Nurse middle managers contributions to person-centred care in nursing homes: A qualitative managerial work analysis

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Abstract

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Background: Many residents in nursing homes receive poor care. Person-centred care (PCC) is an innovative approach aimed to improve the quality and is therefore the first pillar of the new quality framework for Dutch nursing homes. This framework encourages nurse middle managers (NMMs) to give substance to the themes of PCC. Considering this, it is crucial to comprehend how NMMs contribute to PCC.
Aim: The aim is to explore what NMMs in nursing homes do in their daily work and how they contribute to PCC.
Methods: This managerial work study combined time-use patterns with ethnographic work. The study focused on NMMs working in Dutch nursing homes. Six NMMs were shadowed for in total 95 hours.
Results: With regard to NMMs contribution to PCC three characteristic findings stand out. First, NMMs who seldom visit the ward and not see residents do not contribute to PCC. Secondly, NMMs who were ‘hands-on’ involved in direct residential care did contribute to PCC. At last, NMMs who shown a ‘heads-on’ focus did contribute to PCC. Those NMMs kept a focus on resident-related issues when doing ‘organizing work’.
Conclusion: NMMs in nursing homes contribute to PCC when they show a ‘heads-on’ or/and ‘hands-on’ focus within their daily work.
Recommendations: Development of NMMs clinical leadership towards PCC is crucial for nursing home practices. Perceptions of excessive bureaucracy that interferes with care provision and losing focus on core value of care are important pitfalls. Therefore, support from the higher management is needed. Further studies should consider action research and practice-based approach to identify organisations where they are in relation to PCC and supporting those organisations in becoming more person centred.
Keywords: person-centred care, ethnography, clinical leadership, nursing homes, managerial work study

Samenvatting

Titel: De bijdragen van verpleegkundige midden managers aan persoonsgerichte zorg in verpleeghuizen: een kwalitatieve 'managerial work study'

Achtergrondinformatie: Veel ouderen in verpleeghuizen ontvangen slechte zorg. Persoonsgerichte zorg is een innovatie die de kwaliteit kan verhogen en is daardoor de eerste pijler van het nieuw kwaliteitskader Nederlandse verpleeghuiszorg. Dit kwaliteitskader moedigt managers aan inhoud te geven aan de thema's van persoonsgerichte zorg. Daarom is het cruciaal om te begrijpen hoe managers bijdragen aan persoonsgerichte zorg.
Doel: Het doel is om inzicht te geven in het dagelijks werk van verpleegkundige midden managers in verpleeghuizen en hoe zij bijdragen aan persoonsgerichte zorg.
Methode: Deze 'managerial work study' bestond uit een combinatie van tijdsanalyse en etnografie. Het onderzoek richtte zich op managers in Nederlandse verpleeghuizen. In totaal zijn zes managers 95 uur geschaduwd.
Resultaten: Drie karakteristieke bevindingen vallen op als het gaat om hoe managers bijdragen aan persoonsgerichte zorg. De eerste is dat managers die de afdeling niet bezoeken, niet bijdragen aan persoonsgerichte zorg. De tweede is dat managers die 'hands-on' betrokken zijn in de directe zorg wel bijdragen aan persoonsgerichte zorg. Hun bedoeling is om teamleden te coachen. De laatste is dat managers met een 'heads-on' focus bijdragen aan persoonsgerichte zorg. Deze managers hielden ook tijdens organiserende activiteiten een focus op de bewoner.
Conclusie: Managers dragen bij aan persoonsgerichte zorg wanneer zij een 'heads-on' of/en 'hands-on' focus praktiseren.
Aanbevelingen: Ontwikkeling van het klinisch leiderschap van managers richting persoonsgerichte zorg is belangrijk. Het verliezen van de kernwaarde van zorg zijn valkuilen. Support van hoger management is daarom noodzakelijk. Verdere studies kunnen zich richten op praktijkgericht actieonderzoek zodat organisaties zich kunnen identificeren waar ze zijn in relatie tot persoonsgerichte zorg en het ondersteunen van organisaties om hierin te groeien is belangrijk om te overwegen.
Kernwoorden: persoonsgerichte zorg, etnografie, klinisch leiderschap, verpleeghuizen, managerial work study

Introduction

The worldwide population is ageing [1–4]. This can lead to an increasing demand for nursing homes[5–8]. Still, there is growing evidence that many residents receive poor care[9–16]. Person-centred care (PCC) is an innovation that could intently improve the quality of care[17–25].

PCC is 'a status that is bestowed upon one human by others, in the context of relationship and social being[26]'. PCC is an individual approach[32–40] based on positive relationship[34,36,38]. McCormack and McCance (2006) developed a framework which presents four core constructs: 1) prerequisites focus on the attributes of the care worker; 2) the environment focuses on context; 3) person-centred processes focus on delivering care; and 4) outcomes[28]. The word person in PCC is used interchangeable with patient[30]. In this article the term person is used because there is a trend in describing illness which conveys the notion that the whole person must be recognized[23,41,42].

According to literature, (clinical) leadership plays a key role in implementing[29,35,40] and developing PCC[41]. Clinical leadership is the ability to influence all actors in and outside the organization to act clinical performance, provide motivation, play a role in enacting strategic direction, challenge processes and to possess the ability to implement the vision of delivering safety[42]. According to literature, there are indicators that NMMs clinical leadership practices can have positive effects on PCC[42]. NMMs are positioned between the ward and higher management with responsibilities regarding quality of care[43,44], supervision and finances'[45,46]. Given this position and their role in implementing[47–49], it is reasonable that NMMs play a significant role in PCC[50]. However, the way in which NMMs contribute to PCC has yet been based on self-reports of NMMs.

Managerial work studies have employed observation lists or classic time use analyses[45,51,52], diaries and questionnaires[53] to focus on 'sayings'. However, work activities or 'doings' are difficult to understand[54,55].Therefore, the managerial study approach has moved beyond and had now embraced ethnographic work as well[53]. This recent 'practice turn' stimulates to use a practical approach and bring work back in the studies[53]. This turn necessitates departing from certain kinds of research upon which the field was built, specifically quantification of activities based on categories with the aim of capturing its essence[53]. To attend managerial work meaningfully, the move to strong engagements is needed, like ethnographic studies capable of explaining actions, instead of simply registering.

An example of a study is Lalleman et al. (2017) who illustrates how the work of NMMs in hospitals contribute to PCC conducting a shadowing technique[45]. Shadowing is a technique to register rich qualitative observation[56]. It involves a researcher closely following the

shadowee over a period[56,57]. This study obtain insights in the work of NMMs regarding PCC, which were not only based on interview data but on daily observations.

A manifest of journalist Borst (2016) about problems in elderly care led to a new quality framework for Dutch nursing homes that is promoted since 2017[58,59]. This quality framework is the legal basis in Dutch nursing homes[59]. The first pillar of this framework encourages NMMs clinical leadership to give substance to the themes of PCC[59]. Considering this new framework[59], it is crucial to comprehend how NMMs in their daily work contribute to PCC.

Aim

The aim of this study is to explore the daily work of nurse middle managers in nursing homes and how they contribute to person-centred care.

Method

Design

The aim of this managerial work study is to interpret the 'doings' of NMMs. This was done with an ethnographic design which made it possible to explain actions and interpret behaviours of the NMMs[60,61]. The 'shadowing-technique' was used whereby the researcher immersed as 'shadower' in the setting. Also, a clear daily work description is necessary to capture activities. This was completed with time-use analyses whereby a timeframe was used in order to write down observations.

The study is part of a research project on NMMs patient centredness in various settings.

Setting and study sample

The study population focused on NMMs working in Dutch nursing homes and was conducted in a healthcare organisation. The initial permission was obtained from higher management. Furthermore, a contact person performed the selection of participants. In order to participate, the participant must be working as a middle manager in the primary healthcare. The contact person did send an invitation letter to the eighteen included NMMs. The NMMs were asked to return their answer on participation. Ten NMMs did not respond and two did not want to participate for unknown reasons. Finally, six NNMs did sign the informed consent. Those six NMMs work in three different locations.

Data collection

Data collection was performed through shadowing the NMMs in their daily work for two working days each, resulting in 95 hours of observation. During shadowing, a 15-minute timeframe was used. This was done to assure that the generated data was possible for comparison amongst other studies. Every 15 minutes, the researcher noted the following categories in a bloc note: 1) the place, 2) with whom NMMs were interacting, 3) the activity and 4) the purpose of the activity (appendix 1). These categories were used in the study of Lalleman et al. (2017)[45] and were based on Arman et al. (2009)[51] and Mintzberg's (1973) original framework[62]. Based on the work of Lalleman et al. (2017), two extra subcategories in the fourth category were used, namely: set-up time and socializing. During shadowing, questions were asked to the NMMs for clarification or to explain the situation[56]. Thereby, other field notes including quotes or mood of the NMMs were written down.

Data analysis

Data was analysed within an iterative process. After each day, the researcher transcribed all field notes. This made it easier to decode what was written at speed[56]. The individual time use of the framework were placed in a table (appendix 2). For every NMM four histograms where created to illustrate the findings: 1) places, 2) participants, 3) activity and 4) purpose.

Following Lalleman et al. (2017), the category purpose was focused with the Translational Mobilisation Theory to explore how NMMs contribute to PCC[45]. This theory gives insight in the balance of the work activities 'caring work' and 'organizing work'[63]. This fifth histogram has three distinct categories: 1) caring work; 2) organizing work; and 3) margin work (appendix 3). The first, contains activities that involve care. The second, covers all activities that does not involve care. The third, illustrates flexibility. Activities related to 'caring work' are the ones that emerge when NMMs support residents or nurses to provide PCC[63]. NMMs have always organizational tasks. A balance between 'organizing work' and 'caring work' can be seen as precondition to NMMs person-centredness[45].

Furthermore, the framework of McCormack and McCance was used to select fragments that refer to PCC[28]. All the selected fragments were analysed using the thematic analysis method of Braun and Clarke (2006)[64]. This was necessary to theorise the meaning of the whole story[60].

Quality

The researcher executed a pilot of the shadowing-technique for 48 hours. This was valuable because the researcher learned from the critical reflection and on practical aspects.

During this study a research group has given feedback during the whole process in order to sustain quality. Additionally, the consolidated criteria for reporting qualitative research (COREQ) was used in order to guideline and facilitate the process of analysis of qualitative data[65].

Ethical issues

This study was executed in accordance with the World Medical Association Declaration of Helsinki on ethical principles. The study was approved by the science commission of the organization and does not fall under the scope of the WMO according to the METC[66,67].

Results

First the characteristics of the NMMs are described. Than a description of the categories 'place, participants, activity, purpose and summary' with four emerging themes illustrates what NMMs do in their daily work and how they contribute to PCC.

Key characteristics

Four NMMs were women and two were men. Their work experiences as manager varied between 11 and 35 years. Other key characterises are presented in table 1.

[Insert table 1 here]

Place

All NMMs spent most of their time in offices. The NMMs of location 1 and 2 were also present at the ward or nursing station. Location 3 seems to be an exception, here the NMMs lacked time. Only NMMs of location 1 spent time in resident rooms. Time spent in conference rooms and corridor varied between NMMs.

[Insert figure 1 here]

Participants

NMMs spent little time with residents and family. The NMMs of location 1 spent more time with them than others. The amount of time spent alone varied. NMMs worked, approximately one fifth of their time closely together with nurses. Time spent with colleague managers varied.

[Insert figure 2 here]

Activity

The amount of time spent on meetings varied. The NMMs of location 3 and NMM 2 spent most of their time on meetings. Deskwork was part of the daily work of all NMMs. All NMMs spent little time on telephone calls. Clinical work was mainly observed at location 1.

[Insert figure 3 here]

Purpose

Scarcely any time was spent on clinical work, only NMMs of location 1 were an exception. All NMMs spent time to quality improvements. NMMs of location 1 spent less time on administration than the others. Time spent on scheduling did not varie much. All NMMs did not spent much time on rounds, with the NMMs of location 1 as exception.

[Insert figure 4 here]

Contributions of NMMs to PCC

To explore how NMMs contributed to PCC, the category 'purpose' was focused on. Figure 5 demonstrates that NMM 2 spent more time on caring work than organizing work. All the others NMMs spent more time on organizing work than caring work.

[Insert figure 5 here]

At least, four emerging themes portray the contributions of NMMs to PCC. Additional quotes which support the empirical work are presented in appendix 4.

Place office

The NMMs of location 1 had their offices directly adjacent to the ward in comparison with the others, who had their offices outside the ward. The NMMs of location 1 and 2 both spent time visiting the ward or nursing station. The NMMs of location 3, spent less time visiting the ward then other NMMs. Next fragment illustrates the importance of the place:

> The NMM was working with an open door in the office and heard a resident calling for help. The NMM immediately got up to respond on the resident. "*Hey Mrs. X… How are you? Can I help you?... Come walk with me for a while…*" [*NMM 1, location 1*]

This fragment illustrates that an office on the ward makes it easier for others to walk in, especially for residents. When nurses, residents or family are having the opportunity to walk in the office did contribute to PCC. NMMs were not easily visited with an office out of sight.

Visiting or working on the ward / nursing station

NMMs all have a different habit when it comes to visiting the ward or nursing station. At location 1, the ward was visited regular during the day. At location 2, the ward was mainly visited at the beginning of the shift. The next fragment illustrates the purpose of those NMMs:

> "*When I am working at the ward, I see staff walking by and I make contact with them… Also, I hear things and I see how things are on the ward… I am doing this for the staff and residents, with this I am showing my involvement… I am visibly present and approachable.*" *[NMM 4, location 2]*

This shows that NMMs visit the ward to be approachable, involved and participate. Visiting the ward, seeing nurses and talking with residents on a regular basis, potentially facilitated dialogue and were important for PCC.

The NMMs of location 3 seldom visited the ward or nursing station. As illustrated in the next fragment:

> *"I think managers do not have to visit the ward… this does not contribute to the independence of the team members." [NMM 5, location 3]*

This fragment illustrates that NMMs who seldom visit the ward are doing this because they believe that team members learn to be more independ when they work without a manager nearby. However, seldom visiting the ward did not support PCC. NMMs who are visible at the ward are more easily addressed or consulted by others. Thereby, visiting the ward ensures that NMMs are better informed about the wellbeing of the ward.

Involvement in residential care

Regarding involvement in care, all NMMs contributed in different ways. At location 1, the NMMs spent time on care activities, like clinical work, participating in multidisciplinary consultation and care plan reviews. Also, those NMMs had conversation with residents on a regular day. This is illustrated in the next fragments:

> "*Every morning I read all the residents files… I want to stay informed about the well-being of the residents… sometimes I give advice to team members… like maybe you can try something else…" [NMM 2, location 1]*

The NMM was in a meeting about wandering behaviour of a resident. The resident sometimes walks away and gets lost. Within a meeting the NMM says: "*We see that X is bored… we need to find something… what are his needs? What does he like?... Back in the days, he liked gardening… Why don't we try a mini garden cabinet for him?" [NMM 2, location 1]*

This fragement shows that the NMMs were well informed about care due to their activities. The authority of those NMMs were based on their long track record as nurses and knowledge of the care process. We call this a 'hands on focus'. This focus made it possible for those NMMs to directly support and facilitate PCC practices.

At location 2, the NMMs kept informed by team members when there were particularities and they were involved through participating in handovers. One example in the next fragment:

During a nurses handover the NMM informed the team members about the interventions of the psychologist. The NMM says to the team members: *"It is important to read the residents files and read the interventions of the psychologist… if we all apply different interventions, the resident does not benefit… it is important for this resident to clearly follow the advice of the psychologist. " [NMM 3, location 2]*

Those NMMs did not practice 'hands-on' in direct care but kept involved and always position the individual resident as an unique human being at the centre of care. The NMMs kept focus on residents perspectives. We call this a 'heads-on' focus, which contribute to their person-centredness.

At location 3, the NMMs did not spent much time on direct care activities. Here the NMMs often consulted senior nurses to be active or informed in the residential care. As illustrated:

The NMM was in a meeting with the senior nurse. He said he wanted the senior nurse to be active within a specific case of aggression. After the meeting, the NMM responded to the researcher: *"I think it is important that the senior nurse follows this case… I have no time to do this, so I ask the senior nurse to play an active role… I think that every healthcare related things are the task of the senior nurse… For me as manager, I facilitate … ". [NMM 6, location 3]*

Those managers mainly spend time on meetings then involvement in the care. We call this a 'hands off' focus, which did not contribute to PCC.

NMMs contribute to PCC when they show a 'hands-on' or/and 'heads-on focus'. With this NMMs keep focus on the residents' needs. When NMMs did not play an active role regarding to care they did not contribute to PCC.

Coaching and role model behaviour

Coaching and role model behaviour was observed at all NMMs. At location 1, the NMMs visibility and knowledge enabled team members to ask questions. As illustrated in the next examples:

One nurse consulted the NMM. A resident did not want her medication at precisely 8.00 morning, because she was used to take her medication later. Here the NMM advised the nurse: "*You just need to meet the wishes of the residents... She [*the resident*] can clearly indicate her own direction." [NMM 2, location 1]*
The NMM was reading in resident files on the ward. A nurse walked by, she was planning to start her shift without reading first. The NMM started to chat with nurse: "*So… I am very surprised… A lot is happened this weekend… And Mrs X. is passed away…*". The nurse turned around to the nursing station to start up the computer and said: "O.. It seems like there is a lot happening… I think am going to read first…" [NMM 1, location 1]

The examples shows that the activity and role model behaviour of the NMM directly can stimulate nurses. Those NMMs work with the team in different ways enabling learning in and from practice.

At location 2, the NMMs enabling learning situations at a staff handover or by bringing staff together. As illustrated:

The NMM said to the nurse: *"Just try sometimes to put the radio on… Or sing a little song… the residents love that… try to create a comfortable atmosphere in the living room for the residents…". [NMM 3, location 2]*

This fragment illustrates the coaching behaviour of those NMMs. The purpose of this coaching and reflection was to support team members into PCC. Also those NMMs had a plan and vision to support PCC.

At location 3 the NMMs spent time on monitoring and evaluating standards of care. As illustrated next:

The NMM is in conversation with a nurse who is struggling in the collaboration with other nurses. The NMM said to the nurse: "*do not doubt yourself… you are performing well… you will see… it all gets better soon…*" [NMM 6, location 3]

This fragment shows that the coaching of the NMMs were mainly focused on performances of team members into independency, which did not directly support PCC. NMMs with a clear vision about PCC and who are coaching team members can positively support a person centred focus.

Discussion

This study explores how NMMs in nursing homes contribute to PCC. Within this research it has become clear that NMMs contribute to PCC when they show a 'heads-on' or/and 'hands-on' focus within their daily work.

With regard to NMMs contribution to PCC three characteristic findings stand out. The first is that NMMs with a 'hands-off' focus, as at location 3, seldom contribute to PCC. Approximately 30% of their time was spent on 'caring work'. This may suggest that the daily work of those NMMs did contribute to PCC. However, the categories of place, participant and activity were strong indicators for lack of contributions. The second shows that NMMs who were 'hands-on' involved, as at location 1, did contribute to PCC. In the third, NMMs as seen in location 2, 'heads-on' focus did contribute to PCC. Those NMMs kept a focus on resident-related issues when doing 'organizing work'. Their practices were corresponding to the 'heads-on' focus[50]. NMMs who work 'hands or' and/or 'heads on' where, as seen in the framework of McCormack and McCance, able to position the resident as a unique human being[28]and to coach nurses into person-centredness[50].

The themes portray the contributions of NMMs regarding PCC. The first theme demonstrates that the place of the office did not discriminate regarding to NMMs' spending time on the ward. This finding does not correspond with previous literature where is found that having an office off the ward decreases the time spent on ward[45]. Nevertheless, having an office on the ward makes it easier for others to walk in. Theories about the influence of place are described in studies like Andrews (2002)[68] and Andes et al. (2006)[69]. The second theme illustrates that NMMs who regular visit the ward facilitate PCC. Seldom visiting the ward does not support PCC corresponding with earlier literature[45,50,70]. Thereby, other theories showed that accessibility is recommended for leaders[71] in order to support PCC[70,72]. The third theme demonstrates that when NMMs are spending time on activities that involved care, they can directly support PCC. Clinical work[70,73] is according to earlier research, an important daily task to remain responsive to individual' needs[70]. The last theme shows that when NMMs give advice to team members, they can directly support PCC. According to earlier studies, enabling the growth of the team to person-centred moving[74–76] and providing feedback[40,70,77,78], are considered as important roles of NMMs. Thereby, coaching or active learning activities[39,40,78,79] and role model behaviour[71,74,80–82] is needed for a PCC focus. Having a 'heads on' and/or 'hands on' focus corresponds to the framework of McCormack and McCance that suggest that to deliver person-centred outcomes, account must be taken of the perquisites and the care environment that are necessary for providing effective care through the care processes[28].

This study has several strengths. This study gives insights about the work of NMMs and made it possible to portray what is difficult. As positive side effect, the shadowing-technique emerged as experiential learning for both shadowee and researcher[42,56]. This study has a few limitations that warrant consideration. Due to a lack of time only six NMMs were shadowed. If more NMMs at different locations were shadowed, comparisons could be conducted. Thereby, the design uses ethnographic work and time-analysis to collect data. Other methods, like interviews and comparison with the NMMs interpretations can be important to complete the picture of the meaning of actions[51]. Also, shadowing led to difficulties. Shadowing is a method that generate a big amount of data and the processing of it made it a time consuming method. More, sometimes shadowing led to awkward moments. By example, the researcher (who is also a nurse) had the tendency to act on a request of help because the manager did not respond.

Conclusion

NMMs in nursing homes contribute to PCC when they show a 'heads-on' or/and 'hands-on' focus. NMMs who often visit the ward, who are involved in care and who had interaction with residents contribute to PCC. When NMMs are showing a role model or coaching behaviour they can directly support person-centredness. Not visiting the ward, not seeing patients or a lack of involvement into care with a 'heads-off' focus did not contribute.

Recommendations

Previous research showed that organisations who failed at improving PCC, were often due to a lack of managerial support[40,83,84]. Development of NMMs clinical leadership into person-centredness is therefore crucial. Perceptions of bureaucracy that interferes with care provision of NMMs[85] and losing focus on core value of care[86] are earlier reported. Therefore, support from higher management is needed for NMMs to engage with care issues[87].

Further studies should consider shadowing and interview methods. Also action[88] and practice-based research[78] like the use of data to identify organisations where they are in relation to person-centred I framework[89] and supporting those organisations in becoming more person centred should be considered[90].

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Table and figures

Table 1 Key characteristics of participants

	Nurse middle manager (NMM)	Setting	Span of control	Number of beds	Other particularities
Location 1	NMM 1	Psychogeriatric and somatic care	23	50	No particularities
	NMM 2	Psychogeriatric and somatic care	19	42	No particularities
Location 2	NMM 3	Psychogeriatric and somatic care	18	44	No health background. With support of senior nurse
	NMM 4	Psychogeriatric care	44	45	No particularities
Location 3	NMM 5	Somatic care	45	90	With support of senior nurse
	NMM 6	Psychogeriatric care	45	60	With support of senior nurse

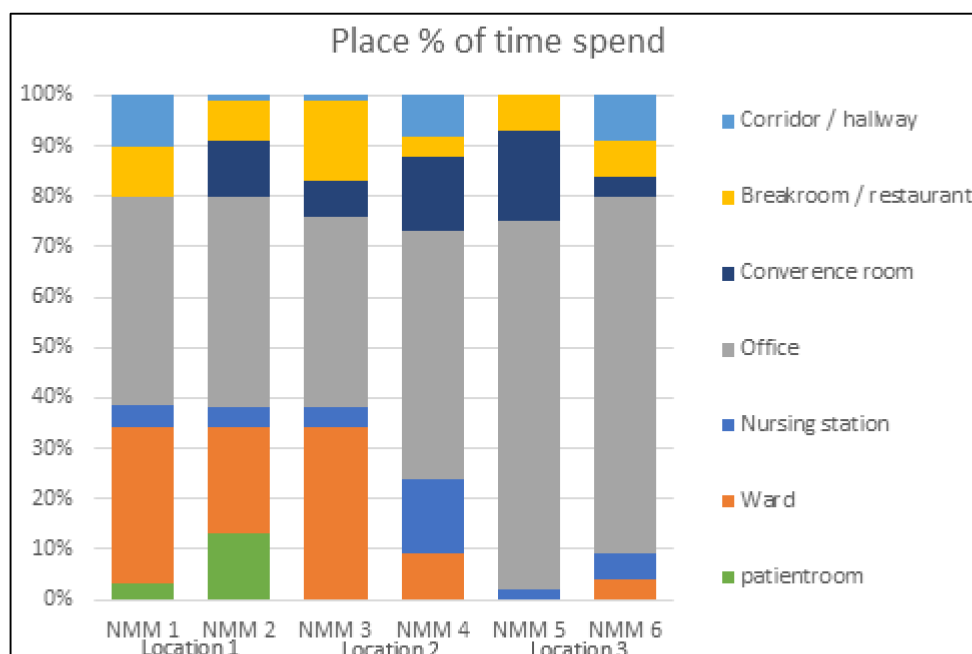

Figure 1 Place NMM

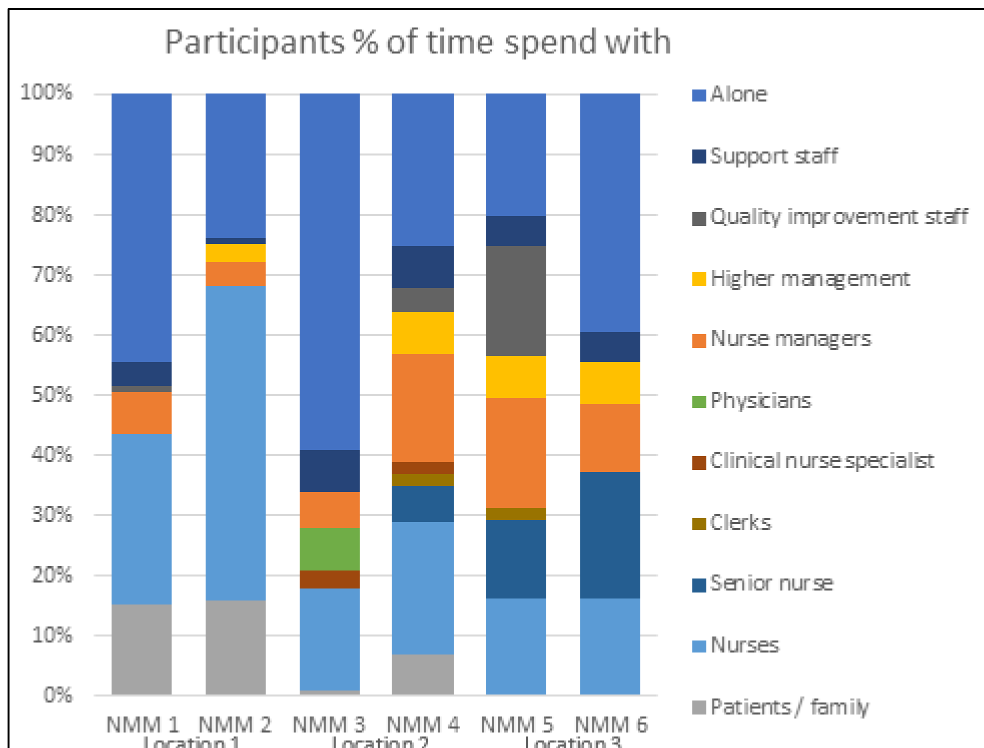

Figure 2 Participants NMM

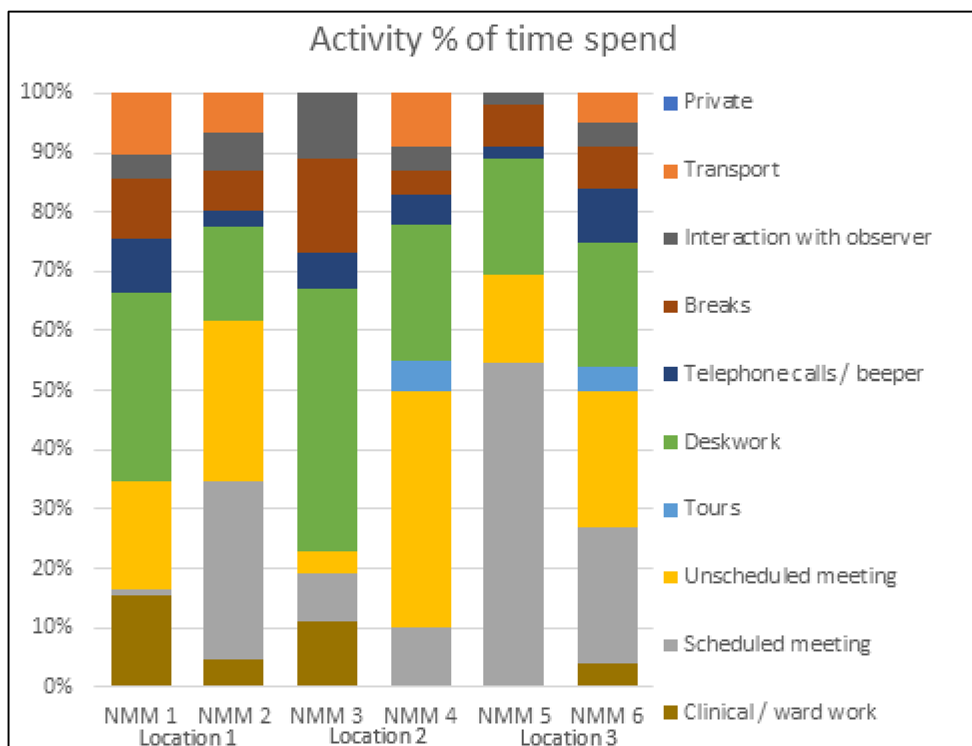

Figure 3 Activity NMM

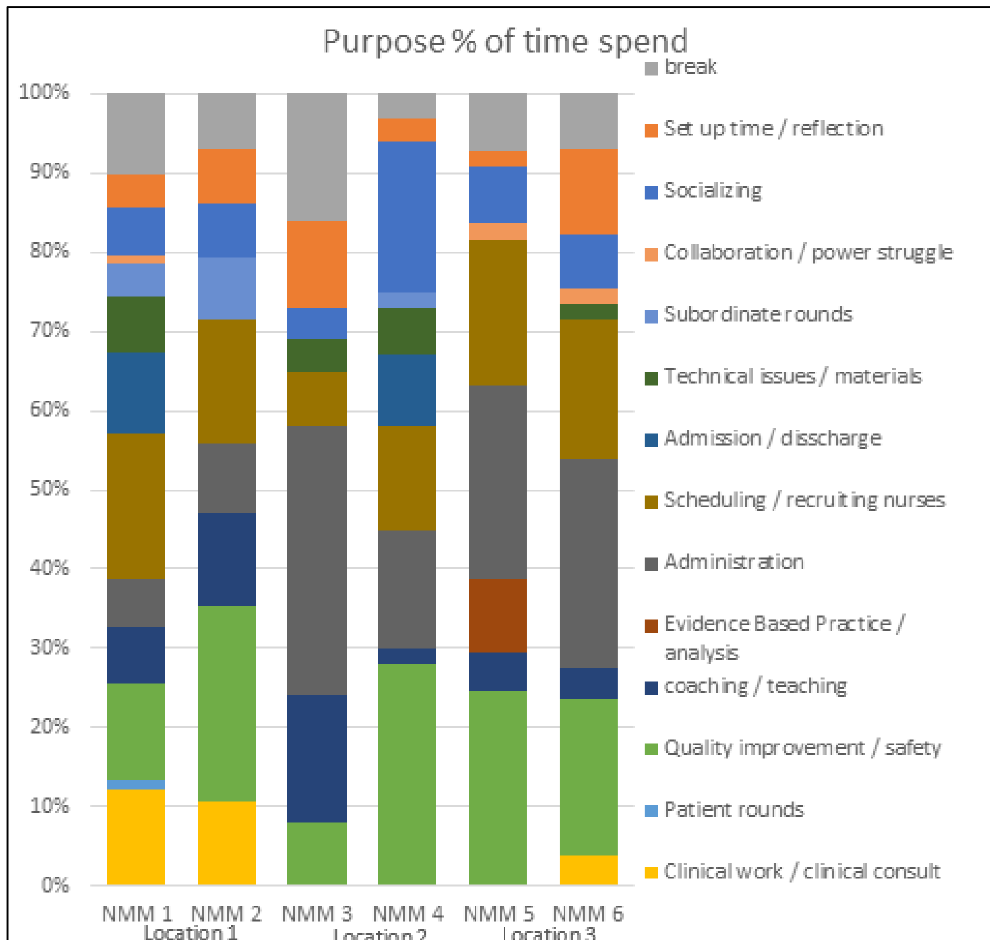

Figure 4 Purpose NMM

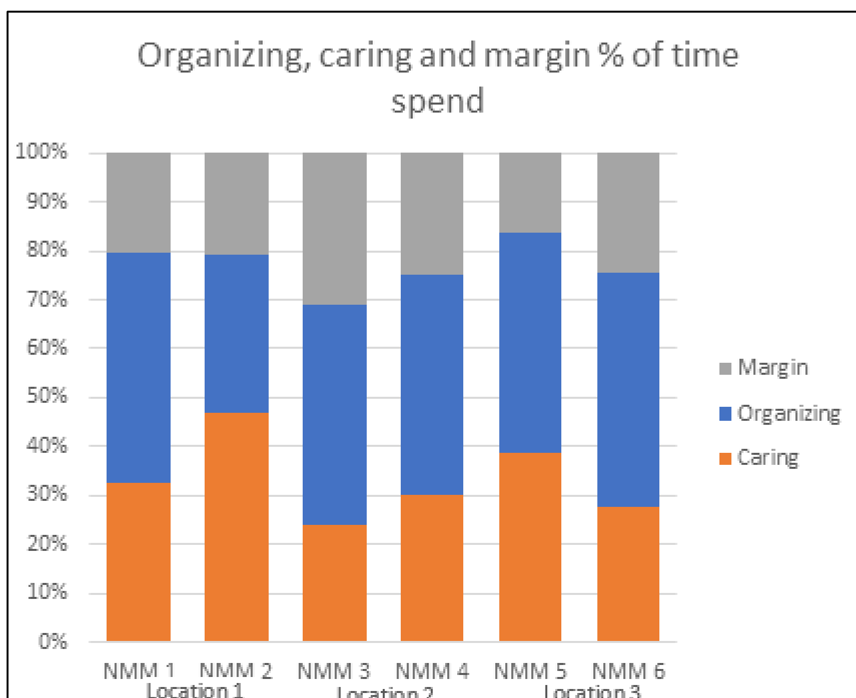

Figure 5 Organizing – caring – margin

Appendix

Appendix 1 15 minutes framework

Place	Participants	Activity	Purpose
Corridor / hallway Breakroom / restaurant Conference room Office Nursing station Ward Patient room	Alone Support staff Higher management Nurse managers Physicians Clerks Senior nurse Nurses Patients / family	Private Transport Interaction with observer Breaks Telephone calls Desk work Tours Unscheduled meetings Scheduled meetings Clinical work / ward work	Breaks Set up time / reflection / interview Socializing Collaboration / power struggle Subordinate rounds Technical issues / materials Admission / discharge Evidence based practice / analysis Scheduling / recruiting nurses Administration Coaching / teaching Quality improvement / safety Patient rounds Clinical work / consult

Appendix 2 Organizing – caring and margin activities

Organizing	Caring	Margin
Collaboration / power struggle Subordinate rounds Technical issues / materials Admission / discharge Scheduling / recruiting nurses Administration	Coaching / teaching Quality improvement / safety Patient rounds Clinical work / consult Evidence based practice / analysis	Breaks Set up time / reflection / interview Socializing

Appendix 3 Summary

Place % of time spend	Location 1		Location 2		Location 3	
	NMM 1	**NMM 2**	**NMM 3**	**NMM 4**	**NMM 5**	**NMM 6**
Nursing station	4%	4%	4%	15%	2%	5%
Ward	31%	21%	34%	9%	0%	4%
Office	41%	42%	38%	49%	73%	71%
Breakroom / restaurant	10%	8%	16%	4%	7%	7%
Corridor / hallway / passageway	10%	1%	1%	8%	0%	9%
Patient room	3%	13%	0%	0%	0%	0%
Conference room	0%	11%	7%	15%	18%	4%

Participants % of time spend with	**NMM 1**	**NMM 2**	**NMM 3**	**NMM 4**	**NMM 5**	**NMM 6**
Alone	44%	24%	59%	25%	20%	39%
Nurse managers	7%	4%	6%	18%	18%	11%
Patients / family	15%	16%	1%	7%	0%	0%
Higher management	0%	3%	0%	7%	7%	7%
Nurses	28%	53%	17%	22%	16%	16%
Physicians	0%	0%	7%	0%	0%	0%
Support staff / HR / Education	4%	1%	7%	7%	5%	5%
Clinical nurse specialist	0%	0%	3%	2%	0%	0%
Quality improvement staff	1%	0%	0%	4%	18%	0%
Clerks	0%	0%	0%	2%	2%	0%
Senior nurse / unit coordinator / head nurse	0%	0%	0%	6%	13%	21%

Activity % of time	**NMM 1**	**NMM 2**	**NMM 3**	**NMM 4**	**NMM 5**	**NMM 6**
Private	0%	**0%**	0%	0%	0%	0%
Transport	10%	7%	0%	9%	0%	5%
Scheduled meeting	1%	32%	8%	10%	55%	23%
Unscheduled meeting	18%	29%	4%	40%	15%	23%
Tours	0%	0%	0%	5%	0%	4%
Deskwork	31%	17%	44%	23%	20%	21%
Telephone calls / beeper	9%	3%	6%	5%	2%	9%
Breaks	10%	7%	16%	4%	7%	7%
Interaction with observer	4%	7%	11%	4%	2%	4%
Clinical / ward work	15%	5%	11%	0%	0%	4%

Organizing work % of time	**NMM 1**	**NMM 2**	**NMM 3**	**NMM 4**	**NMM 5**	**NMM 6**
Administration	6%	9%	34%	15%	24%	27%
Scheduling / recruiting nurses	18%	16%	7%	13%	18%	18%
Admission / discharge / beds census / patient-nurse ratio	10%	0%	0%	9%	0%	0%
Technical issues / materials	7%	0%	4%	6%	0%	2%
Subordinate rounds / observational tours / check / monitor	4%	8%	0%	2%	0%	0%
Collaboration / power struggle / control issues / organization change	1%	0%	0%	0%	2%	2%
Total organizing	46%	33%	45%	45%	44%	49%

Caring work % of time	**NMM 1**	**NMM 2**	**NMM 3**	**NMM 4**	**NMM 5**	**NMM 6**
Clinical work / clinical consult	12%	11%	0%	0%	0%	4%
Patient rounds / observational tours / check / monitor	1%	0%	0%	0%	0%	0%
Quality improvement / safety / concerns / errors / risk management	12%	25%	8%	28%	24%	20%
coaching / teaching / instructing	7%	12%	16%	2%	5%	4%
Evidence Based Practice / analysis / research / guidelines	0%	0%	0%	0%	9%	0%
Total caring	32%	48%	24%	30%	38%	28%

Margin % of time	**NMM 1**	**NMM 2**	**NMM 3**	**NMM 4**	**NMM 5**	**NMM 6**
Socializing	6%	7%	4%	19%	7%	7%
Set up time / reflection / clarification of work / interview	4%	7%	11%	3%	2%	11%
break	10%	7%	16%	3%	7%	7%
Total margin	20%	21%	31%	25%	16%	25%

Organizing, caring en margin % of time	**NMM 1**	**NMM 2**	**NMM 3**	**NMM 4**	**NMM 5**	**NMM 6**
Organizing	46%	33%	45%	45%	44%	49%
Caring	32%	48%	24%	30%	38%	28%
Margin	20%	21%	31%	25%	16%	25%

Appendix 4 Additional quotes

Place office

The NMM was working in the office with an open door. From this office you can directly look in a shared bathroom. A resident walked in the bathroom to use the toilet. The NMM immediately stood up to close the door. [*NMM 1, location 1*]

The NMM is back at the office and shuts the door when saying to the researcher: "I close the door because I need to do administration." [NMM 5, location 3]

Visiting or working on the ward / nursing station

The NMM stood up and said to the researcher: "I always try to divide my time over the different wards…Now, I have worked about one hour on X, so no I am going upstairs…". [NMM 1, location 1]

The NMM walks around the ward. We see a nurse with her hands full and a resident in the hallway. This resident want to go upstairs with the elevator. The NMM walks to the resident and nurse and says: "I can walk with you". The NMM helped the resident with her bag and jacket and walked with the resident. [NMM 2, location 1]

"When I am working on the ward… I see people walk by… And I can talk with residents… In the meanwhile, I am doing some easy administration on the computer…" [NMM 3, location 2]

The NMM sits in the office and said to the researcher: "You will not find me on the ward on a daily basis… But I have a background in nursing and I know the job good enough." [NMM 6, location 3]

Coaching and role model behaviour

The NMM was observing an activity in the hallway. The hallway was filled with rollators. We saw that an old man almost fell because he wanted to take a rest on a rollator. This rollator was not on the brake. The NMM helped the man. Thereafter, the NMM immediately put the brakes on all the rollators. Then, the NMM walked to the nurse who had organized the activity and told what she did: "That man almost fell… I put the brakes

on the rollators now… If rollators are not used, they have to be on the brake at all times… Otherwise people can fall… This is not safe…" [NMM 1, location 1]

The NMM says to the team members: "We all need to look more person-centred… The resident is at the centre of all… " [NMM 2, location 1]

Within a meeting a nurse said to the NMM that some living room assistants do not walk with residents to the toilet. Therefore residents have to wait until a nurse is available. The NMMs responded: " It cannot be that a resident has to wait for the toilet… an assistant can easily walk to the toilet with the resident… when residents have to wait for the toilet, we all have failed…" [NMM 2, location 1]

The NMM gives information about a new resident to a nurse and says: "this man has taken care of himself for all his life… nobody has entered his room before… so it is extremely important that we do not push him… sometimes he walks with the same pants for three weeks… but that does not matter… washing is not important… we need to build trust first before we start to wash him…". [NMM 4, location 2]

Involvement to residential care

The NMM participated within a family meeting: "we are wondering how are you doing?... How have you experienced the past weeks?... corresponding to your wishes?". [NMM 2, location 1]

"I don't read resident files… the nurses will inform me when there are important things…" [NMM 4, location 2]

The NMM was visiting the ward. We see a resident standing in a corner with slumped pants and his belt laying on the floor. The NMM stopped to take the belt of the floor. He put the belt on the side of the aisle and walked by the resident. [NMM 6, location 3]