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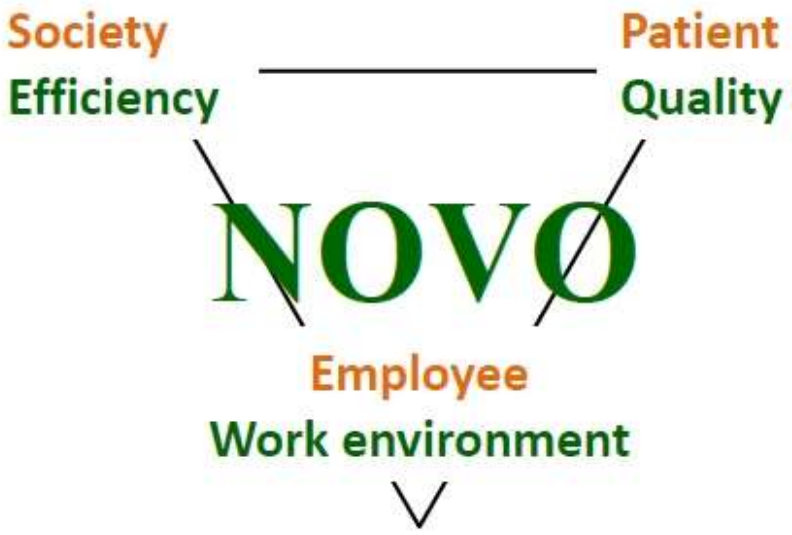
Proceedings

The 15th NOVO-Symposium

Leadership for future challenges in healthcare

University of Iceland, Reykjavík

May 8-9, 2025



NOVO Symposium Proceedings 2025

Edited by:	Sigrún Gunnarsdóttir, Aðalbjörg Stefanía Helgadóttir and Kasper Edwards
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reface

The NOVO-Network started more than 17 years ago, and the core idea of the NOVO-Network is to integrate perspectives of work environment, efficiency, and quality of care (the NOVO-triangle) - to support sustainable healthcare systems.

The NOVO-network is a thriving community of researchers and practitioners who share an interest in understanding and improving healthcare from a multidisciplinary perspective and trying to improve the three corners of the NOVO-triangle at the same time.

Our healthcare systems form a fundamental pillar of our Nordic countries and a constant source of debate and change. A central challenge in our Nordic healthcare systems is the aging population combined with workforce shortages among healthcare professionals. This demands a thorough examination of organizational and leadership strategies to guarantee adequate care and simultaneously prevent the overexploitation of our healthcare professionals.

At this symposium, we focus on *Leadership for future challenges in healthcare,* which encompasses topics such as sustainable strategies, emerging digital services, teamwork, and more.

We have categorized this year's presentations into five themes:

- Leadership
- Well-being
- Structure
- Digital health
- Teams

The NOVO-symposium brings together researchers from various fields to discuss shared interest in health care. We prioritize the networking aspect of coming together and therefore keep the symposium single-track. The multidisciplinary composition of our network and the comparable yet unique healthcare systems across the Nordic countries form a core strength of the NOVO network and a great source of inspiration in our discussions.

We hope you will enjoy the Symposium in Reykjavík and that it brings fresh ideas and new connections with colleagues.

Kasper Edwards & Sigrún Gunnarsdóttir

The NOVO Steering group

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Peter Hasle
University of Southern Denmark, Department of Technology and Innovation

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Finnish Institute for Health and Welfare

Tuula Oksanen
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NTNU Norwegian University of Science and Technology Business School

SWEDEN
Andrea Eriksson
KTH, Division of Ergonomics

Peter Almström
Chalmers University of Technology, Department of Technology Management and Economics

Location and Social program

The symposium will take place at **Gróska**, on the first floor in the meeting room *Fenjamýri*. Gróska is situated on the University of Iceland campus, near the Reykjavík city centre, Bjargargata 1, 101 Reykjavík

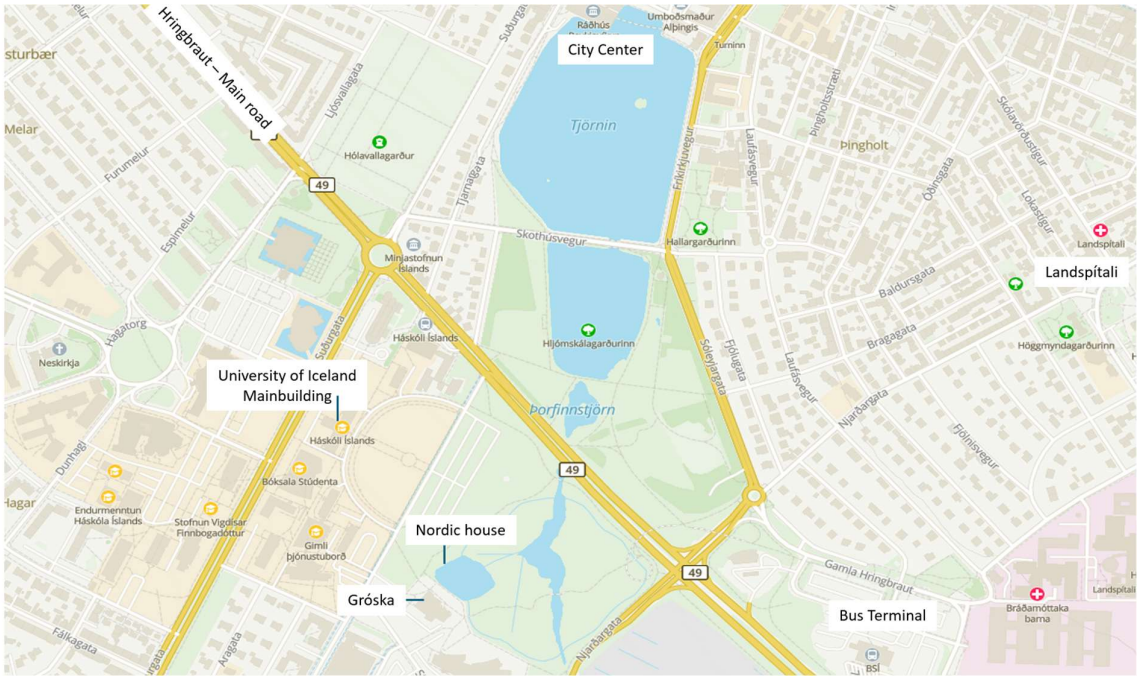
https://hi.is/haskolinn/groska

The social program will take place at the **Nordic house**, followed by dinner at the restaurant **Plantan** located within the Nordic house.

The Nordic house is located next to the University of Iceland campus, close to Gróska.

https://nordichouse.is/

https://www.plantankaffihus.is/



Keynote speaker – Lotta Dellve, University of Gothenburg

Health-promoting leadership and communication flow

Professor Lotta Dellve

Lotta Dellve is a professor in work science, with a background in nursing and a doctoral thesis in public health and occupational medicine. She holds professorships in ergonomics and leadership in healthcare. Lotta has been an active researcher for 30 years, focusing on organizational and social work environments and conditions, leadership, and organizing work. Most studies are conducted within eldercare, social, and healthcare, and from sustainability and capability perspectives. These often evaluate or contribute to the further development of practices. Additionally, Lotta has also developed pedagogical materials for use in practice and has received the prize “HRM-researcher of the year” and three of her PhD-students have received “Best PhD-thesis of the year”.

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Leadership for future challenges in health care

Venue: Gróska, University of Iceland, Meeting room *Fenjamýri*, Bjargargata 1, 101 Reykjavík

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8:00 Registration and coffee

8:30 Opening of Symposium

8:40 Keynote:

- **Professor Lotta Dellve,** University of Gothenburg
  Health-promoting leadership and communication flow

9:30 Session 1: Healthcare leadership

- **Mira Karjalainen:** Leadership culture in healthcare administration
- **Monica Nyström:** Agile Stepwise Quality Improvement – a way to support staff improvement initiatives and enhance change in volatile healthcare context
- **Sigrún Gunnarsdóttir:** The importance of leadership for role clarity and accountability in healthcare
- **Majken Epstein:** How to support first-line healthcare managers in promoting both their own and employees´ recovery: A qualitative interview study

10:50 Coffee

11:10 Session 2: Healthcare leadership and well-being at work

- **Anna Dahlgren:** The design and content of a group-based program supporting first-line managers´ recovery and their leadership for promoting employees´ recovery
- **Aðalbjörg S Helgadóttir:** Healthcare leaders in Iceland's lived experience of leadership during a creeping crisis
- **Hanne Berthelsen:** How can we combat future labor shortages in the healthcare sector? – Analyses of factors related to high staff turnover and of how organizations address future skill supply

12:10 Lunch

13:00 Session 3: Healthcare structure and reform

- **Katrin Skagert:** Welfare technology as resources to improve and upskill eldercare work (or not)
- **Kasper Edwards**: Organizing healthcare at the margins: Local variation and structural gaps in the Danish Temporary Stay Units (MIDO)
- **Mahan Rajaeigolsefidi:** Identifying and characterizing distinct subgroups of medically complex older patients in Danish municipal temporary stay

14:00 Coffee

14:20 Session 4: Digital healthcare

- **Anu Kaihlanen:** Digitalization and leadership – identifying the needs of health and social care professionals
- **Emma Kainiemi:** Associations of digital appointments with continuity and quality of care among patients with long-term illness
- **Lotta Virtanen:** Clinical evaluations via teleconsultations: Physicians´ perspectives across different work environments in Finland

15:20 Break

15:40 Session 5: Healthcare leadership and teams

- **Monica Andersson Bäck:** Present leadership in human service organizations
- **Vilhelmina Lehto-Niskala:** Pitfalls of collaborative decision-making? The positions of nursing professionals in workplace decision-making practices in long-term care

16:20 Closing of the day

18:00 Visit and dinner at the Nordic House

Friday May 9th, 2025

8:00 Opening

8:10 Session 6: Digital healthcare and teams

- **Timo Sinervo:** Technology in assisted living facilities with 24/7 service – effects on staffing levels
- **Susanne Fennert:** Digital services in eldercare: Exploring the dualities in the domestication of welfare technologies
- **Malin Edqvist:** Team-Birth – a multidimensional intervention aiming to improve teamwork, person-centered care and patient safety in maternity care
- **Carl Savage:** Deliberately Developmental Healthcare

9:30 Coffee

9:50 Session 7: Healthcare safety and well-being at work

- **Helga Bragadóttir:** Missed nursing care – a global concern of every health care professional
- **Wendill Viejo:** The experience of foreign nurses working at Landspítali University Hospital in Iceland: Focus group interviews
- **Salla Ruotsalainen:** Work organization and employee well-being among Finnish home care employees
- **Andrea Eriksson:** Development of interactive workshops aiming at promoting and evaluating municipal managers´ capability to have a voice in their working conditions

11:10 Break

11:30 Session 8: Healthcare quality and generative AI in team context

- **Jonna Puustinen:** Recognition of individuality in enhancing quality home care and services for older people: Findings of an integrative review
- **Peter Almström:** Focused patient flows
- **Frode Heldal:** The social identity of generative AI in team context: Examining human-AI collaborative dynamics

12:30 Closing of Symposium and Lunch

Session 1: Healthcare leadership

Leadership culture in healthcare administration

Mira Karjalainen
University of Helsinki & JSBE Jyväskylä University School of Business and Economics

While organizations generally are turning more and more towards flat hierarchical structures, especially in knowledge work sector, the public sector health care organizations seem to drag behind. In Finland, the wellbeing services counties each have thousands of workers, and each administration consists of hundreds of highly qualified employees conducting knowledge work. Often, however, it seems that these highly skilled knowledge professionals are managed with hierarchical leadership principles, often derived from central hospitals.

Knowledge work involves labor of an intellectual nature requiring higher education qualifications (Alvesson, 2001). This includes various and complex tasks that require problem solving and creativity, intertwined with relative autonomy and independence on decision-making (Costas & Kärreman 2016). Autonomous knowledge work emphasizes the importance of individual and organizational flexibility, thus contributing to the blurring of work boundaries. Knowledge work is interdependent by nature (Pillemer & Rothad, 2018) and therefore it often is in conflict with the hierarchical culture originating from hospital environment.

This study looks at the leadership conceptualizations of a large healthcare organization operating in the public sector in Finland. These conceptualizations are analyzed in juxtaposition with the needs of knowledge professionals employed in the administration. The data for the study consists of documents on leadership advocated and utilized in the organization, scrutinized by employing discourse analysis. The preliminary results suggest that while there is an abundance of leadership material promoting various kinds of approaches to leadership, their discursive reality does not meet the lived experiences of knowledge professionals. The overarching question of flat and high hierarchical management, and the prevailing leadership culture, remain untackled.

The study asks how to mediate the contradictions in leadership theories and practice. It also looks for ways to develop a leadership culture that better accommodates the nature of knowledge work and the needs of knowledge professionals operating in highly hierarchical public healthcare sector.

Key words: leadership, public healthcare sector, administration, knowledge work, organizational dynamics

Agile Stepwise Quality Improvement – a way to support staff improvement initiatives and enhance change in volatile healthcare contexts

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Introduction: Despite known deficiencies changing healthcare organizations and their services remains challenging, especially in staff-intensive 24-hour care. The practical use of quality improvement (QI) approaches and the Plan-Do-Study-Act cycle has highlighted shortcomings, revealing that often the resources and supportive context needed for success are insufficient. Even so, in difficult periods and volatile organizational contexts improvements in care quality are still needed. QI can benefit from higher resilience to contextual volatility and less favourable staff situations.

Aim: To test if an agile stepwise QI approach could improve the QI work, encourage tests of staff initiatives, and enhance changes in obstetric 24-hour care, despite expected contextual volatility.

Methods: This case study of a large obstetric unit with two geographically dispersed sites uses an in-depth longitudinal process approach. Conventional content analyses were used to analyse repeated interviews with the members of two multi-professional improvement teams and other key actors. Archival data and systematic field notes provided data on process and contextual changes.

Results: The ≈2-year implementation of the agile, stepwise QI approach took place during an extremely volatile period with high staff and managerial turnover. Still, it positively affected the QI work within the unit. Repeated problem analyses, agile, small tests, ingroup testing loops, and slower stepwise scaling enhanced changes and reduced the feelings of failure when the change was harder to achieve. QI work was perceived as more positive and experienced as more effective. Staff felt more motivated, and the tests and adaptation of their improvement ideas were enhanced. To test before the implementation of any change became more common at the unit. Scaling up tested solutions was still not easy, but having team members with decision-making mandates facilitated it. It was hard to involve managers and senior staff due to high turnover, which affected sustainability. Still, the approach endures at one site 2,5 years after implementation.

Conclusions: Agile Stepwise QI had a positive impact on the effectiveness of the QI work in the obstetric unit. Achieving changes by involving colleagues in a stepwise manner was an important feature that enhanced change.

The importance of leadership for role clarity and accountability in healthcare

Sigrún Gunnarsdóttir[1], Birna D. Birgisdóttir[2]
[1]University of Iceland
[2]Reykjavík University

Introduction: Rapidly changing work environments are characterized by decreased role clarity which pertains to understanding one's job responsibilities, expectations and objectives. Role clarity is suggested to enhance performance and well-being. A supportive health work environment includes clear accountability and roles along with supportive and participative leadership granting staff autonomy and self-efficacy to craft their jobs creatively. The relationship between leadership and employee creative self-efficacy is complex and contingent upon moderating variables.

Aim: This study seeks to examine the moderating role of role clarity among healthcare personnel concerning the positive correlation between servant leadership exercised by first-line managers and the creative self-efficacy of staff.

Material and Methods: Data was collected from a survey among 116 emergency room employees to test the research model using moderated ordinary least squares regression. Creative self-efficacy was measured by the 13-item scale (Zhou and George), servant leadership by the SLS instrument and role clarity by questions form the COPSOQ. Proposed hypotheses were tested using hierarchical moderated ordinary least squares regression.

Results: The results confirm a positive relationship between servant leadership and creative self-efficacy and suggest a U-shaped relationship between role clarity and creative self-efficacy. Furthermore, role clarity positively moderates the relationship between servant leadership and creative self-efficacy. Results indicate that leaders tend to see themselves as more creative than other staff.

Conclusion: It is suggested that leaders can support employees' creative self-efficacy through servant leadership, particularly when coupled with high role clarity not by binding employees to a strict and rigid schedule but by providing clarity and understanding of objectives and expectations, removing ambiguities that might otherwise cause stress. Servant leadership's nature appears to embolden employees' belief in their creative capacities safeguarding the balance between clear role boundaries and the freedom within those boundaries. Role clarity and accountability create a structured framework for healthcare staff that defines responsibilities through objectives, job descriptions, and professional requirements while fostering autonomy to enjoy jobs and craft tasks according to expertise creatively.

How to support first-line healthcare managers in promoting both their own and employees´ recovery: A qualitative interview study

Majken Epstein[1], Marie Söderström[1,2], Andrea Eriksson[3], Anna Dahlgren[1,2]
[1]The Division of Psychology, Department of Clinical Neuroscience, Karolinska Institutet, Solna, Sweden
[2]Department of Psychology, Stockholm University, Stockholm, Sweden
[3]Division of Ergonomics, Department of Biomedical Engineering and Health Systems, KTH Royal Institute of Technology, Stockholm, Sweden

Introduction: Nursing staff often face challenging work situations. A proactive recovery program for nurses, focusing on individual strategies, decreased burnout and fatigue symptoms and prevented somatic symptom development. However, the process evaluation highlighted workplace-related factors as barriers. In line with previous research, this highlights the importance of management and leadership for employee recovery. But first-line healthcare managers often themselves face heavy workloads, which may hinder health-promoting leadership.

Aims: 1) To explore managers' strategies for their own recovery and work-related factors affecting their recovery opportunities; 2) To explore if and how managers work for supporting their employees' recovery, and factors affecting such work.

Methods: Semi-structured interviews were conducted with 15 first-line healthcare managers (13 women) working in different medical specialties at two hospitals. The managers had between 9 months to 10 years (M = 5y, SD = 4y) of work experience. Thematic analysis was used.

Results: Managers actively engaged in strategies for their own recovery, e.g. through setting limits for work hours and tasks, and optimizing recovery during breaks. To promote employees' recovery, managers aimed to be present and accessible to pick up signs of employee ill-health and to be an immediate support. They were also promoting open communication about recovery; facilitating detachment by creating opportunities for reflection during work; considering the impact of scheduling; trying to create a manageable workload; and making schedules for breaks. Only a few actively supported shorter micro-breaks. Factors related to the organization (e.g. staffing), the individual manager (e.g. stress management strategies) and the employees (e.g. communication) affected the possibilities for managers' and employees' recovery.

Conclusions: A systems approach for promoting recovery is needed. In addition to addressing organizational conditions, a program for first-line managers supporting both their own recovery and employee recovery could be beneficial. For example, such a program may promote the creation of workplace-related conditions for employee recovery, e.g. creating opportunities for micro-breaks, and could also address the potential conflict between being a present and accessible manager versus own recovery. A behavior analytic approach could be used to address own behaviors and employee behaviors interfering with recovery, and to support recovery behaviors.

Session 2: Healthcare leadership and well-being at work

The design and content of a group-based program supporting first-line managers´ recovery and their leadership for promoting employees´ recovery

Anna Dahlgren[1,2], Majken Epstein[2], **Andrea Eriksson**[3], Marie Söderström[1,2]
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Introduction: Supporting recovery in the form of sleep and recovery behaviours is shown to be beneficial for new nurses in a previous intervention study. A process evaluation showed however that organizational factors such as work hours, social norms, and work processes hindered the use of strategies for recovery (Epstein et al, forthcoming). Thus, a holistic systems approach addressing hindering and promoting factors on an organizational level is also needed for promoting nurses' recovery. In this work, first-line managers are key figures. At the same time, managers also have a strenuous work situation and a need to support their recovery. This presentation aims to outline the content of an intervention program supporting first-line managers' recovery and their leadership for promoting employees' recovery.

Methods: The design and content of the intervention program were based on a recovery program for new nurses ("Bädda för Kvalitet"), a program for health-promoting leadership, and key factors identified in interviews with first-line managers. Process evaluation was performed through observations during sessions and short surveys after each session.

Results: Six group sessions, including manuals for group leaders and material for participants, were developed. The first two sessions focused on the manager's recovery including evidence-based strategies for recovery behaviours. The managers' recovery was also followed up on over the whole program. The following sessions focused on how managers could promote recovery among their employees. These sessions were based on the principles of organizational behaviour management (including behaviour analysis) and also considered the interplay with contextual and organizational factors hindering or facilitating behavioural change. The importance of managers' change management strategies, including delimiting action plans as well as approaches to communication and evaluation was also stressed. The group sessions contained psychoeducation, group reflections, exercises, and a follow-up of the previous sessions.

Conclusions: The process evaluation showed that the program was feasible and overall well-received among participating managers. The clear focus on goal behaviours seemed to support delimited and realistic action plans. A main identified hindering factor seemed to be the managers' limited time to have a dialogue with employees on their perspectives on recovery and how to achieve goal behaviours.

Healthcare leaders in Iceland lived experience of leadership during a creeping crisis

Aðalbjörg Stefanía Helgadóttir[1], Sigrún Gunnarsdóttir[1], Erla Sólveig Kristjánsdóttir[1], Lotta Dellve[2]
[1]University of Iceland
[2]University of Gothenburg

Introduction: Creeping crises are slow-burning, high-risk events threatening essential systems and values in a rapidly changing world. Leadership is crucial in managing creeping crises in enabling adaptability during crises, which are often emotionally charged and affect entire communities. Existing research on crisis leadership often overlooks the specific challenges faced by smaller, multicultural communities like Iceland, which has experienced significant creeping crises in the last decade caused by climate change, ongoing seismic activity in Reykjanes Peninsula and, like the rest of the world, the COVID-19 pandemic. There is a gap in research focusing on how leadership unfolds locally during crises. The creeping crisis of the COVID-19 pandemic has profoundly impacted and compromised healthcare systems. Healthcare leaders play a crucial role in steering their organizations through uncertainty and adversity, in the ever-evolving landscape of healthcare, crises are inevitable. From pandemics to natural disasters, turbulent times require strong and decisive leadership. To thrive in times of crisis, healthcare leaders must prioritize preparedness, adaptability, and empathy. Embrace a growth mindset, seek continuous learning, and leverage technology for agility. Thereto, foster a culture of resilience and empowerment, prioritize the well-being of all stakeholders, and guide their organizations through the crisis with compassion and foresight.

Aim: To gain insight into senior healthcare leaders' lived experience of leadership during the acute phase of a creeping crisis.

Material and Methods: The qualitative method of phenomenology was adopted to gain insight into senior healthcare leaders in Iceland lived experience of leadership during an acute phase of creeping crisis. Semi-structured interviews were conducted with 23 senior healthcare leaders working in Icelandic hospitals and healthcare institutions during the acute phase of the COVID-19 pandemic from May to June 2020.

Results: Preliminary findings revealed five themes: Lack of control, contingencies, survival, solidarity, and self-awareness.

How can we combat future labor shortages in the healthcare sector? – Analyses of factors related to high staff turnover and of how organizations address future skill supply

Hanne Berthelsen[1], Linda Corin[2], Constanze Leineweber[3], Tuija Muhonen[1], Hugo Westerlund[2]
[1]Malmö University
[2]Västra Götaland Region
[3]Stockholm University

Introduction: High staff turnover, a problematic work environment and exit from key professions are threats to healthcare services. The overall research question is therefore how to better retain staff in such services in the future. We aim to address this by investigating: How has the turnover problem developed over time? Who leaves to where and for what reasons? What is the importance of organizational and contextual specific drivers of turnover in welfare occupations? How do HR departments, given their important role supporting line management at strategic and operational level, approach the problem?

Aim: To investigate how to better retain staff in health care services in the future.

Material and Methods: The project has a mixed-methods design based on longitudinal data from the SLOSH cohort, organizational exit survey data from the Region Västra Götaland (VGR), and interviews with HR staff from regional healthcare organizations. Quantitative analyses will be used to investigate: 1) the development of the turnover problem and exit destinations; 2) exit reasons for employees who have terminated their employment; 3) the specific importance of factors such as emotional demands, illegitimate tasks, and quality of work for turnover taking already well-established factors into consideration. Further, qualitative analyses of open-ended responses in VGR survey data will be used to contextualize the quantitative findings. Interview data will be collected and analyzed through the lens of enacted Psychosocial Safety Climate practices to understand the role of HR departments in supporting the line organization to combat staff turnover.

Relevance: Securing skill supply for healthcare services is among the most pertinent problems for the coming decade, making it important to retain existing staff and their skills in the organizations. This project will generate important insights for strategic human resource management in public welfare organizations, and for occupational health professionals as well as authorities and policymakers.

Session 3: Healthcare structure and reform

Welfare technology as resources to improve and upskill eldercare work (or not)

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Introduction: It is a well-known fact that demographic developments will require new ways of working for the elderly to be able to receive care to a similar extent as before. The hope has been placed in the introduction of welfare technology as an important part of the competence supply, not only because it can contribute to maintaining welfare despite more elderly people, but also by making eldercare work more attractive and possible to develop one's skills in different areas. The perspective and use of welfare techniques from those working in eldercare is still relatively unexplored.

Aim: Our study examines how elderly care staff use welfare technology and perceive its influence in daily work.

Material and Methods: The study had a qualitative interactive design where researchers facilitated vignette workshops within eight selected work teams of assistant nurses (a total 44 participants) in four municipalities in southern Sweden. Three themes, “Mobile as a work tool”; “Remote monitoring”; and “Comfort and activation of the elderly” were presented in vignettes followed by a discussion. The transcribed discussions were analysed in themes of care work, collaboration, autonomy and workload.

Preliminary results: The preliminary results showed that direct care work was prioritized and perceived to be about the same, but the boundaries for use and responsibility for making the technology work were unclear. Lack of established working methods for when and how welfare technology could improve care or not was challenging and often created duplication of work, such as documentation both on mobile and with paper and pen. Remote monitoring was perceived to be important for the safety of the elderly, but it increased the workload and fragmentation of work.

Conclusions: Our study contributes to understanding the use of welfare technology in daily work in elderly care. Care work and understanding the individual needs of the elderly is still the most important part of the work and the use of welfare technology seems to be added to rather than replacing established working methods. This in turn contributes to reduced autonomy and increased workload.

Organizing healthcare at the margins: Local variation and structural gaps in the Danish Temporary Stay Units (MIDO)

Kasper Edwards[1], Rebecca Grantriis[1], Mahan Rajaeigolsefidi[1], Kathrin Kirchner[1]
[1]Technical University of Denmark

Introduction: Temporary Stay Units (TS) (DK: Det midlertidige døgnophold) are municipal healthcare facilities in Denmark that serve patients in transition between hospital and home. Despite their growing role in managing increasingly complex patient populations, the organization and management of TS remain locally defined and structurally fragmented. This study explores how work, leadership, and organization are across twelve municipalities.

Aim: To investigate (1) how work and leadership are organized at MIDO, (2) how legal frameworks align with clinical realities, (3) the composition and competencies of staff, and (4) challenges to patient safety and continuity across sectors.

Materials and methods: Data were collected through 22 interviews with managers and eight structured story workshops (EMA) with multidisciplinary staff groups, including nurses, assistants, and therapists. The study included 12 municipalities, though not all were able to provide staff for workshops.

Results: MIDO units vary significantly in structure, staffing, and facilities, with no shared national standards. Although legally framed as rehabilitative, MIDO units handle patients with complex medical needs, often beyond the units' intended scope. Staff face ethical and professional dilemmas due to misalignments between legal mandates (e.g. Serviceloven §84), documentation systems (FSIII), and the actual condition of incoming patients. Nurses are scarce and moved away from direct care, assistants carry increasingly advanced tasks, and therapists often find themselves underutilized due to patients' instability. The presence of other health professionals (e.g. dietitians, social educators) is uneven and based on local priorities. Coordination with hospitals and general practitioners is hampered by incompatible IT systems, limited communication, and significant knowledge gaps about MIDO's capabilities. Organizational instability, including frequent changes in leadership, ad hoc processes, and physical environments not fit for purpose, further complicates service delivery and staff retention.

Conclusions: MIDO has become a vital, yet under-regulated, part of Danish healthcare. The lack of coherent structure, sufficient clinical capacity, and sectoral integration undermines both professional standards and patient safety. A national framework for quality, staffing, and coordination is needed to stabilize MIDO's role and ensure equitable and clinically appropriate care across municipalities.

Identifying and characterizing distinct subgroups of medically complex older patients in Danish municipal temporary stay

Mahan Rajaeigolsefidi[1], Rebecca Futtrup Gantriis[1], Kathrin Kirchner[1], Kasper Edwards[1]
[1]Technical University of Denmark

Introduction: In Denmark, municipal temporary stays (TS) have been established in all Danish municipalities as a post-hospital intermediate care structure to receive mostly older patients, usually after a period of hospitalization. With accelerated discharge processes at hospitals, TSs are expected to play a major role in the sector transition of the future. As there are no treatment and care regimes defined for the widely diverse patients with different characteristics and healthcare needs, all patients are treated as one large group in facilities with generally low specialization levels.

Aim: The objective was to identify distinct profiles of medically complex TS patients through analysis of demographic and clinical characteristics derived from the history of medical events.

Material and Methods: We defined a cohort of 11,169 patients who had at least one temporary stay during 2016-2023, across 14 Danish municipalities. Demographic and clinical information were obtained from Danish administrative and health registries. TS move-in and move-out dates were provided by the municipalities. We employed latent class analysis to identify subgroups of patients. Results were interpreted to characterize the subgroups and establish patient profiles.

Results: We identified five distinct patient profiles: a) patients with high multimorbidity, extreme polypharmacy, high hospitalization frequency, moderate frequency of surgery, short survival times; b) older women with low multimorbidity, moderate polypharmacy, highlighted prevalence of recent fall injuries, longer stays at TS, high survival times; c) younger men with moderate multimorbidity, low polypharmacy, highlighted prevalence of alcohol abuse and alcohol-associated complications, longer stays at TS, high survival times: d) patients without recent hospitalization, with low levels of multimorbidity, polypharmacy, hospitalization frequency, and frequency of surgery, and with the highlighted prevalence of antidementia, anti-Parkinson, and psychotropic medications, shorter stays at TS, and low readmission rates; e) younger men with extreme levels of multimorbidity, polypharmacy, hospitalization and surgery frequency, shorter survival times, high readmission rates.

Conclusion: Regarding the current healthcare reform, our findings can support policy decisions seeking to ensure patient safety in the transitions of patients within integrated care **systems.** Especially, our characterization of TS patient profiles can inform policies on developing designated treatment and care regimes for each patient subgroup.

Session 4: Digital healthcare

Digitalization and leadership – identifying the needs of health and social care professionals

Anu Kaihlanen[1], Emma Kainiemi[1], Lotta Virtanen[1], Tarja Heponiemi[1]
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Introduction: Digitalization has transformed and continues to change the work of health and social care professionals. This requires leaders to adopt new approaches to managing digitalizing and remote work, and leading through digital methods, also known as e-leadership. For successful e-leadership, leaders need up-to-date knowledge on professionals' needs and preferences of the required support as digitalization reshapes their work.

Aim: The aim of this study was to identify the needs and expectations of health and social care professionals for leadership as digitalization changes their work.

Material and Methods: We employed a qualitative group interview method, utilizing the Nominal Group Technique (NGT). Six NGT group interviews were conducted in two Finnish Well-being Services Counties, with health and social care professionals (n = 27) from primary services, including nurses, social care professionals, physicians, and physiotherapists. The data were categorized using an inductive, data-driven approach.

Results: Six main preferences for leadership were identified: **1) Supporting employees and promoting well-being**, including advocating for employees', ensuring safety, and making sure they are heard; **2) Developing and embedding competencies**, focusing on leader's expertise, maintaining and enhancing employees' skills through training, and sufficient orientation time; **3) Promoting motivation and encouraging experimentation**, highlighting the importance of leading by example, being flexible, and fostering a supportive atmosphere for innovation and adoption of new practices; **4) Planning and resourcing digital work**, including the importance of managing working hours, limiting the burden of digital tasks, and ensuring functional work equipment, environments and processes; **5) Improving communication and access to guidance**, focusing on timely, clear, and easily accessible communication and information sharing; and **6) Managing development and implementation processes of digital services**, emphasizing pre-planning, anticipating potential difficulties, utilizing professionals' feedback, and being adaptable when changes are needed.

Conclusions: The study demonstrates the many possibilities and multifaceted role of leaders in fostering a supportive and effective digital work environment for professionals. In 2025–2026, these findings will be complemented with additional group interviews, a survey and a Delphi panel to develop practical e-leadership guidelines for leaders to better support professionals in the changing health and social care work.

Associations of digital appointments with continuity and quality of care among patients with long-term illness

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Introduction: Patients with long-term illnesses often require regular care and monitoring. To enhance cost efficiency and accessibility, digital appointments with healthcare professionals are increasingly utilized. However, it is essential that these services maintain high standards of care and do not compromise quality.

Aim: The aim of our study was to examine the associations of digital appointments (via video or chat) with perceptions of a) consistently meeting the same professional and b) service needs being fulfilled among patients with long-term illnesses.

Material and Methods: A total of 10,160 Finnish residents with long-term illnesses necessitating regular care and monitoring (57.3% female, mean age 57.3, SE .24) responded to a nationwide population survey between September 2022 and March 2023. The Inverse Probability Weighting method was used to correct for bias. Complex samples binary logistic regression was used, and the models were adjusted for the patient's age, gender, education and area of residence.

Results: Altogether 25.8% of the respondents had used digital appointments with a physician and 22.4% with a nurse at least once in the past 12 months. Patients who had used digital appointments with a physician (OR 1.30, 95% CI 1.12–1.52) or a nurse (OR 1.20, 95% CI 1.20–1.42) had greater odds of reporting that they met the same professional consistently compared to those using only in-person visits. However, patients who had used digital appointments with a nurse had lower odds (OR .77, 95% CI .61–.96) of perceiving that their service needs were met when compared to those using only in-person appointments with a nurse.

Conclusions: Digital appointments appear to support continuity of care for patients with long-term illnesses. Enabling consistent interactions with the same healthcare professional is essential, as a professional familiar with the patient's medical history can provide more personalized and effective care. However, the lower perceived fulfilment of service needs in nurse-led digital appointments highlights the need for further research to identify and address potential gaps in the quality of digital care. Ensuring that digital services meet patients' expectations and maintain high standards of care is crucial for their continued integration into healthcare systems.

Clinical evaluations via teleconsultations: Physicians' perspectives across different work environments in Finland

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Introduction: Teleconsultations are increasing due to their potential to improve efficiency and patient access, particularly in primary care settings facing staffing challenges. Alongside these benefits, it is crucial to ensure that remote interactions do not impede physicians' ability to perform reliable clinical evaluations, including assessments and diagnoses. However, physicians' experiences across different work environments remain unexplored.

Aim: We examined the associations of practice settings, staffing problems, patient visit type (initial consultations versus only follow-ups), and received support for teleconsultations with physicians' experiences of clinical evaluations being more challenging via teleconsultations than in-person, compared to finding no difference.

Material and Methods: The Finnish Medical Association conducted a cross-sectional *Physicians' Working Conditions and Health Study* during spring–autumn 2024. Responses from 1,264 physicians, including randomly selected members and a panel followed since 2006, were analysed using binary logistic regression, adjusted for work experience and position.

Results: Among respondents, 71.4% found that clinical evaluations were more challenging via teleconsultations than in-person, while 28.6% reported no difference. The multivariable model showed that physicians conducting teleconsultations in public health centres (OR=1.69, 95% CI [1.16–2.46]) and private clinics (OR=1.75, 95% CI [1.20–2.55]) had greater odds of experiencing challenges compared to those in hospitals. Increased staffing problems (OR=1.77, 95% CI [1.52–2.06]) and conducting initial visits via teleconsultations compared to only follow-ups (OR=2.50, 95% CI [1.86–3.37]) were associated with greater odds of experiencing challenges. Receiving insufficient support for teleconsultations from supervisors was associated with greater odds of challenges compared to sufficient support (OR=3.72, 95% CI [1.88–7.37]).

Conclusions: Physicians in public health centres or private clinics, with staffing problems, initial patient visits, and insufficient support from supervisors, can have a greater chance of finding remote clinical evaluations challenging compared to their counterparts. This might result in misdiagnoses and the need for additional in-person visits, compromising the sustainability of teleconsultations to address challenges in primary care. Enhanced nurse-led initial assessments could ensure that patients needing a physician's consultation have conditions suitable for remote appointments. The challenges in evaluating initial visits via teleconsultations highlight the importance of transitioning to a model that supports continuity of care.

Session 5: Healthcare leadership and teams

Present leadership in human service organizations

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Introduction: A present leader is a common expectation among employees, and managers themselves acknowledge its importance. While research and leadership theories support the value of being present, reality often reveals a stark contrast. The aspiration of a present leader frequently collides with the harsh realities of heavy workloads, time constraints, and limited resources. These challenges are intensified within human service organizations, where managers must navigate diverse needs, regulatory requirements, and the evolving landscape of service delivery.

Aim: This presentation explores present leadership within a Swedish human service organization for disability management comprising approximately 6,000 employees and 250 managers. The study addresses three main questions: what managers understand by present leadership, the strategies they employ to maintain their presence, and how strategic management can create conditions conducive to present leadership. Unit managers oversee multiple units across various geographical locations, managing diverse employee groups and clients with widely differing needs.

Method and material: The study used qualitative and quantitative methods, including 150 semi-structured conversations with managers, a survey of unit managers (176 responses, 88% response rate), and a focus group interview with six unit managers. The research combined insider and outsider perspectives to minimize bias and find new analyses.

Results: Managers perceive present leadership as a combination of physical, mental, and emotional availability. It involves being actively engaged in employees' work, providing support, and acknowledging their efforts. Managers use various strategies to be present, including regular visits to units, participation in workplace meetings, spontaneous and planned meetings with employees, use of digital tools for communication and follow-up, and fostering a trusting relationship with employees. However, managers experience tension between wanting to be present and handling their workload and work-life balance. There are conflicting demands on managers, such as showing both trust and control. Limited resources in terms of time and money make presence difficult. Another challenge is determining when presence and availability are most valuable.

Conclusion: Strategic management can create conditions for present leadership by establishing arenas for meetings and dialogue between different management levels, strengthening the ability and interest to share perspectives, and offering structures for governance and communication.

Pitfalls of collaborative decision-making? The positions of nursing professionals in workplace decision-making practices in long-term care

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Introduction: Collaborative decision-making enhances nursing professionals' work engagement and should therefore be a central focus in all social and healthcare organizations. Supervisors play an important role in facilitating and encouraging nursing professionals to participate in decision-making within their workplaces. While many studies have examined collaborative decision-making between healthcare professionals and patients or across different professional groups, less attention has been given to how it unfolds at the interactional level within teams of nursing professionals and their supervisors. In this study, decision-making is understood as an incremental process where the nursing professionals and their supervisors move on their agenda and construct a decision step by step.

Aim: The aim of this study is to explore the storylines of collaborative decision-making in long-term care staff team meetings and to examine how nursing professionals are positioned within these storylines.

Material and Methods: The data, collected in 2023, consist of videorecorded workplace meetings (n = 10) in four Finnish long-term care facilities for older people. These meetings included weekly or monthly staff meetings chaired by a supervisor. The analysis draws from discourse analysis and positioning theory.

Results: Two storylines of collaborative decision-making were identified: *striving for different opinions* and *seeking verification*. Within the storylines, nursing professionals were positioned as *care work experts* or as *proposal acceptors*. Supervisors played a crucial role in enabling, confirming or rejecting the nursing professionals' positions. Potential pitfalls for collaborative decision-making included: 1) decision-making goes sidetracked, 2) difficulties in opposing supervisors' proposals and 3) bypassing nursing professionals' suggestions.

Conclusions: Health and social care workplaces could benefit from more collaborative leadership and workplace decision-making practices. This study highlights techniques to foster collaborative decision-making, which can be applied to improve decision-making practices and promote sustainable leadership in healthcare organizations. Furthermore, the findings can assist healthcare organizations and teams structuring their meetings more effectively, ensuring that the level and style of collaborative decision-making align with their objectives.

Session 6: Digital healthcare and teams

Technology in assisted living facilities with 24/7 service – effects on staffing levels

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Introduction: Technology in care services is increasing rapidly. The evidence of the impact of technology decreasing the need for personnel in long-term care is scarce. Staffing levels are regulated by law in Finnish assisted living facilities with 24/7 care. Despite good intentions, staffing levels have become an issue because of a shortage of personnel and missing incentives to develop technology.

Aim: Our aim was to assess the impact of technologies on the required staffing levels. In addition, the potential problems and the impact of technology on work stress and work environment is examined.

Material and methods: Qualitative and quantitative data was collected in 2024 through a personnel survey and a week-long time measurement study. The employees recorded their actions during the working day. The study was carried out in 62 units half of which used technology and half were reference units without these technologies. The technologies were night monitoring using smart bracelets or motion sensors, such as smart carpets and secondly medication dispensing. The medications are machine-packed into dose bags in the pharmacy instead of being manually dispensed by the staff in the medication room into pill organizers or onto a tray. The study involved 62 24-hour service housing units. The survey measured stress and work environment as well as employees' experiences of the technology (N=101).

Results: The results showed that technology had an impact on staffing needed in the facilities. Altogether the technologies – if both technologies in use – the staffing levels could be lowered with 0,03 (employee per resident). Due to regulations, however, the potential of night surveillance technologies could not be fully utilized. The night surveillance changed the work from routine rounds to individual visits to clients when technology alarmed, for example, if the client had fallen. Employees experienced both benefits and challenges. Technology frees up time for other tasks and improves medication safety, but in some cases, if medication changes, it increases workload and decreases medication safety. Results on stress and work environment are available during spring 2025.

Conclusion: Our results showed that technology has an effect on required staffing levels in 24-hour assisted living but can also have challenges.

Digital services in eldercare: Exploring the dualities in the domestication of welfare technologies

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Introduction: The implementation of welfare technologies in Swedish eldercare reflects ongoing sociotechnical transitions, which promise to optimize care practices and administrative processes. However, in practice, welfare technologies reconfigure established care dynamics, raising questions about their domestication and the underlying sociotechnical imaginaries shaping their adoption.

Aim: Our study explores how eldercare personnel interpret and ascribe meanings to welfare technologies in their everyday care work, with a focus on the sociotechnical processes of domestication.

Material and Methods: The study draws on an empirical dataset comprising 181 photographs and accompanying textual narratives from 61 participants across four municipalities in southern Sweden. Thematic analysis was employed to identify patterns in how welfare technologies are conceptualized and utilized. Perceived "convenience" emerged as a recurring analytical category. Perceived "convenience" was analysed through the lens of sociotechnical configurations and user interpretations to elucidate the multifaceted roles of welfare technologies in care work

Results: Participants framed welfare technologies within broader cultural narratives of technological solutionism, reflecting policy discourses that promote welfare technologies as tools for feelings of safety, fostering independence and enhancing activity among care recipients. Six dimensions of perceived convenience were identified: remote surveillance, logistics, communication, safety, comfort and activation. The dimensions of perceived convenience illustrate how welfare technologies mediate care practices and relational engagements. Instances of "inconvenience" were also reported, attributed to issues such as technical rigidity, operational inefficiencies and task redundancies.

Conclusions: Our study contributes to understanding the domestication of welfare technologies as a sociotechnical process shaped by care practices, policy imperatives and broader cultural imaginaries. While perceived convenience emerged as a central theme, it cannot be reduced to a singularly positive attribute but instead reflects the co-constitutive dynamics of human and technological actors. Welfare technologies, such as surveillance cameras/ sensors and robotic pets, were often perceived as mediators of care, substituting physical proximity with technological interaction. Our findings highlight how welfare technologies reconfigure care relationships, operational logics and value systems, thereby reinforcing as well as challenging dominant discourses of technological solutionism and care optimization.

Team-Birth – a multidimensional intervention aiming to improve teamwork, person-centered care and patient safety in maternity care

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Introduction: Most adverse events within maternity care stem from communication and teamwork failures. Despite global recommendations, few interventions include person-centered care as a means for safe care. Recently, an intervention process aiming to enhance intrapartum patient safety and person-centered care was developed in the US. The TeamBirth (TB) intervention is composed of team meetings between women, their partners, and caregivers, navigated by a shared planning board placed in the birthing room, visible to everyone. The board promotes transparent and reliable communication and includes four areas: the team member's names, starting with the woman; the woman's preferences; the care plan for the woman, infant, and labor progress; and when the next team huddle (team consultation) is anticipated. TB intends to improve communication and teamwork both among caregivers and with women during childbirth, thereby ensuring patient safety *and* person-centered care. By emphasizing clear oral and visual communication among all professionals, the woman, and her partner, there is also a potential for learning. TB has been adapted to the Swedish setting and piloted at two obstetric units in Stockholm 2022-2023.

Aim: The aim of the pilot study was to study the implementation of TB in the Swedish context and to explore how staff experienced actively involving women and their partners in decision-making during childbirth. Additionally, the study aimed to explore how the use of TB affected staff collaboration and communication, aspects closely linked to intrapartum patient safety.

Methods: Participant observations in the birthing room and semi-structured interviews with caregivers, women, and their partners were conducted, in total, 23 observations, 68 interviews with caregivers, and 14 interviews with women and partners.

Results: When staff used TB, women's and partner's experiences of involvement improved, indicating increased person-centered care. Communication between professions was enhanced, supporting better teamwork. Although signs of improved patient safety were less evident, staff noted that the planning board helped them access information about the woman, allowing them to process the situation more efficiently.

Conclusions: Based on the promising results of the pilot test of TB, this multidimensional intervention is currently being implemented and scientifically evaluated in nine obstetric units in Sweden.

Deliberately developmental healthcare

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Introduction: In a rapidly evolving healthcare environment, traditional top-down leadership models are increasingly ineffective. This case study explores the implementation of a deliberately developmental healthcare (DDH) approach at Horsens Regional Hospital's Obstetrics and Gynaecology department, led by Dr. Marie Højriis Storkholm. The study focuses on enhancing departmental resilience and staff well-being amidst economic constraints and frequent budget cuts.

Aim: The primary aim is to investigate whether a DDH approach can improve staff well-being, patient satisfaction, and overall departmental performance while meeting economic demands.

Material and Methods: The study employs a qualitative action research methodology, drawing on Dr. Storkholm's PhD research and subsequent practical application. Key interventions include offsite camps designed to foster individual and team development, guided by principles such as psychological safety, conflict management, and openness. Data collection methods include interviews, surveys (e.g., Maslach Burnout Inventory), and analysis of departmental performance metrics.

Results: The implementation of DDH principles led to significant improvements in staff well-being, with burnout rates decreasing from 18% in 2019 to 14% in 2023. Staff turnover and sick leave rates also declined, with a 42% reduction in sick leave within one year. Patient satisfaction increased, with the fertility clinic rated best in the country and the obstetrics and gynaecology clinics achieving high national rankings. Quality indicators showed positive trends, including a 50% reduction in hysterectomies.

Conclusions: The DDH approach effectively enhanced staff well-being and departmental performance, demonstrating that integrating developmental principles into daily work can lead to sustainable improvements in healthcare settings. The study highlights the importance of fostering a supportive and collaborative work environment to navigate economic challenges and improve patient care outcomes.

Session 7: Healthcare safety and well-being at work

Missed Nursing Care – a global concern of every health care professional

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Introduction: While a couple of decades ago the concept of missed nursing care was barely known among clinicians, administrators, or academics, this has rapidly changed in the past few years with a growing body of knowledge on its existence. Although 'missed nursing care', measured with the *MISSCARE Survey* originated in the US, is the far most used term on the matter, it has also been identified and studied under the terms 'implicit rationing of nursing care', 'unfinished care', 'care left undone', 'unmet nursing care needs', 'priority setting' and 'failure to maintain'. All terms referring to necessary fundamental nursing care being delayed or not carried out, defining missed nursing care as an error of omission.

Aim: The aim of this paper is to shed light on missed nursing care as a global concern and why minimizing it should be a priority for every health care professional in all health care settings.

Material and Methods: The material of this presentation is knowledge development on the matter of missed nursing care, i.e. the growing body of evidence on missed nursing care and its contribution to quality and safety in health care.

Results: Missed nursing care is a safety and quality issue associated with patient as well as staff outcomes. The main reasons for missed nursing care relate to the work environment of nursing staff, such as human resources, communication and teamwork, and material resources, all aspects within the scope of practice and responsibility of clinicians, administrators and policy makers in health care. Identifying and implementing interventions to minimize missed nursing care in a world of nursing shortage and increased demand of health care, including professional nursing services, is of enormous present and future importance.

Conclusions: Missed nursing care has been studied around the world and is a global concern and should be acknowledged as such by every health care professional.

The experience of foreign nurses working at Landspítali University Hospital in Iceland: Focus group interviews

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Introduction: Foreign nurses make up a substantial part of health care services in many countries including Iceland. The Icelandic healthcare system is marked by a highly multicultural workforce, with a significant rise in the number of foreign nurses in recent years, a trend expected to continue. However, foreign nurses often encounter challenges related to cultural differences and language barriers, which may impact their well-being at work, patient safety, and staff turnover. Despite this, there is a notable gap in research on the adaptation experience of foreign nurses working in Iceland.

Aim: The purpose of this study is to explore the experience of foreign nurses employed at Landspítali University Hospital in Iceland and to identify key factors that facilitate their adaptation to their work environment.

Methods: This is a qualitative study using focus group interviews for data collection with 5–8 focus groups and 4-7 participants in each group. A semi-structured interview guide will be used. Participants will be identified through advertisements on Workplace, the primary internal communication platform at Landspítali University Hospital, with subsequent snowball sampling employed to ensure a diverse range of experiences. Recruitment will continue until sufficient information power is achieved. Data collection is scheduled for the fall of 2024. Data will be analysed using a two-tiered approach: first, through content analysis, followed by targeted interpretive description to provide deeper insights.

Results: Preliminary findings from the final analysis will be presented.

Conclusions: This study has empirical as well as clinical value as it contributes to the body of knowledge on the experience of foreign nurses and identifies factors important to their adaptation. Results will be of particular use for promoting the inclusion of foreign-educated nurses and ensuring favourable work conditions for them. Additionally, it is important that the unique skills and perspectives that foreign nurses bring from their home cultures are fully leveraged. Given the increasing global migration of nurses, these results are expected to be applicable to many other healthcare settings beyond Iceland.

Work organization and employee well-being among Finnish home care employees

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Introduction: In Finland, care for older people has undergone a significant shift in service structure. Institutionalized care has nearly been phased out in favor of non-institutionalized care, such as assisted living facilities and home care. Even though the number of clients and client visits have remained somewhat stable, high turnover rates and shortage of employees in home care have increased problems, such as work stress, low job satisfaction, and poor care continuity.

Aim: To examine which individual-level work characteristics and organizational-level work organization factors are associated with employee well-being in Finnish home care.

Materials and methods: Wellbeing surveys for employees, a survey for managers, and Resident Assessment Instrument (RAI) data were used. Individual-level characteristics were analyzed using linear regression and analysis of covariance, while organizational-level factors were analyzed using ANOVA and t-test.

Results: Work characteristics that strained employees included time pressure, working alone, and interruptions. Those employees who worked in self-organizing teams reported lower job demands and turnover intentions, and higher job satisfaction and job control. Among work organization factors, lower care continuity, lower autonomy in teams, and the use of enterprise resource planning systems were associated with poorer well-being. Clients' higher care needs (measured with the case mix index) were not associated with employee wellbeing.

Conclusions: Home care can be a demanding work environment where work organization factors need to be considered to support both employees' well-being and quality of care. Teams should be given more autonomy to influence work planning, and to ensure care continuity. In addition, employees need support, and managers should provide opportunities for them to discuss difficult situations or cases. Work should be organized in a way that enables the provision of individualized care for clients, rather than just basic care.

Development of interactive workshops aiming at promoting and evaluating municipal managers´ capability to have a voice in their working conditions

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Introduction: Research points to declining psychosocial working conditions in strained female-dominated social care sectors (Aronsson, 2022) and poorer health indicators (Marklund, 2023; Ekbrandt, 2025). There are interlinks between work-related health and supportive organizational structures in these sectors - and line managers' conditions, e.g. lower or decreasing trends of employees' sickness absence and turnover where line managers have less work overload, listening superior and organizational support (Dellve, et al 2019, 2024). Thus, there is a need to focus on improving managers' working conditions, including developing the capability to voice work environment challenges.

Aim: To suggest and reflect on methodological considerations of how interactive workshops can be developed aiming at mutual learning between researchers and management groups on critical conditions for improving line managers' working conditions – to enhance Capability to Craft Sustainable Work Practices.

Methods: The city of Gothenburg has initiated major improvement efforts to improve managers' working conditions. These will be evaluated through analysis of action plans, interviews with the involved, interactive workshops, and questionnaires to employees and managers. This presentation focuses on the development of workshops that will be performed with strategically selected top management teams in 6 organizations.

Outline of the interactive workshops: The planned interactive workshops are inspired by the method of chronicle workshops (Poulsen et al., 2015; Edwards & Winkel, 2018). The core is to create a coherent story from the participants regarding performed improvement work of managers' conditions. The purpose of the workshops is to initiate mutual learning by illustrating processes to develop managers' organizational conditions — structured as mapping, analysis, implementation with necessary adjustments, and evaluate goal fulfillment. More specifically, during the workshop participants jointly put up a timeline for critical activities with the action plan, and then each participant through post-it notes contributed with their perspectives of improvement results, communication flows, and critical conditions for improvements related to the activities. Critical conditions are clustered and summarized by the researcher during the workshop and thus visualized to support insights into broader and integrated aspects of importance for the capability to craft sustainable work. By conducting workshops in several organizations' meta-learning can also take place.

Session 8: Healthcare quality and generative AI in team context

Recognition of individuality in enhancing quality home care and services for older people: Findings of an integrative review

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Introduction: Older people are unique, which necessitates individually tailored, high-quality home care and services to meet their comprehensive needs at home. Individually delivered care also supports the professionals and their well-being and is required when they are providing multifaceted care and services in the home environment. However, a synthesis of knowledge on individuality in home care and services for older people is missing. This knowledge is essential for service providers, managers, and leaders to ensure and enhance the quality of home care and services.

Aim: This review aimed to identify and synthesize previous research on individuality in delivering home care and services for older people.

Material and Methods: An integrative review was conducted using systematic searches in CINAHL, PubMed, SocIndex, and Web of Science databases, as well as manual searches. Peer-reviewed, empirical studies on individuality in home care and services for older people published in English (Jan 2012 - Feb 2024) were included. Records (N=1596) were screened based on eligibility criteria, and selected studies were evaluated on their quality. Data was analyzed and synthesized by inductive content analysis.

Results: 23 studies were included in the review. Based on the results, individuality is delivered on three levels: first, validating the older person in their unique life context; second, preserving their perceived self-determination in mutual care encounters; and third, sharing responsibilities within service delivery. Individuality is a prerequisite for the meaningful life of an older person and their tailored care and services in the home environment. It relies on older people expressing and voicing their self-determination and owning their care which is supported by mutual communication and trust.

Conclusions: Individuality in delivering home care and services is based on the structures that prioritize individuality within the shared responsibilities of stakeholders and multi-professional collaboration in providing these services. Our findings can guide the recognition and evaluation of individuality in professional practices, management and organization of home care. Further research is needed to evaluate older people's and professionals' perceptions of individualized home care and how the delivery can be developed to respect the individuality of older people and support professionals.

Focused patient flows

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Introduction: Productivity must increase in healthcare to cope with the present and future high demands. Popular ways of increasing efficiency are to create specialized facilities such as an eye surgery clinic or to create clinical pathways such as cancer treatment. While these are more efficient for the specific group of patients, this cherry-picking poses a dilemma for the full-service hospital with increased cost pressure that threatens the quality of care for the remaining patients and may negatively affect the work environment.

Aim: This study explores how a more strategic approach to focused patient flows at full-service hospitals can be achieved to simultaneously improve productivity and quality of care.

Material and Methods: A systematic literature review was conducted to develop a framework for enabling focused healthcare organizations. A single case study analyzed patient processes at a full-service medical clinic based on patient volume and variation, after which the framework was applied to evaluate the clinic's operational focus.

Results: This study presents a framework for establishing strategic direction, assessing operational focus, and guiding the design and implementation of focused operations in healthcare. It reveals that if processes are not divided into being either complex or simple, an increase in process volume will most likely come with undesirable process variation, resulting in a reduction in process flow. To address this issue, the framework provides a tool for healthcare providers to better organize patient processes into either focused (high-volume, low-variety) or general (low-volume, high-variety).

Conclusions: This research offers a novel framework for enhancing operational focus in healthcare for full-service healthcare providers. It provides new insights into the relationship between volume, variation, and productivity, offering explanations for inadequate patient flow.

The social identity of generative AI in team context: Examining human-AI collaborative dynamics

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Introduction: The integration of generative artificial intelligence into everyday life has positioned these systems as advisory entities for individual decision-making, with significant implications for professional domains including healthcare.

Aim: This study investigates how humans attribute team roles to a generative AI within collaborative team contexts and thus create a social identity. This is critical given that AI systems primarily communicate through text-based interfaces prone to communicative ambiguities.

Method: Drawing on theoretical frameworks from team science and human-robot interaction, we conducted a longitudinal survey-based study involving over 200 university students who incorporated AI into team-based academic projects. A survey measuring team behaviors was distributed three times across a four-month period, enabling us to measure team development.

Results: Our findings reveal that participants demonstrated tendencies to anthropomorphize AI systems after some time, attributing various team roles ranging from advisory functions, friend/support functions, facilitator to creative contributor and, notably, leadership functions. These role attributions evolved dynamically throughout the team's development, suggesting complex processes of role negotiation that parallel those in human teams.

Conclusion: The theoretical implications extend to fundamental reconceptualization of team composition, role differentiation, and leadership in increasingly AI-integrated environments. Practically, organizations implementing generative AI should develop explicit frameworks for delineating appropriate human-AI role boundaries and establish protocols for effective collaboration that maximize complementary capabilities while mitigating communicative ambiguities. Results, although generalized, are highly applicable and relevant for health care contexts.

This study contributes to the emerging literature on human-AI collaboration by elucidating the social and psychological processes through which humans integrate non-human entities into established team structures, with significant implications for future organizational dynamics. They may have direct consequences for rethinking cross-boundary and interdisciplinary teams in health care.

Keywords: Generative AI, team dynamics, human-AI collaboration, role attribution, leadership

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