In addition, for decades nurses have reported feeling a lack of appreciation and voice in healthcare decision-making.[3] Higher educated nurses in particular tend to leave the profession after a few years.[4] This not only means 'fewer hands at the bedside' but also a drain of much needed nursing knowledge and skills.[5] This combination of factors has made the nursing workforce a top policy priority in national healthcare systems as well as at the European policy level.[2]

Strategies to counter these trends differ from one country to another and depend largely on the composition of the nursing workforce and institutional legacies of healthcare systems.[6] They often include a version of nurse differentiation and skill-mix manipulation.[7] In England, for instance, policymakers and nurse educators long sought to turn the Registered Nursing in-house training course into a baccalaureate and master university programme,[8] but now increasingly focus on formally expanding the roles of nurse associates in response to soaring costs and stringent workforce pressures.[9] In the Netherlands, policymakers and hospitals seek to differentiate between vocationally and bachelor-trained nurses to increase retention among higher educated nurses, improve the position of the nursing profession, and strengthen the engagement of nurses in healthcare decision-making across organisational and institutional layers.[10] What many skill-mix strategies share is that they seek to increase labour power in the operational layers of healthcare systems without considering the broader political economies through which such care work is valued vis-à-vis other types of work. In other words, strategies for dealing with nursing workforce

shortages focus mainly on attracting new sources of labour power while ignoring the need for structural economic investments in the care work that sustains healthcare systems and societies.[11] In this paper we investigate how the political aim of strengthening the nursing workforce plays out in the organisational setting of the hospital.

To move towards a more sustainable nursing workforce, Dutch hospitals have introduced pilot projects in which nurses are provided with time-spaces to learn how to differentiate between vocationally and bachelor-trained nurses and to develop new nursing roles 'from the bottom up'.[12] New roles typically involve combining direct patient care with care coordination, evidence-based practice, quality improvement, and participation in healthcare decision-making at different organisational levels.[13] The impact of these new roles on workforce resilience is expected to be high, as they are supposed to lead to improved job satisfaction and retention of higher educated nurses[14] as well as the further professionalisation of nursing and stronger positioning of the nursing workforce more generally.[15] At the same time, as we will also show in this paper, an understanding of the 'work' that nurses and managers need to invest in when developing such new nursing roles—and the challenges they face in stabilising those roles in the context of existing power relations in hospital organisations—remains underdeveloped. Moreover, retention strategies such as job crafting have been criticised as a delusion; in the words of Ivanova and von Scheve, *'It appears as if free agents are designing their own careers, when simultaneously, their choices and possibilities are pre-structured by and channelled in accordance with top management strategies.'*[16] (p.791)

To better understand whether and how nurses reposition themselves in contemporary healthcare systems, and how this occurs in relation to other healthcare professionals and within the institutionalised setting of a hospital organisation, we studied two nurse differentiation pilots in the Netherlands ethnographically. Our study was informed by the literature on job crafting,[17] professional ecologies,[18] and ethnographic research into nursing practices.[19–22] We used these different bodies of literature to articulate a political approach to understanding job crafting as a retention strategy. This approach, we argue, is necessary because job crafting is not only associated with the establishment of meaningful jobs for individual nurses,[13] but is also used as a strategy to (re)organize, (re)value, and (re)position the nursing profession more generally.[15,23] We ask the following research question: *How are nurses crafting new roles in the nurse differentiation pilots and what challenges do they face in everyday hospital practice?*

Drawing on observations, interviews, and document analysis, we reconstruct how nurses participating in the two hospital pilots sought to define new roles for bachelor-trained nurses by differentiating between training levels and the uptake of care-related organisational responsibilities beyond the traditional nursing role. We present and analyse three data extracts that foreground the lived experience of nurses seeking to stabilise new professional roles, and we tease out the mechanisms through which their efforts were supported, curtailed, and challenged in their daily work. Our analysis shows that the participating nurses had to challenge top-down management strategies that continued to capitalize on nursing work as production work taking place at the bedside. They further needed to overcome deeply rooted nursing conventions about the importance of such bedside work, materialised into dress codes, architectural designs, work rhythms, interprofessional relationships, staffing, and formal and informal valuation practices.[21] We argue that insights into these challenges, and the underlying political mechanisms, are crucial to developing a more effective response to the nursing workforce crisis.

2 | THEORETICAL FRAMEWORK

As a management concept, job crafting was originally coined by Wrzesniewski and Dutton[24] to refer to the '*physical and cognitive changes individuals make in the task or relational boundaries of their work.*' Wrzesnieski and Dutton used this concept to draw attention to bottom-up, employee-initiated work redesign.[17] Over the years, job crafting was extended by management scholars to include the '*actions employees take to shape, mould, and redefine their jobs in order to make them more meaningful.*'[14] (p.546) These scholars identified different job-crafting activities, such as: changing the boundaries of the tasks associated with a job to make it more challenging; changing the relational aspects of the job in terms of interactions with others to increase influence; or changing the ways in which a job is

framed to improve valuation.[24] They furthermore agreed that, even though job crafting is carried out by individual employees, employers should facilitate it by providing job resources, including peer support, coaching, and higher wages.[25] Employers should be inclined to do so, management scholars argued, because job crafting helps to advance organisational change and because it is associated with increased job satisfaction, higher motivation, and better performance.[17]

Informed by management literature, nursing scholars have foregrounded job crafting as a strategy to improve retention.[26–28] Here, job crafting is associated not only with improved job satisfaction, but also with the further professionalisation of nursing, particularly as it helps open up what nursing is or should be about.[15,23] This is important because nurses' positioning in the division of labour in hospital organisations makes their role incredibly dynamic.[18,19] They can take on physician-devolved work while divesting other work to support staff. Moreover, they regularly embrace and embed new technologies in their scope of practice.[20] Yet much of the additional work that nurses take on goes unnoticed or is taken at face value in strategic decision-making on different organisational levels.[29] Making explicit what nurses know and (can) do—besides direct patient care—is therefore essential to strengthening their position in the ecology of professions and better using their unique expertise about patients' needs and organisational processes.[30,31] In this light, job crafting can be considered both an individual undertaking and a strategic organisational intervention.[23]

Yet what it means and takes to craft new nursing roles remains empirically understudied and theoretically underdeveloped. Conceptually, the focus has been on what job crafting is and what it could yield in terms of retention, professionalisation, and organisational change. There has been much less scholarly interest in the organisational context in which employees engage in job-crafting activities, and the politics they face in developing new professional roles. This is striking, because it is precisely in professionalised contexts, such as hospital organisations, that individual workers need to navigate institutionalised roles, hierarchical positions, power relations, and top-down organisational strategies.[32] Informed by the literature on professional ecologies,[18,20] we employ a relational and political approach to job crafting. This approach stresses that job crafting is not done in a vacuum but rather enacted within broader healthcare ecologies and therefore interacts with a plethora of established professional roles, interdisciplinary relationships, and organisational structures.

Our approach prompts us to distinguish between two dimensions.[33] The first is the actual work invested in redefining professional roles. The second is the organisational politics implicated in negotiating role changes in everyday practice vis-à-vis other organisational actors.[17] Starting with the first dimension, Abbott[33] suggests that to better understand how professional roles are defined and redefined within professional ecologies, acts of articulated difference should be foregrounded.[34] Examples of articulated difference are 'primary care versus hospital care', 'registered providers versus not registered providers', or 'bedside care versus management work'. Typically, sites of articulated difference are connected to redefine professional roles and make them distinct from their surroundings, a process that Abbott[33] has labelled 'yoking'. In the field of nursing, an example of yoking is 'registered hospital nurses conduct management work'. For Abbott, events of articulated difference indicate efforts to change professional roles and could pinpoint emergent professional groups.[34] Regarding the second dimension, Abbott[33] suggests that, in making new roles meaningful and valued, those who seek to (re)define professional roles need to engage in organisational politics. More precisely, they must negotiate two kinds of forces. On the one hand, there are the forces that act upon new roles from the outside, for example, government legislation, recognition of claimed expertise by others, and the managerial and organisational structures that capitalize on and channel professional work.[16] On the other hand, there are the forces that act upon new roles from the inside, such as established group identities, internalized norms on which such identities are founded, and specific membership criteria.[19,20,34] In this light, nurses seeking to stabilise new nursing roles must negotiate who is allowed to do what with other organisational actors such as managers and medical specialists.[33,35] In addition, they must navigate conventions among nurses about what is important, meaningful, and valuable.[20,21,36]

Many of the conventions associated with nursing work manifest themselves not only as formal legislation and organisational structures, but also as internalized norms, distinct professional identities, clinical routines, work

rhythms, and socio-material arrangements.[22,37] Ethnographic research into the organisation and provision of nursing work shows how different forms of time (e.g., medical time, patient time, and hospital time) structure what nurses should and should not do, as well as the different ways in which such temporal structures are formalised, negotiated, and sometimes overruled by nurses to get things done.[22] Others have shown how nursing work is affected by the material and architectural context in which it is performed and how the reorganisation of nursing work often also means a reimagination and reshaping of the (material) place in which nursing work is carried out.[10] Yet others have foregrounded the epistemic politics in clinical and organisational decision-making at different levels in hospital organisations: a politics that defines what knowledge is, which knowledge counts, and who is therefore allowed to speak up or empowered to make decisions in specific organisational contexts.[38] These authors have shown, for instance, how nurses are given leeway to improvise when shaping individual patients' healthcare trajectories but are simultaneously bypassed when it comes to rethinking organisational matters on more structural levels.[29]

The examples above indicate that redefining nursing roles and tasks involves navigating and intervening in an established relational and socio-material organisational context. This renders the introduction of job crafting a political intervention.[39] As we will show in this paper, such a project therefore comes with specific challenges. An understanding of these challenges—and the mechanisms behind them—is essential now that job crafting is becoming an important strategy through which healthcare organisations are attempting to tackle workforce issues and improve nursing staff retention.

3 | METHODS

3.1 | Research context

In the Netherlands, attempts to develop distinct nursing roles go back 50 years.[5] Nurse differentiation was a driving force behind the establishment of vocational and bachelor-level training programmes in the 1970s, and prompted the development of occupational nursing profiles in the 1990s[40] Yet despite having distinct nursing profiles and training programmes, all Dutch nurses continued to do similar work and received similar wages, and their engagement in healthcare decision-making remained weak and/or unrecognised. As such, much of the knowledge and skills acquired by bachelor-trained nurses was pushed to the background in everyday nursing practice.[5] This discrepancy between professional training and everyday practice is associated with a high turnover among bachelor-trained nurses.[13]

To enforce change and improve retention, the Dutch Minister of Health announced a statutory amendment in 2019 that would formally differentiate between vocationally trained 'nurses' and bachelor-trained 'supervising nurses' and stipulate what nurses on either side of this distinction would be allowed to do within the broader spectrum of nursing work. The proposed amendment—a top-down act of articulated difference—was met with fierce opposition from the nursing community. In particular, vocationally trained nurses feared they would no longer be able to work as fully qualified nurses (that is, no longer be allowed to treat complex patients). After a summer of heated debates, covered extensively in the Dutch media, the proposed amendment was withdrawn and the task of introducing nurse differentiation was shifted to hospitals.[5] Hospitals subsequently introduced pilot projects in which bachelor-trained supervising nurses were assigned a distinct role on nursing wards. In most hospitals, nurses were given time-spaces to carve out new nursing roles for bachelor-trained nurses from the bottom up and within their teams, leading to a variety of nurse job-crafting practices.[13] We conducted ethnographic fieldwork in a general hospital just after the introduction of two pilots involving supervising nurses on the oncology and surgical wards. We did so in the context of a broader (action) research programme on nurse differentiation funded by the Dutch Ministry of Health, Welfare and Sport, the RN2Blend project, in which we engaged in nurse

differentiation activities in both daily practice and at an overarching organisational level, studying nurse differentiation and job crafting 'from within' (https://rn2blend.nl/en).

3.2 | Data gathering and analysis

This paper is based on ethnographic data gathered in a general hospital that we visited between June 2021 and May 2022. We aimed to understand how nurses define and develop new nursing roles in hospital practice. The first and second author—both trained as social scientists, and not registered nurses themselves—shadowed nurses (>125 h) who had differing educational backgrounds and aspirations. We observed different shifts (day, evening, and night) and attended meetings of the project group in charge of the targeted transition (16 h). During our participatory observations, we had frequent informal conversations with nurses and project managers. We noted down our observations, writing them up and digitising them shortly after. Participation involved our shadowing nurses as 'bystanders', yet when we became better acquainted and more firmly embedded in the team, we occasionally helped out by fetching food, moving beds, and/or cleaning rooms (always accompanied by a qualified nurse, and only at a nurse's request). This 'engaged ethnography' gave us access to many different dimensions of everyday nursing.[22] As a result, we developed from being rather general observers of nursing practice to more focused and knowledgeable observers. It was during this stage that we became interested in the ways in which bachelor-trained nurses needed to negotiate a plethora of relational and socio-material challenges when defining and redefining what they could do.

Frequent check-ins with colleagues in our research consortium (some of them current or former registered nurses) helped us interpret our observations and draw attention to underlying mechanisms. Frequent member checks with the nursing teams furthermore allowed us to validate our observations. In line with our engaged approach, these member checks simultaneously functioned as reflexive time-spaces for nurses on the wards who were participating in the two hospital pilots.[37] An important lesson we—as well as the nurses—learnt during these reflexive moments was the sharp focus on bedside care among nurses, and how hard it was for bachelor-trained supervising nurses to find time to undertake tasks 'away from the patient'. Specific themes that emerged from the data analysis were 'articulated differences', 'nursing rhythms', 'architecture', 'nursing work', and 'valuations'. Based on these themes, we selected three data extracts from our observations and present them in our results section to illustrate the challenges nurses faced while defining and implementing new nursing roles.

3.3 | Ethical considerations

Ethical approval has been granted by a local medical ethics review board. Nurses were informed about the scope of our research and our roles in advance in both written and oral form. To reduce traceability, the names of nurses and patients featured in this paper have been pseudonymised.

4 | RESULTS

Below, we first describe how the project group in the general hospital we studied articulated differences between vocationally and bachelor-trained nurses. We then describe how supervising nurses sought to ensure their new role in everyday practice, elaborate on the challenges faced, and tease out the mechanisms behind them.

4.1 | The general hospital and its pilot projects

The management of the hospital we studied introduced the first pilot with bachelor-trained supervising nurses on the surgical wards in 2020 (the pilot on the oncology wards followed in 2021). Their aim was for 33% of the nurses from the participating wards to be appointed as supervising nurses by 2022, at the end of the pilot, which would also mean higher wages for them. Only nurses who had received bachelor-level training would be eligible to apply for the new job title (project documentation 2020).

A project group was established to guide the transition. Its members sought to use the pilots to (a) define the differences between bachelor-trained 'supervising nurses' and vocationally trained 'nurses', and (b) learn how to embed the new role of 'supervising nurse' on the nursing wards. The project group included the head of the hospital training facility, a project manager connected to the Human Resources department, ward managers, and a group of nurse representatives. Although the idea was to include nurses from different educational backgrounds, the nurse representatives group soon consisted solely of bachelor-trained nurses who aspired to become supervising nurses. During project meetings, they discussed what the new supervising nurse role should be, including in relation to their vocationally trained nursing peers.

Informed by wider developments of nurse differentiation in the Netherlands (see research context above) and the individual ambitions of the aspiring supervising nurses, the project group suggested that supervising nurses should present themselves as proactive professionals and leaders within nursing teams, in interdisciplinary contexts, and on various organisational levels (project documentation 2020). It was furthermore stated that supervising nurses should coordinate quality improvement projects and pursue evidence-based practice. Table 1 is an example of how the project group sought to distinguish between the roles and tasks of nurses and supervising nurses. They were, however, especially focused on the supervising nurse role—as we discuss in more detail below.

By emphasising the work of updating guidelines and protocols and the coordination of generic healthcare processes (having a 'helicopter view'), the project group started to position bachelor-trained nurses closer to the existing role of nurse coordinators and other organisational levels associated with hospital management. Hospital administrators, however, made clear that the new nursing role should not be at the expense of nurse-patient ratios. They insisted that supervising nurses should continue to provide patient care and therefore 'had to be dressed in white' (i.e., should wear their uniforms) and be part of the larger nursing team (fieldnotes June 2020). In other words, the essence of nursing work was rearticulated and bounded from the top down as production work at the bedside, with the new nursing role not being implemented at the expense of the hospital's production metrics.[16]

These top-down preconditions set by hospital management hence limited the scope of new tasks that could be taken on by aspiring supervising nurses. In response, the project group suggested that supervising nurses should act as a bridge between their nursing peers and management. This would offer scope to develop a distinct role for them while allowing them to remain part of the nursing team delivering patient care. To articulate what it means to

TABLE 1 Differences between vocationally and bachelor-trained nurses (project documentation 2020).

Vocationally trained nurses	Bachelor-trained supervising nurses
Evidence-based practice (follower); works in line with protocols and guidelines	Evidence-based practice (user); keeps protocols and guidelines up to date
Providing care independently, assessing risk	Providing (unpredictable) care based on clinical reasoning
Able to coordinate the care process of assigned patients	Coordinating care processes (helicopter view)
Multidisciplinary collaboration	Leadership practices
Left blank	Coaching

TABLE 2 Differences between nurse coordinators and supervising nurses (project documentation 2021).

Nurse coordinators	Supervising nurses
Administration	Innovation
Planning	Envisioning
Maintain	Develop
Monitoring	Influence
Focus on systems and structures	Focus on people
Control	Inspire
Coordinate	Coach
Communicate	Being a role model
Rationally engaged	Emotionally engaged
Expertise	Trustworthy

act as a bridge between nursing peers and management, the project group draughted another document with a table distinguishing between supervising nurses and nurse coordinators (Table 2). By associating the role of the supervising nurse with innovation, development, coaching, and being a role model, the project group placed supervising nurses ahead of and above peers but still positioned them on the wards. At the same time, they made sure that supervising nurses were not associated with any administrative or planning tasks (among others). In line with Abbott's claim that new professional roles are defined based on articulated differences and in between entrenched roles and relations,[18,33] the table thus reflects the definition and moulding of a role for supervising nurses between nursing peers and management ('nurse coordinators').

To support bachelor-trained nurses in their new role as supervising nurses, the project group implemented several activities and infrastructures on the wards. Examples include the introduction of quality improvement boards that nurses could use to identify points for quality improvement in everyday nursing practice, bedside teaching, and the development of reflexive time-spaces within which the nursing team could discuss what needed to be done on the ward during their shifts and who should oversee this ('helicopter view coordination'). Supervising nurses moreover received leadership training and were made responsible for quality improvement projects related to nursing work (project documentation 2020).

Despite the work that the project group invested in defining the role of supervising nurses and the additional job resources made available,[17] they soon found that implementing a new role within extant nursing teams was challenging. Below, we tease out some of the specific challenges supervising nurses faced when trying to embed their new roles on their wards. Drawing on three data extracts from our ethnographic observations, we show that these challenges include a) enrolling others into new ways of working; and b) navigating the socio-material context of everyday nursing. Before foregrounding these challenges, however, we first provide an example of the work that supervising nurses undertook to stabilise their new role within their nursing teams.

4.2 | Implementing and stabilising a new role

The first data extract shows an aspiring supervising nurse named Elise venturing to enact her role as nurse leader. She does so by taking the lead in a specific patient case that the nursing team has been struggling with for weeks.

Data extract 1: Taking responsibility (Fieldnotes January 2022)

Today I am shadowing Elise, a bachelor-trained nurse who aspires to become a supervising nurse. In recent months, Elise has tried, provisionally, to shape her upcoming role as a supervising nurse on the surgical ward. At 7:30 AM the nurses gather at the nursing station. Elise asks for their attention and starts up the day by assigning nurses to patients. She then plans the lunch breaks. She asks how the other nurses are feeling and whether she needs to take anything into consideration in today's planning. It appears to be a normal shift. Elise takes care of three patients divided over two rooms. She starts by reading the patients' files, doing a routine check (e.g. measuring the patient's blood pressure, temperature, pain score) and providing everyday care (washing the patients and helping them dress). Because she only has three patients, she is done in 30 min. Elise goes back to the nursing station. She picks up her phone and starts calling other nurses to see whether someone needs help. The other nurses are also finishing up, however. Elise decides to invest some time in studying overall care processes on the ward (the different cases, time spent on the ward, care provided). She starts to read up on one of her own patients, a woman of 93 who fell in the shower three weeks ago and has been hospitalised ever since. She has recovered but cannot return home because her husband is no longer able to take care of her (according to the assessment recorded by nursing peers in the patient's electronic patient file). Because the patient's family do not want her to go to a nursing home, she has remained hospitalised. However, the patient is becoming increasingly demanding (needing both extensive psycho-social and bodily care) and nurses are struggling with her requests, as they also need to care for other patients. Elise decides to dedicate time to solving this problem. She contacts a nursing home downtown and arranges a room—something quite rare considering the growing waiting lists. She mobilises a resident physician and convinces him to inform the family that the patient must be moved to a nursing home. Elise then kindly but firmly informs the patient about the plan. Her actions overrule the wishes of the patient and her family but are sensitive to the experience of the other nurses (who feel overburdened by the patient's care demands) and in line with the care coordination challenges faced on the ward that week, particularly those involving the number of beds occupied and staffing capacity. The other nurses are impressed by Elise's resolve. Later that day, Elise treats the whole team to snacks during the lunch break and adds, 'this is how I take care of my team'.

In this extract, Elise took a 'helicopter view' of the way healthcare was being coordinated on the ward (e.g., distribution of nursing care to patients and bed capacity) and practised leadership in an interdisciplinary context by mobilising a resident physician, nursing home manager and the patient's family. Her nursing peers recognized the difficult decision she needed to make—overruling the wishes of the patient to reduce the burden on the other nurses—and praised her for it. Elise clearly took charge to enact her role as supervising nurse as defined by the project group (which she herself was a member of) and strategically claimed a leading position among her colleagues by stating that she was taking care of her team. Later that day, however, Elise also admitted to us that she was struggling to shape her new role on the ward and among her nursing peers. In fact, she and other supervising nurses faced several important challenges to their new role in everyday nursing practice. Let us now tease out these challenges in more detail.

4.3 | Enrolling others into new ways of working

Job crafting is not done in a vacuum but interacts with a plethora of established roles and relationships,[18–20] making it inherently a relational and political intervention.[39] As we illustrate below, the relational and political

aspects of job crafting pose a specific challenge for supervising nurses. We have labelled this challenge 'enrolling others into new ways of working' and use another data extract to introduce it. In this extract, a nurse (Femke) tries to enrol other healthcare professionals in a moral deliberation session to discuss how to deal with a delirious young patient on the ward.

Data extract 2: Enrolling others (Fieldnotes February 2022)

Femke is a vocationally trained nurse with 6 years of experience. I am shadowing her today as she attends three patients awaiting surgery. One of them is 45 years of age. He has a severe case of pneumonia and was delirious when he was hospitalised the week before. Since then, he has received several treatments, including a rather intrusive intervention under local anaesthetic. The physician's decision to 'only' use a local anaesthetic for the intrusive intervention was not in line with the patient's wishes and has made him angry. A combination of high fever, pain, and lack of control has furthermore made him afraid and nervous when nurses provide everyday care. In the past few days, he has been aggressive towards Femke's colleagues and some no longer wish to care for him. Femke decides to organise a 'moral deliberation session' to discuss this patient's situation in a multidisciplinary team and to learn from this case for future encounters. Today is a good day to do so because the number of interventions has fallen sharply while staffing levels are being kept high in anticipation of rising numbers of Covid-19 patients. In between reading patients' files, conducting routine patient checks, and providing everyday care, Femke calls the physician involved, the residents, the psychiatrist, the quality manager, and the nurses, trying to convince them to attend the moral deliberation session. She sets specific priorities in picking a place and time for the meeting, making sure that at least the psychiatrist, the residents, the quality manager, and as many nurses as possible can attend. However, the physician and the residents do not show up. 'They almost never do,' Femke tells me as we enter the room. The session itself is chaired by the quality manager and follows specific steps associated with an open exploration of the moral dilemma. Nevertheless, it soon devolves into one in which the nurses share their experience. After this, the psychiatrist takes centre stage and tells the nurses how to deal with such situations. She tells them they should realize that young patients can be delirious and lose control over their behaviour, and that nurses should not take such behaviour personally. Instead, they should take a step back when a patient becomes aggressive—or too demanding—and discuss such behaviour with the patient at a later point in time. Nurses who participated in the session acknowledged their role as learners by nodding and by taking notes.

Femke noticed her colleagues struggling with a specific patient case and decided to discuss this within an interdisciplinary team, especially because it had been the decision of a physician (i.e., to use only a local anaesthetic) that had upset the patient in the first place. The nurses had questions about this decision, as they had to care for an anxious patient and thus bear the consequences. Like Elise in the first data extract, Femke took on a leadership role and tried to mobilise her colleagues. Despite Femke's efforts to schedule the meeting at a convenient time for everybody, the physician and residents did not show up. This hardly surprised her, yet it also made it difficult to discuss the case in an interdisciplinary context. Furthermore, the psychiatrist who did attend immediately positioned herself as counsellor, lecturing the participating nurses on how to respond to a delirious patient. As a result, the nurses' own expertise about caring for delirious patients was completely ignored.[41] Moreover, the nurses themselves immediately took up a 'learners' role instead of foregrounding their own expertise.

This data extract shows that even though the project group envisioned nurses manifesting themselves as equal professionals in an interdisciplinary network, enrolling other organisational actors (and the nurses themselves) into such new ways of working proved challenging. The physician and residents did not feel obligated to respond to the

nurse's invitation, and the psychiatrist who did show up immediately positioned herself as an expert, seemingly unaware that nurses knew very well that the patient was delirious and what that meant in terms of everyday care. The absence of the physician and residents—and the psychiatrist's and nurses' hierarchical role-taking (as teacher and learners)—subverted Femke's intention to question the patient's healthcare plan and learn from it as equals in an interdisciplinary context, turning instead into a top-down counselling session. Hence, nurses struggled to overcome a conventional and hierarchical power relationship in which some organisational actors, in this case the ward physicians and psychiatrist, could ignore or overwrite nurses' invitations or perspectives without risking the breakdown of this relationship.[39,41]

Abbott[33] contends that those who aspire to broaden the scope of activities associated with their professional roles need to challenge forces not only from outside their own profession, such as engrained roles and hierarchies enacted by other organisational actors, but also from within their profession, such as those related to established professional identities.[32] Supervising nurses, like Elise, therefore needed to enrol not only physicians, residents, and managers into new ways of working, but also their nurse colleagues. In this context, it proved risky to articulate a distinct role for supervising nurses in terms of taking leadership, coordinating care, coaching peers, treating complex patients, or overseeing nurse-technical interventions. In fact, many non-supervising nurses also saw such tasks as a fundamental aspect of their nursing profession.[12] Femke, for instance, who took on a leading role in the second data extract, had a vocational training background. And just like Elise, Femke was celebrated by nursing peers for taking charge. Some of the differences between vocationally and bachelor-trained nurses articulated by the pilot project group were therefore contested sites of differentiation, particularly those that revolved around coaching, coordination, and leadership practices (see Table 1). Such contested sites of differentiation, in turn, made nursing teams question the added value of distinguishing between nurses and supervising nurses in terms of roles and tasks, but also in terms of hierarchies ('who takes precedence over whom in the coordination of care') and renumeration (as supervising nurses would receive higher wages). More experienced vocationally trained nurses interpreted the proposed differentiation as a lack of appreciation for the work they had been doing for years. This not only fed a recurring sentiment among nurses about being undervalued as a profession by higher management,[11] but also created scepticism among nurses about the pilot projects. As a result, supervising nurses risked becoming isolated from their colleagues.[5]

It was very difficult for supervising nurses to shape a distinct role for themselves with respect to leadership, ward coordination, coaching peers, and treating complex patients because these tasks were closely associated with an established nursing identity shared among vocationally and bachelor-trained nurses. To emphasise the importance of their having a distinct role, aspiring supervising nurses therefore sought to develop a role that was complementary to the everyday work taking place on the nursing ward. They did this by emphasising the importance of representing their nursing peers in interdisciplinary quality improvement networks and in strategic decision-making at different organisational levels. This direction of role development was very much in line with a broader ambition to reposition the nursing profession amid other healthcare actors and to give voice to nurses in healthcare decision-making. Embedding such representational roles—and the work this involves—in everyday nursing practice, however, came with its own challenges, as we show in the next section.

4.4 | Navigating the socio-material context of everyday nursing

The hospital we studied was dealing with high sick-leave numbers among nurses as well as many nurse vacancies. It was struggling to keep beds open and stay financially healthy. Hospital management therefore stressed that supervising nurses were expected to shape their new role while actively taking care of patients, instead of developing this new role away from the bedside. It was argued that patient numbers and bed occupation rates were fluctuating on a daily basis, leaving supervising nurses with enough 'spare time' to spend on tasks in addition to direct patient care. Nursing work, however, is structured in specific temporal regimes—such as 'patient time' and 'medical time'—

providing scope, purpose, and rhythm to how, when, and where nursing work is done.[10,22] Supervising nurses who sought to free up time to participate in interdisciplinary networks, or engage in organisational decision-making, therefore needed to carefully navigate the socio-material and temporal context of everyday nursing. We now further unpack this challenge.

Data extract 3: Crossing a line (Fieldnotes October 2021)

It is 3 PM and Ilse—a supervising nurse—and I had had a busy morning caring for three patients on the oncology ward. The patients needed rather intensive care and we had been busy doing health checks, everyday care, nurse technical interventions, visitation rounds by physicians, multi-disciplinary conversations, and another round of health checks and everyday care. I had helped a bit by making beds, preparing food, disinfecting chairs, and lifting patients from their beds [together with the nurse]. After we made sure that our patients were okay, Ilse informed me that she needed to go to a meeting. Her tone of voice [kind but matter-of-fact] made it clear that it wasn't a meeting I was invited to attend. Instead, I took my laptop and sat down in the nursing station. I had seen the nurse students do this too when they worked on their student projects. I opened my laptop and decided to start typing up some of my observations. It must have been a minute or two later when another nurse poked her head around the doorframe and said, 'I have now cared for your patient, he was sitting on the side of the bed and wanted to lie down'. 'Should I help?' I asked. 'No,' she responded and added a bit pedantically, 'just wanted to let you know that he needed care and has been cared for by me', after which she moved on, leaving me a bit puzzled about the underlying meaning of what just happened. Sitting behind my laptop in the middle of the nursing station dressed in white, while Ilse was attending a meeting somewhere else in the hospital, we had not seen one of 'our' patients sitting on the side of his bed, requiring help. Together, Ilse and I had failed to be watchful and take care of our patient's needs, something the nurse had snappishly pointed out.

Supervising nurses saw it as an essential component of their new role to give voice to a nursing perspective in their hospital organisation. They were aware of the different interdisciplinary networks they needed to join and the decision-making tables they needed to sit at. Because this required a substantial time investment on their part, nurses were constantly searching for ways to combine representational work away from the ward with patient work and clinical work on the ward. Even though they did so as well as they could—particularly by anticipating everyday rhythms on the nursing ward (see data extract below)—the decision to attend a meeting also meant prioritising it over something else on the ward, like the warning signs and needs of patients or the ad hoc demands of nursing peers. As the extract illustrates, not all nurses agreed with the ways in which supervising nurses made such choices.

Some nurses were visibly annoyed by colleagues who conducted work away from the ward, as they saw them as less focused on their patients' immediate and ongoing needs. According to these nurses, supervising nurses seemed to value 'non-care' tasks over patient care. The other nurses considered this sub-standard care, something 'not done' during a shift and within the general habitat in which nursing work takes place, that is, at the nursing station and ward while dressed in uniform. Supervising nurses therefore started to practise their newly acquired tasks—for example, research, quality improvement, coordination, and representational work—behind closed doors and out of the view of their colleagues on the ward. They often needed to wait until the end of their shift to do such work. Alternatively, supervising nurses worked on such tasks on days when they were officially scheduled as surplus; something would come up only occasionally and irregularly, usually in the context of current workforce shortages. On those rare days, supervising nurses would retreat from the nursing station to an area behind a pair of swing doors, dress in civilian attire to signal they could not take care of patients, and sit in a small room with two computers (the habitat of the nurse managers).[42]

Differences between 'bedside work' and 'other work' were continuously reproduced in everyday nursing practice and manifested themselves in socio-material arrangements (dress codes, swing doors, and back offices), rhythms (first take care of assigned patients and then help peers before the physician rounds start), and embodied expertise (nurses are acknowledged for knowledge and skills in technical interventions but not so much for engagement in interdisciplinary networks or healthcare decision-making). Supervising nurses were managed into an operational care role by hospital administrators to safeguard the production capacity of nursing teams,[16] but they also had to be immediately available to physicians,[43] and the idea of nursing as an operational care profession taking place at the bedside was also upheld by nursing peers.[5] Not only did this make it very hard for supervising nurses to actually engage in other types of work, but those other types of work were also not recognized as important or essential by nursing peers and other organisational actors. The clean divisions in time and space between 'important' bedside care and 'non-essential' other work conflicted sharply with the bridging role envisioned for supervising nurses and nurses' organisational repositioning.

Disillusioned by the difficulties involved in bridging everyday nursing practice and management levels, some bachelor-trained supervising nurses left the pilot projects and even the hospital to pursue a career elsewhere. But we also observed that the supervising nurses who stayed started to mobilise beyond the confines of their own nursing wards to share the challenges they faced in trying to shape a new role and organisational position for themselves, and to discuss collective strategies to deal with these challenges. Supervising nurses thus also started to emerge as a distinct political entity within their hospital organisation, allowing them to identify, articulate, and protect the interests that mattered to them as a distinct actor group, one with enough critical mass so that it cannot be ignored or overruled by others without risking adverse consequences.[39] In line with this development, supervising nurses now started to renegotiate the terms and conditions under which they are assumed to take on their new roles (such as the precondition that they should be dressed in uniform all the time) and also started to demand additional job resources from management (such as the number of days they are scheduled as surplus).[43] This illustrates that, while the introduction of job-crafting strategies does not necessarily—or unilaterally—lead to retention of individual nurses, such strategies *do* have the potential to set in motion organisational changes that can strengthen the position and conditions of employment for nurses in hospital organisations, making the nursing profession a more attractive occupational choice for new generations. Such developments are, however, very fragile and depend heavily on organisational actors (e.g., managers, physicians, and nurses themselves) recognising the need to change as a group, and on structural investments from employers.

5 | CONCLUSIONS

Current workforce shortages and staff turnover rates have turned the organisation and positioning of nursing work into a core challenge for many healthcare systems.[2] In this context, nurse differentiation and job crafting have been identified as important retention strategies.[26–28] Both strategies involve broadening the scope of roles and tasks in which nurses can engage—making it possible for nurses from differing training backgrounds to enter the profession and/or to pursue an attractive career. These strategies are also considered important for leveraging the professionalisation of nurses and for repositioning the nursing profession amid other healthcare professionals, making it a more attractive occupational choice for new generations in the occupational healthcare landscape.[15,23] Dutch hospitals have introduced pilot projects in which nurses developed new nursing roles 'from the bottom up' through principles of nurse differentiation and job crafting.[35] Drawing on ethnographic research conducted on two such pilot projects in one general hospital, we showed how nurses engaged in nurse differentiation and job-crafting activities to broaden the scope of tasks associated with their nursing roles. We identified two specific organisational challenges nurses faced in doing so: a) enrolling others into new ways of working; and b) navigating the socio-material context of everyday nursing. We argue that these challenges have important implications for the literature that foregrounds nurse differentiation and job crafting as retention strategies.[14] Below, we discuss these implications in turn.

First, the Dutch pilot projects combined job crafting with more formal skill-mix change strategies, on the one hand by distinguishing between vocationally trained nurses and bachelor-trained supervising nurses, and on the other by allowing bachelor-trained nurses to explore how to broaden the tasks associated with their new role as supervising nurses.[7] Consequently, the job-crafting activities supervising nurses engaged in also involved an articulation of formalised differences between nurses with varying training qualifications. In everyday nursing practice, however, such differences are often blurred.[18,19] In this context, some of the core tasks associated with the nursing profession became highly contested sites of role differentiation (e.g., who is allowed to treat complex patients, coach peers, or engage in coordination work). Such contestations not only questioned the added value of a new role for bachelor-trained nurses but also turned into a perceived lack of appreciation among nurses from vocational training backgrounds. This sentiment has been growing for years[5] and is associated with a general lack of appreciation for—and valuation of—bedside care work in a broader political economy of healthcare systems.[11] Put differently, job crafting and nurse differentiation are not just human resource strategies to improve the inflow and retention of individual nurses, but also political interventions that touch upon the professional identity of the nursing workforce and its valuation.[44] Hence, these policies can potentially attract or retain specific groups of nurses while simultaneously reinforcing a perceived lack of appreciation for nurses in general.[2] It is therefore very important to be sensitive to the effects that job crafting and nurse differentiation interventions have on individual professionals as well as on the professional groups into which job crafting is introduced as a strategic intervention.

The second and related point is that efforts to retain nurses by facilitating job crafting are destined to fail without a wider transition within the system of hospital organisations. We saw nurses who engaged in job-crafting activities struggling with the spatial-temporal context of the nursing wards,[10] interdisciplinary power relations,[41] the rhythms in everyday nursing work,[22] and traditional nursing conventions about what is considered important in nursing work.[45] Hospital management's reluctance to invest in 'more hands at the bedside'—and their inability to do so due to workforce shortages—moreover translated into a situation in which supervising nurses could only spend time on tasks associated with their new roles in between or after patient care. On the one hand, this situation resonates well with a broader neoliberal critique of job crafting[16] that approaches it as a top-down management technique promoting empowerment while simultaneously channelling the possibilities of workers to develop new roles in line with top-down managerial strategies. Through such techniques, hospital management continues to capitalize on nurses in terms of labour power. In our case, higher educated nurses who sought to develop new roles in addition to bedside care indeed seemed to be gently but consistently coerced into production.[16] On the other hand, the new organisational tasks and empowerment narratives associated with a distinct role for supervising nurses also provided scope for political mobilisation. This in fact developed into a situation that allowed supervising nurses to collectively challenge the very pre-conditions through which hospital management sought to capitalize on their labour power and control their job-crafting activities.[39] This success was hard fought, however, and we saw multiple nurses leaving the hospital organisation because of the political nature of the work that job crafting new nursing roles entailed for them.

From a policymaker's or employer's perspective, job crafting might seem a low-cost investment strategy with potentially large rewards in terms of organisational commitment and retention. After all, allowing nurses to broaden the scope of their tasks, and to create meaningful jobs for themselves, places the freedom to pursue job satisfaction, or an interesting career, on nurses' own shoulders (but also the burden of responsibility to do so). Nurses who participated in job crafting, however, found themselves caught between human resource policies and traditional nursing conventions ('the patient always comes first'), with only limited room to broaden the scope of activities in which they could engage as part of their new role. Not only was this a disappointment for supervising nurses, but it also ran counter to their employers' aim of retaining nurses and strengthening the position and engagement of nurses in strategic decision-making at different organisational levels. It shows that if no structural investments are made beyond the job-crafting initiatives, it will be hard to improve the organisational engagement

of nurses in a meaningful way. Our analysis hence shows that job crafting and nurse differentiation can only succeed as retention strategies when backed up by substantial investments on the part of employer organisations, policymakers, and other healthcare actors in the healthcare occupational landscape. Such investments should not only be aimed at increasing or retaining nursing numbers, but also at improving the political position of nurses in healthcare organisations.[2] Hospital managers, physicians, and nurses themselves all have an important part to play here. It is only through a shared recognition of this need to change and through structural organisational investments that the nursing profession can develop into a more attractive occupational choice for new generations of healthcare professionals.

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CONFLICT OF INTEREST STATEMENT

No conflict of interest was reported by the authors.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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APPENDIX

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