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Something else than usual hospital nursing care: An ethnographic study of nurse case managers' everyday practices

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Abstract

Support interventions, such as nurse case managers, has been developed in response to the inequality in health and a growing population with multi-morbidity. The aim of the present study was to explore the everyday practices of nurse case managers at a Danish university hospital. An ethnographic approach with a constructionist perspective was applied. Data generation entailed participant observation and one group interviews with all nurse case managers in a Danish region ($n = 4$). The data were analysed using thematic analysis. The everyday practices of nurse case managers were characterised by providing something else than the usual hospital nursing care by continuously establishing and maintaining relationships with their patients. They emphasised the patient's psychosocial needs in a biomedical context and accompanied patients across different healthcare settings. The nurse case managers' everyday practices resonate with the key values of nursing. These values are under pressure in healthcare dominated by technical rationality and efficiency leading to increased inequality in health. Further exploration of the potential benefits for multi-morbidity and co-existing social issues is needed. There is a need for continued critical debate about the conditions for caring for patients' psychosocial needs. The implications of continuing to neglect patients' psychosocial needs are related to further increasing inequality in health and impeding equal access to services.

Keywords

care coordination, field work, inequality in health, nurse case managers, nursing, qualitative research, thematic analysis

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Background

The increased prevalence of people experiencing multi-morbidity has been a global concern for several years.[1,2] In Denmark, one-third of the population experiences multi-morbidity, which is described as two or more co-existing chronic physical and/or mental conditions.[1] Globally, hospital settings are experiencing an increasing number of patients with multi-morbidity. These patients can be challenging to manage in hospitals due to the highly specialised and siloed organisational structures that characterise these settings.[3] Currently, healthcare systems are structured in specialist wards, a general healthcare division and specialist psychiatric care services. This impedes options for coherent clinical pathways, creating barriers to the provision of person-centred care.[4] In a Danish context, such fragmented organisational structures are sustained by a division of healthcare responsibilities between municipal and regional health authorities. The organisational structures and ongoing changes in healthcare delivery, as well as in population demographics, have increased the need for care coordination services.[5] In response to the growing population experiencing multi-morbidity, various support interventions in healthcare have been developed.[6]

The nurse case manager (NCM) service was developed in the 1970s in response to concerns about the costs and quality of outcomes caused by changes in society, population demographics and population health status. Changes in the 1970s – and today – include advances in healthcare technology, an ageing population, and the increased incidence of chronic illnesses.[5] According to White et al.,[5] nurse case management is a dynamic and systematic collaborative approach that coordinates and provides healthcare services to a defined population. NCMs actively engage with their clients to identify options and facilitate services that meet individual health needs.[5] NCMs provide support to patients with complex clinical pathways in the hospital setting, during discharge and in

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the transition to their home. Internationally, NCMs responsibilities vary according to the organisation and setting.[7,8] In Denmark, NCM interventions typically aim to achieve equality in health for vulnerable or marginalised groups in society.[9]

To improve services for patients with complex health and social issues, four registered nurses were employed as NCMs in the North Denmark Region in 2019. The NCMs are currently organised as an outpatient service of the existing emergency departments, targeting patients with complex treatment trajectories who are admitted to the region's university hospital. These treatment trajectories involve cross-sectional collaboration with multiple healthcare and social services. Typically, patients need extended support during admission and in the transition to home when discharged from hospital. Patients are referred to the service by the NCMs or other healthcare workers at the university hospital and stay enrolled in the service as long as necessary. At this time, different types of similar support services were established across Denmark; however, the specific constellation of the NCM practice in the North Denmark Region that was examined in the current study was unique, understood to be different from other similar functions or services.

Although the NCMs have a long history internationally,[5] little is known about the actual practices that constitute the NCM service in Denmark. Previous research has advocated the development of theoretical frameworks to increase understanding of NCM interventions.[10,11] Across international healthcare settings, NCMs have most often been introduced with common objectives of decreasing fragmentation of care, enhancing the quality of individual health outcomes cost-effectively and reducing inequality in health. Typically, the NCM approach is adjusted to fit local contexts or specific medical specialties.[5] To accommodate this heterogony, this study drew on a flexible research approach to explore the everyday practices of the NCM in clinical practice settings.

The aim of the study was to explore the everyday practices of NCMs in a Danish university hospital.

Materials and methods

Design

An ethnographic approach[12] was used to generate detailed and in-depth knowledge of NCMs' everyday practices. In this study, social constructionism[13] provided a theoretical perspective for exploring and for better understanding the meanings embedded in NCMs' narrative accounts and everyday practices. The core assumptions within the social constructionist perspective are that accounts in verbal interactions are seen as active in constructing different versions of social reality and that the world becomes assessable through social processes of constructing, re-producing, and presenting reality in language.[13] This means there is not only one truth and that through this perspective it becomes possible to questions taken-for-granted truths within healthcare. In this study, the construction of data was achieved through interactions between NCM participants and the researchers (first and last authors). Furthermore, the analytical process of engaging with data and producing interpretations was also understood as a way of interacting with the data to gain understanding about the realities presented in the participants' accounts.[14]

Participants

Four NCMs were eligible to participate, and all agreed to take part in the study. The function of these four NCMs was unique in a Danish context at this time. They were employed at a Danish university hospital covering three geographical locations in the North Denmark Region. When the NCMs were introduced to the hospital, a job description was developed by nurse managers and a nurse specialist in care coordination at the hospital. This description included an introduction to the NCMs' areas of responsibility and the proposed target population (Table 1). The NCMs were employed in three emergency and acute medical departments, but they were intended to provide care for patients throughout the hospital in need of extended care coordination.

Two of the NCMs were involved in framing the aim of the study to ensure a scope that was relevant to clinical practice. All four NCMs were women (age range = 33–46 years), with previous nursing experience in hospital and municipal healthcare settings.

Data generation

Data were generated through participant observation of social situations. According to Spradley,[12] social situations are characterised by three main features: actors; activities; and places. In this case, the *actors* were nurse case managers, the *activities* were the NCMs' everyday practices involving patients and collaborators, and the *places* were different locations as they occurred in the everyday practices of the NCMs, e.g. locations in the university hospital setting or the private home of the patient.

Two experienced female nurse researchers (first and last authors) performed participant observations on eight occasions. Each occasion lasted approximately 4 hours and during these eight sessions everyday practices of all four NCMs were covered. The researchers were employed at the hospital and had no prior relationships with the participants or knowledge of the NCM function. Initially, an open and descriptive observation approach was applied. This was followed by focused and selected observations of NCMs' everyday practices.[12] These observations focused on collaboration with patients and professionals. This focus was chosen because building and maintaining relationships with patients and collaborators were observed to be key activities in the NCMs' everyday practices. Handwritten fieldnotes were generated during each participant observation occasion. These initial notes included jottings and small drawings. Descriptive elaborations were added to the field notes immediately after each session.

The authors' iterative and continuous discussions clarified the need for expansion of the NCMs' own descriptions of establishing and terminating relationships, of the patient group and of their everyday practices. These descriptions were explored in a group interview with NCMs. The interview guide was developed based on the knowledge gained from the participant observations (the questions are displayed in

Table 1. Target population, function and responsibilities of nurse case managers at the university hospital.[a]

Feature	Description
Target population	All vulnerable, exposed patients who could benefit from coordination of their patient trajectory. This includes: • Patients with co-existing illnesses requiring treatment • Patients with mental illness • Patients with addiction issues • Patients who are unable to maintain expedient behaviour and self-care, hence dependent on healthcare and social services • Particularly exposed patients who are unable to seek out help when needed, hence unknown to the healthcare services
Main function	• To coordinate complex discharges and establish follow-up across hospital specialties and healthcare sectors including somatic and psychiatric services • To support vulnerable citizens with complex problems in completing the planned healthcare treatment plan at the hospital and in the private home I collaboration with the general practitioner, municipal authorities and other relevant collaboration partners • To engage in the patient trajectory at admission to represent a well-known and present face in a system where patients often meet many different healthcare professionals
Responsibilities	• To coordinate discharge plans in collaboration with nurse and doctor at the main hospital ward • To 'spot' patients in need of a targeted effort in collaboration with healthcare professionals from the hospital wards • To ensure that information about the patients' needs and health are handed over in a way that general practitioner and municipal authorities can act on them • To reach out to municipal authorities, general practice and other relevant actors before the patient is discharged to make arrangement and make sure that the patient can manage at home • To be assertive and take initiative to development and implementation of the function at the hospital and interdisciplinary collaboration partners • To establish a good and trusting relationship with the patient and relatives • To support the individual patient during admission as inpatient or outpatient, and in the home based on nursing ethics guidelines; this is with regard to the patient's challenges, resources, ability to adhere to treatment and individual health efficacy • To contribute to quality of care in transitions that live up to national, regional and local standards of care • To engage in a local nurse case manager network in order to develop the function including strong relationships with municipalities, and to support each other across local placements (e.g. during vacation)
Competencies	• Ability to perform independent, responsible and structured work in everyday work situations entailing ongoing changes and high workload • Ability to build overview, to prioritise, to coordinate day-to-day running • Ability to communicate constructively in all situations • Be oriented towards change • Understand the terms and conditions that exist across organisations and politically • Thorough knowledge about the Health Agreements[b]

[a]The table is based on job description of the nurse case managers' function at the university hospital [b]Health Agreements are political agreements related to treatment and care. They are made between regional and municipal health authorities in Denmark.

Table 2). Three NCMs participated in the group interview (one had left the job). The group interview lasted 76 minutes and was facilitated by the last author. The first author participated as an observer and contributed questions to facilitate the participants' descriptions. The final dataset consisted of written fieldnotes from eight observation days with four NCMs, audio recordings and written notes from the group interview.

Data analysis

The data were analysed using thematic analysis, which is suitable for producing a rich and detailed account of data and is compatible with a constructionist perspective.[14] Throughout the analyses, social constructionism provided a frame for exploring and understanding patterns of social behaviour and how NCMs engaged with people involved in their everyday practices.[13] The analysis was conducted in six phases.[14] In phase 1, the authors familiarised themselves with the data material, which was explored by reading through the field notes and transcripts from the group interview. This was combined with memo-writing, where semantic content was described. In phase 2, the authors inductively generated initial codes and developed memos on the data extracts concerning the NCMs' functions and practices. In phase 3, these codes and memos were the basis for identifying the initial themes across the field notes. In phase 4, the initial themes were revised and further developed, and the content merged across the themes. This process involved the interpretation of the data based on contextual knowledge. In phase 5, the final themes were defined and named as follows: 1) *Emphasising the patient's psychosocial needs in a biomedical healthcare context*; and 2) *Accompanying the patient across healthcare settings*. Phase 6 encompassed producing the report and writing up the themes, which included providing contextualised, illustrative quotes to strengthen the presentation of the themes. The findings represent themes that were found across the entire dataset.

Ethical considerations

The study was registered at the regional authorities (project ID: 2021-127), according to Danish data protection

Table 2. Interview guide for group interviews.

Introduction This group interview is focused around three areas: 1) How are patients 'spotted'? 2) Descriptions of the core task? 3) Terminating patient trajectories We ask you to engage in small exercises related to two of the three areas as a way to facilitate your reflections around the specific topic.		
1) Question How do nurse case managers '*spot*' potential patients?	Exercise • You have 2–3 min • Write down 3–5 characteristics that are important when you 'spot' a patient that will potentially benefit from being engaged with the nurse case managers service • Read your characteristics to the group • Prioritise all the mentioned characteristics according to what you believe is the most influential	Exploring questions • What are the things about the patient that catches your attention? • What makes this characteristic the most influential? • What makes other characteristics less influential?
2) Question What characterises the core task of a nurse case manager?		Exploring questions • What entails the core task of a nurse case manager at this hospital? • How much do you get involved in the core task? • How does this play out? • How are the tasks prioritised in times with high workload? • Where do you see your core task interface with similar services within and outside the hospital? • What is it that you do that no one else does?
3) Question What determines when a patient trajectory can be terminated from the nurse case manager service?	Exercise • You have 2–3 min • Write down 3–5 conditions or characteristics that determines when a patient can be terminated from your services • Read your conditions or characteristics to the group • Among the ones mentioned by the group, what has been influential in the trajectories that you have terminated?	Exploring questions • When is it most obvious that the patient needs to be terminated from your service? • Can you describe a trajectory that was difficult to terminate? • What makes it difficult to terminate patients from your service?

regulations. The study was supported by nurse managers, who acted as gatekeepers by allowing the researchers access to the field and to the NCMs' contributions to the research. The participating NCMs received oral and written information about the study and provided informed consent to participate, which assured them about confidentiality and their right to withdraw.[15,16] The study is reported using the consolidated criteria for reporting qualitative research (COREQ) checklist[17] (Supplementary file 1).

Findings

Overall, the NCMs defined themselves as providing 'something else' than usual hospital nursing care. Thus, participants compared their role to the care provided by hospital nurses employed in the different specialty wards at the hospital. This 'something else' was characterised by continuously establishing and maintaining relationships, which was observed in the NCMs' approaches to meeting and accompanying patients. The 'something else' is further described in relation to two themes: 1) *Emphasising the patients' psychosocial needs in a biomedical healthcare context*; and 2) *Accompanying patients across healthcare settings*.

Emphasising the patient's psychosocial needs in a biomedical healthcare context

Exploring the NCMs' everyday work practices provided insight into how their practices, to a large extent, depended on the personal and clinical characteristics of the patients with whom they interacted. The NCMs provided nursing care to patients who experienced severe social or mental health challenges besides the physical reasons for hospitalisation. Seen as a whole, these patients constituted a heterogenetic group in life

situations characterised by high complexity. This complexity affected different aspects of the patients' everyday lives outside the hospital, such as living conditions, financial situations and social relations. These circumstances pointed the NCMs' nursing care activities in another direction other than the usual hospital nursing care. This was reflected in the field notes:

> 'The patient, who is known to have diabetes mellitus and uses drugs, was admitted for a surgical procedure. His kneecap was cracked in four places and put back together, but he cannot lean on his leg. If it does not heal properly, his leg will have to be amputated. He has not been in his apartment in 2 months. He is afraid to go there, as he was attacked and beaten up there. He has nowhere to go and has stayed with friends since the attack. The NCM has arranged for him to stay temporarily at a municipal place offer. He will be charged a daily fee that he cannot pay. When we (NCM and the observer) enter the room, he tells the NCM that he does not want to go there. They talk about his situation and options in relation to going home. Not related to his injury or newly operated knee but related to how he is going to manage everyday life in general. During this talk he reaches the conclusion that he does not have anywhere else to go.' (Field note, day 3)

Exploring the NCMs' everyday practices revealed how the care provided by the NCMs emphasised the patients' psychosocial needs rather than focusing on the physical health issues that caused the hospital admission.

The patients' health status was the starting point for NCMs' practices. The NCMs described how the patients usually lived with several chronic illnesses that affected different organ systems. These illnesses, together with social and mental health challenges, affected patients' ability to navigate the usual specialised and accelerated hospital trajectories and manage everyday life in general. Hence, the NCMs' nursing care typically supported patients in following hospital treatment plans, as well as strengthening their ability to manage everyday life outside the hospital. During the group interview, the NCMs described their target group as patients with '*social challenges*', '*cognitive impairment*', '*abuse problems*', '*multimorbidity*', '*lacking resources*' and having '*low self-care*', a '*weak social network*' and/or '*unmet healthcare needs*'. Social challenges were explained as being related to economic status and, consequently, the patients' inability to afford prescribed medications. Other patients did not have access to electronic invitations from the hospital, as these were delivered in a secure electronic mail system that could not be accessed without proper Internet access and access to a personal electronic device. Such challenges might be further worsened by mental health problems or alcohol or drug use. This led the NCMs to focus on the patients psychosocial needs and daily lives, and this was described as opposed to the focus of usual hospital nursing care. Examples of the prominence of social problems in the target group were homelessness, other unhealthy housing situations, economic problems, debt, and lack of income. During the participant observations, the NCMs explained that they supported patients who were '*hard to accommodate*' in the specialised hospital wards if they were '*angry or hot-tempered*' or showing '*chaotic, threatening or conflicting*' behaviour. In those cases, the NCMs described themselves as helping patients who were '*treated badly*' or '*not welcomed by the hospital*'. Other patients were described as '*invisible*' within the healthcare system, leading to their severe problems being overlooked. The NCMs explained how the hospital nurses could experience these patients as reluctant to follow a treatment plan or difficult to manage, for example, if they did not show up for appointments or did not follow recommendations for care and treatment. According to the NCMs, this could cause the usual hospital nurses to '*abandon all hope of helping the patient*', which was described as a '*defeatist attitude*' among healthcare professionals. NCMs defined themselves as opposed to usual hospital nurses by seeing themselves as '*the 11th go with a 10-ride ticket*'. The NCMs' everyday practices constituting 'something else' was underlined in their descriptions of their target group as patients who were '*left over*' or '*did not fit in*' occasionally due to their psychosocial needs overshadowing their physical needs.

Although the patients' physical needs were usually the reason for hospitalisation, their psychosocial needs could be the reason for prolonged in-hospital stays. For example, when the NCMs emphasised psychosocial needs in initiating a search for new accommodation with proper professional assistance tailored to the patient's situation. In those cases, the NCM could insist that the patient stayed in hospital until the new accommodation was in place. The NCMs explained in the group interview that '*it's not always that the quick solution is the best solution*' and '*we can't always fix things*'. Such explanations underpinned the fact that NCMs' practices differed from the usual biomedical-focused and accelerated hospital trajectories.

The NCMs' everyday practices differed from usual hospital nursing care, as they did not get involved in fulfilling the patients' physical needs by providing direct nursing care or administering medical treatment. This was a distinct contrast to usual hospital nurses, who were often observed to have a specific agenda when approaching patients, such as measuring vital signs, providing food or medication. As such, the NCMs often approached the patient openly and without a specific task to perform. The NCMs noted that they, in contrast to usual hospital nurses, generally conducted analytical detective work, unravelled the professional boundaries of their role, and worked on establishing relationships. They described approaching patients with a different agenda than the other hospital staff, as their agenda was based on curiosity in relation to the person in front of them (psychosocial needs) and contrasted this to the illness- and treatment-focused (physical needs) approach enacted by the hospital staff.

This curious approach to engaging with patients was flexible and situational in nature, as it depended on the individual patient and could be observed in the NCMs' initial contact with a patient. One NCM explained that she preferred to meet the patient unprepared to be open to the patient's current status and perception of the situation. A result of the curious approach to meeting the patient is described in the following extract from the field notes:

> 'Going into the patient room, the NCM says with a loud voice, "Hello, Lotte". Lotte, the female patient, lies in the only bed in the middle of a four-bed patient room. She is very thin and has long, thin red hair. Next, the NCM sits down on a rollator beside the bed and is now at eye level with the patient. At the same time, a hospital nurse enters the room. She approaches the patient and says that she must establish an IV line as preparation for a planned radiology examination. The NCM moves back – away from the patient. The patient says, "I think it is awful" and looks at the NCM with a knowing expression, which surprises me (the observer) because they just met a few seconds ago.' (Field note, day 1)

This knowing expression shared by the patient and the NCM indicated how the NCM, in just a moment, had succeeded in establishing a meaningful relationship with the patient by emphasising the patient's psychosocial needs. As one NCM elaborated, '*I am really on the patient's side*'.

Accompanying the patient across healthcare settings

While usual hospital nurses provided nursing care to all the patients in the wards, the NCMs provided nursing care for selected patients across different hospital wards, as well as outside the hospital. The patients receiving support from NCMs were often admitted to different wards and had several recurring hospital admissions. Likewise, when wards were overcrowded, these patients were often the first to be transferred to another ward because they were not medical specialty-specific patients. In some cases, patients ended up visiting several different wards in just a few days. One NCM problematised this ironically by saying, '*Do we actually have the intention that these patients should stay on as many different wards as possible?*' The NCMs explained that they provided security for patients who did not seem to benefit from the usual healthcare services. They described themselves as '*someone who catches the patient*', '*someone who gets involved*' and '*takes charge and gives back responsibility*'. In addition, they described how they acted as '*a lifeline*', '*a spokesman*' and the one who '*gave the patient a voice in their care trajectory*'.

As opposed to the usual hospital staff, the NCMs needed the patients' permission to accompany them. This influenced the NCMs' practices at their first meeting with a patient. One NCM said, '*Actually, I am a salesperson*' to underline how she had to be accepted by the patients to be able to accompany them. The field notes revealed how they used different wording to describe their service to the patient, for example, '*someone to keep an eye on you*', '*something other than what they are able to be on the traditional hospital wards*' or '*to go along with you when you are also at home*'. These descriptions underpinned the accompanying approach and the difference from usual hospital care.

In accompanying patients across multiple wards and medical specialties, the NCM became a crucial person possessing comprehensive knowledge of the patient's situation. This was observed in formal and informal meetings with the patient, which could occur in a wide variety of locations:

> 'The NCM walks past a large, catatonic woman with short red hair wearing a hospital shirt at the breakfast trolley on the ward. The NCM bends her knees and puts her face close to the patient's face while she smiles and exclaims: "How WAS it?" The patient's face turns into a big smile, and she replies, "Cool".' (Field note, day 2)

This showed how the NCMs used spontaneous meetings to underpin the accompanying approach in the patient's trajectory. Approaching patients without a clear goal like this could occur when NCMs went on a round at the hospital; one NCM said, '*I am just prying around to find out what is at stake at the moment*', which also significantly contrasted with the usual hospital nurses' care activities. At the hospital, it was common for the NCMs to find and talk to patients in the outdoor smoking area when the patient was not present in the ward. One NCM explained, '*Sometimes the equality in the conversation is enhanced when we sit beside each other on a bench outside the ward*'. As such, small talk during informal meetings could serve to maintain the relationship between the NCM and the patient:

> 'In the hospital corridor, the NCM approaches a patient from behind. They both laugh because they find it strange that she recognises him from the back. As they follow each other through the corridor, the NCM mentions the possibility of the patient having a rollator in his home. He replies that it could be a possibility and that there are no steps in the house. Building on the knowledge she has about the patient's previous work as a carpenter, the NCM confirms that she can hear that he is a handyman.' (Field note, day 8)

In this situation, the relationship was consolidated because the NCM showed the patient that she remembered him and their previous conversations and recognised his personal skills. This showed that the accompanying role was underpinned when NCMs built on previously established relationships and common knowledge. However, the accompanying approach was also characterised by requiring the NCMs to balance the thin line between professional and/or private relationships, for example, regarding time, place and content in text on mobile phones.

The NCMs' knowledge about the individual patients, which was acquired by accompanying patients, was the foundation for the NCMs' practices. This knowledge provided NCMs with opportunities to actively influence the content of a conversation, to have a clear plan for a meeting or for setting up boundaries or posing confronting questions in response to the patient's expressions. This could involve the ability to change habits, follow treatment plans or set boundaries for social relationships. This is exemplified in the following data extract:

> 'The NCM sits leaning forward a little towards the patient and her daughter. The daughter has her baby son in a pushchair in front of her. The NCM says that the daughter must not be responsible for the patient's disulfiram treatment at home. Instead, home care nurses should be responsible. The patient says that her daughter is involved in all purchases, and the

> NCM looks firmly at the daughter and says, "And I don't want you to have this responsibility".' (Field note, day 2)

This situation exemplified the observation that the NCMs' target group was not restricted to the single patient, but also included accompanying the patient's social network, in this case a daughter and a grandchild. Further, the conversation revealed abuse problems in the wider network, which led to restrictions from social services. The NCMs made efforts to support patients in following the care and treatment plans that were introduced during in-hospital stays by accompanying patients after hospital discharge. This could include meeting patients in outpatient clinics or in their own homes.

Accompanying patients after hospital discharge also included establishing a proper professional network for the patients, in which the NCMs drew on specialist knowledge about the treatment of withdrawal symptoms and specialist social and municipal accommodation, care and treatment possibilities. As such, social problems in the family affected the NCMs' practices. The NCMs accompanied patients in their complex network of professionals from health and social services and linked different views and offers from actors, such as employment counsellors, employment centres, benefit consultants, rehabilitation programmes, abuse centres, dementia units, residential care facilities and voluntary services. The patients' combination of physical, social and mental health challenges required the NCMs to draw on a substantial network of contacts in different social services in both municipal and regional settings. One NCM explained, '*We solve issues that are out of control*'. The NCMs' extensive professional network in health and social services outside the hospital was a prerequisite for unravelling the best possible solution for the patients. One NCM said, '*I need a blank cheque to contact different instances*', while another said, '*We need active consent to talk to collaborators across settings*'. This meant that the NCMs needed permission to contact collaborators and share information about the patient's situation. Unravelling possibilities and orchestrating solutions by contacting different actors in a wide variety of settings, as well as different actors in the same setting without the involvement of the patients, occupied much of their work. In telephone contacts, relationships with collaborators were underpinned by laughter, sharing anecdotes and previous common experiences. The close relationship with collaborators was underpinned by an NCM who said, '*They are my best friends*'.

Although the NCMs were intended to fulfil the role of a consistent person accompanying the patient across different health and social contacts, this consistency could be challenged when hospital managers encouraged NCMs to terminate their involvement in patient trajectories. Occasionally, this was experienced as hard or impossible, and NCMs described some patients as being '*connected to the NCM function for life*'. Other relationships with patients could be terminated if '*someone else had taken over responsibility*'. One NCM expressed the dilemma as follows: '*Every actor must take care of the small parts; no one is allowed to take care of the whole*'. As such, the NCMs experienced a contradiction between fulfilling their roles and fulfilling the organisation's goals.

Discussion

The aim of this study was to explore the everyday practices of NCMs in a Danish university hospital. The key findings of the study describe how the NCMs' everyday practices were characterised by the provision of 'something else' than usual hospital nursing care. This 'something else' encompassed their approach to continuously establishing and maintaining relationships with patients with complex physical and psychosocial issues. These findings add to the existing knowledge base by providing in-depth insights into the everyday practices of a support service such as the NCMs. The NCMs' approach to care focused on patients' psychosocial needs in a hospital setting characterised by a traditional biomedical approach and entailed accompanying patients across healthcare settings and into their private homes. Political and clinical authorities' recognition of the need for NCMs as a bridge-building service within healthcare[18] points to possible weaknesses in the existing organisation of healthcare services. Contemporary healthcare can be understood as the result of years of increased medical specialisation and the centralisation of services.[3,19] These trends in healthcare can lead to improvements in both treatment possibilities and productivity, which benefit most patients. However, other patients experience increased difficulties in accessing and navigating healthcare services.[19] As described by the NCMs in this study, they typically provide care to patients who have multiple diagnoses and who might also be struggling with coexisting severe social issues; a specific example being the patient with knee injury who had no housing opportunities after hospital discharge. Focusing treatment and care on only one of these patients' co-existing issues does not make sense.

Increasing specialisation and productivity in hospitals seems to have accentuated fragmentation and complexity in patient trajectories and evolved healthcare services to include the engagement of more healthcare professionals and healthcare services at different locations.[19] For example, expansion of new treatment possibilities, more preventive services and individualised treatment opportunities requires more examinations that will often take place in different geographical locations. Furthermore, increasing societal norms and expectations related to the individual rights and duties of the patient within the welfare system may leave the most vulnerable groups in society with poor possibilities for accessing healthcare,[20,21] for example, some patients who were described by NCMs as unable to access electronic messages or comply with restricted rules for telephone contact to healthcare services.

In this context, NCMs were perceived as a potential solution. However, there is a paradox embedded in attempting to fix problems in a fragmented healthcare system by adding a new service and potentially increasing fragmentation and complexity. Based on current population development, healthcare systems need to accommodate complex disease pictures among patients and the fact that these may be associated with social circumstances.[19] Consequently, physical and psychosocial issues should be considered in the planning and delivery of care and treatment for these patients.[1] NCMs' focus on patients' psychosocial needs could be an example of taking these social circumstances into account. However, further

research is needed to explore the potential benefits and outcomes related to NCMs' practices in a hospital setting.

Caring for patients' psychosocial needs and establishing and maintaining relationships have been well known in nursing care for decades[22,23] and may be expected as core competencies among all nurses. Therefore, it is surprising that such needs were predominantly addressed by NCMs' everyday practices and not the usual hospital staff. However, it could also indicate how such caring practices are put under pressure in existing healthcare settings. It is well known that the continuous development of healthcare contexts may challenge different aspects of nursing care.[24] A possible explanation for this might be that technical rationality is society's prevailing value and hence dominates the healthcare system.[25,26] In a healthcare system dominated by technical rationality, dependence on others is seen as negative and may lead to the neglect of patients' psychosocial needs. As described by the NCMs in this study, their everyday practices of managing these needs among the patients included dealing with housing, network and communication issues in care trajectories. In contrast, self-care and independence are prominent values that are in accordance with the core concepts of steering documents for the existing healthcare system. The Norwegian nurse philosopher Kari Martinsen[27] raise that autonomy as a core value can lead to neglect of the patient's needs, and Delmar[25] adds that peoples striving for self-care is good, except when the reason is the absence of nursing care. The question arises whether the dominant technical rationality in healthcare systems implies that it becomes the patient's own problem to solve their psychosocial needs. In contrast, Martinsen has raised dependence as a basic human condition.[25,27] Acknowledging human dependency implies that nurses must challenge the values and norms of society by respecting human worth when people are categorised and stigmatised as drug addicts or alcoholics.[25] In this study, NCMs described meeting patients who were otherwise not welcomed at the hospital or who were met by staff with a defeatist attitude. A core approach in NCMs everyday practices that they are depicted as 'something other' than usual hospital care was to focus on the person in front of them in every meeting. This is important as negative attitudes among staff towards patients with mental illness in the healthcare system may lead to stigmatisation[28] and constitute a barrier to free and equal access to healthcare.[29–31] In this sense, it could be raised that NCMs challenged the existing norms and values by taking care of psychosocial needs among patients who do not benefit from standard care trajectories.

Based on the descriptions of NCMs everyday practices and the need for such services in contemporary healthcare, it could be questioned whether the healthcare system's insistence on specialised and accelerated treatment trajectories, resulting in multiple contacts for the most vulnerable patients, could be understood as a misuse of power. Power is a basic human condition[25,27] and a system that is more bound to rules and principles than to people, risks executing a morally irresponsible balance of power, for example as described by NCMs in this study, when a patient in usual hospital care is discharged to inappropriate housing, or when a patient is discharged with a treatment plan and the patient cannot afford the medication, or when a patient does receive notice from the hospital or general practitioner as these are sent as personal electronic communication, which the patient may not have access to. Instead of the healthcare system's misuse of power by neglecting the patients' psychosocial needs, Martinsen would call for a morally responsible execution of power acts in such a way that the other's space of action is increased.[25,27] This means that acknowledging and caring for patients' psychosocial needs could ultimately add to patients' self-care capacity.

Besides caring for the patients' psychosocial needs, the NCMs' everyday practices were also characterised by establishing and maintaining relationships. As such, nursing can be described as a relationship-based moral practice.[25,27] Likewise, the Fundamentals of Care framework puts the nurse–patient relationship at the centre of nursing care.[22,32] This focus of care fits well with the NCMs' everyday practices. The NCMs' relational-based approach to meeting and accompanying patients differed from usual hospital nursing care, which was characterised by approaching patients for specific instrumental tasks. This underpins the usual hospital nurses' experiences of incompatibility between normative good care and the actual care performed.[25] It could be questioned whether the prominence of specific instrumental tasks is a result of technical rationality dominating contemporary healthcare systems.[26] Striving for acceleration, standard care and treatment trajectories and efficiency may have blurred the focus on the uniqueness of each patient's situation.[19,33] Martinsen states that nursing should stick to the ideal of a relationship-based moral practice in which the nurse meets the patient in a sincere, open and receptive relationship with a professional assessment and professional judgement.[25–27] Hence, NCMs insisting on sticking to meetings and accompanying patients represents an unusual effort that deserves to be documented.

Limitations

An important limitation in this study was the lack of consensus about the NCM function and similar services, which could impede the transferability of the findings. Internationally, different services have been developed in different healthcare systems to support the patient's health trajectory, including coordination of transitions between hospital and home, for example, advanced practice nurses,[34] transitional care nurses[34,35] and, in a Danish context, social nurses.[9,36] Transitional care nursing has been tested internationally to demonstrate its effectiveness in transitional care for older adults with complex trajectories.[37–39] However, the differences entailed in these services and in healthcare systems make it difficult to measure and compare the effect of such services.[40,41] To respond to some of these challenges, this study provides a detailed description of the context of care, as well as a job description for NCMs in the North Denmark Region.

Even though ethnographic research is small-sample research and that every NCM in the region agreed to participate in the study, the limited number of participants should be mentioned as another limitation. To establish trustworthiness of data and validate the interpretations made in our study, we approached the phenomenon under study using

researcher and data triangulation.[42] Furthermore, this study sought to provide nuanced descriptions instead of general descriptions. As such, the findings add to the existing literature on international trends such as specialisation, fragmentation and acceleration.

Conclusion

NCMs' everyday practices were characterised as entailing the provision of 'something other than usual nursing care' in the hospital. Their everyday practices resonate with values described as being key to nursing. However, contemporary organisation and developments within healthcare systems enforce an increased focus on medical specialties and productivity, putting the psychosocial needs of patients and relational-based nursing practice under pressure. These circumstances create a need for additional (almost parallel) services to accommodate the needs of the most vulnerable patients. The findings of this study underline the need for further exploration of the potential benefits of person-centred nursing care targeting people with multi-morbidities and co-existing social issues.

Conflict of interest

The authors declare that there is no conflict of interest.

Data availability statement

Data are available by contacting the corresponding author.

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Supplemental material

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