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Translating the quality idea in a healthcare organization

Master of Science Thesis

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Abstract

Healthcare organizations in Sweden are expected to reduce waiting times and save money. A common criticism of the healthcare field is that its organizations are structured around medical specialties instead of patients. The quality idea, characterized by its customer centered norms and their systematic communication to workers, has become widely regarded as a solution to healthcare organizations' problems but in practice there are mixed reports of its success.

Using the case of a quality project at a large university hospital, we investigate how the quality idea is translated from idea to practice and what effects this translation has on organizing. We find that the translation starts long before the project and is inspired by organizations, education and research in the field. Translation is not carried out by a lone implementer but by many of the project's participants who partake in the project and the translation in different ways.

Our study does not last long enough to see if the project leads to higher standards of care or saved money, however we do see that the translated idea leads to an increased understanding among project participants of the patient's journey along the care chain. Work over organizational boundaries is facilitated by patient focus; the patient is an idea of which participants share enough of a mutual understanding in order to work around together. However, we see that the one of project's goals becomes adjusted during translation due to the perceived difficulty of engaging and collaborating with external organizations, whose numbers have vastly increased since the marketization of elderly care.

Keywords: action net, adoption, boundary object, constructivism, diffusion, healthcare, management, organization, organizing, patient, process, project, quality, social, translation.

Foreword

The beginning of this thesis coincided with the start of a project at Large Hospital. Our contact at the hospital wanted us to evaluate what was happening, particularly with a new steering group. We set about gathering information about stroke and TIA care, the new strokeTIA process and the people involved. Contrary to our belief that hospitals are conflict-ridden environments where professionals fight to protect their interests, a commonly occuring representation in research texts, we found that hospital staff involved in the project worked together harmoniously. More than that, they were happy to accommodate us and often very enthusiastic about getting an outsider's point of view. We would like to thank them, especially the process leader, for their time and assistance and hope that this thesis can be of use to them.

We would also like to extend out thanks to our supervisor Torbjörn Jacobsson who gave us the space to work with theoretical ideas from the sphere of Scandinavian new institutionalism. We hope that we have effectively recommunicated the fantastic and persuasive ideas we have had opportunity to read.

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Ewan Barr and Karin Khajador

Contents

Introduction

A problem in healthcare

> Stroke/TIA care at Large Hospital has undergone major improvements during recent years. Through these improvements, it has become clearer to Large Hospital that it is necessary to work with processes, since so many different functions are involved in stroke/TIA care. Some of these functions even belong to other organizations, so cooperation, work routines and information flow are very important.
>
> 'Stroke/TIA process' is a new process which includes five of the six function areas as well as primary care and communal healthcare. The stroke/TIA process is a pilot project for a general approach for working with processes. This approach includes a structure and definition of terms to do with working with processes. There is to be a process steering group to resolve the tensions between functional hierarchy and process orientated work.

This is an excerpt from a document from our case study at 'Large Hospital' in Sweden. The document summons line managers at Large Hospital to be part of a new project for working with processes relating to the treatment of patients who suffer from stroke and a related condition called transient ischemic attack (TIA). Large Hospital would like to work more effectively with patient groups which require treatment from several groups of staff in different parts of the hospital, such as stroke/TIA patients, and the new project is hoped to improve cooperation between functions by working process-orientated.

Large Hospital has developed their own idea for working with processes which they hope will improve stroke care, help them to meet national guidelines for stroke and TIA care and keep them up to date with developments in the field. Their idea involves using tools typical for process-orientated working such as process mapping and continuous improvement. Working with processes is considered to be a way of focusing on the patients' journeys through the hospital and finding and solving problems with coordination between functions.

Large Hospital's situation is not unique in the healthcare field or indeed in the public sector. In Sweden, the UK, Australia and USA, the need to work more effectively over boundaries is a commonly stated problem for healthcare providers. This particular problem formulation seems partly to be the result of economic restrictions on the public sector, something which is relatively new for Sweden's publicly funded healthcare system. The Swedish public sector has come under increasing attack in recent years for being inefficient and not meeting public demand, a trend which is visible in public healthcare, where crisis is assumed to be the result of a permanent lack of resources, and otherwise, no extra resources are required to improve services (Borgenhammar 1994). The public healthcare sector has moved from dispensing resources to increase quality and availability (Jönsson 1997) to economic restrictions and demands on efficiency (Calltorp et al. 1998).

Nor is Large Hospital's solution to this problem unique in the healthcare field or the public sector. It is an idea about organizing which features norms, centred around customers' preferences, which are communicated to workers through systematic measurements and improvements, and is thus a variety of the quality idea (Bejerot et al. 2002). There are several popular models for organising healthcare provision which are varieties of the quality idea, for example total quality management and lean healthcare, and these are reported both to have

helped organisations perform more effectively and not to have helped at all (see e.g. T. C. Powell 1995; Jacobsson 2010), though failure to perform is often attributed to failure to correctly implement the prescribed model. Lean healthcare has become widely discussed (Borgström 2010; Bertholds 2010) since one of Sweden's larger hospitals declared itself to be lean. Common criticism is that lean healthcare dehumanises healthcare, by expecting staff to work with machine-like regularity and reconceiving of patients as customers and medical care as a service.

As ideas about new ways of organizing spread through an organization field, organizations adopt those ideas which not only offer solutions to problems, but which are also considered to be attractive and legitimate. The quality idea is an example of an idea which comes from outside of the healthcare and public sector fields, but has become remarkably popular within those fields. An explanation for this is the recent pressure on the public sector to improve efficiency, which has been accompanied by the public sector comparing itself to the private sector, creating problems and solutions from this new perspective, and implementing reforms. These reforms are often referred to collectively as New Public Management and share a common ideal: market logic, which is assumed to promote efficiency (Power 1997). However, some ideas such as competition and customer choice are less easily explained in new contexts such as healthcare, and reforms have mostly affected ways of organizing, steering, controlling and guiding but not the resulting care (Brunsson & Sahlin-Andersson 1998). Despite the reforms, market logic has not lead to any obvious successes in the public sector (Power 1997).

Purpose of Study

Different manifestations of the quality idea are currently seen to provide solutions to the problems faced by healthcare providers. Healthcare organizations are formulating organizational problems in the terms of the quality idea and attempting to solve them with quality management models such as lean thinking, total quality management, and process-flow solutions. Many hospitals, like Large Hospital, are looking to the quality idea to help them work over boundaries more effectively and with economic constraints.

There is a variety of research assessing the implementation of quality management models in healthcare, but this research usually portrays organizations as simple, technical-rational systems, ignoring social processes. There is also contradictory research attempting to establish various organising models based on the quality idea as fallible or infallible, but there is relatively little research which describes how organizing itself is affected by the quality idea.

The question we are then interested in is: How does the quality idea, or more precisely any model for organising which bears the characteristics of the quality idea, help to effectively organize actions which take place in different times and places? This thesis will use a case study to describe and analyze the way in which the quality idea is put into practice at a large hospital and how this affects the organizing of actions in different times and places. This line of enquiry enables us to represent a limited perspective which we think will be useful to future organizers who attempt to implement the quality idea in a Swedish hospital.

Research questions

In our theoretical framework we will present literature to the effect that organizations do not so much implement ideas about organizing, as translate them, and that organizing can be

studied in terms of actions and the connections between them. We can thus rephrase our research questions as follows, using the theoretical terms which will be introduced in our theoretical framework:

1. What affects the way in which an idea is translated?
2. How does the quality idea affect an action net?

We take up these questions again in our discussion after presenting our study organization, the empirical data we collected, and discussing different aspects of the empirical data.

Theoretical Framework

The purpose of this section is to present and argue for our theoretical assumptions, since the results of this study are constrained in advance by the assumptions we make about how organizing works, and what it is possible to investigate. We present a brief review of relevant literature and then the theoretical ideas which describe our views of reality and organizing These ideas are the basis for the theoretical framework which we use in the analysis and discussion sections.

Literature review

Some research into quality management and organizations takes a simplified, technical-rational approach and ignores social processes. One particular topic which recurs within the field of quality science research is implementation of quality management models. Case studies dealing with implementation usually describe a model for organising which features the characteristics of the quality idea, and which is destined to improve organising. Failure by the case organization to achieve organizational efficacy is usually assumed to indicate failure to implement the prescribed model, and failure to faithfully implement the prescribed model is usually attributed to some form of resistance or ignorance.

These studies miss the aspects of organizing that do not exist in the simple systems that quality management models portray. Organizations are not simple mechanical systems, if they were, quality management models would have been a lot more effective in helping organizations to organize. One study found that patients which were channeled into the mechanical patient flows set up under a new quality management idea underwent swift treatment. But those that could not fit into one of those streams fell instead into an intertwined, complex system, with longer waiting times (E. Lindberg 2003). Simplified, technical-rationally inclined quality management studies miss the social processes which constitute organizing.

By ignoring both the complex and the non technical-rational, organizations can be presented as comparable and equivalent. But in reality, organizations differ in more than simple technical-rational terms, so organizations which subscribe to the same ideas look different in practice (Blomquist 1996) because ideas about organizing have to be interpreted and manipulated in order to fit reality and be practicable, and because this process of translation from idea to practice is somewhat difficult to predict. The quality idea has been reinterpreted by many different actors in the healthcare field (Erlingsdottir 1999), and translation has led to heteregenization of organizational forms as well as homogenization (Erlingsdottir et al. 2005). It is unrealistic to expect groups of individuals working in an organization to translate an idea in exactly the same way as each other or another organization (Pettersen 2009) – or in the same way as the observing researcher .

There are few studies of quality management and social processes of organizing. One study which examined how organizations organize with each other during a quality project is Kajsa Lindberg's dissertation *Kopplandets Kraft* (2002). Lindberg used Czarniawska's (2005) action net idea, that organizing is webs of interrelated actions, in order to focus on how actions carried out in different times and places were related to each other by workers, and how these actions became reorganized. Lindberg found a variety of connections between people, actions and things, describing how these arose and their nature. In order to consider how people can

connect people, actions and things together, she used the idea of translation. She found that the project facilitated the creation of loose couplings between organizations, that such flexible couplings were more useful between organizations with no formal control over each other than tight couplings, and concluded that mimetic processes deserved more attention when trying to achieve cooperation between organizations (K. Lindberg 2002).

There have, however, been similar approaches in other studies. Caroline Waks' award-winning dissertation *Arbetsorganisering och professionella gränsdragninar* (2003) is a constructivist study of how professional boundaries are constructed. Professional boundaries are often cited as the cause for many problems in healthcare reformation. Waks observed how physiotherapists constructed their professional boundaries through their daily activities. In doing so, she challenged the conventional assumption by researchers that professional boundaries are invisible lines drawn between professions. Instead, Waks observed that responsibility was not always clearly divided between professionals, rather that there were many grey areas of responsibility, and that professionals used their professional boundaries to help them negotiate which work activities were their responsibility. In addition, *En teori om organisering (Czarniawska 2005)* has been invaluable in refuting the essentialist approaches to organization theory which seem to naturally appeal to us as engineers.

A view of reality

In one of the author's experience, discussions about what constitutes reality (ontology) are often polarized by the following question: if a tree falls in the forest and nobody is there to hear it, does it make a sound? Philosophically interesting as this may be, we prefer to avoid polarization by taking the rather more common commonsensical view that we do indeed share a single reality, but that different people find different meanings in it. The view that individuals construct their own and each other's meaning-filled realities is called social constructivism and forms the theoretical starting point for our thesis. Before we move on to other ideas, we need to quickly clarify what social constructivism means in this thesis.

Czarniawska (2005) explains that the word construction in English commonly refers to two things: an object made by humans with properties that can be described or measured, or a process by which something becomes built using available material (i.e. not creation which in principle happens using nothing). The second definition forms the basis for our study and this perspective is often called social constructivism. However, the word social can also be understood to mean two things: to do with humans and their actions, typically language, or more faithful to the word's latin roots: the opposite of alone. It is this latter meaning that we want to invoke when we refer to social constructivism, and it implies that the social world includes both the human and the non-human. Humans share relationships not only with other humans but also with non-human objects and ideas.

Translation

Society consists of human and non-human actants, and relations between humans and non-humans gives society a stable structure (Latour 1998). Humans, actions and objects are inherently different, but we somehow succeed in relating them to each other in an act of social construction. Translation is the idea that actions, objects, symbols and language can be translated to each other, rather than being limited to languages. According to Lindberg and Czarniawska (2003) the concept comes from Bruno Latour, who borrowed it from the French philosopher Michael Serres. Translation is also an idea which can be applied to the realization

of ideas about organizing, and we look more closely at this particular use in the section of the theoretical framework which deals with organizing.

Boundary Objects and Procedures

Even though people live in their own social worlds, they (often) manage to communicate quite successfully. People often share similar social constructions with each other. A boundary object is an object which humans can understand and work around. Star and Griesemer (1989) describe boundary objects:

> They have different meanings in different social worlds but their structure is common enough to more than one world to make them recognizable, a means of translation. The creation and management of boundary objects is a key process in developing and maintaining coherence across intersecting social worlds.

An example of a boundary object which most of us are familiar with is money. Money means different things to people in different parts of the world who have different cultures, traditions, values, jobs, but it is also widely recognized. Boundary procedures are activities which make use of boundary objects (K. Lindberg 2002). The activities acquire different meanings for different actors while the procedures themselves remain unchanged.

Loose coupling

Systems theory can be used to help to describe the nature of social connections, e.g. interpersonal or between and within organizations. The loose coupling concept is a description of a system whose elements are connected with determinacy while still retaining some independence and being capable of spontaneity (Orton & Weick 1990). A tightly coupled system is characterized by elements which are interdependent and incapable of spontaneity. Healthcare providers in some instances resemble tightly coupled systems, for example to the extent that certain procedures must be performed in the right order, without exception. In other instances, healthcare providers are loosely coupled, for example where responsibility is shared by organisations but division of labour is not taken for granted.

Mimesis

Czarniawska (2002) uses mimesis as the motivation for why translation happens. Mimesis is the intentional and unintentional copying behavior of humans. It is the social process of imitating, as in reproducing or re-presenting. Not exact copying, but inspired copying. A practical example of mimesis taken from Lindberg (2002), is nurses who faced with uncertainty when carrying work activities look to how others carry out their work activities rather than to laws or regulations.

A view of organizing

There is a range of views how and why organizations do what they do. Scott (2008) asks:

> How are we to regard behavior in organizational settings? Does it reflect the pursuit of rational interests and the exercise of conscious choice, or is behavior primarily shaped by conventions, routines, and habits?

The following ideas from new and Scandinavian institutionalism and organization theory outline our stance in the above question.

Institutions

We know roughly what to expect from a teacher before we meet them, we know exactly what a family comprises and we know more or less how an organization works before we examine it. These are institutions which are so obvious to us that we may not even realize they exist. In fact, we can first become aware of institutions when we break convention. Scott (2008) defines institutions:

> *Institutions are comprised of regulative, normative and cultural-cognitive elements that, together with associated activities and resources, provide stability and meaning to social life. ... Regulative, normative and cultural-cognitive elements are the central building blocks of institutional structures, providing the elastic fibers that guide behavior and resist change.*

Institutions are like rule books which provide our lives with consistency. Institutionalism has in the past focused on how institutions preserve themselves, for example through rules and norms. However, more recent institutionalism has focused on how institutions arise, change and disappear. Institutions are perpetuated by people, because individuals cannot conceive that there is an alternative, or entertain one. However, DiMaggio and Powell observe that: "institutions do not only constrain options: they establish the very criteria by which people discover their preferences" (1991, p.11).

While organizations were once considered as units which become institutionalized, new institutionalism considers institutions to exist throughout and between organizations, i.e. that which becomes institutionalized is actually ideas, structures and forms. The space that organizations who are part of the same institution occupy is called an organization field.

Organization Field

The organization field concept provides a way of examining an organization's environment, and is based on the observation that organizations seem to exist with some degree of connectedness e.g. following trends and responding to each other's behavior The idea is then that local social orders constitute a greater social system. Thus the organization field links organizations to wider levels of change. DiMaggio (1986, p.337) asserts the organization field to be a "critical unit bridging the organizational and the societal levels in the study of social and community change". Scott describes an organization field practically, as a diverse array of organizations working within a given arena or domain (Scott 2008). The organizational field idea is widely used in research where the precise nature of connections between organizations is less important. Another idea, action nets, develops the organization field idea and shows the nature of connections between organizations, or more specifically, between their actions (Czarniawska 2005)

Action nets

An action net is a net of connected actions (Czarniawska 2005). The idea comes from new institutional theory, that at every point in time and space there is an institutional order: a set of (not necessarily coherent) institutions which currently apply. These institutions guide organizing to the extent that they dictate which actions are legitimately related to each other.

In an action net, connections between actions creates actors. In this respect, they differ to networks, which are created by actors, and actor-networks, in which bonds between people transform them into actors. They also differ to organization fields, in which organizations may not have any direct connections between them at all.

The action net idea addresses a basic problems that occurs when one tries to describe the essence of an organization, whether it be in terms of size, people, location, events, problems, etc. Reality proves to be unwieldy and complicated, and any resulting description is a simplification which hides a layer of analysis in which the author has already decided what aspects of the organization they think are worth including. The struggle to identify simple boundaries between these organizations, functions and departments disappears in the action net idea because the focus instead lies on the actions that are carried out, and the connections between these actions.

Lindberg (2002) classified connections between actions in their case study as having cognitive, emotional or mimetic character.

- trust and reliability are built upon shared experiences, so connections between actions conceived of in this way described these types of connections as emotional, because of the personal nature of trust and reliability. (2002; K. Lindberg & Czarniawska 2003)
- cognitive connections you know about, but don't necessarily care about
- mimetic connections are both deliberate and subconscious imitation

Translation of ideas about organizing

Something that many of us take part in, possibly without realizing it, is the spreading of ideas. Czarniawska and Joerges' (1996) model of the spreading of ideas about organizing utilizes the translation concept and has been applied to the spreading of management ideas in organization fields (Pettersen 2009; Erlingsdottir 1999). It considers disembedding an idea, packaging it, and reembedding it. Disembedding an idea is in other words removing characteristics that are specific to a specific time or place and would hinder the idea from being reinterpreted. A disembedded idea is of course not completely without context. It is still connected to certain technologies and organization fields. Relatively short-lived ideas are linked to more enduring institutions through masterideas. Packaging an idea means objectifying it, e.g. as a text or a prototype. An idea can be packaged to make it attractive, e.g. with rhetoric. When a packaged idea is adopted in a different situation, it must be reembedded into the new time and space. In a new context, the idea changes character. The idea is translated into different objects and actions than it was associated with in its original context.

In fact, the translation principle and this model in particular imply that any idea's original context would be hard to find. Ideas are continuously being modified as they circulate and are translated time and time again. Translation is thus particularly useful in organization studies, where one is interested in how an idea is adopted and transformed into reality in new situations.

Other ideas

Quality management models

There are many quality management models which promise to lead to more effective organizing, the most well-known probably being lean thinking and total quality management. Quality management models tend to share several characteristics, the most distinguishing being that norms are centered around customers' preferences and are communicated to

workers through systematic measurements and improvements (Bejerot et al. 2002). The models usually also involve mapping processes, in which the term process is used to refer to the actions which constitute the creation of a service or product, continuous improvement and some kind of ideology or philosophy emphasizing the importance of universal participation.

Quality management models also strive for regular flow/production (as opposed to abrupt changes). Systematic measurements of and improvements to processes are carried out with the aim of achieving fast production without variations in frequency, often called an even flow. It is for this reason that quality management models and tools are often sometimes referred to as process-flow solutions.

Care chain

The term care chain is a quality management term which is used specifically in healthcare and has been around since the late 1980s. It is a generally defined as a description of a patient's journey through the hospital, both a geographical journey and also a series of activities to do with the treatment of the patient. Definitions of the term usually refer to a series of formalized (standardized) activities reminiscent of production line production (Leffler 1996). Like all variants of the quality idea, care chains are customer-centered and systematically measured and improved accordingly.

The term is also very similar to the term value chain, from lean thinking. Whereas value chains focus on the activities necessary to produce something or provide a service, care chains focus on the activities necessary to treat patients.

Summary

One way of looking at organizing is to focus on actions, how they are related to each other and how these connections become stable. Czarniawska (2005) says that organizing is connected actions - action nets. Why the actions are connected may or may not be known by the people who carry them out, but in any particular set of connected actions, the connections can, if necessary, be explained in a way which is institutionally acceptable. Following this model, new sets of actions or existing actions coordinated in a novel way which can be explained in terms of prevailing institutions, can be repeated. If sets of connected actions are institutionally justifiable and repeated enough, then those actions and the connections between them get taken for granted. The action net becomes stable because the connections between actions become taken for granted and can be explained away using prevailing institutions.

So, temporary action nets crop up all the time, as people experiment with doing things in different ways, but the only action nets which become stable are those where the connections between actions can be explained away in terms of accepted institutions. Even stable action nets can become unstable as institutions change, and old ways of organizing are adjusted and renewed.

If we consider institutions as rules and guides which are established to the point that they are recognizable, institutionalization is the process by which small, unstable innovations become stable, recognized, generalized and established. But institutions are too stable and long lasting to be directly linked to small unstable innovations. Instead, Czarniawska and Sevon (1996) link heavy duty institutions and short lived ideas about organizing through longer lived ideas about organizing called 'master ideas'. Putting the three ideas together, action nets, institutions and master ideas, we assume that temporary action nets both appeal to and constitute master

ideas, which in term constitute institutions. At the same time, institutions steer which master ideas and thus which temporary action nets are conceivable. Thus institutions represent stability, but their continuous reconstitution is institutionalization and this represents the stabilizing of change.

Case Study Background

Our case study was carried out at a university hospital, Large Hospital. The hospital conducted a project to work process-orientated when treating stroke patients, and this project was the focus for our study.

Large Hospital

Large Hospital is one of the largest hospital in Sweden. It has over 10,000 employees and is based on several sites. The hospital is structured in several administrative areas, each of which has a management group comprising managers from each function. Most functions are medical specialties, for example surgery, others are services, for example x-ray.

The hospital has a functional structure and while individual functions have worked with processes, there has not yet been an all-encompassing focus on processes at the hospital. According to the research proposal by large hospital, strokeTIA care at the hospital has undergone major improvements during recent years, and through these improvements it has become clear that it is necessary to work with processes, since so many different functions are involved. Some of these functions even belong to other organizations, so cooperation, work routines and information flow are very important.

Stroke and TIA

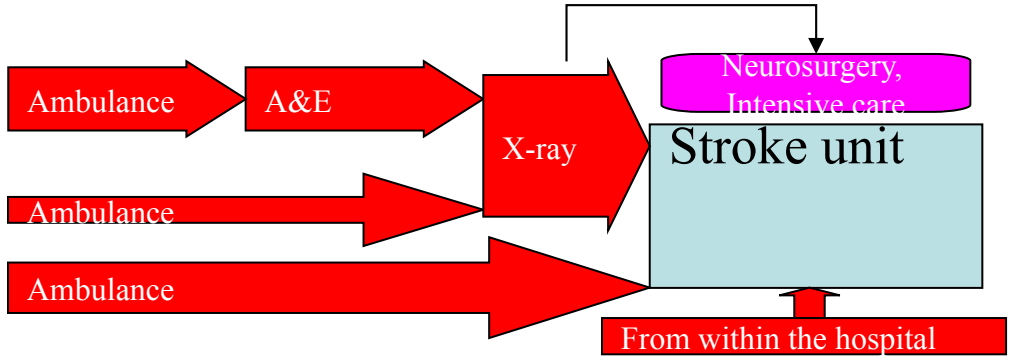
The project we observed was a pilot project whose aim was to work process-orientated with stroke and TIA patients. Stroke and TIA patients are often referred to as a single group because the two illnesses both involve abnormal blood flow to the brain. A stroke is a blood clot or bleeding in the brain and the damage it causes usually causes a loss of physical function, often to one side of the body. A transient ischemic attack (TIA) is a temporary reduction in blood supply to the brain usually caused by a blood clot and it can cause a temporary loss of physical function.

The treatment of stroke and TIA patients also shares similarities. All stroke and TIA patients benefit from immediate attention. Thrombolysis, a procedure which thins the blood to remove clots, can be performed in the acute stage of a stroke, i.e. when the clot is still present, to lessen the risk of permanent brain damage. Although TIA only causes a temporary loss of function, TIA patients have an increased risk of suffering a stroke in the future, and these risks can be examined and possibly mitigated through surgery. Stroke patients can regain lost function through rehabilitation, and they rehabilitate better if rehabilitation starts soon after a stroke.

The strokeTIA care chain

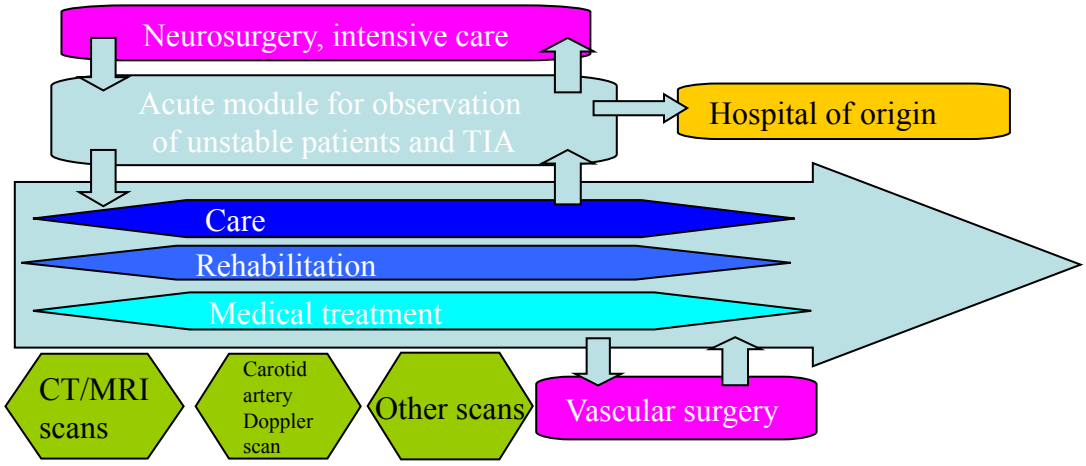
The strokeTIA care chain is the strokeTIA patient's journey through the hospital. In this section we describe the strokeTIA care chain as it is described in the process map which was made by the process leader and the process team, and complemented using information from interviews. The diagrams come from a presentation by the process leader (Process leader 2011) and show the different medical specialties and services involved in stroke and TIA care at one of Large hospital's bases, as well as the major patient flows.

Entry to the stroke unit



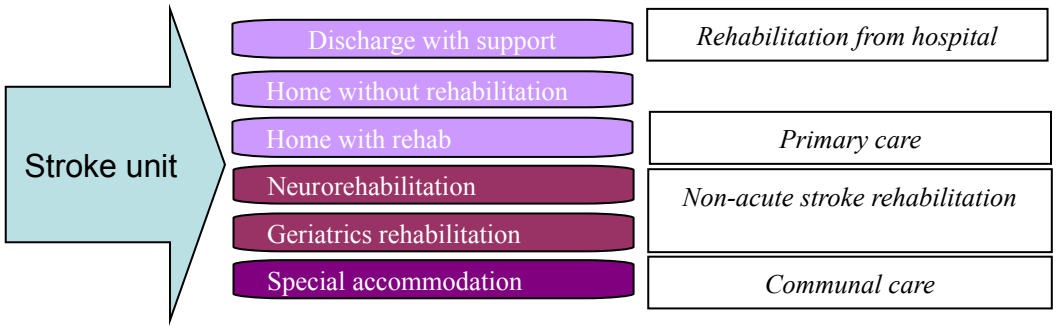
The strokeTIA care chain starts when a patient with a suspected stroke or TIA first comes into contact with Large Hospital personnel. A patient who arrives at the hospital by private transport is diagnosed at accident and emergency and referred to the local stroke unit. An ambulance with a suspected strokeTIA patient can contact the hospital's strokeTIA care coordinator to arrange to inscribe the patient directly into one of the stroke units at the different bases, or deliver the patient to accident and emergency (A&E) if they have complications, i.e. other illnesses. Direct inscription of strokeTIA patients to a stroke unit gets them care faster but takes ambulance teams more time. Patients who arrive by transport from other hospitals are inscribed directly to the stroke unit.

In the stroke unit



All patients who arrive at a stroke unit are examined by an occupational and physiotherapist, logopedist (speech therapist), and care staff (i.e. nurses) and a care plan is created. During patients' stay in a stroke unit, they receive rehabilitative training, medical care and nursing. Patients' conditions are reviewed in daily 'rounds', which rehabilitative staff join twice a week.

Discharge from the stroke unit



The patient's doctor has responsibility for deciding when a patient can be discharged from the stroke unit. Patients with complications go to other parts of the hospital. Elderly stroke patients with complications can be referred to geriatrics' medical rehabilitation ward, which offers specialist medical care and rehabilitation for elderly patients. Care for elderly patients outside the hospital is the commune's responsibility. For patients who require further rehabilitation or help in the home, the hospital will arrange a meeting with the commune to discuss exactly what care the patient requires. This meeting is called a care planning meeting. Stroke patients who are ready to leave the hospital and do not require further care will be discharged without a care planning meeting. The hospital also has an on-going home rehabilitation project, in which some patients are discharged early and receive their hospital rehabilitation at home.

A discharged stroke patient may not be fully functional and thus cannot lead an independent life. With rehabilitation, a stroke patient can regain some function and independence. The hospital has a project providing rehabilitation for patients at home, but generally speaking, following discharge from the hospital the commune provides temporary accommodation, old people's homes, help at home for the elderly and some rehabilitation for the elderly, complemented by primary care's occupational therapists, physiotherapists and logopedists. Young stroke patients have different rehabilitative needs to elderly patients. Who has responsibility for rehabilitating and caring for young stroke patients is unclear.

Case study: the strokeTIA process

The pilot project tested a general approach for working with processes which included a slightly developed organizational structure with additional roles/responsibilities and a definition of terms to do with working with processes. The strokeTIA process project's scope included several of the administrative areas at the hospital as well as primary care and communal healthcare.

The general approach for working with processes was documented and included two new groups and several new roles such as a process leader. According to the authors who documented the process idea at Large Hospital, an innovation of the process was a steering group to resolve the tensions between functional hierarchy and process orientated work.

The steering group was made up of the line managers of the different parts of the care chain. There was also a process team made up of representatives from different parts of the care chain and which was led by the process leader. The steering group members were process owners and along with the process leader shared responsibility for the strokeTIA process. We reviewed the project documentation in our empirical data section.

The word process appears in many different contexts in the project, perhaps most confusingly in the name of the project itself, so we offer the following explanation of terminology used in this thesis.

1. The *strokeTIA process project* is the name of a pilot project to implement a new way of working process-orientated. It comprises a number of processes and two teams for improving these processes.
2. The activities which have to do with caring for stroke and TIA patients make up the strokeTIA process project's *care process*. We will refer to the care process as the *care chain*.
3. The activities which have to do with caring for stroke patients (i.e. care process/chain activities) are called *care activities* or *job tasks.*
4. The activities which have to do with the strokeTIA process project are called *process activities* or *project activities*.

The strokeTIA process has two groups: a process team and a steering group.

5. Anybody participating in these groups is a *process participant*.

In summary, the project can be envisaged as two groups and several documents: a steering group and process team, and a process guide and project assignment. The project involved only one new role, a 'process leader', and all other participants would partake in the project in addition to their other work activities.

Methodology

Introduction

In this section we describe how we have decided what to study, what information to collect from the field, how to interpret this information and how to present this thesis. We have chosen to write about our method in a way which acknowledges our presence during our research, because we have interacted with the research subjects, we have had discussions and points of views and become part of our own research (Wax 1986).

Overview

At the outset of the study, we knew relatively little about hospitals, healthcare and organization theory. We needed an introduction to Large Hospital, so we planned a stage of introductory, open interviews followed by a stage with interviews and observations focused on obtaining material for analysis. However, we became increasingly aware of the time constraint: three months to get to know an organization more or less as well as its employees, without actually working there, and do an insightful analysis. We realized that in such a short study, a large portion of our time would go towards giving us a basic understanding of the organization and we decided that the more time we could spend with the organization, the more we could understand the organizing that takes place there. On the other hand, we had a limited amount of time for the study, so we had to decide early on how we were going to select data.

We discussed expectations on our thesis regularly and were aware that the study had two goals: theoretical and practical, i.e. academic and for the hospital. We were happy with our open approach to our theoretical goals - we would allow our research questions to emerge as the study progressed. However, we also wanted to realise some practical goals for the hospital but we were not sure which. We were examining the strokeTIA process during its first four months so statistical measures of the success of the process would be premature and in any case performed by the hospital as part of its annual audit six months later. The supervisor at the hospital was primarily interested in the steering group, however the steering group would only meet once during the first four months for an introductory meeting. We couldn’t quantify if the strokeTIA process was working because it was too early. We could roughly qualify if the process was functioning as intended but again it was too early to draw conclusions, and possibly unnecessary in light of the fact that performance statistics would soon be published. We could, however, describe what was happening: how staff had constructed the process and what they felt about it. The hospital could use this information to reflect over how the process had come into existence, how it worked currently, what could be different about it, and what staff's wishes were for the process.

Deciding what information to create from the field was a point of discussion from the very beginning of the study. Reality is incredibly richly detailed, and collecting field material necessarily involves paying attention to certain details while ignoring others. Already by selecting what field material to collect, the researcher is analysing reality using his or their own preconceptions and dictating what information will be available for analysis. Creation of field material also offers the practical challenge of recording the information which is deemed worthy of being remembered.

Creation of field material

The process leader told us in our first meeting that we could expect to be able to interview or observe hospital staff involved with the project, observe project meetings and see documents relating to the project, provided the individuals involved agree. We did not intend to interview a statistically representative group of process team or steering group members partly because we did not have time, and partly because we did not see any need to present a statistically representative set of views for the group. Our semi-structured interview questions generated between half an hour and an hour of discussion, and transcription took at least three times as long depending on the interviewee and the quality of the recording, so we realized very quickly that we could not manage more than about ten interviews. Furthermore, the number of process team and steering group members was less than twenty in both cases, making sampling techniques unreliable. In any case, we were interested in presenting all the interesting views that came up in the interviews, not in giving weight to or validating those views based on how many interviewees they were shared by.

We started with open interviews with the process leader with the aim of building up background information about the hospital, its structures and the strokeTIA process. We then used this information and documentation from the strokeTIA process to construct a set of interview questions and used these to carry out semi-structured interviews with participants in the strokeTIA process. Throughout our three month period for creating field material, we reflected on the answers we were getting and updated our questions several times.

We selected interviewees in several ways. We sent two emails, one to the steering group and one to the process team members explaining who we were and asking to arrange an interview in the near future. We arranged interviews with those that replied. Ewan also arranged an interview with a member who sat in both the steering group and the process team following a meeting. We also sent an email to two steering group members requesting to shadow them but we were informed that strokeTIA patients made up such a small proportion of the function's patients that shadowing would not be a good use of our time and instead arranged an interview.

About half way through our 3 month research period, we wrote down the data collection methods available to us, the interviewees' different positions in the strokeTIA process and the regular hospital hierarchy, and the research areas we had identified in our interview questions. We then decided which research method we could use to obtain information about each research area for each part of the strokeTIA process. Interviews and observations of meetings would provide the data for our analysis. The strokeTIA meetings were an integral part of the strokeTIA process so we predicted that they would form part of our analysis. Our first unstructured interviews, small talks and direct observations would provide information for our understanding of the strokeTIA background and possibly also prove useful in our analysis. In total we carried out ten interviews, seven semi-structured interviews and three open 'information' interviews.

We initially intended to observe staff in their daily work but the two people we were recommended to observe insisted that their day did not consist of enough strokeTIA work for it to be worth observing them, and one of them offered to be interviewed instead. We decided to consider observations of personnel as desirable for increasing our understanding of the strokeTIA process but not necessary in order to create enough empirical material for analysis. By the time we had finished our analysis, we had not observed any personnel performing their daily work activities.

The assignment for the strokeTIA project lists the organizations and hospital functions involved in the treatment of strokeTIA patients as shown below. We interviewed the areas marked with *.

1. Primary care
2. Ambulance care
3. Acute care
4. Stroke unit care *(internal medicine, neurology, geriatrics*, physiotherapy*, occupational therapy, logopedy)*
5. Medical examination *(functional and image medicine, laboratory medicine)*
6. Medical treatment *(neurosurgery*, intensive care, vascular surgery)*
7. Care*, early mobilization*, rehabilitation* and discharge planning
8. In some cases continued hospital care *(rehabilitation*, geriatrics*)*
9. Post-hospital care

Timeline

For a timeline showing our field work, see the appendix.

Open and semi-structured interviews

As with any communication, there is a risk that an interviewer and interviewee misunderstand each other. Since Ewan speaks Swedish as a foreign language, he wanted to record interviews so that he could listen to them again and check his understanding. Having recorded interviews also gave us the opportunity to use different types of analysis later on, and provided us and the interviewees with the security of knowing that there will not be any misquotations. A counter-argument for recording interviews is that interviewees may not feel comfortable to speak freely if they are being recorded. We gave interviewees the choice of not being recorded but none took it. We also assured them that we would not quote without first checking that they were happy with the quote.

We started with a few open interviews with the aim of building up background information about the stroke/TIA process. The interviews were initially with our supervisor at the hospital, the process leader, and later with process participants who we met in the meetings. We went into the interviews with questions about the project and the process document: how they started, who was involved, what the goals were, how they could succeed or fail and so forth.

Using the information we collected in the open interviews, we started writing a background to the strokeTIA process, and then an interview guide. For the interview guide, we wrote down any questions that felt relevant, referring to the stroke/TIA process documents. Two documents were particularly influential: the general description of process work (the process guide), and the specific assignment for process work within stroke (the strokeTIA assignment). The documents defined terms and concepts relating to processes, describe a structure for working with processes consisting of groups of healthcare staff, and give a loose, step by step guide to working with processes. When we grouped similar questions, we found five broad topics focusing on the interviewee's experience of the stroke/TIA process: what the stroke/TIA process is, boundaries (i.e. organizational), goals, improvement work,

and connections between people. We also quoted parts of the strokeTIA documentation to provide background information for groups of questions. Our intent was not to test interviewees' knowledge of the process, so we were prepared to clarify or rephrase questions if necessary.

We emailed the eight members of the steering group to arrange interviews at their convenience. Of the four that responded, we interviewed three within a couple of weeks of each other, transcribing the recordings and reflecting on the interview guide after each interview. The first thing that we noticed was that we needed to introduce ourselves more carefully; we had gotten half way through our first interview before both ourselves and the interviewee realized that we were asking and answering questions about different processes and groups.

We felt from the very first interview that some questions and answers were repetitive, and some answers were much longer than we expected. When we later compared the first three transcripts we tried to identify what was causing this repetition and found a few possible explanations. First, these interviews were our first opportunity to find out what line managers and their functions did, so we began by asking for a short description of the interviewee's work. This introductory question took a quarter of the total interview time and partly answered some questions that would come later. We thought that we needed to try to collect more select information in less time, even more so since we were becoming familiar with line managers' responsibilities and the work that their departments engaged in. Second, the questions we were asking were sometimes closely related to each other, for example those regarding process goals and improvement work goals. Answers often partly repeated answers given earlier. We became aware of a possible third reason during our analysis. It is not unusual for interviewees to answer questions with narratives, using narration as a way of making sense of and ordering events (Czarniawska-Joerges 1997). The long answers we received were often narratives which re-ordered and made sense of the same information that came up in the interviewee's other answers. Although we did not realist it at the time, narratives are a rich source of information about how people make sense of their organization

Our interviews also lacked discussion, because we were unsure whether to interrupt what we later discovered to be narrative answers. We decided to remove or rephrase certain questions and also to interrupt more freely, in order to clarify and discuss interesting parts of answers. Because we had a limited amount of time with each interviewee, we wanted to chase information instead of relying on a time consuming, exhaustive list of questions to extract information for us.

Not all interviewees could answer all questions because of their different relations to the strokeTIA process. For example, the geriatrics director didn't have responsibility over their personnel that work directly with strokeTIA patients, the neurosurgery director's staff only treated stroke patients temporarily in the neurosurgery ward and the physiotherapist director's staff were peripatetic. We had a diverse range of interviewees, so far just from the steering group. Furthermore, questions were interpreted and answered in different ways by different line managers. We weren't sure if this variation was something we should try to control. The way in which an interviewee interprets and answers questions can reveal insights into how they experience the social reality they share with others. We decided that a mixture of more closed and direct, and more open questions would enable us to understand the workings of the hospital as well as provide information about how strokeTIA is constructed by the staff involved.

Having made the decision to include both open and closed questions in the interview guide, we now had to decide how we could pose closed questions that were relevant to all of our interviewees, i.e. if we would keep the same interview questions for everyone that we interviewed. It had become apparent during the first three interviews that line managers answered questions about improvement work in general terms and not often from an individual's perspective. We presumed that different groups of staff would give different perspectives regardless what questions we asked. We decided that interviews should focus on the same areas regardless of the interviewee's position in the strokeTIA process, and that questions could be adjusted according to the interviewee's position.

Observations of meetings

The strokeTIA process comprised three groups that met regularly: steering group, process team and part process team. Observations of meetings served to complement interviews by expanding focus to include not only what interviewees think, but also what they actually do, helping us to understand relations and interactions in the strokeTIA process (Wax 1986; Silverman 1993). We chose not to record meetings because it would be difficult to record in an environment with several people speaking. Instead we endeavored to make detail-rich notes both about what was being said and the context in which we found ourselves: where we were, what was happening and when, how people were acting, what mood people were in, the way the room was arranged, and the atmosphere (Martin & Turner 1986). After each meeting, we used these notes to write a summary of the meeting. Initially we did not have the minutes and agendas for the meetings, but when we received them we also included these in the summaries.

In our first meetings with each of the three groups, we were presented by the process leader as students carrying out a masters thesis on the process. We sat amongst the meeting participants, usually apart from each other, and openly made notes during the meetings. During the first two meetings participants often referred to things that we did not understand, so after checking with the process leader we started to ask for clarifications during the meetings. We also stayed at the end of meetings to talk to participants, arrange interviews, check certain items that had come up in during the meetings and get answers to any other questions we had.

Written Material

At the outset of this thesis, the process leader sent us a collection of documents that could help us to understand the stroke/TIA process' background. During our interviews, interviewees referred to earlier events outside the project, and we were able to find these events in the collection of documents we were sent. Documentation has been useful for increasing our understanding of the project, for example why the project started, what expectations for the project were etc.

Interpretation of field material

Our approach can be described as grounded theory (Glaser & Strauss 1967), or more specifically grounded theory for organizational studies (Martin & Turner 1986). Grounded theory involves building up categories and patterns from field data, and eventually comparing these categories and patterns with existing theoretical ideas.

We first built up an explanation describing the translation of the idea to practice and the social construction of the process, and in doing so inadvertently recognized three categories: individuals' social worlds, the actions they performed within them, and communication across these social worlds. This explanation was based on our theoretical view that different people found different meanings in their realities, and that reorganization would presumably require some sort of common understanding of each other's social worlds. However, although the description which we produced appealed to us, when we read it again after a week, we found that it failed to fully explain our field material, and in some parts oversimplified it.

Our description allowed us to compare our ideas with some in research literature and use them to further develop our explanation. We looked in literature in the fields of organizational and institutional theory including similar studies, and this stage of theoretical synthesis let in lots of theoretical ideas which helped us to look at our data in new ways, see different patterns and phenomenon and come up with new explanations and ways to categorize our data. Some of the most interesting categorizations we made were inspired by the action net idea, dividing participants' actions into 'normal' actions carried out for strokeTIA care patients, and 'process activities' carried out directly for the strokeTIA process, and considering how project activities affected strokeTIA care chain activities. As part of this approach we considered how actions were connected and what effects this had on organizing.

Interpreting our data has been a continuous process involving looking for patterns in our data, looking for similar phenomenon in research literature, looking at explanations for these phenomenon and seeing what they have in common with and how they differ with our data, finding new possible points of interest in our data, and trying to explain them. The theoretically enhanced explanation is the one which we present in this study, and we do not claim that it is the only, or the best, explanation. However, by developing our own observations using the ideas of much more established researchers we hope that we can offer a serious theoretical insight into our case study.

Validity and reliability

Validity and reliability are often said to be indicators of high quality research. Validity concerns correct measurement: that one measures what one intends to measure. Reliability concerns how correctly measurement instruments function. In addition to validity and reliability the requirement of generalizability is often added. Generalizability requires that the result of a study can be relevant and apply to a larger population. These three requirements have come under criticism, particularly in relation to qualitative research (Kvale 1997).

Regarding generalizability, qualitative research can be related to larger populations if it includes detailed, solid descriptions and is compared to existing theories (Alvesson & Sköldberg 1994). It is for this reason that we have endeavored to describe our empirical material in detail in our analysis sections. Sociological phenomena such as organizing involve huge numbers of interactions between people and things, and the people involved are probably of widely varying character. Detailed description and comparison to theoretical ideas enables generalization.

Waks (2003) likens validity and reliability with believability. A researcher can check how believable their depictions of the field are by constantly questioning them to see if they are well-grounded, defensible, persuasive and in the case of interviews, if the researcher's summaries reflect that which the interviewee intended to express. We transcribed and summarized some interviews and sent copies to interviewees for comments before analysing

them. We have attempted to build believability into our study by reflecting on our field material and our analysis of it. Working as a pair involves discussing ideas with each other and this offers an opportunity for reflection and feedback. In addition, we have had meetings with our hospital contact and our supervisor at Chalmers throughout our research in which we have discussed both the field material we have created and to a lesser extent our theoretical ideas. We have also sought feedback from three other researchers who either share an interest in the theories we have used or the field of healthcare research. Towards the end of our study period, we presented our conclusions to both of the process groups in feedback sessions. We received valuable feedback which confirmed and contested some of our analysis and was useful in developing our ideas.

Empirical Data

Growth of the strokeTIA process and thesis

The health authority have had a published definition of a stroke unit for several years, e.g.:

...an organized in-patient unit which entirely or almost entirely takes care of patients with stroke and which is run by a multidisciplinary team with special skills in the care of stroke *(Socialstyrelsen 2006, p.12)*.

In 2005, the health authority published a new national guideline stating that hospital care for stroke patients should take place in specialized stroke units. At this time, not every hospital had a stroke unit. Stroke care at Large Hospital was performed in the three specialties most often required to treat stroke patients: elderly care, neurology and internal medicine. By 2006, Large Hospital had reached an agreement with the local health authority about how to follow the national guidelines. The agreement was a set of requirements (e.g. that 90% of stroke/TIA patients would be cared for in specialist stroke units, acute stroke cases would be treated so that trombolysis can be performed within three hours, all stroke patients would be added to a regional stroke register, etc.).

In April 2007, the hospital director initiated an investigation into the care chain for stroke/TIA care. The investigation revealed that Large Hospital was falling short of meeting the terms of the agreement with the regional health council so groups were formed to work on improvements in strokecare. The regional healthcare council asked Large Hospital to work on another agreement with it regarding stroke care. The agreement required the hospital to report certain information regarding strokecare in 2009 (e.g. how many stroke patients had been nationally registered, total number of stroke patients treated in stroke units, etc.).

As part of the improvement work, the hospital director created several work groups with different assignments for improving strokecare. One of these assignments was to prepare for the creation of a stroke unit with directly inscribed stroke patients and acute stroke care. In September 2008, one nurse and one doctor were given instructions to manage the merger of the existing stroke units to create a new unit. They were responsible for non-medical and medical aspects of the merger respectively.

In Spring 2009, the hospital hosted a masters project from a technical university. The project followed the merger of the stroke units from a theoretical perspective and made suggestions about how to structure the new stroke care unit. The new stroke care unit opened in June 2009.

The manager of the stroke unit assembled a team of staff involved with stroke care with the task 'to improve stroke care'. The team was called *Large Hospital stroke council.* They had their first meeting in February 2010 and their second in May. They reviewed different on-going improvement projects relevant to stroke care and mapped the stroke care process from patient inscription to release.

Also during the first half of 2010, the stroke unit manager and Large Hospital's quality director worked together to create a guide for how to work with processes at Large Hospital. According to an interviewee, Large Hospital was prohibited from adopting a ready-made model such as lean thinking or total quality management because of the controversy these ideas had generated. The two hospital staff had taken courses in organizational development

at a technical university, were aware of other improvement projects in the hospital and one of them said that they were interested in literature about healthcare and quality, and related developments at other hospitals, particularly specific hospitals which were leading the field in different ways, such as with lean thinking or process-orientated organization. They consulted other hospitals' websites while making this document and tried to fit their new terminology in with that used by other hospitals in the region. The stroke unit manager was going to test the new guide within stroke care in autumn, and they worked together again to create a more detailed assignment focused on care for strokeTIA patients.

The idea that was produced, the process guide, was a collection of definitions, new roles and procedures for working with processes. The new roles were not necessarily new posts, rather new responsibilities for existing members of staff and the procedure for working with processes was cyclical and basically consisted of evaluating and measuring the current state and then implementing and measuring improvements.

The stroke unit manager later contacted a technical university to present a thesis opportunity to evaluate this guide in action. This thesis proposal briefly presented the hospital, the recent history of stroke care at the hospital, national stroke care regulations and process work at the hospital, as well as proposing specific research questions. The university researcher who received the proposal added more potential research questions to the proposal before sending it to us, the authors, who were both looking for a thesis.

When the process document was approved by the hospital director in June 2010 it contained a new structure of cross-functional teams, a list of terms to do with processes and process teams along with definitions and finally a set of instructions for working with processes. On June 28th, the stroke unit manager received an assignment to test the guide. This person became the project manager for a pilot project with strokeTIA, or, in keeping with the terminology presented in the guide, 'stroke process leader' for the 'stroke/TIA process'. The Large Hospital stroke council became the 'stroke process team' and a steering group was created. Another smaller group, the Smaller Group, was incorporated by the process and became a 'stroke part-process teams'.

The process documents

As described above, the stroke unit doctor and Quality Director worked together during the first half of 2010 to produce a process guide which gave general instructions about how to work with processes. In addition, the stroke unit doctor wrote an assignment which focused on working process-orientated within stroke and TIA care, and an assignment for a 'process leader'. In July 2010, the hospital director assigned the stroke unit doctor as the strokeTIA process leader with the task of carrying out the strokeTIA project assignment. We will thus refer to the stroke unit doctor as the process leader.

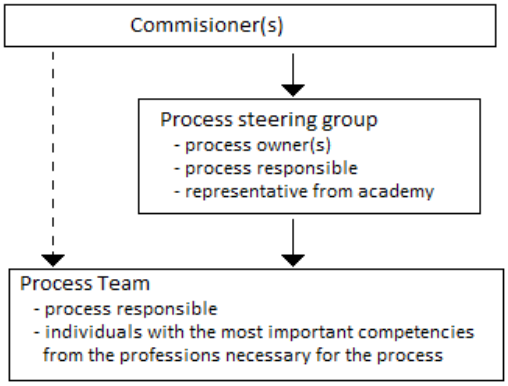
The process guide

The process guide starts with a short paragraph explaining that hospital leadership includes the management of processes and a diagram showing how management, support processes, care, research and education are all linked by the flow of patients through the hospital. The process document then defines eleven terms: processes in general, four types of processes, and three roles and two groups associated with processes (i.e. the process team and steering group – the Smaller Group was not included). The definitions are flexible enough to be interpreted by the different areas of the hospital. For example:

> Process är ett flöde aktiviteter som upprepas i tiden och vars syfte är att skapa värde för en extern eller intern kund. Processorienterad verksamhet har fokusering på kunder, de vi är till för, och på kontinuerligt förbättringsarbete.

A process is described as a repeated flow of activities which aim to create value for a customer, and a process orientated operation focuses on customers and continuous improvement. The remaining process definitions focus on types of processes: leadership, support, care and core. The first two are self explanatory, care processes are standardized flows of patient groups starting from a request for care at another care provider and finishing with completed care, and core processes are the hospital's overall aims, i.e. to care for patients, to research and to educate.

The individual roles that are defined are: task designator, process owner and process leader. The two groups defined by the process guide are process team and steering group. The steering group consists of process owners, that is line managers whose functions partake in the same part of the care process. The process owners are responsible for managing their own resources, i.e. their own functions, and the steering group must 'take a stance on the care process' goals, contents and responsibility and work division. The following diagram describing the process comes from the process guide:



The document also describes what tasks a process team should undertake. Quality, effectiveness and agility are defined for care processes before a list details process team work in three phases: describe the process, follow the process through, and evaluate process work. The first two phases are broken down into smaller steps, sometimes with additional details. The first phase, *describe the process*, involves process mapping, identifying areas for improvement, developing routines for measuring performance and updating process documentation. The instructions are flexible enough to be carried out in different ways. For example:

> Utveckla rutiner för mätning och resultatrapportering

One person could understand and carry out this instruction quite differently to another because there is no exhaustive explanation of what types of routines one is trying to achieve and what results are to be measured. Some of the instructions are more detailed but still remain quite open to interpretation. For example:

> Identifiera förbättringsområden för att uppnå högre kvalitet, effektivitet och för anpassning till förändrade förutsättningar genom att kartlägga:

- Patient- och arbetsflöden och samverkan mellan olika verksamheter och nödvändiga kompetenser

The instruction could be interpreted in different ways depending on the reader's understanding of what is meant by workflow, cooperation and necessary competencies.

The second phase, *follow the process through,* is a diagram of a cycle with the stages: identify areas for improvement, measure and analyze, prioritize improvements and set goals, carry out improvements, and finally evaluate, secure, spread and document improvements. Finally, the third phase, *evaluate the process*, states that the process team shall report to the steering group at least once a year, both regularly and as necessary

The strokeTIA project assignment and strokeTIA process leader assignment

The document starts by describing which types of care and which organizations and parts of the hospital are part of the strokeTIA process. It describes what the strokeTIA process should achieve, how the process team should work, on-going improvement work within strokeTIA care, and regional goals for stroke care. The description of what the process should achieve and how the process team should work are identical to those found in the process guide, except that the strokeTIA process is specified. The document also identifies the steering group and process team members.

The strokeTIA process leader assignment lists the process leader's responsibilities and goals and specifies that the steering group should be reported to annually. The responsibilities can all be found in different parts of the process guide and the strokeTIA project assignment. Although the document refers to a strokeTIA process, the responsibilities were written so that they could apply to care of many different types of patients, e.g.:

> Processansvarig ansvarar för:
>
> – framtagande av underlag för planering och styrning för ett arbete som karaktäriseras av jämna och snabba vårdflöden utan stress

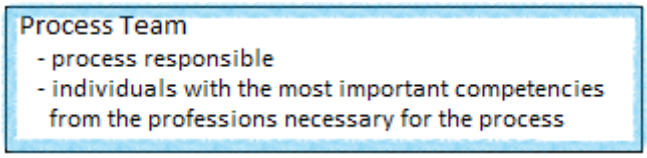
There were no specific instructions about how exactly the process leader should take responsibility for planning and steering.

The strokeTIA process project

As described previously, the stroke unit manager helped to create the strokeTIA process project and was eventually given the role 'strokeTIA process leader' by the hospital director. The creation of the project's two main groups, a strokeTIA process team and steering group, are discussed below. Both groups were started in connection with the strokeTIA process. A group called the *stroke council* was started in the first half of 2010 while the process guide and strokeTIA project assignment were being created, and this group later changed some members and became the project's process team. The steering group, on the other hand, met for the first time after the official start of the strokeTIA process.

The process guide and strokeTIA project assignment only names two groups: the process team and the steering group. In fact, the process has incorporated one more group called the Smaller Group as a part-process team. However, we will consider this team together with other improvement projects affecting strokeTIA care.

Process team



StrokeTIA process team was a renaming of and slight changing of Large Hospital's existing stroke council, which the process leader assembled and met with during the first half of 2010 to improve stroke care (not to be confused with the regional stroke council). The process leader consulted various managers to help identify potential council members. Each of the council's members represented a different hospital function or external organization involved in stroke care. The stroke council met twice in total, once in February and once in May 2010. In the second meeting, the process leader informed the members about the ongoing work to formulate a guide for working with processes at Large Hospital, and that the stroke council would become the process team for the strokeTIA process when they next met in September.

The strokeTIA project assignment listed twenty two people for the process team. These included representatives from almost every part of the care chain, managers of doctors, nurses, physiotherapists, occupational therapists, research and development officers and speech therapists, and ambulance care, primary care and residential care plus one representative from the regional stroke council. Two members of the process team were from other organizations: primary care and residential care. Seventeen of the Large Hospital's stroke council's nineteen team members proceeded under the new name strokeTIA process team. The two members of the stroke council that did not become part of the process team were replaced with other representatives from the same organizations

Both the stroke council and strokeTIA process team had meetings and email as their main points of contact. Before each stroke council meeting, the process leader sent an email to council/team members containing the next meeting's time and location, and minutes from the previous meeting.

Large Hospital stroke council meetings

The first stroke council meeting started with members presenting themselves. Eleven members were present. The process leader presented herself as the functional responsible for stroke care at Large Hospital, their role at the time. They informed the stroke council that their task was to improve stroke care and briefly presented the stroke process and the hospital functions which were involved. The team members then took turns to present ongoing improvement projects related to stroke care. The minutes show that the council was to focus on the logistics of acute stroke care in the future, that they considered that many organizations were involved and routines and responsibilities probably needed to be made clear. A council member suggested that they obtain the help of a logistics specialist. They also identified transfer of information to the next care provider (i.e. posthospital) as a weak link in the stroke care process.

The second stroke council meeting started with those not present at the first meeting presenting themselves, including a new logistics specialist. The process leader explained the ongoing work to formulate process concepts at Large Hospital and informed the team that they would become the strokeTIA process team. Smaller Group, an existing group which worked on standardizing care for stroke patients at Large Hospital's multiple stroke units,

would become a stroke part-process team. A steering group comprising representatives from the functions involved in stroke care was in the process of being created. The council proceeded by working on completing the process leader's map of the strokeTIA process and identified several areas where care could be improved. The next meeting would be in September, and the stroke council would then be the stroke process team.

Process team meetings

Prior to each process team meeting, the process leader sent an email to council/team members containing the next meeting's time and location, an agenda, a list of the members required at the next meeting, and minutes from the previous meeting also containing next meeting's agenda. The emails were short, concise and informal and could include attachments related to the meetings.

Meeting times were decided as a group during the previous meeting. Times were suggested and discussed by everyone until one which suited everyone was found. The process leader booked the meeting local.

The process team meeting agendas steered the meetings without detailing exactly how the team should work or prescribing what the result should be. This example comes from the first process team meeting's minutes:

> Vi som fortsätter att mötas i höst skall arbeta med att ta fram förbättringsåtgärder för de prioriterade arbetsområdena och måltal för processen.

The process team is to come up with suggestions for improvements and statistics for measuring improvements but there is no indication as to how they will do this.

The process leader decided meetings' frequency and agendas, which they based on the procedure in the project assignment. They kept the group together for the first two meetings during which all items on the agenda were tackled by the whole group in open discussion. They suggested that the team would split into small groups for the third meeting. The process team's meeting agendas followed the way of working set out in the strokeTIA process assignment.

In the first meeting, the team adjusted the process map for strokeTIA care and identified and prioritized improvement areas. This was a continuation of the work carried out at the previous stroke council meeting. In the second meeting, the team reviewed performance indicators relevant to strokeTIA care and the agenda for the third meeting was to select performance indicators and create action plans for each improvement area.

The process team meetings that we attended started unceremoniously and lasted around two hours. Team members mostly arrived early or on time and chatted until the process leader started talking. During the meetings the atmosphere was relaxed, and team members left the room and used mobile phones freely. The team also took up discussion around any issues that were raised. Occasionally, the process leader would draw attention back to the item that the group were originally discussing or to the next item on the agenda.

At the first meeting, the process leader introduced us as students from Chalmers, and the team presented themselves to us. The process leader gave a short explanation of the steering group, and then started a review of the process map so far. Members discussed the map: its layout, the terminology used and possible patient flows. Seemingly innocuous issues caused

confusion, e.g. the choice of name for the 'prehospital' stage, which actually referred to all hospital care up until patient release. At least one of the team members struggled to make sense of this categorization of hospital strokecare as prehospital. Team members identified new patient flows until the process leader eventually stated that the purpose of the map was to try to capture flows of groups of patients, not every single possible strokeTIA patient's journey through the hospital. Another issue which was discussed was the geographical limitations of the map, since parts of the process could happen at any of the hospital's bases while others could only happen at a single base.

The team then turned their attention to identifying and modifying already-identified improvement areas, i.e. problem areas where improvements can be made. They did this as a group, reviewing a list via a computer projector. After a short coffee break at the process leader's suggestion, the team continued, also prioritizing some areas. Certain improvement areas generated a lot more discussion than others, e.g. handing over information to the next care provider. This was a popular topic, and the team discussed the commune's and Large Hospital's different understanding of routines, rules and regulations. One of the team members identified this as a universal problem, not unique to strokeTIA care. Although the team suggested rehabilitation be made a priority, this never happened.

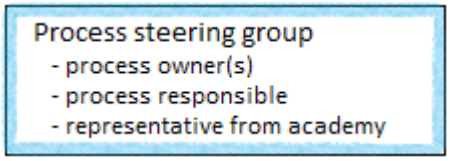
The second meeting started with an update from the process leader. They informed the process team about the first steering group meeting, which had taken place about a week before. In the meeting, the steering group had approved the process team's prioritized improvement areas but thought that there may be too many. They also told the team about neuroradiology's new prioritization of work tasks which deprioritized a strokeTIA treatment which is considered high priority. One of the team members brought up an issue with young stroke patients, namely that the Large Hospital base had better competencies for treating young stroke patients but that there was no firm decision as to who had responsibility for them. Young stroke patients require special rehabilitation to be able to return to work and lead a young person's lifestyle, but the team came to the conclusion that this responsibility was not clearly divided between A-kassan, the commune or Large Hospital. During this conversation, the team referred to the idea of receiving equally good healthcare regardless of where or when a patient enters the healthcare service several times.

The process leader focused the group on performance measurements, presenting statistics already collected by the hospital that they compiled because they thought that they were relevant to the strokeTIA process. The team started to discuss the statistics, which were good, bad and desirable, and the process leader explained to the group that they should work within the already-identified improvement areas and focus on being able to measurement performance and set goals. Statistics relating to rehabilitation ignited a discussion about marketization of stroke rehabilitation, unclear division of responsibility between the commune, primary care and Large Hospital, and the local group for cooperation, a regional program of healthcare organization cooperation projects.

The process leader recommended that the team divided into small work groups which each tackled an improvement area and investigated potential performance indicators. Discussion turned to assessing whether patients are fit to retain their driving licences. The process leader repeated their recommendation, wrote up the improvement areas on the board and invited team members to write their names next to an area they would like to make decisions about. The team members obliged. A few members were not sure what the groups would do or how they would have time for the work. The process leader explained that the groups would

investigate potential performance indicators and goals and start to make action plans for measuring and improving each area. The group work would take place during the next meeting time.

Steering group



The steering group consists of the managers for each functional area of the hospital which partakes in stroke care. The group has eleven members, each of which represents a different functional area of the hospital. None are representatives for other organizations

The process leader decided that the strokeTIA steering group would meet once in September and once in February and the first meeting's agenda and form. The steering group's first meeting took place a few weeks after the first process team meeting and about a month after the beginning of the strokeTIA process and it lasted about one and a half hours. The leader summoned the group to the first meeting via email, including an introductory paragraph to the strokeTIA process, the meeting time and date, and a meeting agenda which they had decided and was in accordance with the project assignment. The introductory paragraph summarized recent improvements in strokecare, e.g. direct inscription of stroke patients in stroke wards, stated that cooperation was necessary for good stroke care and listed the medical functions and external organizations involved in stroke care. It said that stroke care had become the first transfunctional process at Large Hospital and that the steering group had been created to facilitate cooperation between the functional organization and the process organization Finally; the steering group members were selected by area chiefs as representatives for the functional organization's functions which participate in stroke care.

Steering group members arrived at the meeting more or less on time. The process leader presented us and the steering group themselves to us. The process leader then gave a brief presentation of the strokeTIA processes history, mentioning the various assignments they had received from the hospital director. They presented the process map for strokeTIA care, which caused some members to ask who did this and when. Different parts of the process map were annotated with ongoing improvement projects, eight in total. The process leader reviewed the improvement areas identified by the process team in three stages, prestroke, stroke and poststroke care. The improvement areas could occasionally generate a bit of discussion among the steering group members. These discussions covered stroke place availability and unclear responsibilities between specialties, decision making concerning the patient being carried out too quickly and a problem with x-ray coding and interpretation. During the discussion about x-rays the process leader pointed out that the steering group's function was to make decisions. When presenting the improvement areas in the poststroke care phase, the process leader remarked that the hospital lacked authority here and that all sides were dissatisfied but that the hospital could make transfer as good as possible.

The process map was presented to the steering group again, this time with all the new improvement areas marked. Some group members were concerned that they might not have time to carry out this work, and a the steering group make a few jokes about money. The process leader offered to create an action plan with the process team to show to the steering

group to familiarize them with the pace of work. At the process leader's suggestion, the team arranged another meeting for february.

Other groups

In their first meeting, members of the stroke council presented twelve on-going works relating to stroke care and Large Hospital. One of these was the Smaller Group, which worked to standardize care at the three stroke units at the different hospital bases, and had previously had great success in organizing direct inscription of stroke patients to stroke units. The group comprised doctors and care staff mainly from the stroke units but occasionally other staff. The group was started before the process guide and strokeTIA project assignment were being formulated. The group became incorporated into the strokeTIA process by being given the status part-process team. It retained its original title, the Smaller Group and its work was unaffected by the strokeTIA process. The group met once a month at one of the stroke unit bases on a rotating basis.

Interview material

Here we present a summary of views about stroke and TIA care which came up in our interviews. We have chosen views which relate to the strokeTIA process and its aims as stated in the process documents. We start with a reflection upon the interview material before presenting the recurrent themes we found.

Reflections on the interview material

The steering group members described their functions differently, emphasizing different aspects of their work. This is normal, since they work in different places, with different people, with different tasks, different skills and different equipment. It is unrealistic to expect line managers to automatically share an identical understanding of ideas such as ‘improvement’, since they mean different things in each function. For example, when we discussed improvement in the interviews, line managers told us about different types of improvements with different aims: the neurosurgeon told us about the improvement of surgical routines, while the OPT manager was very interested in improving of coordination between people, and the geriatrist spoke about a quality program focused on tackling standard health problems in geriatrics.

One can talk about people each occupying their own social world, meaning that individuals populate their own realities with their own relationships to people and connections to things. A neurosurgeon considers his work tasks in a historical context which a therapist does not share, a therapist has a relationship with a conscious patient while a neurosurgeon has a relationship with an unconscious patient, a geriatrist thinks about standard geriatrics health problems that a therapist does not have to think about, and so on. The interview material shows the obvious: that these line managers live in different social worlds.

However, we also find ideas that the managers share, e.g. all of them linked their work to the well-being of the patient and said that resources are limited. Both the patient and money are things which are common to all of the managers, and despite their different relationships to them, patients and money retain enough of their identities to be instantly recognizable throughout the care chain. Star and Greisemar (1989) call such objects ‘boundary objects’ and describe how people in different social worlds can use boundary objects to work together.

In our interviews with the line managers, we were regularly reminded by the interviewees that the strokeTIA process was very new, that the steering group had only had one meeting and that the improvement work had not yet begun. Rather than finding that the steering group members had a shared understanding about the strokeTIA process' goals, or that they disagreed with each other, we found that steering group had quite different although not contradictory ideas about goals, and answered questions in surprisingly different ways. Steering group members had not yet socially developed a shared understanding of the strokeTIA process, partly because it was so new, but also partly because this was a consequence of the type of contact that the steering group had had together, as presented and analyzed in the previous section. Specifically, the steering group is not intended to carry out any improvement work itself, it is supposed to choose whether or not to approve process team's recommendations and its members are to reallocate resources within their functions accordingly. The project procedure does not stipulate the steering group members must work together in the same way as the process team.

Views about the process

Our interviews revealed that the strokeTIA process was so new that staff did not have much experience working with it and were not sure what to expect from it, but interviewees brought up many wider issues which were related to the strokeTIA process' aims. These 'themes' were: cooperation within the hospital, cooperation with the next care providers, expectations and desires for the process.

Cooperating around the patient

The importance of cooperating for the patient's sake was a common theme throughout the interviews, and the patient had a central role in enabling staff to create the same goals and avoid conflict. As epitomized by one interviewee:

> "Om man inte har patienten i fokus, så kan det väldigt lätt komma intressekonflikter"

This care unit manager stressed the importance of focusing on the patient to find common ground. The interviewees often seemed to share this view, often repeating similar phrases to do with 'benefit for the patient'.

The popularity of cooperation

In general, cooperation and team work were considered important and part of the job for staff working in stroke units and with rehabilitation. Only one interviewee expressed reservation about the way in which the hospital was encouraging staff to cooperate:

> "Avgjort behöver man inte ha samma bakgrundskultur för att kunna jobba ihop och uträtta någonting bra för patienten. Men det viktigt är en öppen attityd och att man verkligen är överens om vem som ska göra vad och när. Det anser jag är grundfråga men jag tillhör inte alls de som förespråkar en gemensam kultur och att alla vårdarbete stöps i samma form."

This interviewee seemed to be fearing that the hospital was moving towards forcing everyone to work in the same way, and that this would be a negative development.

Improvements in stroke and TIA care

At present, there are massive projects going on in stroke care and the strokeTIA process is just one example. Stroke care is really becoming a celebrity illness with scheduled TV

adverts warning patients about strokes, information sessions in the town center and regional improvement projects. It is also one of the few illnesses to have national guidelines, although national guidelines are in the making for several more illness groups and are expected to be released within the next year. With all of these improvements and developments to stroke and TIA, stroke care staff have their work cut out for them.

> "Det är jättefokus på stroke och TIA nu. Alla är vi ju med på det här VGRs stora jättesatsning på TIA och där jobbar alla och oerhört intensivt och sedan har vi Smaller Group mötena och styrgruppen, alltså mer... Nu får vi liksom börja att tugga, för det måste ju ner, det liksom måste ju ner här. Och så måste vi ju därifrån... Bygga upp och se att det kommer ner hela vägen, att vi tar rätt prover, att vi gör rätt saker."

So many improvements meant a lot of meetings and groups and new information. The stroke staff we interviewed were busy and keen to reduce the number of meetings or streamline them in some way. And with so much to do, two of the interviewees stressed the importance of a dedicated process leader to lighten the load.

A dedicated process leader and conditions for the process' success

About half of the interviewees spoke about the process leader, and all of those did so in positive terms. One of the reasons for the process coming so far was that the process leader was open to others' differences:

> "[Förutsättningarna för att strokeTIAprocessen ska lyckas är] att vi fortsätter att träget jobba som det sättet som vi gör, att vi har den här den öppna kommunikationen som vi har, och just nu tror jag att processledaren är en oerhört viktig person, och att hon vill lyssna in på vad alla har att säga."

According to the interviewee, the process leader was willing to listen to everyone. The interviewees that we asked considered the success of the process to depend on agreeing common goals, managers' attendance at the steering group meetings and being open to each other's differences, and the process leader apparently did a good job of the latter.

Two interviewees emphasized the importance of a dedicated process leader, e.g.:

> "...Hade processledaren inte varit den den är hade vi inte kommit så långt. Det här är dennes uppdrag att driva detta, så att säga, och det är det som driver oss framåt. För mig, en fot i patientarbetet och där är det ju patientarbetet som hela tiden får gå först. Jag hinner ju aldrig att sitta och läsa eller hitta data på det sättet som processledaren gör. Jag får det från denne och sedan får jag läsa och komma med synpunkter"

According to these two staff, the strokeTIA process depended upon having a full-time process leader without other commitments. Although only two interviewees expressed this view, everyone had something to say about the relation between resources and stroke and TIA care.

Resources

StrokeTIA has been undergoing reorganization for several years, roughly since 2006. But not all, if any parts of the hospital are getting extra money to finance improvement activities such as the strokeTIA process. One steering group member even reported that they had to reduce costs by 2% annually. Three of the four interviewees from the steering group said that they have had to prioritize their own work or their staff around strokeTIA care in order to meet national guidelines, and some also pointed out that this redividing of a finite set of resources means that stroke care essentially becomes prioritized at the cost of other patient groups. As put by the neurosurgery manager:

> “Ett nytt regionalt vårdprogram har ibland konsekvenser för många verksamheter, även för vår verksamhet, och ett bra exempel på det är ju för den här senaste behandlingsmetoden för patienter som är insjuknad i en massiv propp i ett ut av hjärnans större kärlområden... Det är exempel på en sådan avvägning som görs alltså som implementeras i nationella och även regionala vårdprogram/riktlinjer. Men det har ju också resurskonsekvenser för hela sjukvård och stroke. Då är det viktigt att identifiera storleken på de här konsekvenserna och säga till så att det i möjligast mån tillförs - om det finns resurser att tillföra - att de resurserna också tillförs så att det sker en uppföljning. Om det inte finns med resurser att tillföra då måste man fråga sig ”på bekostnad av vilken ingrepp på vilka patientkategori ska detta implementeras?”. Och det är inte alltid genom en verksamhets intern diskussion. Utan här får man diskutera mellan olika medicinska verksamheter och ytterst när det gäller de här, som vi säger, horisontella prioriteringarna, ska vi ska att väga en stroke patient mot en med ont i höften. Det är på politikens uppdrag.”

The neurosurgeon was not alone in pointing out that decisions about dividing resources at the hospital are not always within functional areas. One interviewee explained the difficulty that stroke units face in justifying resource usage:

> “Ett problem med stroke enheterna genom tiderna har varit då att vinsterna för samhället ligger inte på den enskilda kliniken som har stroke enhet. Stroke enhetsvården att lägga dom på det, var lite dyrare än att lägga dom på en säng på en vanlig avdelning. Vinsterna kom först i nästa skede när fler patienter kan gå hem och behöver mindre omsorg hemma, anhöriga behöver lägga mindre kraft för att ta hand om sina. Så på 1 eller 2 års sikt är stroke ekonomiskt lönande, men inte lönande för den enskilda medicin kliniken, men självklart så finns det gehör för att man ska ta hand om patienterna på det här sättet och det kanske kostar lite mer men det är okej.”

The treatment of stroke and TIA patients can be costly initially, but results in a lower cost for society in the long run, as treated TIA patients are less likely to suffer a stroke and rehabilitated stroke patients are eventually able to live with less care from the next care provider. The gains for effectively treating acute stroke and TIA patients are thus felt outside of the hospital, by the commune who funds the next care providers.

Most of the interviewees stated the importance of using resources sparingly: medical services should be used only where they can lead to treatment, and patients should leave the hospital as soon as possible. The interviewees mostly agreed that saving money was a driving force for reducing inpatient care but this was not the only reason. These included freeing up beds for other patients, reducing the increased risk of infection associated with staying in a hospital environment and allowing patients to return to their home sooner. One interviewee considered that patients might be sent home even though they might benefit from staying in the hospital a bit longer, while another pointed out that certain stroke patients can be rehabilitated equally at home as in the hospital. The manager of occupational and physiotherapy explained how rehabilitation at home can in fact be more effective than rehabilitation at the hospital:

> ”Det ska vara patientens egen önskan som kan vara svårt för dem, kanske. Så har man fått en skada på hjärna så är det kanske inte så lätt när man är på sjukhuset och veta om vad man kan förvänta sig. Nu är det så ett projekt med hemrehabilitering som ni känner till. Och där har man ju upptäckt på det arbetsterapeuter och sjukgymnaster att när man senare kommer hem då kan de formulera sina mål. Då kan de säga; jag vill kunna äta med kniv och gaffel igen, jag vill kunna klara att duscha själv, jag vill kunna klara trappan ut och

sådär. Väldigt konkret. Då blir det lätt för dem. Men där, jag bara säger att när patienten väl kommer hem, så är det lättare för dem att formulera konkreta mål. Det kan vara svårt för de på sjukhus för då vill de bara... 'jag vill komma upp, jag vill komma hem'...”

Patients can find it easier to conceive of rehabilitation goals when they are at home and realize what tasks they need to be able to perform in order to improve their quality of life.

Aims for the process

The strokeTIA process documentation refers to improving communication, flows of information and flows of patients. All of the interviewees apart from one steering group and one process team member identified external care providers as a major improvement area, usually in the post-hospital part of the care chain. The manager of occupational and physiotherapy indicated that patients were not being fully rehabilitating patients after leaving the hospital:

> “Att vi ska få möjlighet att träffa patienten mycket under tiden den är inne, men också ha en bra överrapportering till den som tar emot patienten. Den kan ju vara primärvård, det kan vara hemsjukvården. Så det är vårt mål att få väldigt bra överrapportering. Sedan vill vi, i vissa fall, också ha möjlighet att träffa patienten på återbesök. Det gör vi inte nu. I tre månaders uppföljning så skulle vi kunna fånga in patienter som skulle behöva lite mer och vårt mål är ju att kunna ha, bara med ett kompetens center där primärvården skulle kunna efterfråga hjälp för svåra patienter när det gäller kognitiva svårigheter där som inte märks förrän de kommer hem att den anhöriga märker att de är kanske deprimerade, att de har ingen drive. Alltså de orkar... de sitter bara, liksom man får ingen...fart. Man är en annan människa, man blir någon annan. Och det märker man inte fram tills man kommer hem och där finns, har vi inom arbetsterapi flera som har kunskap om det. Så tänkte vi att vi skulle kunna ha anhörig träffar för vissa. Och när det gäller sjukgymnastiksidan så skulle vi kunna jobba mer med fysisk träning och hjälpa dem komma ut alltså inte ta tillbaka patienterna till akutsjukvård nu utan att hitta kanaler hur de kan få hjälp att träna hemma vid.”

The manager of occupational and physiotherapy explained how the hospital could cooperate with the external care providers with certain stroke patients, but did not suggest an explanation as to why the external care providers needed assistance. The manager of geriatrics offered this explanation:

> Om du frågar mig så ligger det stora problemet ute i kommunen. Det är där man önskar att det byggdes upp mycket mera resurser. Och öppenvårdslogopedimottagningen är ju en del av detta.

The external care providers lacked the resources necessary to rehabilitate patients, for example logopedics. The wish for better cooperation with the external care providers did not only concern the rehabilitation phase of the care chain. One interviewee expected that the process would also increase cooperation with external care providers in the earlier part of the care chain:

> [En förväntning för processen] är att synliggöra det här att få även distriktsläkarna ute på vårdcentralerna att förstå att det här är viktigt, och det här är, om inte blåljus, i alla fall ett väldigt akut tillstånd vilket gör att man identifiera snabbare, skicka in dem

> snabbare, gör ingenting själv utan skicka in dem till sjukhus. ...I sluten så innebär ju det att färre patienter får stroke, i alla fall i unga år. För vi kan inte säga att vi kan för alltid säga att de inte behöver få stroke, men vi kan ju för fullt att... Alltså om vi säger att vi förhindrar att TIA:n går över till en stroke när man är någonstans mellan 50 och 70 år, så kanske de får sin stroke när de är 80, 85, men det är ju lättare att ta än när man står mitt upp i livet.

Even though the external care provider was an often cited problem in the strokeTIA care chain, the strokeTIA process only had two next care provider representatives, both in the process team. Surprisingly, even though the external care providers were not represented at all in the strokeTIA process steering group, most interviewees did not seem to think that the strokeTIA process was missing representation from external care providers. StrokeTIA participants seemed to expect a lack of participation from next care providers e.g.:

> Q: Upplever du det som att hela vårdkedjan för strokeTIApatienter finns med i strokeTIA-processen?
>
> A: [pause] Nej... Eller ja. ...Eller nej. Det handlar om kommunen och primärvården och de är jättesvåra att få med.

The interviewee hesitantly explained that external care providers are usually difficult to involve in things like the strokeTIA process. Despite this apparent expectation of a lack of participation by next care providers, it must be said that post-hospital care was one of the common subjects to come up in interviews, and that three of the four steering group members we interviewed wanted to tackle the post-hospital issue in the strokeTIA process.

Choice of care providers

The interviewees usually referred to external care providers as communal and primary care. We have chosen to use the term 'external care providers' in order to indicate that pre- and post-hospital care is carried out by any number of organizations, whether privately-owned and profit-making, or public. Since 2008, local governments have been forced to compete with privately-owned profit-making organizations in their provision of non-hospital care (i.e. communal and primary care). This is one of many reforms often referred to collectively as New Public Management which share a common ideal: market logic, which is assumed to promote efficiency (Power 1997). One interviewee told us how the choice of care provider outside the hospital has created a larger number of next care providers, complicated the care chain and augmented all of the challenges already faced by the care chain:

> “Det fria vårdvalet har fördubblat antalet vårdcentraler, det var inget bra ur patient perspektiv. Det är väl bra om frisk och ska söka hjälp för ont i halsen och hämta ut blodtrycksmedicin men för den gamla multisjuka gruppen dom vårdkedjor vi var på väg att jobba upp, därmed tar vi flera steg tillbaka. Det har nog inte stått i deras krav bok, dom som har fått tillåtelse för att starta upp en privat vårdcentral att dom ska ha med dom här olika delarna. Jag har suttit på möten med företrädare från privata vårdcentral ”det där tänker inte vi på i första hand”. Den offentliga primärvården har jobbat mycket på det. Då borde dom tala om för patienten om du är listad på ”den” vårdcentralen så kan du få hjälp med ditten och datten, men du får ingenting utav det ”här”. Det är inte allmänt känt att det är så, men så är det. Om du är ung så kanske du kan välja bil, vilken som passar kassan och prestanda och vad du vill ha för utseende, men när du ska välja doktor, vad gör du för research då? Om man är gammal, hur mycket jobbar du aktivt med det då? Om du är gammal och sjuk, ringer ni verkligen runt till vårdcentralen och frågar 'vad har ni att erbjuda mig som är gammal och sjuk,

> har lite fotsår och lite diabetes och har haft en stroke, vad kan jag få för träning här?'. Det gör du ju inte."

All of our interviewees reported that strokeTIA patients often have communication problems. And even when they don't have physical communication problems, they can find it difficult to conceive of their needs because after having a stroke they are in a completely new situation and can be incredibly difficult to deal with. The choice of next care provider model is based upon the patient being able to decide which organization can best meet his or their needs. This is obviously completely inappropriate for stroke patients who at best are in an alien situation and find it difficult to conceive of their rehabilitation needs and at worst are incapable of communication and are relying on equally inexperienced next of kin.

In summary, the challenges stated by the strokeTIA process documents are made much more complicated by the array of next care providers. And not only has the choice of care providers complicated existing challenges faced by the care chain, it has also disturbed an on-going cooperation project between a next care provider and a stroke unit which was forced to stop due to the reorganisation that followed the choice of care reform. And as the interviewee points out, elderly patients and stroke patients are not a group who do not necessarily want and are often even incapable of comparing care providers and choosing the best for them. In other words, market logic principles, via a choice of care providers, are unlikely to result in the best possible care for stroke patients.

Steering group members' goals

As discussed, cooperation with external care providers was an almost universal wish from the interviewees. Below we present other goals for the process as stated by the steering group members we interviewed.

> Jag ser fram emot att få vara med och jobba med det här med, både dokumentation var en sak [dubbeldokumentation inom verksamheten] och vårdkedjor. … Och hur patienten kan få en aktiv miljö som ger större utrymme för aktivitet. Så, jag ser fram emot att jobba med dem och kommer att verkligen uppmuntra medarbetare att vara aktiva i processen och ser till att de får tid och möjlighet att vara med dom processerna. … Jag tror att vi kan försöka identifiera vad kan vi göra, vad är problem tydligare, vilka handlingsplaner ska vi ha, hur ska vi jobba med det på en plan som är ju förstås långsiktig. Det är inte bara vi, utan det är också att tydliggöra vad vår roll är, vad är era roll? Alltihop.

The occupational and physiotherapy manager saw the process as an opportunity to develop a more effective cooperation around care of stroke patients by occupational therapists and physiotherapists, as well as an opportunity to work with the care chain. The interviewee speculated that the process could identify problems and make action plans, and acknowledged that participants' needed to clarify each other's rolls. Clarification of roles and responsibilities within the hospital was also brought up by the neurosurgery manager:

> Ja, ni var ju själva med och såg vilka områden som prioriterades där och det är ett antal gråzoner som behöver sorteras ut. Och någon utav de grå zonerna involverade också neurokirugi och jag räknar ju med att det här ska kunna sorteras ut så att man har, så att säga, bli överens och gör de här multilaterala nödvändiga åtgärdena för att det ska fungera på ett optimalt sätt för patienterna.

The neurosurgery manager expected the process to be able to solve a 'grey zone' involving neurosurgery, namely pushing post-operation TIA patients back into the stroke unit.

Finally, the geriatrics manager refered to the different standards of care at the different hospital bases:

> Jag vill att det ska bli en likvärdig behandling av strokepatienter. Inte samma behandling men en likvärdig behandling av strokeTIApatienter över hela Large Hospital. Det tycker jag är det viktigaste. Det ska inte skilja om du kommer från tomt A eller om du kommer från tomt B eller om du kommer från tomt C. Det är det viktigaste i den synvinkeln/styrgruppen.

Conditions for success

Most thought that getting everybody to agree on goals and what is important would be necessary for the process to be able to succeed. All of the steering group members considered the success of the project to depend on openness, attendance at steering group meetings and taking an active role in managing their respective parts of the process within their own functions.

> Den goda viljan hos cheferna. Och sedan ett väldig tungt chefsansvar att implementera detta på respektive verksamhet. Först och främst måste man vara positiv som chef, och sedan måste man använda sin chefskap. Hur nu man gör. Att man implementera... arbetssätt, organisationssätt osv på den egna verksamheten. Att man också då påverkar den personal som finns inom den egna enheten på ett så sätt att man arbeta på ett likvärdigt sätt. Jag tror egentligen att chefens roll är nyckeln.

Discussion

In this section we discuss our research questions. First, what affects the way in which an idea is translated? We ask this question because the main question in which we are interested requires us to consider what role translation plays in an organization's realization of the quality idea. Second, does the quality idea affect the organizing of actions in different times and places, and if so, how?

What affects the way in which an idea is translated?

Translation: idea formulation to idea realisation

The translation from idea to practice at Large Hospital was a long process which started six months before the strokeTIA project, with the formulation of an idea, followed by its realisation. According to the authors of the idea, it was inspired by other ideas in the field, both in practice and literature, and it also contained original elements to fit the hospital, such as a steering group to help work over the multitude of internal organisatory boundaries within the hospital. The translation thus started with the amalgamation and interpretation of ideas in the field.

During the realisation of the idea, it continued to be interpreted in the context of local practice. Various participants interpreted the idea and set monthly meetings, agendas and activities, and took part in the meetings, carrying out activities with their own experiences as input. Different parts of the idea were still being interpreted three months into the project when we stopped gathering field material. The translation in this case thus started with the formulation of an idea and continued with its realisation after it was formulated.

The process documents partially document the translation from idea formulation to idea realisation. The process guide documented Large Hospital's idea for working with processes – an idea which was translated from other ideas in research and practice in other hospitals. Next, the assignment documents initiated the strokeTIA project using the ideas in the process guide. They repeated the procedure for working with processes from the process guide, listed the hospital functions and external functions involved in treating strokeTIA patients and who would be in the steering group and the process team, and they also gave the project two objectives: improve acute strokeTIA care and improve coordination along the entire care chain. The strokeTIA assignments effectively tied the idea from the process guide down in time and space by referring to specific places, people and goals, but although they were more contextual than the process guide, they contained the same contextless procedure for working with processes. We can thus see the process guide as a translation of ideas in the field to a single idea, fitted for Large Hospital, and the strokeTIA project assignment as a partial translation and repackaging of this idea, embedding the idea slightly deeper in the strokeTIA context at Large Hospital.

Translation with different actors

The translation involved many different people who had varying degrees of opportunity to affect how the idea was formulated and realised. For example, the idea about organising with processes was formulated by the hospital's Quality Director and a stroke unit manager, the project was commisioned by the hospital director and later when the project began it was the

stroke unit manager who as process leader decided meetings' frequencies and agendas based on the procedure in the project assignment. However, the process leader did not produce exhaustive lists of instructions for each project participant, so during meetings, the process team and steering group members carried out the activities in the agendas using their daily work activities and experiences as input, and in so doing, partook in the translation. The steering group had considerably less opportunity (than e.g. the process team) to partake in the translation and affect the realization of the project since they only had one meeting in three months and had little influence over how the process team carried out project activities except for approving its recommendations for improvement areas. Since the process leader had asked us to investigate the steering group idea, our interviews with steering group members gave them an additional opportunity to express their views about and possibly influence the project.

In summary, rather than a single actor selecting and implementing an idea, we see a variety of staff partaking in and affecting the forumlation of and realisation of an idea. This case is important for illustrating the importance of the term translation, which is quite established in organization theory for describing the spread and realisation of ideas. In operations management, spread and realisation are usually refered to as diffusion and adoption/implementation, which can be a bit misleading. For one, ideas do not have an initial energy which causes them to spread until they are slowed down by the friction of resistance. Ideas are passed on between people who translate them according to their own frames of reference, and clashes between ideas and individuals' frames of reference serve to energise and transform ideas rather than being a source of energy zapping resistance (Czarniawska 2005). Likewise, ideas are not units which can be adopted into an organization like an animal or a child into a family, rather they become translated by everyone involved with them.

Legitimated and constrained by other ideas

Large Hospital's idea and the subsequent project were both legitimated and constrained by their links to the quality idea.

One of the reasons why Large Hospital formulated their own idea instead of using one that already existed was that the hospital was prohibited from using ideas which had attracted controversy elsewhere in the field, such as lean thinking. Without direct competition from other ideas, the hospital was relatively free to attempt to address problems with working over organisational boundaries and formulate their solutions in any way they deemed suitable. In addition, the form that the hospital's idea took became less important. Usually, an idea's packaging and rhetoric enable it to appear more or less attractive (Czarniawska & Joerges 1996), but this was less important since the hospital was not able to use other packaged ideas.

Out of all of the possible ways of formulating their organisatory problem and an appropriate solution, Large Hospital's idea and the subsequent strokeTIA project were firmly linked to the quality idea. The hospital's newly formulated idea, packaged as general guide to working with processes, was a collection of tools widely used in quality management. Furthermore, the process documents were, like many quality management models, worded without reference to space or time so that they could be applicable to any of the hospital's operations. Throughout the project, we saw links to the quality idea through focus on regular flow, inclusion of continuous improvement, process mapping and systematic measurement of customer-centered norms, and by presenting the project in terms associated with quality management, such as regular flow, process, process-mapping, care chain, etc. During the steering group's meeting, the process leader compared the strokeTIA project's improvement

areas to ongoing breakthrough projects, which were highly focused, successful and reputed quality projects recognized by many in and outside the hospital. These links to the quality idea are not surprising considering that this aspect of organizational development is currently popular in the healthcare field and in research and practitioner literature and given that the authors of the idea had attended organizational development courses at the local technical university.

When we presented these links to the quality idea in the first feedback session with the process team we received some criticism. Some staff felt that the links were not necessarily made knowingly or deliberately, rather that the project developed in the way that it did because that was what was expected of them and necessary in order for it to continue. In the second feedback session with the steering group, staff said that the new idea and project served to further legitimate improvement work that had already been carried out within strokeTIA care. But the project also included a procedure for working with improving strokeTIA care which the new process team must adhere to, so the project's links to the quality idea apparently both legitimated and constrained it.

Looking to other organizations in the field for inspiration is normal and it is one of the reasons that organizations seem increasingly to resemble each other (P. J. DiMaggio & W. W. Powell 1983) But closer examination reveals that the same ideas are often interpreted differently (Blomquist 1996; Erlingsdottir 1999; Erlingsdottir et al. 2005; Sevón 1996). In our case we see that Large Hospital's idea was an amalgamation of other variants of the quality idea which was interpreted in the context of local practice both while it was formulated and being realised.

Despite the acceptance it enjoyed, Large Hospital's idea could not be described as an institution as defined in our theoretical framework since it was more a consciously selected, local idea than a long-lasting unwritten rule. On the other hand, the hospital's idea appeals to certain longer-lived ideas such as the quality idea which in turn appeals to institutions such as the desirability of technical-rational control and efficiency (which have presumably been with us at least since the switch to mass production in the early 1900s). A solution to the apparent missing theoretical step between fashionable ideas and lethargic institutions is offered by the term 'master idea' (Czarniawska & Joerges 1996). In this case, the quality idea serves as a master idea through which Large Hospital's idea was bridged to institutions, legitimating the project.

To summarise, looking at Large Hospital's idea in the wider contexts of the healthcare and public sector fields, we can say it was new in the sense that it had not before appeared in this particular form, but it was not new in the sense that it was an amalgamation of existing ideas and one of many which shared the characteristics of the quality idea. Furthermore, the clear link to a more durable, so-called master idea was a bridge to institutions which both legitimated and constrained the choice of solution for the organisatory problems faced by Large Hospital.

Translation of objectives

The translation of objectives and procedures in ideas about organizing has been described in a comparative case study which was carried out several years ago at this same organization (Trägårdh & K. Lindberg 2004). In one of the cases studied, text-book procedures were carried out without being developed to suit local conditions or objectives. This lead to little improvement, which was then used as evidence to support the participants' claims that work

practice was already effective but required more resources. The authors concluded that while the project's procedures had been translated very closely, the project's objectives had become translated from identifying problems and finding effective solutions to them to defending current work practices and supporting claims for additional resources. Though the particular circumstances in that study differ considerably to ours, the idea that different parts of ideas about organizing, in particular objectives and procedures, can be translated differently is useful to us.

When the process guide was, as we have argued, partially translated to an assignment, two objectives were added: improve acute strokeTIA care and improve coordination along the entire care chain. Although the objectives were rarely referred to explicitly, participants discussed problems related to the objectives enthusiastically and were concerned for the patients' welfare, especially in connection with external care providers. Coordination with external organisations was seen as a major problem. In meetings, many of the problems discussed were to do with external organisations such as communal care providers, primary care providers and A-kassan. Also in interviews, one of the most common subjects was the need to improve parts of the care chain which for the most part lay outside the hospital.

A curious feature of the project was that one of these objectives seemed to be disregarded right from the start. First, project participants came almost exclusively from within the hospital, so the project had little representation from external organisations involved in strokeTIA care. During the project, some problems involving external organizations were regarded as too large for the project to tackle and deprioritized, e.g. because they were linked to issues which must be resolved on a political level. Also, participants were mainly from the hospital and several interviewees did not know how the project could affect other parts of the strokeTIA care chain.

It is strange, then, that most of the interviewees did not consider the project to be missing representation from any other actors. The hospital staff seemed to simultaneously hold what could be seen as contradictory attitudes: that parts of the care chain involving external organisations beyond the control of the hospital need to be improved, and that the strokeTIA project did not lack representation from these external organisations. We see this as part of a larger, palpable reluctance to engage with external organizations visible in the lack of external representation among the project participants, the participants' uncertainty in interviews regarding how the project could affect events outside of the hospital and regarding the difficulty of coordinating with and engaging and aligning interests with large numbers of profit making healthcare providers, and an acceptance that certain problems with external organizations must be solved by more powerful authorities, e.g. on a political level.

One explanation for the project's lack of attempt to engage external healthcare providers is that project participants were dismayed by the impossible task of coordinating an increasingly large number of healthcare providers, some private, with different interests. The increased number of providers, the result of the recent marketization of healthcare, and the public sector becoming increasingly defined as organisational units with clear boundaries (K. Lindberg 2002) augment the challenge of cooperation and coordination between organizations by increasing the number of organizational boundaries to be transversed. Marketization of communal and primary care providers is motivated by the claim that a diverse array of actors increases effectivity and quality of care (Alliansen 2006) by giving the patient the right to choose their healthcare provider (Blomqvist & Rothstein 2000) this is supposed to give patients power in that the providers which patients do not choose fail and disappear in the

long run (Blomqvist & Rothstein 2000). In reality, marketization seems to exacerbate problems involving cooperation and coordination over organizational boundaries simply by increasing the number of organizations involved. In addition, one interviewee described how some private external healthcare providers were completely disinterested in investing time in improvement work which would not reap economic benefits for themselves. The same interviewee also questioned the appropriateness of market logic for elderly care providers on the grounds that immobile and infirm elderly stroke patients were unlikely to choose care providers based on anything other than geographical convenience. Regardless of one's political stance, marketization and the appearance of private interests are developments which present a huge challenge for healthcare in Sweden (Fredriksson & Winblad 2009).

The relatively new nature of the challenge poses a problem for the organizations involved for which there are not necessarily any clear established, institutionalised solutions. According to (Bergström & Dobers 2000), projects are a good way to work exploratively with such problems. However, as we argued in the previous section, the strokeTIA project's strong links to the quality idea which served to legitimate Large Hospital's idea and subsequent project also served to constrained them. The extent to which the project participants could work exploratively to find novel solutions to problems involving organising with external organisations was limited by the procedure which was part of Large Hospital's idea.

To summarise, as the translation progressed, the project procedure was carefully imitated but the objectives became slightly distorted. The project's focus on improving coordination along the care chain became hospital-centered and involved little collaboration with external organizations during our study. It is, however, very important to say that we observed the project under its first stage, during which it was to map the current state and identify and prioritize improvement areas. We are unable to say if the lack of engagement with external organizations continued after the study's end. We surmise that the project's objectives were at least initially translated from coordinating the entire strokeTIA care chain to coordinating the strokeTIA care chain within the hospital. This is probably connected to the marketization of healthcare providers which has increased the number of providers and also the challenge of coordinating between between them. The relatively new nature of this problem and the lack of institutionalized solutions might explain the hospital's lack of engagement with external organizations during the project. In addition, free choice, the mechanism by which marketization is supposed to lead to improved healthcare providers, seems unsuitable for strokeTIA patients.

How does the quality idea affect an action net?

During our study, the project was evaluating the current state of strokeTIA care, not making changes to it. In our interviews during the first three months of the project, several interviewees laughed away the possibility of the project having already lead to changes within strokeTIA care so quickly. During this beginning stage of the project, the participants were identifying and prioritising potential improvement areas, not planning remediations. However, despite the fact that the project participants were not yet planning or carrying out changes to strokeTIA care, there were subtle changes to organising. The participants were willingly partaking in the project and carrying out its activities, and these activities became part of net of activities that made up strokeTIA (e.g. along with administrative tasks and regular meetings). The main effect of this was that participants learnt more about the strokeTIA carechain, including reconceiving strokeTIA care in the project's terms. A feature

of the project was the concept of the patient, around which participants carried out project activities together.

The patient as a unifying idea

Research often paints a picture of hospitals as fractured environments thanks to differences between doctors, nurses and managers, and between specialties (Glouberman & Mintzberg 2001). In our study, hospital staff worked together harmoniously over internal organisational boundaries without any visible conflict, and an object which facilitated this cooperation was the patient.

The project participants came to meetings with different jobs, daily work tasks, experiences and understandings of strokeTIA care, often in different locations, meaning that they had different social worlds (Star & Griesemer 1989). Despite this, they were able to work around the patient idea because the patient was something which had a meaning common enough to these worlds to make it mutually recognizable by the strokeTIA participants. Star and Griesemer (1989) called this a boundary object, observing that ”the creation of boundary objects is a key process for developing and maintaining coherence across intersecting social worlds”. Discussing boundary objects can reveal differences and similarities between the way in which participants experience the object and hence allow them to understand each other better (K. Lindberg & Czarniawska 2003). Meeting activities and discussions were generally centered on the patient. Process mapping, for example, clearly followed the patient's journey through the strokeTIA care chain. During such activities, the project participants had a common object upon which to act, although they had a different relationship with the object and different information about it.

In both meetings and interviews, project participants often referred to a sort of mantra: “patients should receive equally good care regardless of where (or when) they enter the hospital”. In meetings this mantra seemed to invite the participants to collectively evaluate whether or not the issue being discussed really could be considered a problem that should be addressed. This activity helped to keep the participants cooperating and stabilised the discussions around the commonly recognized boundary object. K Lindberg (2002) uses the term 'boundary activity' for activities which have different meanings for those involved but which the participants share a common enough understanding of to allow them to work together. As with boundary objects, carrying out boundary activities can reveal differences and similarities between the way in which participants experience the activities and allow them to understand each other better (K. Lindberg & Czarniawska 2003). However, the mantra was mentioned during discussions more as a sort of reference point than as a discussion in itself, so it acted more as a boundary object, rather than a boundary activity.

One of the main activities in the project was process-mapping. The process leader started the process map alone and developed it with the Large Hospital stroke council before the project's start. After the project's start, the activity continued with the process team (which had replaced the stroke council). When we observed the activity being carried out by the process team participants in meetings, we saw that it generated discussion in which the participants tried to understand both the representation of patient flows in a map and also what happened in the different parts of the care chain. The activity acted as a boundary activity, since it helped them to understand each others' different information about and experiences of patient flows.

Project participants with different jobs, daily work tasks, experiences and understandings of strokeTIA care, worked together with the help of things which they shared a common understanding of: boundary objects and activities. These boundary objects and activities came in the form of the patient idea, a mantra about equal standards of care (for patients), and process mapping (of patient flows). The project's patient focus was an effective way of facilitating cooperation and learning between participants from different parts of the hospital.

Project activities connected to existing action net

The project and its activities became accepted into the existing strokeTIA arrangement without much opposition. No interviewees were negative about the project (although one interviewee was critical of what they saw as a wider trend to force a monoculture upon medical specialties), we did not notice that the project received any negative attention and the atmosphere in meetings was very positive. According to Berger & Luckmann (1966), activities, or actions, which can be explained away in terms of prevailing institutions are more likely to be allowed to continue. As we argued earlier, Large Hospital's idea and subsequent project were firmly linked to the quality idea, a master idea which bridged the hospital's ideas to long-lasting institutions. This link facilitated the acceptance of project activities into the existing strokeTIA activities. In interviews, we found out that different parts of the hospital engaged in various types of quality improvement work which also supports the conclusion that the quality idea was seen as a legitimate, reasonable approach for the hospital to take in solving organizational problems.

This is not to say that the participants spontaneously carried out the project activities as they saw fit. The process leader informed the participants of the purpose of the meetings and when discussions in meetings veered from the stated agenda, the leader steered discussion back towards it. Such references to agendas were used to guide wandering discussions in meetings at several points. Although the process guide and project assignments themselves were rarely referred to, they were the basis for meeting agendas and activities since the process leader had translated the former to the latter. According to Latour (1991) non-human elements can offer social systems stability, The project documents, i.e. the agendas, the meeting summaries, the process guide and the project assignments, all of these gave stability to the project by serving as solid, unchangeable reference points which were used to guide the project activities.

Using Czarniawska's theoretical idea, action nets (2005), as outlined in the theoretical framework, we can consider strokeTIA care (and all its associated tasks, meetings, administrative work etc) at Large Hospital to be a net of repeated, connected actions. The strokeTIA project activities were new actions which became incorporated into the existing action net, repeated and widely accepted, since they were explainable in terms of prevailing institutions via the quality idea, a master idea. The activities were at times carried out differently than intended, but reference to the documents stabilized the new actions in the action net.

Existing connections in the action net changed

The project activities enabled participants to learn more about existing strokeTIA care. Although the participants already had knowledge of strokeTIA care, during the project they learnt about the strokeTIA care chain anew in the terms of the hospital's idea, e.g. flows, processes, improvement areas, etc. They did this with the activities which were outlined in

Large Hospital's idea and as translated by the process leader, e.g. process mapping and open discussions respectively.

Considering once again strokeTIA care (and all of its associated activities) as a net of connected, repeated actions, we can say that the connections between actions in the net were modified. Participants related their actions to each other's through meeting activities and learned more about how their actions made up the strokeTIA care chain. The meeting activities generally involved participants exchanging experiences about particular flows of patient groups, clarifying the nature of improvement areas from different perspectives and informing each other about recent developments relevant to the project. In so doing, participants were able to connect their actions to each other's in new ways. However, since the project was evaluating the current state of strokeTIA care and not making changes to it, the actions in the strokeTIA action net remained the same (with the exception of the addition of project activities described above).

Although the project enabled participants to reconceive how their actions were related to each other's and how they made up the care chain, this understanding was mainly limited to the process team. This understanding - the reconceived strokeTIA action net, with its modified connections between actions - existed mainly in the heads of the process team. It was relatively fragile, given the small number of people in the team and the difficulty of spreading the interpersonal aspect of connections between actions such as empathy gained from comparing personal experiences in meetings. The participants not only built up a cognitive understanding of how their work activities related to each other but also struck up a sort of rapport which possibly contributed a sort of emotional quality (e.g. empathy or loyalty) to the way in which they related each other's actions. Documents such as the process map could share some of the learning, but the map was informative, not persuasive, and it did not communicate the emotional quality of the connections that personally sharing information and experiences in meetings seemed to provide. If the project meetings stopped or team members changed, the reconceived action net would mostly be forgotten without any changes ever having being made to the work activities that constituted the strokeTIA care chain.

In another study, connections between actions were described as having emotional, cognitive and mimetic characteristics, all of which contributed to the construction of a new handling net. (K. Lindberg 2002). Connections of emotional and mimetic quality were built through the sharing of experiences and auscultations, while cognitive connections came from the sharing of information, even with little personal interaction. The same study also found that loose couplings were more useful than tight couplings for organizing over boundaries because they were more flexible and did not threaten established structures.

We never saw any evidence of mimesis, probably because the team only met two times in two months and did not auscultate, but we did see evidence of cognitive- and emotional-character connections in the participants' reconception of how their actions together constituted the strokeTIA care chain. As for couplings over organizational boundaries, the strokeTIA project meetings provided an opportunity for connections between different parts of the hospital through participants working together. However, the connections in this case were not developed enough to be considered as couplings over organizational boundaries. The elements could not be said to be responsive to each other since the project did not enable participants to make immediate changes to the strokeTIA care chain while we were studying it.

Project informally prioritized

One final change to organizing was the unintended effect on the organizing of non-strokeTIA care, stemming from the fact that the only additional resource for the project was a temporary full-time process leader and that the medical departments involved in the project received no extra resources for it. Some managers of the departments involved considered that there was a real need for coordination between healthcare providers for the elderly in order to satisfy national guidelines, so they informally prioritized the project by giving it the resources they believed it needed in order to progress. Since the managers operated with fixed resources, this informal prioritization was at the expense of patient groups for whom there are no national guidelines. According to an interviewee, national guidelines for more illness groups are planned.

Summary

In this discussion we have taken up a number of points and made links to theoretical concepts in order to generalise the results of our case study. The most important theories we have utilised are translation and action nets for studying the diffusion/adoption of ideas and organizing, respectively. In the following conclusion, we summarize the most important points of this study.

Conclusions

Hospitals are under pressure to become more effective without using more resources. This problem is compounded by the greater need and challenge for hospitals to coordinate with healthcare providers, whose numbers have increased as a result of the marketization of some parts of healthcare provision in Sweden. Against this background, quality management models are seen as a solution to organizatory problems.

At the same time, there is little research into how the quality idea affects organizing in healthcare. That research which exists often simplifies organizations to simple technical rational systems, missing both the complex systems behaviour that organizations can exhibit and the social aspects of organizing. There is a need for research which asks how the quality idea helps hospitals to organize activities that are carried out in different times and in different places.

In the introduction, we asked the question: How is the quality idea realised and how does it help to organize actions which take place in different times and places? Using the theoretical ideas translation and action nets, we were able to look at the social aspects of organizing during a quality project at a large hospital. The short duration of our study meant we could only observe the initial phase of the quality project, during which we saw part of the translation process from idea to practice and some changes related to the strokeTIA care chain. The study took place while the project was evaluating the current state of the strokeTIA care chain, so the project made no attempts to reorganize strokeTIA care, but the project's existence itself embodied a change to organizing.

One can summarize our case as follows: a new idea for organizing which shared the characteristics of the quality idea was formulated and then realised in a project. The formulation and realisation of this idea was a translation process which lasted several months and involved many different actors with varying degrees of opportunity to partake in it. Large Hospital's idea was new in the sense that it had not before appeared in this particular form, but it was not new in the sense that it was an amalgamation of existing ideas and one of many which shared the characteristics of the quality idea. The links to a the more durable quality idea, a so-called master idea, was a bridge to institutions which legitimated the choice of solution for the organizatory problems faced by Large Hospital, that is organizing over organizational boundaries.

The project participants learned about the strokeTIA care chain through process activities, though no changes to the organizing of strokeTIA care were made. The project showed a clear focus on patient groups which extended over organizational and functional boundaries and the patient was an object around which healthcare staff could effectively relate each other's work. The patient acted as a boundary object of which participants shared enough of a common understanding to be able to work around it together. Amongst the participants, the project succeeded in emphasizing the patient's journey through the hospital and external organizations as opposed to within medical specialties. In this case, the quality idea's customer-focus was translated into activities centered around the patient which facilitated cooperation between staff from different parts of the hospital.

The project group shared experiences and related their actions to each other's. However, the new conception of the strokeTIA care chain was shared by the few people that participated in the project. Information about the newly conceived care chain was shared between groups

within the project via documents, but this was informative rather than persuasive, and did not communicate the interpersonal, emotional way in which process member's had connected their actions to conceive the strokeTIA care chain.

Finally, the organizing idea was translated in different ways. The procedure set out the in documented idea was imitated by the project, but the objectives set out in the project assignment were slightly adjusted from coordinating the entire strokeTIA care chain to coordinating the strokeTIA care chain in the hospital. In general, the project seemed reluctant to attempt to engage with external organizations, and one explanation for this is that the relatively recent marketization of external care providers has lead to an increased number of providers with which to coordinate and cooperate. This relatively new challenge has no established, institutionalized solutions. While projects can be useful for exploring novel problems, Large Hospital's idea's link to the widely-accepted quality idea which legitimated the project also constrained it to following the procedure set out in the idea.

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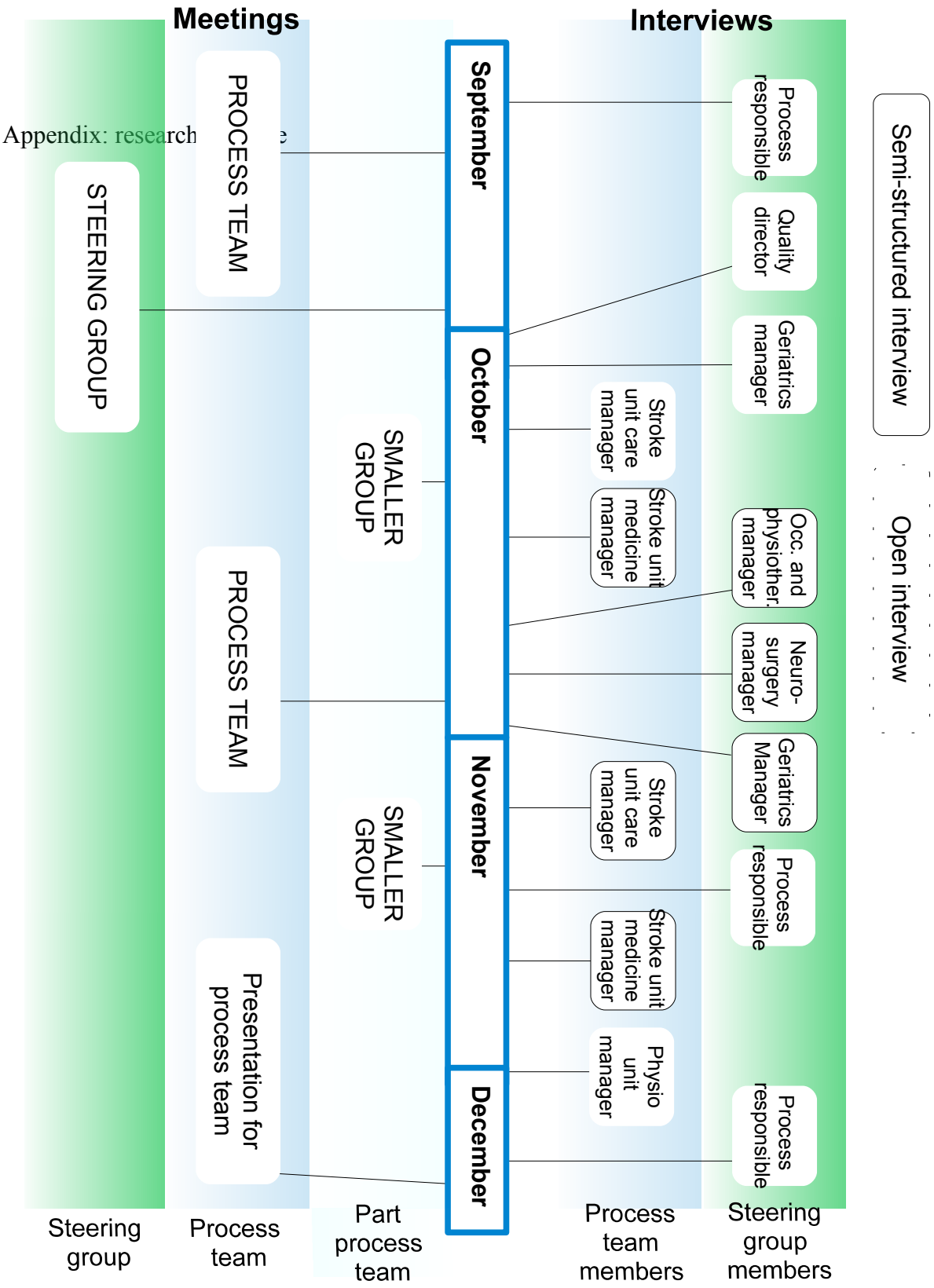
Meetings
Interviews
Semi-structured interview
Open interview
STEERING GROUP
PROCESS TEAM
SMALLER GROUP
PROCESS TEAM
SMALLER GROUP
Presentation for process team
September
October
November
December
Process responsible
Quality director
Geriatrics manager
Stroke unit care manager
Stroke unit medicine manager
Occ. and physiother. manager
Neuro-surgery manager
Geriatrics Manager
Stroke unit care manager
Process responsible
Stroke unit medicine manager
Physio unit manager
Process responsible
Steering group
Process team
Part process team
Process team members
Steering group members