Proceedings

The 13th NOVO-Symposium

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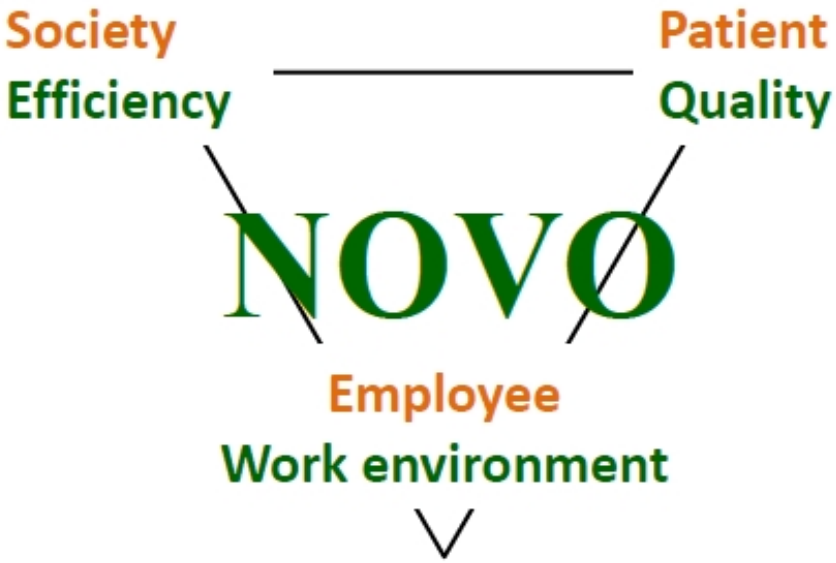
Sustainable work and inter professional collaboration in health care

DTU, Lyngby, 12-13 December 2019



Edited by Kasper Edwards

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Preface

The NOVO-Network started more than 13 years ago and the core idea of the NOVO is to integrate perspectives of work environment, efficiency and quality of care (the NOVO-triangle) - to support sustainable health care systems.

Our health care systems are dynamic and ever changing trying to satisfy increasing demands for services while meeting economic constraints. New treatments are developed as well as new care paths are moving elements of care and treatment from hospital to municipality. Another major development is value-based health care where the patients' value perception is sought integrated in the planning (and funding) of care and treatment.

Tools and methods from operations management are no longer an exception but used on a regular basis to increase productivity. These and other development have implications for employees, patients and society. With the increasingly shortage of professional staff and high absenteeism in health care, it is increasingly important to consider integrate the perspectives of efficiency and quality of performance with the development of beneficial working conditions.

For this symposium we have organized the abstract in 7 themes:

- Communities and collaboration
- Leadership/care models/interprofessional collaboration
- New organizational forms
- Operations and productivity
- Implementation
- Leadership
- Stress, turnover and municipalities

The NOVO-symposium brings together researchers from different fields to discuss our common interest in health care. This multi disciplinarity and our similar yet different health care systems in the Nordic countries are a core strength of the NOVO-network and a great source of inspiration for our discussions.

We hope you will enjoy the Symposium in Lyngby and discover new ideas and colleagues!

Kasper Edwards & Peter Hasle

The NOVO Steering group

DENMARK
Kasper Edwards (Chairman)
DTU Management, Technical University of Denmark

Peter Hasle
SDU Engineering Operations Management

FINLAND
Timo Sinervo
THL National Institute for Health and Welfare PALO/PAAR,

Tuula Oksanen
Finnish Institute of Occupational Health

ISLAND
Sigrún Gunnarsdóttir
University of Iceland, Faculty of Nursing,

Aðalbjörg Stefanía Helgadóttir
Nurse manager at The NLFI Spa and Medical Clinic

NORWAY
Beate André
Høgskolen i Sør-Trøndelag, Avdeling for sykepleie

Arne Orvik
Norwegian University of Science and Technology

SWEDEN
Andrea Eriksson
KTH, Sweden

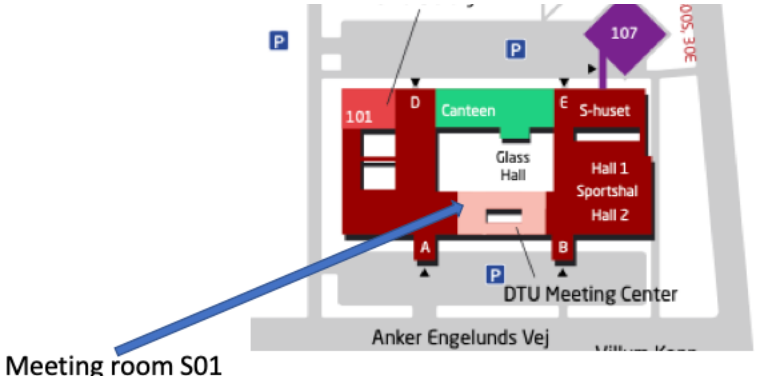
Peter Almström
Department of Technology Management and Economics, Chalmers University of Technology

Getting to DTU

DTU's main campus is located in Lyngby 15 km north of Copenhagen. You can reach the main campus by car or by public transportation.

For links to transportation info see: https://www.dtu.dk/english/about/campuses/dtu-lyngby-campus/getting-there

Finding Meeting Room S01 on campus:
Go to building 101 – the main building. Take entrance A and turn right inside to go to the meeting centre and find room S01.



Keynote speaker Kjeld Møller Pedersen

Kjeld Møller Pedersen, professor in health economics, Aalborg University. Kjeld has researched and healthcare and has served as SVP and EVP for LEGO. Keld has contributed to several ministerial committees on the Danish health care sector. His research interest cover a wide range of topics such as hospital management, health policy and decision-making, health care reforms, the use of economics evaluations for actual decision-making, use of transaction cost economics/new institutional economics as a paradigm for health economics and measurement and valuation of health status Quality and economics.

Keynote speaker Peter Hasle

Peter Hasle, professor in sustainable production, University of Southern Denmark. He has for the last decade studied collaboration in hospitals, and he will talk about the possibilities to design local collaboration in wards and departments which can meet the challenges from limited resources as well as the tendency to move coordination away from humans to still more standardized and sophisticated IT-systems.

Social program Thursday evening

Private tour at Artist Bjørn Wiinblads house

Thursday 18:00-19:00

Adress: Bjorn Wiinblads Vaerksted A/S, Højskolevej 5, DK-2800 Kgs. Lyngby

Take bus 194 towards Nærum St. from Lyngby Kirke (Lyngby Hovedgade) to Frilandsmuseet (Kongevejen) – its just 4 minutes (5 stops) by bus.

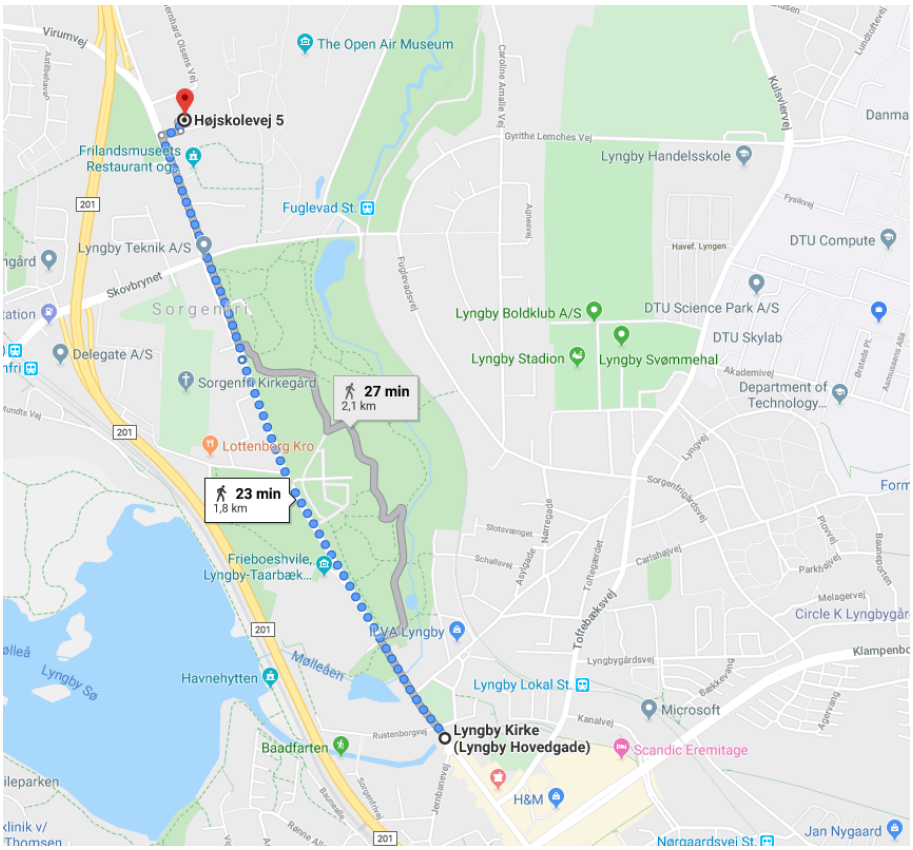
The bus leaves 17:53 and you will be at the house 18:01.

Or walk 1,8 Km (23 minutes according to google maps)

Getting a bus ticket:

Download the “DOT Ticket” app from app store or google play and follow the instructions. You need a 2-zone ticket (24kr) from Lyngby to Bjørn Wiinblads house.

Not having a ticket will result in a fine of 750 kr ☹



Artist Bjorn Wiinblad (1918-2006) was one of a kind in Danish art and in all areas an amusing, colourful and exuberant artist. Bjorn Wiinblad’s guiding motive was ”Give people pleasure”. This is reflected in

his often luxurious and imposing oriental-inspired style with numerous colours, a compact decoration with flowers, small birds, flourishes and plump figures.

Bjorn Wiinblad went his own ways and stood out significantly from the simple and pure style Nordic design.

Bjorn Wiinblad's home, The Blue House, stands untouched after his death in 2006. It was Bjorn Wiinblad's own wish that his home should be an open home for artists and a living workshop for ceramic artists.

The house encompasses the most fantastic interior which consist of a large and comprehensive art collection and bears witness of a popular multi-artist who wanted to make people happy in his own quirky way.

Thursday 19:30 Dinner at Meyers Spisehus

Adress: Handelstorvet 10, 2800 Kgs. Lyngby

Meyers Spisehus is in the centre of Lyngby and close to the scandic Erimitage Hotel.

Getting there from Artist Bjørn Wiinblads house is simply taking the bus back or walk back to lyngby.

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Program: The 13th NOVO symposium

Sustainable work and inter professional collaboration in health care

Venue: Meeting room S01, Bygning 101, Danmarks Tekniske Universitet, Anker Engelunds Vej 1, 2800 Kgs. Lyngby

Thursday 12 December 2019

9.00 Registration and coffee

10.00 Opening the Symposium

10:15 Keynote:

- Professor Kjeld Møller Pedersen
  Immutable organizational structures in health care?

11.00 Session 1:

- Beate Andre: Differences in communication within the nursing group and with members of other professions at a hospital unit
- Gunnar Gillberg: Collaborative agency as means for trust-based organizing of eldercare: experiences of assistant nurses
- Rasmus Jørgensen: Sustainable management of knowledge in healthcare
- Maria Wolmesjö: Bringing Policy into Practice – Models of Value Integrated Eldercare in India and Sweden

12.00 Lunch

13:00 Session 2:

- Anna Jansson: Conditions for learning in temporary agency work – the case of Swedish nurses
- Kasper Edwards: A wealth of Ideas - A hospital innovation system
- Jeppe Gustafsson: Integration across professional and organizational boundaries in Danish Health Care

13.45 Coffee

14.15 Session 3:

- Monica Bäck: Successful entrepreneurial organisational development of Swedish and Indian elder care service

- Christopher Mathieu: Mimicking the market in hierarchy to reduce use of the market: the challenges of an internal temporary employment agency at a Swedish university hospital
- Gerd Nordhus: Can a combined clinical placement model enhance undergraduate nursing students' knowledge and understanding regarding care integration in the Norwegian health services?

15.00 Coffee

15:15 Session 4:

- Henrik Breddam: Creating better patient schedules by gaining an understanding of the work of a medical secretary
- Peter Almström: How to increase capacity with existing resources at a surgery
- Simon Hermansson: A review of research on improvement of flow efficiency and resource efficiency in healthcare
- Christofer Rydenfält: Transition to digital aftercare and how it affects the professionals' work and the cost efficiency

16.15 Closing the day

16:30 Steering group meeting (Steering group only)

18:00 Private tour at Artist Bjørn Wiinblads house, Højskolevej 5, DK-2800 Kgs. Lyngby

19:30 Dinner at Meyers Spisehus, Handelstorvet 10, 2800 Kgs. Lyngby

Friday 13 December 2019

9:00 Keynote:

- Professor Peter Hasle
  Local cooperation and coordination in hospitals – challenged by resource scarcity and digitalization

9.45 Session 5:

- Sigrún Gunnarsdóttir: Implementation of servant leadership in elderly care
- Maria Wolmesjö: Sustainable leadership through participation – value-based work for increased quality of life in care of older persons
- HelenaHåkansson: Employee driven developments, a way forward? - Analyzing attractivity and participation in new forms of developmental work
- Timo Sinervo: Large-scale integration of health and social services in Finland: facilitators and barriers of implementation

10.45 Coffee

11.15 Session 6:

- Frederik Bååthe: How hospital management handle the dynamic tensions between professional fulfilment, organizational factors and quality of patient care – an interview based study
- Sigrún Gunnarsdóttir: Servant leadership as health promoting leadership in elderly care
- Lotta Dellve: Distributive leadership to support development of value- and perspective integrated eldercare

12.00 Lunch

13.00 Session 7:

- Roger Larsson: Care coordination challenges between regional and municipal care when integrating mobile interprofessional teams in practice
- Erika Wall: Carpets in the homes of elderly. Dilemmas on risk and well-being in the intersection between governmental information and everyday life understanding
- Andrea Eriksson: Mechanisms influencing nurses' staff turnover in a hospital – Analysis from a system perspective
- Judith Rosta: Changes in perceived work stress among doctors in Norway from 2010 to 2019: a study based on repeated surveys
- Kasper Edwards: A strategic MSD prevention tool for municipalities.

14.15 Symposium Closing

14:30 The End ☺

Session 1: Communities and collaboration

Differences in communication within the nursing group and with members of other professions at a hospital unit

Beate André and Endre Sjøvold

Aims and objectives. To investigate what differences, exist in nurses' communications with each other as opposed to their communications with members of other healthcare professions.

Background. Difficulties have been reported related to the introduction of interdisciplinary collaboration in hospitals even when their efficacy has been demonstrated. Design. This paper is a report of a project that was a cross-sectional survey design. Method. Nurses and assistant nurses received questionnaires that examined two different components of interdisciplinary collaboration. Using the psychometric method known as Systematizing Person-Group Relations to gather data and for analysis, the method aims to investigate the dominant aspects of the particular work environment by identifying key characteristics of interdisciplinary collaboration.

Results. The respondents reported significant differences in six of the 12 factors; high scores on caring, acceptance, engagement and empathy characterized communication with members of their own professional group as low scores on the same factors characterized communication with other healthcare professions.

Conclusion. Findings in this study suggests that nurses behave in a more loyal, accepting and critical manner when communicating with each other than they do when communicating with members of other healthcare professions. Nurses are more influenced by behaviors characterized by assertiveness and resignation in their communication with members of other healthcare professions. The findings indicate that nurse's experience mixed emotions and behaviors that influence their communications with healthcare personnel from other professions.

Relevance to clinical practice. Nurses often hold key positions on interdisciplinary collaboration; therefore, they must develop the communicative skills required in this position to be able to improve the quality of patient care in hospitals, related to nurses' experiences and skills.

Collaborative agency as means for trust-based organizing of eldercare: experiences of assistant nurses

Gunnar Gillberg, Helena Håkansson, Lotta Dellve

Department of Sociology and Work Science, Gothenburg University, Sweden

E-mail: gunnar.gillberg@socav.gu.se

Introduction: Today, the organization and management of elderly care are being discussed extensively for a number of reasons. Problem areas related to this discussion include recruitment problems, high sickness numbers and loss of competence as a result of extensive staff turnover. We investigate organizational changes with the overall objective to counteract these negative developments.

Aim: To analyze forms and preconditions for sustainable trust-based organizing of elder care, from the perspective of assistant nurses

Material and methods: The investigated projects were carried out in the elderly care sector in the city of Gothenburg, Sweden. The study was based on interviews with a total of 74 assistant nurses and the processing of the interviews was inspired by a grounded theoretical coding. As an analytical framework, a realistic evaluation model was used, which in practice means that various enabling and inhibiting factors were focused in order to understand what effects the current management and organizational changes had for assistant nurses at the base level.

Results: The redistribution of power and influence to operative levels, in those cases where it took place, supported improvements of job quality and working conditions for the assistant nurses. It also affected the situation of the elderly in a positive direction when an increased scope of action among the assistant nurses led to that the older people's needs could be met in a more direct and individual-oriented way. The change in the managers' role to a more facilitating and supportive function, as well as the organizational change that resulted in local steering groups, which included assistant nurses, were important mechanisms behind this development.

Conclusions: As a consequence of the distribution of power and influence, the employees experienced a significant positive change in their work. Although some of the employees still felt that issues such as salary and working hours were more important than influence and increased responsibility, the analysis indicated that a collaborative agency was developed, which among other things, led to an increased self-esteem and a professional pride among the assistant nurses.

Sustainable management of knowledge in healthcare

Rasmus Jørgensen, PhD student, rajor@dtu.dk.

Kasper Edwards, Senior Researcher and PhD

DTU Management, Technical University of Denmark

Managers in healthcare face continuous changes; new technology, improvements to work processes, new medicine, new research etc. Changes impacts how the work is done thus employees must continuously acquire new knowledge and develop new ways of working. Managers often rely on the classic solution; disciplined adherence to written guidelines. However, this type of management of knowledge does not support a flexible workforce that is adaptive to changes and autonomously develop knowledge and work processes. Thus, today management of knowledge does not support a "healthcare systems that is sustainable" in the sense that employees autonomously develop knowledge. Instead managers must expand their behavior repertoire and connect employees in communities that autonomously develop knowledge, implement changes and share knowledge resulting in a sustainable knowledge management approach. Through the development of communities employees develop relationships where they participate voluntarily and share and develop knowledge, and these communities thrive under management that focus on building relationships and interactions. Thus, today managers in healthcare must span a wide range of behaviors to support a sustainable healthcare.

Bringing Policy into Practice – Models of Value Integrated Eldercare in India and Sweden

Maria Wolmesjö, Associate Professor in Social Work, Faculty of Caring Science, Work Life and Social Science, University of Borås, Sweden, maria.wolmesjo@hb.se (corresponding author)
Lotta Dellve, Professor in Work Science, Department of Sociology and Work Science, Gothenburg University, Sweden
Anindo Bhattacharjee Assistant Professor in Buisness Administration and Management, Narsee Monjee Institute of Management Studies, Mumbai, India

Introduction: First line managers in eldercare have to handle several different values, which sometimes can come in conflict with each other. Providing a qualitative care of older people is a common global challenge since the amount of older people is increasing and the younger generations are difficult to find, recruit and keep in eldercare. Even thou the welfare systems differ between India – traditionally based on family care giving, and Sweden – based on the public sector as main support for family care giving, there are common issues for founders and managers to handle when trying to integrate a value-based leadership and develop a healthy and sustainable work environment.

Aim of this paper is to explore how general policies and principles are translated into practice in two different contexts of eldercare, India and Sweden and what ethical dilemmas founders and managers have to handle bringing policy into practice, i.e. integrating a value-based leadership.

Material and methods: Initially a document study of existing policy documents was made (laws, regulations and guidelines) and analyzed by using a systematic scoping review. This was followed up with in-depth interviews with founders of eldercare organizations and managers at different organizational levels in eldercare in India and in Sweden. Interviews where analyzed with a constructive grounded theory approach.

Results point out managers and care workers are given the policies through laws and guidelines but there seem to be a lack of models of how to implement values and norms on what, how and when to “do care”, i.e. how to bring policy into practice. Regardless of welfare system, this gives consequences for efficiency, sustainability and capability when trying to develop a healthy work environment of employees and quality of care for patients/users. First line managers and their preconditions are important for introduce, develop and support a sustainable social and health care system in eldercare.

Conclusion is there is a need of an interprofessional collaboration, between politicians, researchers, professionals at different organizational levels and users in order to give preconditions to implement policies into practice and reach a sustainable quality of care for older people.

The study is a part of an Indo-Sweden collaborative research project sponsored by the ICMR of the Ministry of Family and Health Affairs in India and the FORTE in Sweden.

Session 2: New organizational forms A

HR and temporary agency staff? A study of Swedish temporary agency nurses' experiences of work and learning

Anna Berg Jansson, phD. Human Work Science

Luleå University of Technology, Sweden

Introduction

Organizations of today not only face the challenges of managing a 'blended workforce', but also severe labour market crisis. Hence, the need to deepen the understanding of temporary employment practices are emphasized (Koene et al., 2014). Indeed, the need of specific HRM attention for temporary agency workers (TAWs) has been underestimated, suggesting that TAWs can be used rather opportunistically without risks for the client organization (CO) (Koene & van Riemsdijk, 2005). However, TAWs also can pose different kinds of risks for COs, especially so when used in core organizational roles such as in nursing (Kirkpatrick et al., 2018). Hence, COs are suggested to become more involved in the HRM of TAWs (Koene et al. 2014; Koene & van Riemsdijk, 2005). Indeed, the increased use of TAWs in core service roles has been discussed in terms of rising fees and potentially negative consequences regarding service quality (Cornes et al., 2013). However, as Manthorpe et al. (2012) argue "it may often be the poor management of agency workers rather than agency working itself which poses a risk to service users" (p. 127). With departure in the above, this paper focuses COs' HR management of temporary agency nurses, following the assumption that this case illustrate "…high-risk situations where, in theory at least, there is greater incentive for client organizations to invest in the HR management of agency workers" (Kirkpatrick, 2018:2).

Aim

The overall aim with this paper is to describe and analyze temporary agency nurses' (ANs) experiences of work and learning focusing the HRM of COs. Which HR activities are mirrored? Which learning conditions can be identified and how can these be discussed from a CO perspective?

Material and methods

The paper is based on 13 in-depth interviews with Swedish ANs and a web-based survey.

Preliminary results

Relations to supervisors (management) at COs appears central as they lead and allocate daily work. However, they vary a lot, thus indicating few organized and structured HR activities towards the ANs. Furthermore, the preliminary results indicate low expectations of ANs participation and some cultural aspects (norms) hindering such participation. Overall, this indicate both opportunities and challenges for COs regarding learning.

Ideriget – A Wealth of Ideas – A hospital wide innovation system

Kasper Edwards[1]. Christine Ipsen[1],

Technical University of Denmark, Kgs. Lyngby, Denmark, 2. Rigshospitalet, Denmark

Employee driven changes are thought to result in sustainable work that balances organizational performance and employee well-being. By explicating in-house knowledge about problems and potential solutions, direction of change is aligned with employee's knowledge of what is needed and professional insight. Consequently, the identified changes are preferred by employees ensuring that implementation is welcomed resulting in increased wellbeing at work and improvement of the work practices.

Method

A larger Danish university hospital developed an innovation program, a "Wealth of Ideas" (WoI) to engage employees across all functions and seniority in the incubation and implementation of their ideas to introduce new or improve existing procedures and practices in the hospital.

We performed a post-project analysis of the program and interviewed the head of the innovation program and four of the 10 participants about their experiences with program and subsequent implementation of the selected work-related changes. Two of the respondents got funding for their idea for change and two did not.

The WoI program invited employees to submit ideas for innovation projects and through a 3-stage selection process 60 project proposals were analyzed and 10 projects were awarded funding allowing the employee(s) to work on the innovation full time for six month. The participants were further trained in innovation methods and implementation to support development of their innovation/change. Following the development phase, the employees were to return to their original wards and implement the idea for change.

Building on acknowledged principles for sustainable changes, the designers of the innovation project hypothesized that this particular participatory program and generation of new ideas for work practice would motivate employees to bring forward ideas that would improve the daily patient care and gain immediate support from their wards.

Analysis and results

However, upon returning to their wards the program participants discovered that the wards were not aligned with the change they were about to implement. From the wards' perspective the change represented a personal interest from the participant – not the wards' interest.

From a ward management perspective this particular participatory and bottom up innovation process creates tension within the wards. The hospital top management supports the participants and the changes, however, the ward managers have not been included in the neither the change of the work nor the implementation process. Following the development phase the participant is empowered to implement the innovation by top management. Ward management on the other hand focuses on maintaining daily operation using all available resources. Thus, a conflict arises as the innovation project not only uses the resource of the participant but also require resources and changes in the ward to support implementation. All in all, the Idea of Wealth program and the identified work related changes spurred a lot of creativity and good ideas. But the implementation was not aligned with the organization and performance goals which frustration and unneeded conflict in the wards.

Integration across professional and organizational boundaries in Danish Health Care

Prof. Janne Seemann and ass.prof. Jeppe Gustafsson, Aalborg University

The longstanding trend within medicine towards greater specialization intensifies fragmentation and silo problems in traditional health systems. As a consequence, we have seen many different interventions to create integration and coherent patient flows across both intra- and inter-organizational health systems, mainly through new modes of organizing, managing and collaborating. However, integration across professional and organizational boundaries still remain one of the greatest challenges in developed health care systems (Rudkjøbing et al., 2014; Seemann & Gustafsson, 2016).

The empirical background is primarily a qualitative longitudinal case study of a radical change initiative in Aalborg University Hospital (AAUH) situated in the North Region of Denmark. AAUH's vision is that all patients should feel that their patient course is coherent, with few mishaps in transitions and with high quality. Focus is on improving coordination of patient flows through the hospital units and also between the hospital and the primary care sector (municipalities and general practitioners). The radical initiative was launched as a comprehensive top down change project in 2013 and followed by several bottom-up projects

The theoretical backdrop focus on horizontal processes in and across professional organizations at levels of leadership, structure, systems and organizational culture, drawing on perspectives from research concerning organizational design, and inter-professional, inter-organizational theory of coordination and integration (Abbott 1988, Alter & Hage 1996, Oliver & Ebers 1998, McNulty & Ferlie 2002, Galbraith 2008, Cropper et al 2008, Scott et al 2000, Keast et al. 2014) as well as hybrid leadership (Byrkjeflot and Jespersen 2014).

The overall aim of the trailing project is to document the main features of the change process and identify critical challenges for managers and employees to improve our understanding and gain more knowledge of dynamics related to the creation of coherent patient flows through horizontal integration. Patient involvement which can be perceived as an integrative mechanism is excluded from the study.

Our findings indicate that integration across professional and organizational units demands multiple hybrid management, which in turn increase ambiguity and cross pressure in involved organizations, thereby requiring the development of organizational and individual capabilities to math multiple audits.

Session 3 New organizational forms B

Successful entrepreneurial organisational development of Swedish and Indian elder care service

Andersson Bäck, Monica[1]; Bhattacharjee, Anindo[2] , Dellve, Lotta[1]

1. University of Gothenburg, Dept of Sociology and Work Science
2. ASM-SOC and School of Business Management, NMIMS, Mumbai

Introduction

Indian and Swedish elder care faces several sever challenges; such as a demographic change towards an escalating population of elder persons in an era approaching digital technical revolution. The two countries suffer from an apparent lack of staff and competence as well as resources to make elder care an attractive workplace with few environmental issues and low risk for occupational health and wellbeing. Besides similarities, the two countries have their own differences: elder care in India is a stage of development, while the Swedish counterpart is mature but under transition, which make their respective elder care management appealing to study and compare. Some elder care organisations are more successful than the average considering capability to handle simultaneous challenges.

Aim

of the paper is to contribute to our understanding of entrepreneurial organizational development of elder care service, particularly considering organizational solutions with focus on attracting and keeping competent staff and providing the best possible services .

Material and method

The sampling focused cases of entrepreneurial developed elder care organizations estimated successful in national ratings and evaluations in Sweden and India. The material cover in-depth interviews with 47 managers, employees, other stakeholders and founders. In India, two large home health care organizations (nearly 1000 employees each) were selected. In Sweden, the selected organizations were one intrapreneurial (within-municipality entrepreneurial) and one focusing integrated health and care with help from case-management.

Results

The results presents comparisons of innovative forms of organizing that are simultaneously handling working conditions, quality of care and effectiveness. The cases explore organizational innovations regarding 1) development of intraprenad forms and the residents' and staff's involvement and accountability with nursing assistants in an enlarged role; 2) process management integrating health and care with case managers as elder's close guide in a complex system; 3) how entrepreneurial purpose manifests into innovative solutions; and 4) stakeholder centric approach in innovations. The success and dilemmas of the innovative forms are elaborated in relation to managers' motives, preconditions and strategies and the perceptions described by employees.

Mimicking the market in hierarchy to reduce use of the market: the challenges of an internal temporary employment agency at a Swedish university hospital

Chris Mathieu, Department of Sociology, Lund University, Sweden, Christopher.mathieu@soc.lu.se
Susanne Boethius, Department of Sociology, Lund University, Sweden, Susanne.boethius@soc.lu.se

A major challenge for hospitals in Sweden, as elsewhere, is the shortage of trained staff, mainly nurses, willing to work under current employment conditions (SCB 2017:3). To offer sufficient medical care, personnel from temporary work agencies (TWAs) are used. This is expensive for hospitals and also prevents a sustainable workforce from emerging in hospital wards, with ensuing treatment and care quality, making it a goal for hospitals to minimize or eliminate the use of commercial TWAs.

The aim of this paper is to analyzes the challenges and paradoxes encountered by a Swedish university hospital operating an internal temporary work agency (ITWA). The ITWA is a market-mimicking response, providing security for both the hospital, via a workforce permanently employed by the hospital deployable across the hospital, and employees by offering both permanent employment as well as better conditions and workplace mobility.

We use a case study approach (Byrne & Ragin 2009) including document analysis and interviews with managers and employees, the ITWA's organizational operation and institutional facilitation and limitations are analysed along with employees' subjective motivations and job quality experiences.

Though seemingly an optimal solution, mimicking the market as a hybrid has paradoxes, limitations and challenges. A sustainability paradox is that the ITWA is premised on a situation where trained and experienced medical staff, who previously were permanent employees on wards work for the ITWA; a type of employees that the ITWA cannot produce itself. Working for the ITWA becomes at one and the same time a means of showing solidarity with the public healthcare system and public employment, while also striving for better material and temporal conditions. For the employees of the ITWA it also becomes a means of "adventure" – experiencing a wide range of work-settings, and tasks. Employees of the internal TWA lead a hybrid and ambiguous existence at the workplace due to their mobility. They are at the same time "non-market" temporary workers, but known by their permanent colleagues to enjoy comparatively better employment conditions, and freed from workplace conflicts and "office-politics" associated with permanent employment on wards (Palukka and Tiilikka, 2011).

Can a combined clinical placement model enhance undergraduate nursing students' knowledge and understanding regarding care integration in the Norwegian health services?

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Introduction: This paper reports a study of a clinical placement model involving Norwegian undergraduate nursing students. The model combined clinical placement in primary and secondary care. Clinical placements constitute half of the Norwegian bachelor's program in nursing, and play an integral part in the students' learning process towards professional practice as nurses. To ensure relevance, the nursing educational programs should be adaptable towards developments in the health care environment. In recent years, care integration has become an important focus in Norwegian health reforms. The aim is to provide sustainable and integrated health services that better meets the needs of the users. One area of concern has been transitions between primary and secondary care. Given their coordinating function and proximity to patients in all levels of health services, nurses play an important role in such integration processes, and nursing students should be prepared for this aspect of nursing care.

Aim: The aim is to explore whether a combined clinical placement model can enhance undergraduate nursing students' knowledge and understanding of care integration in the transition between primary and secondary health services. The model combined six weeks of medical placement in specialized community nursing homes with two weeks in relevant hospital wards.

Material and methods: The nursing students who had completed the placement, their mentors and placement teachers, were interviewed using a qualitative, exploratory approach.

Results: The students experienced that the placement provided some insight into care integration between primary and secondary health services. They felt that the learning experience would have been better with a more equal division of time between the two levels of care. They found their transition from nursing home to hospital placement stressful, which may have affected learning. The mentors and teachers expressed that it was necessary to help the students identify relevant learning opportunities regarding integrated care through reflection and discussions.

Conclusion: This combined clinical placement model did to some extent enhance the nursing students' knowledge and understanding of integrated care. Mentors and placement teachers played an important role in the students' learning process. Further research is required to explore this field of learning more extensively.

Session 4: Operations and productivity

Creating better patient schedules by gaining an understanding of the work of a medical secretary

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Introduction: Grown-Ups with Congenital Heart disease (GUCH) patients go through life with extensive check-ups every year. Check-ups include a sequence of physiological tests, analysis and doctor consultation requiring complex planning by the secretaries at the outpatient clinic. Additionally, the no-show rate among this patient group is high. Patients missing appointments take a toll on the resources of the clinic and can cause problems for the patients if important signs of regression are not detected early. There is therefore a need for better planning that takes the risk of no-shows into account in order to get better resource utilization.

Operations Research (OR) is the science of making better decisions by applying an analytical approach to problem solving, where the complex decisions are captured in mathematical models that help optimize the outcomes. Using methods of OR it is possible to create models where all patients are planned optimally according to the criteria in the model.

Aim: The aim of the study was to use OR methods to create patient schedules that would optimize the value created in the clinic.

Material and methods: The project takes place at an outpatient clinic servicing over 1600 GUCH patients. Through observations and interviews with clinic staff a mathematical model of the planning problem was developed.

Results: We present the results and account for how we, in an effort to create the best possible schedules for each patient discovered that the medical secretaries were creating schedules of a very high quality for each individual patient. We also present how to integrate the highly compassionate planning capabilities of the medical secretaries with an algorithm acting as a decision support system, solving the combinatorial puzzle of attaining high utilization.

Conclusions: The health care system exists for the sake of the patient. With improved planning, the patients will need to visit the clinic over fewer days and have a shorter waiting time between invitation and appointment, which will reduce the no-shows.

Gaining a thorough understanding of the work of the employee is crucial to creating optimization tools that create value both for society and for the patients as well.

How to increase capacity with existing resources at a surgery unit

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Introduction

There are long queues to different kinds of surgery at all public hospitals in Sweden. The bottle-neck to increase the capacity is in most cases the lack of competent personnel. A key for meeting the increasing demand in the future is to use the existing staff in a smarter and more efficient way, i.e. to increase productivity. The physical and psychosocial work environment also need to improve to keep the staff. Surgical operations are among the activities with the most obvious potential for production planning and control. The input and outputs are often clearly defined and the transformation process is to a large extent standardized. This might lead to the belief that the surgical operations process is optimal and that the only way of increasing capacity is to add more resources, however a detailed analysis of all processes and activities reveals that there is a lot that can be improved.

Aim

The aim of this research is to demonstrate how the capacity for surgical operations can increase with existing resources by focusing foremost on the set-up time between the actual operations. To practically increase the capacity requires at least one more operation per day.

Material and methods

An activity mapping was used to set up a work sampling study to gather data about the work time distribution on different activities. This was followed by a comprehensive process mapping conducted in a series workshops with different personnel groups. Data about planned operation times were gathered from the production planning system and statistics of real times were collected through a business intelligence interface. Analysis and synthesis were made together with staff and managers.

Results

The result is a number of improvements actions that need to be implemented to achieve the goal of one more operation per day. The single most influential action is to parallelize activities during the changeover phase. One surprising result was that a precondition for implementing any improvement in practice was that some fundamental changes were made to the production planning software.

Conclusions

It is possible to carry out one more operation per day, in this case from 2 to 3 and from 3 to 4, for some of the most frequent surgical procedures. However, several improvement actions are needed: Changeover activities need to be parallelized, variations due to late changes and different disturbances need to decrease and several supporting activities need to be carried out more efficiently.

A review of research on improvement of flow efficiency and resource efficiency in healthcare

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Introduction

Healthcare systems are focused on optimization, and methods from operations management are regularly employed to increase productivity. But what type of optimization has been focused on? This study aims to explore and categorize different types of resource efficiency and flow efficiency research activities that have been conducted in healthcare.

Aim

The aim of this study is to explore and categorize what types of research activities have been conducted to improve resource efficiency and flow efficiency in healthcare.

Material and methods

A systematic literature review using Scopus has been conducted. Title, Abstract, and Keywords have been searched for all available years. A delimiting search for "Healthcare", Health care", OR "hospital(s)" has been combined with several searches using different terms related to improving resource efficiency (searches A-F) and improving flow efficiency (search G):

A) "Work study method*" OR "Work-Study method*"
B) "Pre(-)determined (Motion) Time System*"
C) "Methods-Time Measurement" OR "Methods Time Measurement"
D) {Methods Engineering}
E) ({Time and motion study} OR {Motion and time study}) AND {work}
F) "Lean" AND ({Resource efficiency} OR {Work efficiency} OR {Work method})
G) "Lean" AND ("Flow" OR "Process" OR "Value stream" OR "Pathway") AND NOT ({Resource efficiency} OR {Work efficiency})

The search terms used are from Industrial engineering terminology and may not be the terms used in healthcare improvement terminology but there have been no such indications.

Results

Initial results show that in healthcare research improving flow efficiency research outnumbers improving resource efficiency research by 17:1 (search G compared to A-F). This is a strong indication that more research needs to be conducted on improving resource efficiency in healthcare.

Contributions

This review highlights the need for more research on improving resource efficiency for efficient work methods. Improving resource efficiency to follow efficient work methods is beneficial both for maintaining high quality and good work environment. Scarcity of resources, staff shortages and increasing care complexity due to patient comorbidity increases the need to focus on improving resource efficiency to efficiently provide care that is less dependent on streamlined patient care processes.

Transition to digital aftercare and how it affects the professionals' work and the cost efficiency

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Technological developments in the e-health field are constantly enabling new and more advanced methods to monitor and care for patients digitally. Through continuous monitoring of the patient's health via digitally transmitted data and communication between the healthcare staff and the patient, feedback and recommendations can be tailored to the patient's needs and conditions. As the technology is relatively new, various studies are currently being conducted to investigate the effects on patients' health. An example of such a study is WEBBIT-CR, which is one of the first studies in Sweden of the use of an advanced digital system for aftercare, in this case, for patients who have suffered a heart attack. In the study, patients will receive aftercare via the digital system LifePod. Information exchange and communication between the healthcare staff and the patient takes place via a special application. The purpose of the system is that better decisions can be made about the patient's care and that the patient, through advice and support, can change their lifestyle and avoid more heart attacks.

However, little is known about how this type of digital care affects the work and work environment of the professionals and the cost-effectiveness of care. In the research project "Between Pod and Patient", we will thus "shadow" the WEBBIT-CR study, through observations, interviews and time studies, to investigate and compare how healthcare professionals work digitally and "traditionally" with the aftercare of patients who have had a heart attack. The purpose is to increase the knowledge of 1) how digital care affects the working methods and work environment of healthcare staff compared to "traditional" care, 2) if, and then how the staff integrate the digital systems in their way of working and 3) compare the cost-effectiveness between the two modes of care. In our presentation we will describe the project in more depth and present findings from our pre-study on how the professionals reflect on the transition to digital aftercare, how they are prepared for the transition and the estimation of the cost of the traditional aftercare.

Session 5: Implementation

Implementation of servant leadership in elderly care

Sigrún Gunnarsdóttir, associate professor University of Iceland and Bifröst University

Background

High levels of burnout, job dissatisfaction and high turnover is a common problem in elderly care jeopardising the safety and wellbeing of patients and staff. Growing evidence about the potentials of servant leadership to prevent burnout and increase job satisfaction indicates that the philosophy can support successful organizational strategies, communication and first line leadership in elderly care. Towards this aim a project has been developed to implement servant leadership in a nursing home in a small town run by local municipalities.

Method

The initiative was taken by local leadership, i.e. the human resource management team in collaboration with front-line managers at the nursing home (n=50). The estimated time-period of the project is three years including three phases where the first phase was the preparation in terms of education to enhance awareness and motivation as well as dialogue about potential approaches. The implementation is designed as a scientific project in collaboration with with local human recourse management team, front line managers and an academic team according to an agreement signed at the end of the preparation phase. The academic team serves as consultants, are responsible for data gathering and data analysis as well as providing education via e-learning methods. Action research is used as a method including an ongoing dialogue about steps taken according to level of preparedness of key players, data collection about staff views on servant leadership of front line managers and their self-reported levels of burnout, job satisfaction and autonomy.

Discussion

In this presentation key steps of the project will be presented covering strategy and steps taken to prepare local participants, educational activities, methods to measure level of servant leadership and wellbeing of staff before formal implementation and plans to measure same again after second phase of implementation. Also communication between local and academical participants will be discussed and methods to support the success of the implementation process.

Sustainable leadership through participation – value-based work for increased quality of life in care of older persons

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Introduction: According to national regulations and policies of older persons in the Social service Act in Sweden, older persons should, as long as possible get opportunities to participate in decisions. Further on they should be given the preconditions to live a life in dignity and maintain their autonomy and independency. Quality of care should be provided and the older persons and their relatives should be treated with respect. Previous studies have shown, there were deficits related to care routines where the staff members own interests were put before the older persons individual needs, (organizational culture). It could also be related to how the work was organized and managed (work environment). Difficulties to recruit, keep and develop staff members and managers and maintain efficiency could be related to this and all together affected the quality of care, quality of life of older persons and their possibility to take an active part in the care giving process at different levels.

Aim of this study, is to follow the implementation process of a person-centered approach at two different housings of older people. It has been developed in close collaboration between Centre of Welfare Studies at University of Borås and two municipalities in the south west part of Sweden. Focus is on values, organizational and structural changes, preconditions of managers to implement a value-based work, to reach quality of care/life for older people. An expected outcome is to create a model, which can support managers to develop and maintain a sustainable leadership (and care system).

Material and methods used are built on active participation and co-production through the research project. Creative methods as Future workshops, reflection-groups, focus groups interviews as well as individual interviews and a questionnaire has been used.

The study is ongoing (2018-2020) and preliminary **results** point out creative methods can be used to highlight challenges and develop a common vision on *what* is needed to be developed. Through reflection groups common values can be developed and further implemented in the daily work.

Conclusions (this far) is, to develop a model, which contribute to "*the how"* of providing a quality of care/life of older persons, a healthy work environment of care givers and a sustainable leadership in eldercare, managers need to "be brave and dare to let go" and "open" for new perspectives developed in interprofessional collaboration as well as with the older persons.

Employee driven developments, a way forward? Analyzing attractivity and participation in new forms of developmental work

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Introduction

The municipal care sector in Sweden is facing many challenges. The prognosis for the future shows a situation with both lower tax revenues and a quantitative need for more care workers due to demographic changes. At the same time many municipalities have problems with retention and recruitment of care workers already today. To increase participation and include employees in developmental work is one way to increase employee retention and work attractiveness within the municipal care.

Aim

The aim was to examine the relation between participation through employee driven developmental work and notions of an attractive work within municipal human service organizations.

Material and methods

The study is a comparative case study on two different projects on employee driven developmental work within municipal care in one of Sweden's biggest cities. The data consists of interviews with employees (n=74) and managers (n=17) and observations analyzed through thematic analysis.

Results

All unit managers and strategic functions highlighted participation as a mean to raise the notion of attractive work within the care sector. All employees, on the other side, expressed improved structural conditions (work conditions, salary, working time) as the main mean to increase attractiveness of jobs. The significance of participation for increased attractiveness was related to the implementation of development work as well as the kind, form and degree of improved participation. This had implication for how their participation had led to improvements of local working conditions (work-place attractiveness), and how their work were valued in the larger organization (organizational attractiveness).

Conclusion

Participation in employee driven developmental work at unit level can contribute to employee influence on their work and job attractiveness at a local level. But as long as participation is restricted to the unit level it does not seem to affect the overall organizational attractiveness in any substantial way.

Large-scale integration of health and social services in Finland: facilitators and barriers of implementation

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Introduction: Since the early 2000s, Government policies in Finland have supported integration of health and social care to create larger care authorities. Despite the unsuccessful national reforms at the local level, municipalities have collaborated to create regional joint health and social care authorities to boost administrative integration and to innovate care integration at the floor level. Integration is supposed to increase efficiency and patient satisfaction by decreasing the number of visits and waiting times. In the point of view of personnel repetitive and seemingly unnecessary visits of some clients may decrease as client can be guided straight to right professional without referral and visit to physician for the referral. To evaluate the success of care integration at the floor level, as well as barriers and facilitators of care integration, we study two county level authorities which have merged primary and specialised health care and social services.

Methods: The study focuses on the operation of the authorities and services provided particularly for client groups benefiting from integration. We compiled regional health and social care policy and evaluation documents, and carried out individual and group interviews of managers (32) and employees (22). Auschra's framework (2018) is used in classification of barriers and facilitators of integration.

Results: The counties with 130,000-169,000 inhabitants consist of a larger town and several rural municipalities. The integration of children's and young people's services is based on organisational changes in which the services from primary health care, hospitals, social work and schools (pupils' and students' healthcare) were brought to one organisation. The health and well-being centres were created by bringing mental health, substance abuse services and social services into health centre facilities, but under their own managers. In both cases, experiences of workers and managers are positive. Care processes have improved and waiting times decreased without deteriorating patient satisfaction. Early experiences underline shared management to address smooth work processes between professional groups. Without planning the common work processes workers continue working separately.

Discussion: In the two counties experiences on integrated care are positive, but developing multi-professional work requires shared understanding, time for networking and mutual respect on others' skills.

Session 6: Leadership

How hospital management handle the dynamic tensions between professional fulfilment, organizational factors and quality of patient care – an interview based study

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Abstract

Introduction:

Factors in the health care organisation can substantially influence doctors' working conditions and that may in turn impact quality of patient care. We have studied how doctors experience the interactions between professional fulfilment, organizational aspects and quality of care by interviewing clinically active doctors and the immediate leadership level in three hospitals (2 Norwegian and one American). Findings from the first Norwegian hospital was published during 2019[1]. Going forward we add the perspective of how central hospital management relate to the same interactions. This complement the findings from interview with the clinically active doctors and their local leadership. Taken together we strive to create a platform for pragmatic interventions.

Aims:

To explore how central hospital management relate to the interactions between professional fulfilment, organizational aspects and quality of care.

Material and methods:

Individual interviews with upper management (C-level executives and their medical equivalents-Chairs) analysed by qualitative method.

Results:

Ongoing study. Early indications is that the often presented gap between doctors and managers "living in different worlds", "belonging to different tribes" might need to be revisited. We will present emerging themes from the interviews substantiated by quotes.

Conclusions:

It is of scientific merit to further the knowledge about the balancing role in hospital management.

[1] Baathe, F., Rosta, J., Bringedal, B., & Rø, K. I. (2019). How do doctors experience the interactions among professional fulfilment, organisational factors and quality of patient care? A qualitative study in a Norwegian hospital. *BMJ open, 9*(5), e026971.

Servant leadership as health promoting leadership in elderly care.

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Background

Despite increasing knowledge about determinants of wellbeing of health care staff there is still a need for deeper knowledge about the topic to meet the ongoing problem of staff shortages, in particular in elderly care where burnout and turnover are common problems. In recent years knowledge about health promoting leadership has shed light on the importance of supportive communication, empowerment and shared accountability with increasing evidence about the usefulness of servant leadership in this regard. To increase knowledge in this field a survey was conducted among staff in a nursing home investigating attitudes toward servant leadership and well-being at work.

Method

To estimate the level of front-line servant leadership the SLS measure was used. Burnout levels were measured by self reports on Maslach burnout inventory, autonomy was mesured by selected questions from QPSnordic and job satisfaction by a single item. Paricipants were total number of staff at one nursing home (n=117), response rate was 54%. Logistic regression was used to calculate link between frontline leadership and staff outcomes.

Findings

One third of participants reported on medium or high levels of burnout, 67% reported on being autonomous in how to perform tasks (always, very often and often) and 70% reported on being satisfied at work (satisfied and very satisfied). Significant positive correlation was found between servant leadership (total scale) and all staff outcome variables meaning with higher levels of front line servant leadership it was less likely to report on burnout, lack of autonomy and job dissatisfaction.

Discussion

Findings on staff outcomes indicate a need to strengthen focus at the nursing home on burnout prevention, job satisfaction and job autonomy. Findings on link between variables are in line with findings from previous research. There are reasons to believe that servant leadership could be useful for the leadership and management in the nursing home to promote staff well-being with focus on supportive communication, empowerment and shared accountability.

Distributive leadership to support development of value- and perspective integrated eldercare

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Introduction Public eldercare organizations suffers from lack of resources and trained staff as well as high expectations from users. Many initiatives have been tried to improve both job quality and care quality (value- and perspective integrated eldercare) but few have managed to get any noticeable impact in practice. Organizational gaps, managers' work-overload and poor functional support have been identified as important hinders. Moreover, the implementation of over-controlled top-down initiatives has spurred decreased engagement and increased stress among employees and operative managers. A few recent studies show that a more thorough distribution of leadership in everyday work processes can better meet the needs of the older through more committed and knowledgeable staff who takes responsibility for the care and want to stay. Nevertheless, there is need for deeper knowledge about proximal processes (the work, forms and pre-conditions) for distributed leadership practices.

Aim to contribute to knowledge about forms and preconditions for distributed leadership that supports value- and perspective integrated eldercare.

Material and methods Multiple case-study of eldercare organizations working with improvements of everyday work through distribution of leadership over the improvement work to employees. Analysis of interviews with managers at strategic (n=5) and operative levels (n=17) in line with grounded theory.

Results Forms of distributed leadership comprised delegation of improvement work, responsibilities and activities to individual employees and local steering groups of ass nurses. Preconditions for real distribution of leadership was related to (a) leadership training, i.e. practice-based and supporting de-hierarchization; (b) a strong management team supporting mangers to release control to employees while staying engaged; (c) supporting conditions for learning in organization and training for employees taking on responsibilities; (d) use of dialogue as method; (e) active handling of negative attitudes and work climate; (f) schedule development work (g) build capacity for handling integrated perspectives through active learning, building trust and having relation-focused leadership. Important hindrance conditions were for example individuals' work-overload, little time for work-groups to meet, work-groups subordination, strategic managements mistrust and lack of involvement, poor anchoring of development work in the overall organization. Managers that were distributing their control, decreased their work overload.

Conclusion Despite variation of success in the studies cases, the empirically grounded hypothesis are: (1) leadership practices of distributed power will increase job attractiveness and improved value- and perspective integrated eldercare; (2) learning climate, training for employees and support across system levels are important preconditions.

Session 7: Stress, turnover and municipalities

Care coordination challenges between regional and municipal care when integrating mobile interprofessional teams in practice

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The Swedish public healthcare system has a divided field of care delivery responsibility. Municipalities run homecare nursing and nursing homes while the regions deliver care through hospitals and the primary care centers (PCCs). Due to the trend of caring for multi- and long-term ill patients in their homes, a new healthcare agreement was signed in 2016 between a region in Southern Sweden and its municipalities. The region and municipalities are thus implementing a cooperation across professional and organizational boarders when conducting home- and healthcare in the patients' homes in the form of mobile interprofessional homecare teams. Our ongoing research project will follow the development of these teams in four municipalities, investigating how the new organization affects the work environment for homecare nursing personnel. We will also propose organizational solutions and digital support systems.

A part of a pre-study and inventory session of the integration of interprofessional homecare teams in practice is to interview personnel from both homecare nursing and PCCs in the four participating municipalities in order to investigate how they interpret the signed agreement. So far, we have interviewed the homecare nursing personnel in each municipality. Preliminary results show that the municipal organizations interpret the agreement differently in relation to their local contexts. Also, from the homecare nursing perspective, PCCs are perceived as bottle necks to this team-based way of work due to a lack in both resources and personnel. The PCCs are thus expected to have a hard time delivering from their end of the agreement.

This fall we will investigate how the PCCs interpret the agreement and their role in the mobile interprofessional teams. Personnel from the PCCs will be interviewed through semi-structured interviews. The results will be analyzed and compared with the homecare nursing personnel's interpretation. The presentation for the NOVO 2019 symposium will thus extend the results from the pre-study of how the agreement has been interpreted in the local context in the four municipalities.

Carpets in the homes of elderly. Dilemmas on risk and well-being in the intersection between governmental information and everyday life understanding

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Introduction. In Sweden, among 100 000 elderly need hospital care after falling and more than 1500 dies due to consequences after falling. From that, prevent falling is crucial. Here, carpets in the home of elderly is focused, thus carpets are often related to the risk of and occurrence of falling among elderly.

Aim. The aim of the study is to gain knowledge of how carpets in homes of elderly people are discussed by authorities, in conversations between the elderly and their close relatives, and from the relative's perspective.

Material and methods. The study is based on eight interviews with children of elderly parents living alone, two home visits to elderly and also web-based government information.

Results. The analysis shows how an authority perspective defines the carpet as a risk and that this perspective is embraced by relatives to elderly when seeking to reduce risks at the home of elderly. However, in conversations about carpets, between elderly and close relatives, these perspectives are challenges by the elderly themselves pointing out the carpets as important for well-being. That is, there is a conflict between the carpet defined as a risk and the carpet seen as part of the elderly's well-being. How risk and well-being is constructed and challenged in the relation between elderly and their relatives provide knowledge about various views on elderly's ability, self-determination and well-being, and how these perspectives give rise to dilemmas among the adult children.

Conclusions. The study contributes with valuable perspectives on home care, mainly that what defined as a risk varies depending on perspectives. In this case authority information, elderly's views and the relative's perspectives was investigated, but the relevance of various perspectives on risk is true also in inter professional collaboration. It's important in health care to make those various perspectives viable, thus when working for safety among elderly (for example by removing carpets to prevent falling), elderly's well-being can decrease. Our conclusion is that a health-promoting perspective could help reduce this contradiction and promote well-being among as well elderly as their relatives.

Changes in perceived work stress among doctors in Norway from 2010 to 2019: a study based on repeated surveys

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Introduction:

Changes in the health care organisation can substantially influence doctors' working conditions, that may in turn impact on doctors' perception of stress at work. Since a high level of work stress has been found to affect both the doctors own health and the quality of patient care, regular assessments of work stress are in themselves useful interventions both on the individual and on the system level.

Aims:

The study describes the changes in the level of perceived work stress for Norwegian doctors in different job categories from 2010 to 2018-2019, and the associations of self-rated health and sickness absence with work stress in 2018-2019.

Material and methods:

Data come from repeated questionnaire surveys in 2010, 2016 and 2018-2019 among a representative sample of practising doctors in different job positions, where samples were partly overlapping. Response rates were 66.7% (1014/1520) in 2010, 73.1% (1604/2195) in 2016 and 72.5% (1511/2084) in 2018-19. Main outcome measure was the validated short form of the "Effort-Reward Imbalance Questionnaire" (ERI). High level of work stress was measured by an effort/reward ratio beyond 1.0. Analyses included linear mixed models with estimated marginal means controlled for gender, age, job positions, proportions with 95% confidence intervals and logistic regression model.

Results:

From 2010 to 2018-2019, the scores on the effort items (time pressure, responsibility, demands) increased significantly and the scores on the reward items (promotion prospects, undesirable change in work situation, job security, respect and prestige, adequate income) decreased significantly for GPs, but were not significantly changed for doctors in other positions. The proportion of doctors with high levels of work stress increased significantly for GPs. In 2018-2019, high levels of work stress were associated with being a GP as compared with other job positions, younger age groups, average or poor health vs. very good or good health, but not with sickness absence or gender.

Conclusions:

Significant changes in work stress for GPs may be partly due to several health care reforms. Initiatives to decrease work stress may improve the situation for doctors as well as the quality of care for patient.

Mechanisms influencing nurses' staff turnover in a hospital – Analysis from a system perspective

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Introduction: Many hospitals report challenges recruiting and retaining nurses and although not necessarily leaving their professions, at least Swedish statistics show that turnover rates at hospitals are increasing. Few research studies have combined a system perspective with investigating mechanisms over time associated with nurses' tendency to quit their jobs.

Aim: The aim of this study was to analyze mechanisms contributing to individual nurses' decisions to quit their job.

Method: We used a mixed-method approach with data from Swedish hospitals. Longitudinal data concerning organizational demands, organizational resources and intentions to leave were collected using questionnaires administered to assistant and registered nurses at five hospitals 2012-2014. In one of these hospitals, long-term consequences for turnover were studied by examining register-based data for 2015-2019. We also used interviews and questionnaire data from 2019, concerning critical incidences influencing individual decisions to quit. Analyses were aimed to find out how factors at different system levels (macro, meso, micro and individual) interacted over time (chrono-level) and contributed to individual decisions.

Results: Personal motives (individual level) of quitting often interacted with experiences of increased organization demands (i.e. increased work load) and decreased organizational resources (i.e. deterioration of psychosocial group climate) at the specific workplace (micro level). Critical factors for staff turnover at the micro level could be related to decisions taken by the hospital management (meso) or county-council level (macro). Decisions by the hospital management to take drastic measures, such as streamlining the organization or specific regional policy changes, influenced the work environment at micro level, which in turn affected the personnel's decisions of quitting (chrono level). All interviewed respondents voiced an absence of direct dialogue between the hospital management and health-care professionals during times of important decision-making processes and/or organizational changes. Management's lack of initiatives to communicate was a central theme in the nurses' motives for quitting.

Conclusions: Decisions taken at hospital or county council level may contribute to staff turnover when direct dialogues with nurses are poor. Managers may neutralize negative consequences of top-down initiated decisions aimed to streamline the organization by improving the lateral dialogue across different levels in the organization.

A strategic MSD prevention tool for municipalities

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Introduction

Musculoskeletal disorders (MSDs) are a common designation for pain, stiffness or tenderness in the joints, ligaments, tendons, muscles or bones and the associated cardiovascular and nervous system often resulting in symptoms as swelling, restriction of motion and functional impairment.

This project is a result of a collaboration between the sector work environment council for the social and health care sector (BAR SOSU) and researchers at the Department of Management at DTU. The purpose of this paper is to present a strategic MSD prevention tool synthesized from an exploratory study of best practice in Danish municipalities.

Methods

All 98 Danish municipalities were contacted for a telephone interview focusing on the top administrative level of the elder care in municipalities – the chief of elderly care. Three municipalities were selected for in-depth interviews as they were characterised as nuanced and insightful in their continuous work environment effort as well as reaching their improvement goals. The three municipalities also represented three different organisational approaches to organising their continuous work environment effort. The data and insights from the interviews formed the base for the development of a strategic prevention tool.

The strategic prevention tool

The developed strategic prevention tool consists of two volumes: 1) a method (Edwards et al. 2016a) and 2) a tool box with seven tools for reducing MSD (Edwards et al. 2016b).

The method assumes an organizational setup where a central authority is responsible for coordinating and evaluating the over-all working environment effort. In the context of Danish municipalities this central authority is - in almost all municipalities - the MED-committee.

The MED-committee is the organizational anchor point for the method and responsible for managing the process. The work of the MED-committee is only specified in general terms leaving the MED-committee free to organize the work as they see fit. Consequently, there are huge differences between methods and results of the individual the MED-committees across Denmark.

Conclusion

We have developed a tool intended for use at strategic level with managers and working environment specialists deciding overall direction and asking organisations and teams to locally develop MSD interventions. Results and experiences from interventions are then reported back to the strategic level who may then learn and take corrective action to further improve MSD.

The tool taps into the annual cycle of work for strategic MSD prevention ensures a systematic follow-up, evaluation and learning from MSD prevention activities.

Poster

Overuse of medication, a risk factor that should be prevented?

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Introduction: "*If you worry about safety expenses - try an accident"* says people who are working with security issues. In the health services, medication errors and accidental falls are among the most common adverse events. The Norwegian Coordination Reform entails that nursing homes now have increased responsibility for medical treatment. Older people often have an inappropriate drug prescribing and an overuse of medication. Many medicines have significantly more side effects in older than in younger users, and unnecessary medication can reduce quality of life. Dizziness is one common side effect which in turn enhances tendencies to fall in the elderly.

Aim: To explore the extent to which nurses and nursing students are aware of the risk of overuse of medication and whether they can influence on the risk of incorrect medication and unnecessary drug treatment in nursing homes.

Material and methods: Qualitative design involving focus group interviews with nurses and student nurses, and a study of student nurses' learning logs from three different nursing homes.

Results: The overall finding was that there are high risks associated with medication management in nursing homes. Risks related to overuse of medication were: 1) Nurses and student nurses had high attention on unnecessary medication, but less influence on prescription activities. 2) Structural factors such as time constraints were barriers towards safe medication. According to student nurses it was easier to give tranquilizers to save time instead of offering activities. Two learning logs described serious adverse events as an accidental fall, and overmedication with analgesics and psychopharmaceuticals.

Discussion and conclusion: New reforms and time-consuming tasks such as cleaning and preparing food mean that nurses are being pushed to become less aware of overuse of medication. Findings from this study show that although nurses and student nurses have medication competence, there is a lack of realistic framework conditions to apply and further develop such competence. To achieve a sustainable medication management, nurses' medication competence should be utilized to reduce the risk for adverse events and this way also prevent accidental falls caused by medication errors.