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Master Degree Project in Management

Logical tensions in health care
A case study in quality improvement work

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Abstract

Today's healthcare organizations face increasing challenges which has led to the interest in Quality improvement (QI) work in healthcare. Studies have found that a focus on developing care quality is one way to combat these challenges. However, previous research has given limited focus to the local context, the development of new healthcare systems for QI work and the interests and relationships of local actors on a micro-level. This paper aims to investigate how QI work is organized and practiced in a Swedish health care organization at a specific clinic. Using sociology of translation and institutional logic as theoretical foundation, it details how local actors organize QI work, what guides them and how they engage in QI practices from a micro-level perspective. Findings demonstrate how a local system for QI work is translated and organized where QI projects can be seen to go through a four-step process; QI ideas are born, anchoring and treating QI ideas, decision-making and implementation, evaluation and reporting of results, where actors experience conflicting demands derived from segmented practices and reliance upon pragmatic collaboration between actors of separate institutional logics to manage their work with QI. This paper contributes to the existing literature on institutional logics in health care by providing a descriptive example of the creation and organization of a local QI system. Moreover, access to resources with competence in project management and a understanding of quantitative techniques proved an instrumental aspect when engaging in QI work.

Keywords

Swedish Healthcare, Organizing, Practice, Quality improvement, Science of Improvement, Institutional logics, Translation of Ideas

Introduction

Health care organizations face increasing challenges, such as; increasing costs, budget constraints or the need to become more efficient and effective in providing care (Williamsson, Eriksson and Dellve, 2016). Adding to this, an increased interest for health and wellbeing among western populations paired with media's uncovering of the shortcomings and mistreatments, like; long waiting times for patients, mistreatments or shortage of personnel,

contribute to the reasons for organizations to find ways in which to improve their delivery and quality of care. However, in solving these issues there are no silver bullets (Shojania and Grimshaw 2004), but a focus on improvement work addressing care quality appears to be part of the solution (Andreasson, Eriksson and Dellve, 2016; Bergman, Hellström, Lifvergren and Gustavsson. 2015; Gadolin and Andersson, 2017; Williamson et al., 2016).

As a discipline, Quality improvement (QI) within healthcare is in the most general sense about any form of planned organizational change or attempt to improve on any part of the quality of care in an organization (Alexander and Herald, 2009). In more detail, it aims to achieve improvements by trying to understand the current situation or context, design strategies in identified areas to improve, apply tools and measure outcomes to alter the strategy (Flynn, Scott, Rotter and Hartfield, 2016; Lion and Raphael, 2015). However, due to a growing demand for improved healthcare, a lack of evidence-based QI work and rigorous methods, a new area known as improvement science or science of improvement has emerged over the past decades (Flynn et al., 2016).

Previous research concerning QI in health care can be categorized either by concentrating on what and how healthcare organizations engage in QI efforts (descriptive), understanding how QI and aspects of it can lead to increased quality in healthcare organizations (instrumental), and/or what the recognized best practices of QI are (normative).

While recognizing the varied nature of QI and improvement science and its need to fit the local context (Kaplan, Provost, Froehle and Margolis, 2012) researchers like Alexander and Herald (2009) state that healthcare organizations commonly engage in system redesign of its processes for how to deliver care. These processes commonly involve continuous monitoring of performance in terms of quality and management (Giannini, 2015) where control charts aid in measuring progress and tools like PDSA help plan and manage QI efforts (Bergman et al., 2015). Others study different actors; patients, nurses or clinicians and their roles in QI in healthcare organizations (Balbale, Locatelli and LaVela, 2016; Dellve et al. 2018; Flynn et al. 2016).

In terms of aspects of QI and science of improvement, it is hard to point at specific factors to be instrumental for efforts to become successful. Instead, establishing systems for how to work with QI and that it fits with the local context remains valid starting points, hence, many factors of QI in healthcare organizations have been recognized as important in attempts to improve delivery and quality of care due to its varied nature: operational focus, provider improvement or expected outcomes (Alexander and Herald, 2009). Factors such as; understanding contextual influences (Kaplan et al, 2012), the need for inter-connection between QI and core organizational processes (Höög, et al. 2014), access to improvement knowledge experts for guidance and assistance in measurement for improvement (Brandrud et al., 2017), and availability of information technology facilitating data collection and multidisciplinary teams (Kringos et al., 2015) all contribute towards improving quality of care. Normative research has focused extensively on how QI in healthcare should be practiced, often taking an implementer perspective on methods, tools and systematizing of QI processes like those of International Organization for Standardization (ISO-9000) (Andreasson et al, 2016; Gadolin and Andersson, 2017; Stanton et al, 2014). Others, like Bergman et al (2015) or Gustavsson (2014) propagate for increased patient centeredness of QI, allowing them to be co-designer and co-producer of

QI processes. However, the normative side of QI, especially the implementation perspective, where planned approaches (Lean, Lean Six Sigma or Total Quality Management) borrowed from industry disregard the importance of contextual factors and the inherent variability associated with QI (Kaplan et al, 2012; Holden et al, 2015; Øvretveit et al, 2012).

Despite the vast amount of scientific research on QI in healthcare, critiques and weaknesses remain. Previous research focused on implementation of methodologies like Lean or Total Quality Management (TQM) face criticism as they are claimed to disregard the complexity of healthcare organizations that are characterized by competing logics of managerialism, professionalism and resistance from health care groups opposing change initiatives based on management concepts from industry (Waring and Bishop, 2010; Williamson et al., 2016). D'Andreamatteo, Ianni, Lega and Sargiacomo (2015) and Höög et al (2014) further claim this narrow scope to be too occupied with single processes, units and departments or tools, and instead advocate for a more holistic perspective on implementing such methodologies (Lean or TQM) by integrating them with core organization-specific processes. Hence, there has been a tendency for researchers to focus on implementation of solutions and operational process improvement than innovation and improvement of the health care system itself (Bergman et al. 2015).

From these weaknesses, the more recent development of the Science of improvement has emerged, taking a scientific stance on QI by relying on scientific evidence translated into local practices (Flynn et al., 2016). Thus, one must acknowledge the social and political dimensions of the local context and reframe QI initiatives as a social problem by considering the interests, values and relationships of local actors (Harnett, 2018; Langley and Denis, 2011). However, initiating local QI efforts via grassroot movements may subject the Science of improvement to the same critique posed at previous QI efforts, that initiatives lack scientific basis (Marshall, Pronovost and Dixon Woods, 2013) and become initiated based on intuition and anecdotal evidence as opposed to scientific evidence and a rigorous systematized approach (Shojania and Grimshaw, 2004). This weakness can be further sparked by the call for additional patient inclusion in the identification of what to improve as well as how to design care processes (Gustavsson, 2014).

From this discussion, this study contributes to the existing research literature on QI in health care in several ways. By studying an organization that celebrates own initiatives to drive QI as opposed to implementation of planned approaches, it takes a starting point from the importance of context as suggested by Kaplan et al (2012). Further, by applying the theoretical concepts of translation of ideas from Scandinavian institutionalism together with institutional logics, it takes into account the social and political dimensions of QI in a given context, its actors and interests (Harnett, 2018; Langley and Denis, 2011). Thus, this paper aims to understand how quality improvement work is organized in a specific health care organization and how it unfolds in practice.

This article will proceed by presenting the theoretical framework constituted by the two theoretical concepts; sociology of translation and institutional logics. What follows is a description of the methodology detailing the collection of data and how it was analyzed. Third,

the findings are presented and fourth, findings are discussed by use of theoretical framework. Lastly, conclusion and implications are presented.

Theoretical framework

Introducing Translation theory

How ideas and practices circulate within and across organizational fields have seen increased attention from researchers over the past two decades (Grinsven, Heusinkveld and Cornelissen, 2016). Ideas such as management concepts (Lean and TQM) become adopted, leading to organizations becoming similar. Yet, the adoption of the same ideas by organizations in the same field does not always lead to the same results (Sévon, 1996). Instead, studies have found that the same idea often change and take on different shapes when enacted in practice by the actors of organizations (Blomquist, 1996).

Traditional change and implementation theory link this variation to deviation from the planned process of implementing ideas or the resistance from local actors towards the idea. Further, the traditional view subscribed to the spreading of ideas according to the Diffusion model where ideas possess own inertia (Rogers, 1995), meaning that, as long as an actor initiates by spreading the idea, the idea will travel with rather passive adoption by actors until resisted, whereby spreading ends.

However, in contrast to the diffusion model, the Translation theory refute the idea of inherent inertia in ideas and instead claim the spread of ideas to depend on the local actors who come into contact with the idea (Latour, 1986). These actors can modify the idea by translating it based on each actor's experiences or interests, thereby, resisting an idea can lead to further translation which can enable the idea to continue travel as opposed to reaching an impasse as in the case of the diffusion model. Thus, by taking on a translation perspective on the traveling of ideas, the complexity of local context and its effect on the process from adoption to result is recognized (Czarniawska, 2004).

The translation model

The concept of Translation originates from the Sociologist of Science and Technology by Michael Callon and Bruno Latour. The concept view people as paramount to the spread of ideas as they can alter, add to or take away aspects of an idea which travels (Latour, 1986).

Building on that concept, Scandinavian institutionalism and the authors Czarniawska and Sévon (1996) developed it further, emphasizing that translation is a notion of movement and a process of change as the traveling idea encounter new actors translating the idea. Ideas can be procedures, management concepts, organizational structures or technology (Sévon, 1996) which travels into new contexts where they take on the shape of a transferable object; picture, text or other media forms which is translated into practice. This occurs repeatedly, as ideas move from one context into a new, they become stripped of the previous context's features, reframed and embedded in the new context. As exemplified by Lindberg and Ehlingsdóttir (2005) "the translation model describes a chain of translations, at a given place and time, where an idea is translated into an object which is translated into practice which is

translated/repeated/stabilized into an institution, which is translated again and so forth” (p.30). In their paper, the authors breakdown the process by describing four different moments; displacement, packaging, reception and practice and institutionalization of traveling ideas. Translation process begins with the selection of an idea, stripping it of its original contextual features, such as time and space-bound features which enables the idea to be translated into the new and receiving context. But, for the idea to fit the receiving context, it becomes repackaged, often into a model or a text which enables the idea to be easily communicated. To make it easy to communicate, the idea takes the shape of a recipe that is based on logic that demonstrates a solution to a local problem. However, when the idea enters the receiving context the reception of it depend on the local practices and culture of the receiving context, what Czarniawska and Joerges (1996) refer to as ideas in residence. Hence, it becomes unpacked by the local actors to become enacted in practice which can result in the transformation or relabeling of the idea. To mobilize the local actors, the idea is made actionable by attaching it with concrete properties such as connecting it to established practices and routines. The result of the process from displacement, packaging, reception and finally practice and institutionalization has allowed the idea and practice to become one in the new context and if the new practice becomes repeated over time, the idea and following practice becomes taken for granted (institutionalized) (Lindberg and Ehrlingsdóttir, 2005).

However, the translation process is not as defied as outlined by the authors. Instead, the steps or moments of translation can occur simultaneously, some not at all and others at the same time. Hence, the process of translation depends on the translations made, the actors making them and their interests and motives. Thus, why certain ideas are selected for translation and how they are translated into working practices remain under-researched (Morris and Lancaster, 2006).

The translation or editing of ideas by actors is according to Sahlin and Wedlin (2008) rational attempts by local actors to make the idea fit with their own local context. In so doing, actors translate according to own experiences and interests whereby they try to align the new idea with own interests and thereby transforming the idea (Boxenbaum and Strandgaard Pedersen, 2010). An example could be the adoption of a new quality enhancing routine in a given context, like a specific ward that becomes altered based on the interests and experiences of a particular profession.

Institutional Logics

The concept of institutional logics is a central part of institutional theory and used by researchers to study how social context shape behavior of social actors (Nicolini et al., 2016). Scott (2001) define institutional logics as “...the belief systems and related practices that predominate in an organizational field” (p.139), for instance the healthcare field. Lindberg (2014) further build on this conceptualization stating that institutional logics guide and legitimize certain actions in a given field, or as put forth by Friedland and Alford (1991) institutional logics are “ways of ordering reality” (p.243). Hence, institutional logic provides meaning to behaviors and practices of social actors that is visible both symbolically and in

action when enacted in practice (Waldorff, 2013). In more detail, a given logic indicate appropriate goals and values within its domain which directs behavior, in this case; actions to take and interactions to make (Thornton, Ocasio and Lounsbury, 2012).

While early institutional logic research has acknowledged the existence of multiple institutional logics, like Thornton's ideal type logics; family, community, religion, state, market, profession and corporation in a field, focus has primarily been directed to the one dominant logic guiding actions of social actors on a macro level (Lounsbury, 2007). Moreover, in a review on institutional logics by Zilber (2013), she finds that such studies often focus on macro-level processes with few studies focusing on institutional logics on ground level and their impact on micro-level actors and their behavior.

Therefore, recent literature (Arman, Liff and Wikström, 2014; Kristiansen, Obstfelder and Lotherington, 2015; Styhre, Roth and Roth, 2016) attempts to address the criticism by focusing on individual actor level as opposed to field level. Together, these studies demonstrate the impact of logics in the day-to-day work of actors and how they navigate a context of institutional complexity, being the conflicting demands of multiple institutional logics (Greenwood et al., 2011).

Health care organizations are typically characterized as faced by institutional complexity (Reay and Hinings, 2009; Waring and Bishop, 2010; Greenwood et al., 2011) and focus is often directed towards the conflict and tension arising from the distinct demands of the medical professional logic and the managerial logic also known as the business-like logic. One such study was done by Reay and Hinings (2005) who focused on the re-stabilization period following a shift from the dominant professional logic to the new business-like logic in the health care field in Canada. They concluded that, while the business-like logic became the new dominant logic, the old professional logic remained subdued but with some level of influence, especially for the physicians. Doolin (2001) and Kirkpatrick, Jespersen, Dent and Neogy, (2009) extends such findings as they both conclude that medical professionals are reluctant to take on managerial roles due to it clashing with their medical professional logic as they seek to maintain their professional identity and autonomy.

Others have elaborated on the co-existence of logics by showing how competing logics can remain unsolved. Greenwood et al (2011) refers to such an instance as enduring institutional complexity which can be seen as a form of truce between competing logics. Reay and Hinings (2009) support this notion of truce between competing logics. In their paper, studying competing logics in the health care field with particular attention to micro-level actors inside organizations, they found that creation of localized systems and structures helped manage the day-to-day work of actors guided by different institutional logics. They also conclude that, pragmatic collaboration; collaboration based on shared interests in terms of work outcome and separation instead of merging of identities enabled actors and their coexisting logics to function in parallel while reaching shared objectives. In another study by Goodrick and Reay (2011), they developed a theoretical conceptualization of constellations of logics to understand the coexistence of multiple logics relevant to professional work amongst pharmacists. Using the perspective of constellations of logics enables understanding of how a set of logics collectively influence the behavior of a social actor, thereby extending the previous perspective by also demonstrating the influence of the less strong and dormant logics' influences. Moreover, their

findings of the collaborative and competitive relationships between logics extends the literature. They found that logics can coexist competitively for long time periods due to practices being segmented: different practices guided by different logics. An example would be the conflicting demands faced by a physician as they must practice and provide care according to praxis (professional logic) while doing so in a resourceful and efficient way (managerial logic). Relationships between logics can also be cooperative, either in a facilitative fashion; one logic gains in influence and the changes in practice supports an alternative logic without decreasing its influence, or in an additive fashion; the result from cooperation of logics means an increased number of demands to be met by the social actor.

Detailing institutional logics

Building on the work with ideal type logics, what follows are descriptions of features and aspects of two logics; professional and managerial relevant to health care organizations.

The professional logic in health care is recognized as nuanced and may not be the same for different professional groups such as nurses or physicians. However, according Goodrick and Reay (2011) autonomy is a prominent aspect of the professional logic and exemplified in several ways. Health care professionals would practice their profession along with other professionals, thereby having control over what type of work and how it would be practiced. Credentialing, education of health care professionals and the quality of the care provided would be judged and controlled by the profession (Goodrick and Reay, 2011). Thus, central elements of the professional logic in health care are; ample time spent with patients, autonomy and high-quality care (Kitchener, 2002).

The managerial logic, also referred to as the business-like logic, is concerned with providing care in an efficient and cost-effective way (Reay and Hinings, 2009). Decisions related to type of care to provide, how it is practiced and organized, and education of health care professionals are made by managers and executives working in the health care organizations instead of health care professionals, like physicians. These decisions are based on ideas of efficiency, like, how to decrease the time spent on each patient, and costs, like, finding ways to save money via savings in terms of materials or layoffs.

Summary of Theoretical framework

The primary theoretical concept used in this paper is institutional logics. Similar to the more recent institutional logics literature (Arman et al., 2014; Kristiansen et al., 2015; Styhre et al., 2016) it is used to study what guides the day-to-day actions and practice of social actors related to the process of quality improvement at a single pediatric ward in Sweden. More specifically, how the process of QI can be guided by different logics, in this case the professional logic and the managerial logic depending on stage in the process from inception to implementation or by the various actors subscribing to the logics.

The secondary theoretical concept; sociology of translation, is used descriptively to describe how quality improvement work is organized, how it unfold in practice as well as the meanings local actors ascribe to their work with quality improvement.

Methodology

Research design

To meet the purpose of this study, a qualitative research method was employed. The choice was deemed appropriate as the study aimed to focus on social interactions and behaviors of individual actors. With the aim of gaining a deeper understanding of a phenomenon, in this case quality improvement work in the public health care sector in Sweden as well as how it unfolds in practice, a case study method was adopted (Czarniawska, 2014). By being positioned in the context of study an appreciation and understanding of the studied phenomenon could be achieved (Flyvbjerg, 2006). This enabled the possibility to understand how the people in the context interacted with each other (Silverman, 2013) in their work with the improvement programs and how it unfolded in practice.

The process of data collection can be thought of as split in two phases. The first phase can be characterized as an informative phase aimed at gaining insights into how quality improvement work is organized within the setting. To attain this, collection of text-based secondary data was requested from an initial contact person within the organization where QI work was practiced, gaining an early understanding of what material and tools that guided the organization in their QI efforts as well as which actors were involved in the process. Moreover, the contact person proved invaluable for the second phase of the data collection process where primary data was collected by use of semi-structured interviews. By knowing the organization and its members, the contact person provided suggestions for further interviews of individuals with varying degrees of experience and roles related to QI. Hence, a snowball method directed phase two and made sure to create a relevant sample of participants (Silverman, 2013). These participants held varying roles; physicians, charge nurses, pediatric nurses, children nurses, enrolled nurses and dieticians, some of which also held managerial roles, such as; ward manager or clinic director. This ensured a multitude of perspectives related to the concept of QI work in the organization.

Data collection method

The secondary text-based data provided an initial insight into the organizations work with QI. This material was collected by use of internet, the organization's own webpage, but also via the relationship established with the initial contact person whom provided access to internal QI documents. At this stage, it became clear that, due to the size of the organization, its number of employees and many wards, a demarcation had to be made to be able to meet the purpose of the paper; how is quality improvement work organized in a specific organization and how does it unfold in practice? Hence, while the text-based material collected during the first phase guided the complete organization in its QI work, a great deal of variation in its application across parts of the organization appeared. Thus, going forward with the collection of primary data using semi-structured interviews, a single ward, the pediatric ward, was selected to be able to gain a deeper understanding of how they worked with QI.

Semi-structured interviews

Qualitative data was collected through semi-structured interviews. Due to the flexible nature of this method (Bryman and Bell, 2011), participants could talk freely about their experiences of QI, enabling detailed narratives to be collected (Silverman, 2011). This made possible for the researcher to gain an understanding of the studied phenomenon via the accounts of the people who were the real experts with practical experience in the area of QI work (Silverman, 2013). Moreover, prior to all interviews, participants were informed about the subject of discussion, how their response would be used, and that anonymity was ensured (Silverman, 2013). Upon granted consent, interviews were recorded and at a later stage transcribed verbatim to ensure accurate accounts but also to enable the interviewer to focus more on listening instead of note-taking during the interviews (Czarniawska, 2014) which aided in the rapport between interviewer and interviewee allowing for considerations of objectivity and ethics, thereby remedy what Kvale (2006) refer to as the inherent power asymmetry of the chosen method. During the interviews, an interview guide with questions was used, but tailored to each participant according to their experience, role and the flow of the conversation. Moreover, while conducting the interviews, respondents were asked to contextualize their responses by use of examples to further aid the researchers understanding of QI and its practice at the clinic (Watson, 2011). For instances where additional information was required after an interview, interviewees were contacted again by telephone or e-mail. This occurred on two occasions whereby the same person was interviewed twice.

The starting point for the collection of primary data began with a telephone interview with the contact person who was a business development officer at the pediatric clinic. From this first interview, the business development officer suggested colleagues at the clinic with varying roles and experience to approach for additional interviews. 12 interviews were conducted in total, four of which took place in person and the remaining eight over telephone. The reason why the majority took place over the phone was because this was the desired option by participants, in part due to their irregular working hours, but also because of the dynamic work environment at the clinic making it hard to determine a specific time for interviews. The four interviews held in person took place either at the clinic or in respondents' homes.

The 12 respondents accounted for all, but one role related to QI at the clinic, the clinic director. However, members of the clinic management team chaired by the clinic director was included in the sample. The wide range of roles included in the sample ensured a nuanced perspective on QI at the clinic (Flyvbjerg, 2006) which reduced subjectivity issues (Charmaz, 2014). However, while this provides some level of comparability of answers, a recognized drawback of the semi-structured interview is the potential for interviewees to answer what they believe the interviewer wanting to hear or provide answers in a way that reflects the organization in a positive way (Watson, 2011). To remedy this drawback, its advocated to make use of multiple data collection methods to compare data from different perspectives (Silverman, 2013). Ethnographic observations were intended and would have served as an appropriate method to study QI in practice, thereby facilitating comparison of accounts gathered from interviews with own observations (Czarniawska, 2014). However, due to the sensitive context of study, i.e. the pediatric clinic, privacy for all included actors and ethics became important reasons for not to engage in observations.

Data analysis

The collected data was analyzed with the influence of grounded theory. This perspective proved useful as it allowed for continuous comparative analysis of the collected field material (Glaser and Strauss, 1968). Further, it was considered appropriate as it is claimed to fit qualitative research where vast amounts of data can be collected using semi-structured interviews and case-study material (Martin and Turner, 1986). Thus, the grounded theory approach was suitable to understand how QI work was interpreted, organized and enacted in practice in the studied context.

The analysis of the data occurred in phases, starting with transcribing the recorded interviews, coding and categorizing. This generated an abundance of data (Martin and Turner, 1986), but using grounded theory, concepts relevant to the research aim were identified. Such concepts related to how actors interpreted QI, its related practices, and relationships between QI actors. These concepts are what Van Maanen (1979) refer to as first-order concepts as they possess both descriptive properties of the research phenomenon and respondents' interpretation of it. The concepts were then compared to detect patterns and connections between them (Czarniawska, 2014).

In the second phase, coding and categorizing of the collected secondary data, i.e. the document material was done which was then compared to the interviews. The comparison enabled discovery of useful theoretical concepts to address the study. While the document material mainly described QI, it did not detail how to engage directly with it. Hence, the theoretical concept of translation was selected to analyze and describe how the actors translated QI into practice and consequently, how they organized it. Further, a second theoretical perspective; institutional logics, was added to understand why QI was organized in such a way, but also to understand what values and beliefs guided actors in the way they practiced QI. In analyzing the qualitative data in relation to institutional logics, the work of Reay and Jones (2015) proved useful. Their pattern matching method for analyzing data was utilized whereby collected data was compared to the professional and managerial logics present in health care already established by previous literature (Goodrick and Reay, 2011; Reay and Hinings, 2009).

The process of data analysis can therefore be seen as moving from a low to a higher level of abstraction. From the outset, data was approached with an open mind without theoretical considerations, but, as data was organized and connected, theoretical connections could be detected (Martin and Turner, 1986). In the final stage of analysis, institutional logics and translation was useful to explain themes in the data.

Limitations of this study pertains to two aspects; generalizability and number of authors. In terms of generalizability, this is a case study with limited data gathered. The author does not claim to have the full or completely accurate data on how QI is practiced at the clinic. Hence, the possibility of a flawed picture of the clinics work with QI is a possibility. However, many perspectives on QI was included as actors of separate roles were represented in the sample. Additionally, the study would have benefitted from additional methods, such as observations as this had facilitated comparison of accounts gathered from interviews with observations. The second limitation concerned depth of analysis. As this paper was written by a single author, other and different connections of the data gathered would have been possible which could have allowed for greater depth in the analysis and other surprising findings.

Empirical chapter

Presenting the organizational setting

The organization of study was a county hospital located in the southern part of Sweden. Specifically, this study focused on one clinic at the hospital, the pediatric clinic. As the hospital and clinic wished to remain anonymous it was given the alias Alpha.

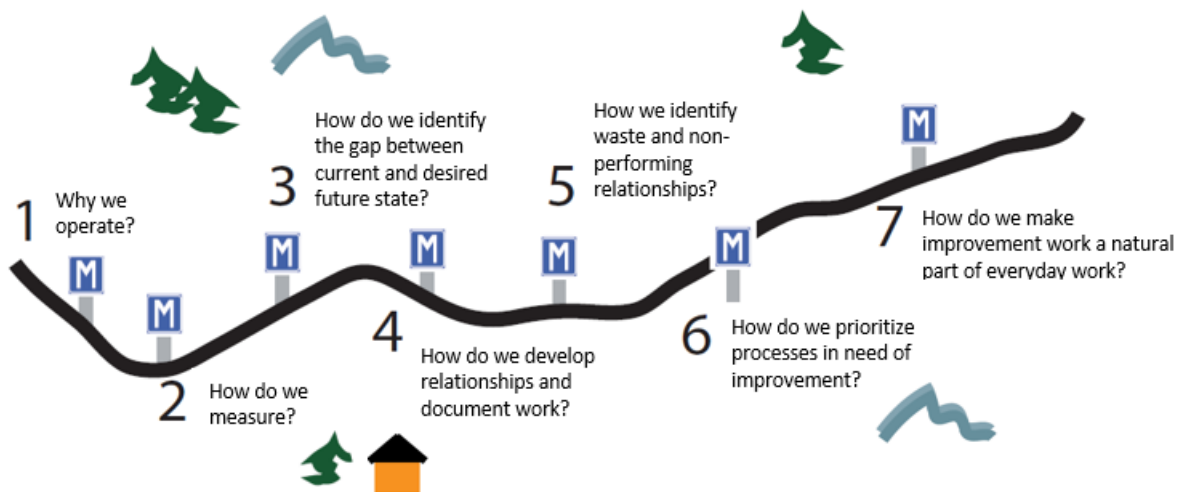
The clinic provides both neonatal intensive care as well as pediatric medicinal care for patients between 0-17 years of age. Providing care, the clinic works with inter-professional teams of members within the clinic as well as other parts of the hospital to utilize the competence residing in the organization and to ensure care quality.

Working with and towards improved care quality and safety is a central aspect of the job at the clinic. This work is directed according to the Micro systems theory, developed in detail later, and managed by the clinic director and the business development officer who manages and are responsible for driving these issues according to directives from the national board of health and welfare in Sweden.

The clinic works actively with developing their care, its safety and quality by involving the majority of its 160 clinic members, such as; physicians, charge nurses, pediatric nurses, children nurses, enrolled nurses and dieticians in different groups of QI work focus; illnesses, pain or supporting processes like drugs or medical technology. Within each group, independent of the three, multiple roles exist, but common for them all is to have one responsible physician, one responsible nurse and a secretary along with the other group members.

With QI work being mandated from the national board of Health and welfare in Sweden, it does leave ample room for how to execute it. In the case of Alpha, QI work is guided by the Swedish Institute for Quality SIQ model which emphasize a customer-oriented way of developing and providing care according to 13 values (see appendix A). Practically, QI work undertaken at the clinic is guided by a system called Micro system which is aimed at creating value for the patient whom is seen as the customer. This system is used throughout the county to guide QI work and spread successful attempts of continuous improvements amongst its actors. The approach takes on a perspective of QI work where included actors are all seen as part-leaders in the everyday focus on providing the best possible care. Central to the system is the customer/patient focus, the emphasis on QI as a continuous process and the coexistence between multiple micro systems forming one large system. The micro systems nature is continuous and adapts according to the patient, making the process of creating value for the customer a changing endeavor depending on involved people and their needs. See figure 1, Vägguiden, a 7-step reflective process according to the Micro system theory.

Figure 1: Vägguiden



(Qulturum, 2008, p. 3)

We must engage in QI

According to the Swedish law, specifically the Health and Medical Services Act, all organizations must actively and systematically develop their provided care, section 31 “quality assurance”. This directive was also brought up as one reason for why the clinic engaged in QI work by participants. Engaging the personnel in QI was therefore an active effort by the ward managers who made clear early after employment that new recruits had two jobs at the clinic, primarily, to provide care and secondly, be part of developing the care given. As put forward by a ward manager:

it is important for employees to become members of an improvement group as early as possible to be able to contribute. Often, they have a new perspective on things and it is believed that it is easier for them to contribute with new insights if it is first brought up in the groups to later be implemented on ward level, hence, being part of a group works as a way to facilitate change in an easier way for employees

When asked what QI work meant to the members of the clinic, words like; fun, onwards, must and improvement were used to describe it. A recurring theme stressed the importance of the work to improve both quality and safety of the care given for both patients as well as personnel. It was seen as a must to engage in QI work for multiple reasons, such as; adapting to a changing environment, improve quality and safety in care given and as a means of evaluating own work with providing care. Yet, as some stressed, being a means of evaluating care given, several mentioned the fact that all change is not by default improvement. Hence, while engaging in QI work was also seen as a source to scrutinize own care processes, so too should the outcome of the own efforts be evaluated to determine if it were an improvement or merely a change.

The process of QI at the clinic

The remaining part of the empirical chapter will detail the process of QI projects at the clinic, from its inception to implementation, evaluation and reporting of results. The process is presented according to two perspectives; group A; roles with managerial responsibilities, and group B; roles without managerial responsibilities.

QI ideas are born (Group A)

With a recognized need and willingness to engage in QI work at the clinic, roles and relationships of authoritative figures with managerial responsibilities, such as; physicians, group responsible nurses, the business development officer and ward and clinic managers, was to create conditions enabling clinic employees to do so. One of the main ways in which employees was engaged in QI work was through almost mandatory inclusion in a QI group. It was made clear already during the process of employment that new recruits would have two jobs at the clinic; to provide care and being part of developing that care. As put forward by one of the ward managers:

We believe it is important that you join a group already from the beginning so that you can contribute which shows to the employees that they have the possibility to do so from the start. This way they don't have to have worked here for a long time before contributing

Communication in the shape of meetings and discussion was also a platform where managerial roles would gather with matters related to QI. These were represented by annual and monthly ward and clinic meetings where mandated QI projects from the clinic management group could be discussed or the current situation at the clinic could be assessed. These would then serve as a basis from which to take decisions on which projects to proceed with and to delegate QI ideas to appropriate groups at the different wards at the clinic.

Other areas of influence regarding QI work came from relationships and collaborations with other hospitals where knowledge and ideas for how to best give, provide and develop care and its safety originated. These relationships provided the clinic personnel with ideas which could be used at the own clinic. Yet, as put forward by a physician on how ideas from outside influence can be brought in and adopted at the own clinic:

You can bring in complete ideas of how the others do it, or you can take parts of it. A good idea from another place (ward or hospital) can be brought into ours, but it must fit our own context

Anchoring and treating QI ideas (Group A)

Anchoring for staff with managerial responsibilities was two-fold. One side concerned anchoring towards their complete work force and the other side related to anchoring exclusively for staff with managerial responsibility. Anchoring in regard to the entire workforce was concerned with availability and support. Availability was ensured in the daily work as staff with management responsibility (specific nurses, physicians and ward managers) was mixed with

the workforce. Availability was practiced in different ways. For instance, the business development officer actively tried to be present amongst staff instead of remaining in her office which was the case for others as well which made it possible for employees to approach them during the daily work. Also, morning meetings was a venue where all staff was gathered and accessible, or meetings such as the yearly meetings with both ward manager or business development officer. Moreover, demonstrating support was seen as a key part of anchoring for this group of staff. As expressed by a ward boss:

A large part of my work is about picking up on signals from my staff. I know from own experience that, if I identify an opportunity for improvement, I need the support from my closest manager. Hence, I know how important it is for my staff to know that I support them in their work with QI

Upon asked how support was demonstrated, delegation of work and responsibility to take on or proceed with a QI idea was thought of as showing belief in people and their abilities. Additionally, communicating support for a QI group and their work at times when the complete workforce was gathered such as during the morning meetings or work place meetings was perceived as carrying additional weight for groups chance of mobilizing staff and later successful implementation. Other aspects of providing support was allocation of resources. Giving time to prioritized groups to work on their projects or allocating time for them to present results of their QI projects during gatherings like work place meetings. While they were able to grant some time to groups, the ambition was to be able to provide even more.

The possibility to utilize the business development officer to help with planning and executing QI work as well as a dedicated office space where groups could work in private and have the possibility to keep their work was also examples of resources that could be granted to groups in their work with QI.

Anchoring exclusively amongst staff with managerial responsibility was mainly practiced during scheduled meetings. Every month, representatives from every ward at the clinic met to discuss issues related to routines for how care was practiced. This to ensure continuity in routines across the clinic, but also for everyone who work there to feel like they belong to one and the same unit working under equal and similar conditions.

Decision making (Group A)

What appeared a common aspect in the progression of QI projects was the element of formal acceptance gained from either ward or clinic management groups comprised of specific nurses with management responsibilities, doctors, ward and clinic manager and the business development officer. In several ways they directed the work of QI from delegating new ideas to appropriate groups to prioritization of what to focus on. Typically, all projects that incurred costs, medicinal changes and safety or education of staff related to work routines needed formal acceptance. These ideas were often first treated by ward management groups and if deemed highly costly or disruptive in some way, they would be taken further on to be decided by the

clinic management group, including the clinic manager. Together, they would often judge the costs associated with a QI project by conducting a cost-to-benefit analysis where the benefit was represented by improvements for the patient as that was the fundamental goal; to improve care and care safety for their patients.

Moreover, their decision-making was linked to prioritization of what to focus on. Ward management groups tried to prioritize certain areas to improve per semester based on self-identified QI work at the clinic and their urgency, relevance of focus area, that is, a diagnose with a large patient group or it could be mandated from the clinic management groups. Prioritizing was seen as a way to make the work with QI at the clinic more structured and planned which allowed specific groups to plan QI work by trying to schedule so that group members could work together by working the same shifts.

Few QI projects was ever rejected as the majority of them was claimed to be minor improvements that did not incur costs or were particularly disruptive. The decision to go ahead could mean different things and often depended on the nature of the improvements. At times, no formal decision was needed, sometimes approval to continue working on an idea was given but contingent on the request that a group came back with a more detailed plan or collected data to support the idea.

Implementation, evaluation and reporting of results (Group A)

Implementation depended to a great extent on the nature of the QI project and the for people with managerial responsibility this meant supporting and facilitating groups in their implementation.

Evaluation of QI projects remained a central concern for this group to ensure that efforts actually resulted in improvements. Therefore, the use of measurements like the PDSA-wheel was encouraged, however, the reluctance by groups to use them was something they were aware of. It was recognized that knowing of and interpreting data was something outside of the primary tasks of employees, but another reason hindering its use was the fact that QI projects was not always measurable, as stated by a physician:

There are plenty of instances where it's not possible to concretely show how something is an improvement. For instance, increased engagement among parents. We can see how it's an improvement but it's hard to objectively measure, especially if connected to the wellbeing of their child. However, we wouldn't have it any other way.

Yet, reviewing national patient surveys was brought up as a possibility when no own measurements was possible. Overall, despite the drive to use measurements as a natural part of QI projects, several people noted that this was an area for improvement and that they would benefit from a more structured approach for both working with QI and reporting results of QI efforts.

QI ideas are born (Group B)

Given the clinic's commitment to constantly develop their care and safely executing it, innovative ideas for what to improve was a part of the everyday work of staff. One of the main sources from which new ideas emerged was the staff itself. By working according to the micro systems theory, employees (for this group, Group B, refers to roles of staff without managerial responsibilities) had over time developed a mindset of constantly looking for elements of their work which could be improved upon. One way in which this could happen was through their membership in a QI group where they could address ideas via discussing what they believed to be able to improve on in their respective groups. Additionally, groups also evaluated aspects of work procedures and routines where underperforming elements were identified which guided future QI work projects and provided inspiration for starting new projects.

Besides the relationship between staff of the same QI group, other working relationships can be seen to represent sources from which ideas for improvements could surface. The relationship between staff and patient for instance, in this case often the parents of the patient due to the young age of the patients (0-17 years of age), could provide invaluable insight towards what could be improved by staff at the clinic. For example, starting a new QI project, staff utilized the approach of experienced-based co-design where multiple people of varying roles; patient, parents, nurses, doctors, dieticians etc. together discussed areas of care which could be improved on as a starting point for a new project. As put forward by one of the employees connected to the project:

I almost went in the classic trap where I tried to figure out what was to be improved on based on what I wanted and needed. But this was much better as it came from the patients themselves

This relationship enabled employees to gain input relevant to the care process from the perspective of patients and their parents. Such areas of improvement could be represented by elements or procedures of the care process that was experienced as problematic by the patient or their parents. These ideas were usually communicated either verbally directly between patient/parent and employees or via written notes placed in a suggestion box located at the clinic. Notes were then handled by an elected nurse at the clinic and distributed as a source of improvement to the appropriate QI group.

Additionally, more distant relationships also generated ideas for what to improve at the clinic, such as: cross-departmental collaborations within the clinic but also across the hospital, new scientific findings or educational conferences attended by staff. However, ideas of this sort differed from the ones previously mentioned as they were claimed to be slower to initiate, as in the case of new scientific findings which had to be vetted by the hospital before acted upon.

Anchoring and treating QI ideas (group B)

With plenty of sources generating new ideas for QI projects, the next step was to cultivate ideas into something more tangible. This was done in varied ways based on wards within the clinic, the nature of the idea and how costly it could be to mention a few. Yet, a common next step

was discussion of the idea. Usually, ideas for improvements would firstly get treated in QI groups to gain initial insights. For example, within a QI group, an idea could be raised among group members to substantiate the idea, start documentation and planning for how to proceed with it. After, the idea was further molded by discussing it with additional staff outside of the own group to gain extended perspectives to make the idea fit with the local context. This could be done by bringing up the ideas during the formal morning meetings where all personnel present during that shift attended. These meetings were always documented by minute taking and printed out for staff to read to keep themselves informed on the activities taking place at each of the clinic's wards.

By sharing ideas with people outside the own QI groups, key insights into potential benefits and problems concerning an idea could surface. A second aspect of lifting ideas outside of own groups was the effect of anchoring them amongst other staff which would allow colleagues to feel included which would benefit later stages of implementations as staff claimed to be more inclined to partake in the implementation of new ideas when knowing early on what the benefits of a new idea were going to be, for whom and how it affected them in person and their job. Moreover, during the process of making an idea become more tangible, inclusion of the business development officer would often take place. With her expertise in methods for how to plan QI work, such as; tools, measurements and evaluation, the business development officer supported staff in making ideas become more tangible and was perceived to provide support in driving projects.

By first discussing ideas in dedicated groups and later among staff as well as including the business development officer, ideas became more tangible while at the same time anchored amongst large parts of the staff. However, the main challenge that hindered the staff from engaging in QI was time.

With each workday consisting of three shifts, staff rotation proved challenging for groups to be able to progress as members of the same QI groups could work different shifts. Moreover, with staff knowing that providing care always came first and that it was always dependent on the current situation, QI work was left as a secondary work task to be done at times when patient care demand was low. These facts; QI work as a secondary part of staff work due to the dynamic work environment and split groups due to multiple work shifts left staff with conflicting feelings regarding QI work. While the majority was positive in conducting such work, seeing the importance of engaging in it, it was experienced as stressful and provocative at the same time.

It can be stressful to find time to work with QI and I have heard over the years that we (the hospital) like to bring up our work with QI as something to brag about. But, these people sure don't know how it is for us who work on the floor. I believe there to be a gap and that they haven't really been able to communicate how they think

To remedy parts of the perceived time problem, scheduling was mentioned and used at one of the wards at the clinic while remaining a hope to be available at the other wards. The so-called time overlap between the morning and evening shift where double staffing occurred was being used when the situation allowed for groups to work on their projects. Prioritized groups focusing on specific QI projects allowed members of the same groups to schedule adjacent shifts to utilize this overlap between shifts. Additionally, if all but one of the members of the

same group were able to work during this time it was possible for that one member to come in and work with the QI group and get compensated.

Another time issue experienced by the staff related to the access to specific individuals. For instance, QI work related to medicinal safety or creation of new PMs had to be approved by a responsible doctor who alone held the responsibility for taking such decisions for multiple QI groups. This was perceived as problematic by QI groups as they had limited access to the individual for both meetings and decisions which ultimately halted their progress. The relationship between groups working on such issues and the responsible doctor was therefore one where the doctor operated from a distance.

Decision-making (Group B)

QI groups had limited autonomy in driving their projects and varied responses was noted when asked what degree of autonomy groups had to make own decisions. Minor changes not directly related to patients and their care could be made by the teams themselves. How groups chose to work with their projects was up to them or what was referred to as simpler projects, such as changing instructions for how to use certain medical equipment was brought up as examples where no formal acceptance or decision had to be given from someone in charge. Other projects, like when groups wanted to incorporate new scientific evidence would take considerably longer as they included many different people and roles at the clinic.

However, groups could gain increased autonomy by including the business development officer. One of the nurses stated:

“it is kind of natural to turn to the business development officer due to her role, and by doing so, she can take things further by being in contact with the ward manager or the clinic management group if needed, thereby, she can grant preliminary autonomy to groups to proceed with their projects

Implementation, evaluation and reporting of results (Group B)

For minor projects, implementation of changes could be as easy as writing a new set of instructions or relocating material. Yet, informing the concerned staff was key to adapt the new ways. Implementation of major QI projects took more time and having received acceptance to proceed, additional information had to be attained, in-house and outside actors needed to be contacted or staff needed new education. Again, communicating and instructing the changes imposed by new projects was identified as vital to enroll staff in the new ways. This was recognized as challenging, but by reiterating the purpose, benefits and personal or role-related impact already at the early idea stage of a new QI project, adoption became easier. However, finding the time to communicate this was challenging. Again, the morning meeting, but also dedicated educational days were forums for relaying such information. But just like QI work, being able to attend these days was dependent on the current situation and demand for care at the clinic which rendered QI a secondary part of working at the clinic.

To evaluate new QI initiatives, metrics and measurements was put in place with the help of the business development officer which were continuously monitored and treated in the dedicated groups throughout the projects. The results were also relayed to ward managers and the business development officer to keep them informed on the progress of the projects which enabled them to act on it or further relay information to the clinic management group. However, groups struggled with measurements as all aspects of providing care was claimed to not be measurable. Another reason for the struggle was the perceived difficult nature of dealing with what measurement to use and how to interpret the results. For this, the relationship with the business development officer proved particularly important.

Reporting the results of QI projects were a continuous responsibility for the dedicated groups to inform others on their progress but also to let them know what the current focus was. This was verbally communicated at the morning meetings and the educational days as well as in writing. The written reporting was presented at multiple forums to increase exposure. Written content was generated and posted on dedicated webpages on the own intranet or physical documentation was produced in the shape of posters hung on noticeboards at the clinic's wards.

QI process summary

Every QI project started with an idea, an idea where someone had identified an opportunity for improvement which in the case of Alpha meant; in any way improve the care and its safety to the patients. Multiple sources generating ideas existed, but a first step towards actualizing ideas was to discuss them in the appropriate QI group. Either, the idea had been identified by the own group or it was delegated by management personnel. In the initial phase, ideas were formulated and processed as they shifted from the idea stage towards becoming tangible and actionable. Inclusion of the business development officer with competences in planning and measurement knowledge proved valuable in this regard, but central to this stage was the step-wise communication of the idea moving from the own QI group to remaining staff at the ward in an iterative fashion which allowed multiple perspectives to be attached to each idea while at the same time anchoring it amongst the workforce.

The second stage depended on the nature of the QI idea, if regarded as minor, groups needed no formal decision or acceptance from staff with management responsibilities to proceed or implement the idea. However, for substantial ideas, ideas directly related to providing care or ideas incurring costs, groups had to lift them to their ward manager, medically responsible physician or ward management group where a cost-to-benefit analysis would be made. At times, this meant that groups needed to go back and process their ideas further or collect additional data to support its implementation.

The final stages concerned implementation and evaluation of QI projects. Work place meetings was the primary venue where groups informed changes incurred by QI projects and educated staff on the practicalities associated with a project.

Evaluation of QI initiatives were made possible by using metrics as a natural part of QI projects. Using metrics and collecting data were something managerial personnel advocated to be able

to assess if QI projects did in fact result in improvements or simply changes. However, using metrics and interpreting data were one of two main challenges faced by personnel, the other challenge was to find time to work with QI as it was always secondary to providing care. Yet, reporting of results were a continuous responsibility and presented either verbally at meetings or in writing published both online and physically at the clinic's noticeboards.

Group A (Employees)	Group B (Managers)
Initiation of QI projects in QI groups	Facilitating conditions for groups to initiate QI projects
Shape QI ideas via iterative communication process amongst staff	Communicating support, granting resources and demonstrating availability/access
Limited autonomy with control over project approach	Prioritization of QI areas and vetting QI projects
Communication as vehicle for mobilization, implementation and reporting of results	Focus on measurements and evaluation

Table 1. Summary of QI process based on group

Discussion

Creation and organizing of local QI structure via Translation

To understand how QI was organized and practiced by local actors at the clinic, the theoretical concept of translation was used (Czarniawska and Joerges, 1996).

From the outset, actively working with QI was mandated by the national board of welfare and health in Sweden, however, while legislated to be practiced by all health care organizations, it was not specified how it should be practiced. In the case of Alpha, the values from the institute for quality, their SIQ model and the Micro system theory was used to direct the work with QI. These documents and directives can be seen to represent the selected ideas chosen to direct the QI work at Alpha. However, the documents were sufficiently ambiguous in their formulation which enabled management at Alpha to retain their values as they repackaged and translated them into a localized system or structure to work with QI at the clinic (Lindberg and Ehrlingsdóttir, 2005). The basis for the localized system was to enroll the majority of employees at the clinic into QI groups with specific focus areas, thereby enabling the structure to become actionable as it was connected to already established practices. Already at the point of employment, managers conveyed QI work to be a natural part of work for the majority of staff at the clinic. Thus, with each new QI project or with every new person hired, the local system became reinforced as practices became repeated and taken for granted. At the same time, the values brought from the initial ideas (Micro system and SIQ) became merged with the practice that is QI work, making the idea of QI and its consequent practice one (Lindberg and Ehrlingsdóttir, 2005). In sum, based on previous evidence for how to practice QI work, Alpha created an own system for working with QI instead of adopting an already existing approach (Holden et al, 2015). Further, they also integrated it with the core objective of the clinic, i.e. to

provide care, as suggested by Höög et al. (2014) while also accounted for the interests of the local actors' and context as the complete work force was engaged in QI work (Kaplan et al., 2012). Hence, from a theoretical standpoint, the local QI system at Alpha meets several of the scientifically found needs of a system that can yield successful QI work.

Logics guiding the QI process from the two groups perspectives

From the outset, members of both groups expressed similar understandings of the meaning of QI work according to the professional logic, namely the development of quality and safety for both patients and personnel (Kitchener, 2002). However, the micro system approach utilized to guide the work at the clinic can be seen to be influenced from the management or business-like logic in terms of language where patients are viewed as customers and the care given is recognized as providing value to the customer/patient. Moreover, a basic intent of the approach was the maximization of the resulting benefit from QI work by spreading it across the care facilities of the county, hence, by extension making the complete care system of the county more efficient (Reay and Hinings, 2009).

In the first stage of the QI process; ideas are born, the professional logic dominated for both groups, yet, practiced differently. For group A (roles with management responsibility) this stage primarily relates to the organizing of work at the clinic. These roles, like that of the ward manager, own the control to organize the workforce by assigning staff and new-hires into QI groups. This control grants them considerable influence and autonomy at the clinic which can be linked to the professional logic (Goodrick and Reay, 2011; Kitchener, 2002).

For group B (staff without management responsibilities) the professional logic was also the primary logic at this stage in the process. However, relationships differed between the groups. While for group A, focus was on the relationship between members of group A and B, for group B it was between members of the same group but also their direct relationship with patients and their parents. As suggested by Bergman et al (2015) and Gustavsson (2014) the direct relationship with patients granted them insights into how they might improve care quality and safety from the perspective of patients by spending ample time with them (Kitchener, 2002). Further, by relying on methods like experience-based co-design to guide work with QI, social and political interests of multiple actors was considered (Harnett, 2018; Langley and Denis, 2011), the local context accounted for (Kaplan et al, 2012) while at the same time relying on a scientific approach backed by evidence to guide QI work. Together, the relationship between members of group B and patients and the choice of experience-based co-design enabled the clinic and its practitioners to strike a balance between the potential strengths and weaknesses of patient inclusion in QI work while at the same time draw on the recognized benefits; systematic and an evidence driven approach associated with the science of improvement (Marshall et al., 2013).

Overall, this stage was dominated by the professional logic, but it is possible to make the case for work being organized, not only to improve quality and safety of care, but also to improve the efficiency with which it is given. The organizing of members to work with QI and the potential benefits resulting from such efforts may improve the care provided, but it does not necessarily mean that the following changes are not also more efficient.

At the second stage; Anchoring and treating QI ideas, it was possible to identify how the work of members of group A were guided by different logics, what Goodrick and Reay (2011) refer to as segmented practices. At this stage in the process, group A members actively tried to increase the autonomy of group B members in their work with QI by providing support and by being present and available for any inquiries from groups (professional logic). However, as noted by group B members, time to engage in QI work was limited and always contingent on the current situation at the ward. Hence, due to the time issue, members of group A had to prioritize and delegate resources, in this case time and office space, to specific groups to safeguard progress in the QI work at the clinic. While this can be recognized as organizing of work by care professionals (professional logic), it is rather associated with the managerial logic as the underlying reason and intent for the organizing of staff in this case was to increase efficiency due to time constraints which enables part of the work force to engage in QI activities and thereby secure the clinics commitment to continuous QI work.

The perspective provided by group B at this stage in the process not only lifts the issue of lack of time to engage in QI, but also their perceived limited autonomy due to restricted access to members of group A. This was exemplified by the need to seek approval in matters of medicinal safety and creation of new PMs. To progress, groups needed acceptance from a single physician in charge of such matters. Thus, per the professional logic, abstract knowledge of medical matters was confined to a single individual/profession who alone controlled such decisions.

The third stage; decision-making, was reflected in both groups, however, primarily situated in group A as these people, especially physicians responsible for medical safety matters or ward managers, had to be involved in matters of training (education of staff) and costs associated with QI projects. However, staff with decision-making ability was not purely management employees, but often trained care professionals whom also practiced care. Hence, in the case of Alpha, it is possible to see how management and care professionals merge into the same identity which is contrary to Reay and Hinings (2009) claims that advocate for separation of identities in an institutionally complex context. Instead, this can be seen to reflect a divided identity among members of group A whose job is segmented as aspects of their job are guided both by the managerial logic and the professional logic. The contentious demands from the clashing logics are demonstrated at the clinic as group A members must prioritize, allocate resources and delegate QI work as a means of making the work place more efficient (managerial logic). However, at the same time they must meet the demands of the professional logic of improving the quality of the care which is exemplified by the cost-to-benefit analysis undertaken for QI projects where the benefit represents improvements for the patient. Thus, within group A, members are torn between the competing management logic and professional logic due to the merging of roles and their clashing demands.

The enactment of the managerial logic at this stage for members of group A infringed on the autonomy synonymous with the professional logic dominant at this stage for members of group B as they would need formal acceptance to pursue major QI projects. The relationship dynamic of group B members having to ask for formal acceptance from members of group A can be likened with pragmatic collaboration (Reay and Hinings, 2009) as members of the two groups, even though guided by separate logics, must work together to meet the shared objective of improving the quality and safety of the care given at the clinic. Moreover, the pragmatic collaboration was facilitated by the localized system or structure for how to work with QI at the clinic (Reay and Hinings, 2009), but also via the business development officer who proved an

important link between group A and B due to her expert knowledge (Brandrud et al., 2017) and possibility to grant increased autonomy to group B members.

The fourth and final stage; implementation, evaluation and reporting of results, evaluation and measurements proved important. To be able to evaluate QI efforts to ensure they resulted in improvements, not mere changes, members of group A advocated for the use of data collection and metrics as a means of assessing the resulting benefits of QI work. Being able to evaluate QI work satisfies the professional and managerial logics' demands placed on members of group B as it enabled assessment of improvements in care quality and efficiency. However, the need to use metrics and interpreting their results proved problematic for members of group B as it is positioned farther from the professional logic guiding this group. Hence, while the relationship between the groups and their logics can be considered pragmatically collaborative as they share the same goal of improving care quality, the increased additional demands placed on members of group B can be characterized as additive according to Goodrick and Reay (2011). In other words, members of group B at Alpha must be proficient in the use of data collection and metrics as these represent new demands added to their already existing roles. The struggle to use metrics and interpreting data expressed by members of group B explains the important role of the business development officer whom is a local resource with expertise in this area. These findings support the claim made by Brandrud et al. (2017) that, to be able to practice evidence-driven QI work, access to individuals with expert knowledge who can assist in matters of project management and measurements remain an important instrumental fact related to QI work in healthcare.

Summary of logics for the two groups

The first stage of the process was dominated by the professional logic for both groups, yet, from a relationship perspective, differed between the groups. For group A, they organized work by mandating and enrolling staff in QI groups to ensure development of care and safety of the care given. For group B, their close relationship with patients and their parents granted them invaluable insights to what QI improvements meant and how it could be applied from their perspective.

At the second stage of the process, segmented practices are identified among group A which was triggered by the time factor. While they practice the professional logic by trying to increase autonomy for group B by providing support and being available, they must enact the management logic by prioritizing and delegating resources based on efficiency requirements.

At the third stage, the dual nature of the role for members of group A is evident as management responsibility is situated in clinical care roles like physicians and ward managers. This further explains the segmented practices among these members where the relationship between the two logics can be seen as competitive. Further, the competitive nature between the logics will likely remain long-term due to the segmented practices, but also because of the pragmatic collaboration between group A and group B which is made possible by the local system created for QI work at the clinic as well as by the role of the business development officer who functions as a mediator between the groups.

Central to the fourth stage of the process was evaluation of QI work via data collection and

metrics. Making this a natural part of the process of working with QI satisfies the demands posed by both logics for group A. Moreover, being advocated by group A, competence in quantitative methods and data interpretation for evaluation purposes became pushed on to members of group B and adds to their already existing role and demands. However, with such competence not being a natural part of group B members, the role of the business development officer proved important to uphold evidence-based evaluation of QI work.

Conclusion

This paper has taken an interest in how QI work was organized and practiced at a single Swedish health care organization. In more detail, it has investigated an institutionally complex context where actors guided by multiple logics organized and practiced QI work, thereby, contributing to the more recent literature and call for additional research from a micro-level perspective (Zilber, 2013). The findings detail the creation of a local system for QI work via translations of national standards and initiatives where QI projects would typically go through a four-step process; QI ideas are born, anchoring and treating QI ideas, decision-making and implementation, evaluation and reporting of results. Moreover, central elements of the local QI system were the inclusion of the majority of the personnel at the clinic in QI work, access to a dedicated resource with capabilities in project knowledge and assessment techniques (the business development officer) and evaluation of QI initiatives by use of data collection and measurements.

Findings show how actors turn to pragmatic collaboration (Reay and Hinings, 2009) to navigate a process characterized as institutionally complex where certain actors (group A members) experience segmented practices inherent to their roles due to merging of identities, in this case by combining the management role with professional care role making them torn between conflicting demands. Further, a consequence of the pragmatic collaboration was the addition of demands placed on actors without management responsibility (group B members) as they needed to become proficient in quantitative methods and data interpretation to engage in evaluation of QI projects.

This study contributes to the existing research on institutional logics and health care in two ways. Firstly, this paper provides a descriptive example of how a local QI system in-line with the more recent science of improvement is created and organized in the Swedish health care setting. In so doing, it demonstrates both conflicting and collaborative elements of the actors navigating the QI process, thus, accounting for the social and political interests of the local actors. Second, findings highlight the importance of the role of the business development officer, a local resource serving as a mediator between actors guided by separate institutional logics, but also as a vital source of competence in project management, metrics and evaluation techniques. Such knowledge is central to engage in QI from a science of improvement perspective but appears to be lacking among actors. Hence, findings support Brandrud et al. (2017) claims as access to such a resource is an instrumental aspect for QI to be successful according to the science of improvement. Thus, the implication for health care organizations is to ensure access to such a resource and to invest in training for its staff in quantitative

methods of data capturing and interpretation. Moreover, future research is advised to study the quantitative knowledge for evaluation purposes among actors of various roles present in health care organizations, how it can be improved as well as actors' willingness and desire to improve in this competence area.

Limitations of this study are two-fold where the first concern generalizability of findings. As context and local influence was found to impact QI work, generalizability of findings is limited, especially outside the Swedish context. The second limitation is a methodological limitation. As this paper relies on primary data gathered solely by interviews, the study would have benefitted from additional data gathering methods like observations to compare the interview data and thereby controlling for social desirability bias.

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Appendix 1

Grundläggande värderingar



SIQs Modell för Kundorienterad Verksamhetsutveckling baseras på tretton grundläggande värderingar. De är kännetecknande för framgångsrika organisationers verksamhet.

Kundorientering

En organisations långsiktiga framgång beror på dess förmåga att skapa värde för dem som den finns till för – kunderna. De externa och interna kundernas uttalade och underförstådda behov, krav, önskemål och förväntningar skall vara vägledande för organisationen, dess medarbetare och verksamhet.

Engagerat ledarskap

För att skapa en kultur som sätter kunden i främsta rummet krävs ett personligt, aktivt och synligt engagemang från varje ledare. Ledarskapets viktigaste uppgifter är att ange riktningen för verksamheten, ta till vara potentialen i individers erfarenheter och olikheter, skapa förutsättningar för medarbetarna samt i dialog med dem definiera och följa upp målen.

Allas delaktighet

En förutsättning för en framgångsrik organisation är att varje medarbetare känner sig ha förtroende att utföra och utveckla sina arbetsuppgifter. Var och en måste därför se sin roll i helheten, ha klara mål, de medel som krävs samt kunskap om de resultat som uppnås.

Kompetensutveckling

Den samlade kompetensen är avgörande för organisationens framgång och konkurrenskraft. Därför måste kompetensutvecklingen ses både ur ett organisatoriskt och ett individuellt perspektiv, för att därmed utveckla och tillföra kompetens på ett sätt som stärker såväl individen som organisationen.

Långsiktighet

Organisationens verksamhet måste värderas med tanke på utveckling och konkurrenskraft över tiden. Ett uthålligt förbättringsarbete leder till ökande produktivitet och effektivitet, bättre miljö, nöjdare kunder och varaktigt lönsamhet på lång sikt.

Samhällsansvar

Varje organisation har ett samhällsansvar utöver lagar och förordningar. Organisationen och dess medarbetare måste se sina processer, varor och tjänster som delar i en större helhet och aktivt medverka till förbättringar i både samhälle och miljö.

Processorientering

Organisationens verksamhet skall ses som processer som skapar värde för kunderna. Processorientering stimulerar till att analysera och förbättra arbetsflöden och arbetsorganisation och lägger grunden för kundorienterad verksamhetsutveckling.

Förebyggande åtgärder

Det är lönsamt att förebygga fel och ta bort risker i processer, varor och tjänster. Framsynthet, förutseende och planering är nyckelord i förbättringsarbetet där även kunder och leverantörer skall engageras.

Ständiga förbättringar

Konkurrenskraft kräver ständiga förbättringar och förnyelse av alla verksamhetens delar. Förutsättningen för detta är ett metodiskt förbättringsarbete som genomsyrar organisationen och en kultur som stimulerar till ständigt lärande, kreativitet och nya idéer.

Lära av andra

För att kunna vidareutvecklas måste organisationen och dess medarbetare på alla områden skaffa sig ny kunskap om vad som är möjligt att uppnå och hur detta kan uppnås. Detta kräver jämförelser med dem som är bäst på en viss process, oavsett vilken bransch eller sektor de tillhör.

Snabbare reaktioner

I alla verksamheter är kortare svarstider, kortare ledtider och snabbare reaktioner på kundernas behov av avgörande betydelse. Det gäller såväl för utveckling, produktion och leverans av varor och tjänster, som för administrativa processer.

Faktabaserade beslut

Beslut måste bygga på dokumenterade och tillförlitliga fakta. Varje medarbetare måste inom sitt arbetsområde få möjlighet att mäta och analysera fakta av betydelse för att uppfylla sina mål och för att tillfredsställa sina kunder.

Samverkan

Samverkan genomsyrar varje framgångsrik organisation. Det är väsentligt att genom samverkan på flera plan och i olika avseenden ta till vara kompetenser och erfarenheter hos såväl medarbetare som kunder, leverantörer, partners, ägare och huvudmän.