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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Orientation in expected and unexpected landscapes – a case study of a newly established municipal healthcare unit

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Abstract

Background: This article examines how staff delivering care (two groups of healthcare workers and leaders) in a newly established unit worked to sustain required performance levels through changes and disruptions. It highlights discrepancies between plans for the unit (work as imagined) and reality in the unit (work as done).

Aim: The aim of this article is to explore the experiences of persons in the workplace in response to discrepancies between work as imagined and work as done.

Methods: Case study methodology is used to give attention to context and complexity, to gain a deepened understanding of the topic and to unveil contradictions and commonalities. The data material includes notes, pictures and soundtracks, and was analysed using qualitative content analysis.

Results: The findings show discrepancies between the plans and practical reality. Staff responses to these are presented as 'being left to oneself' 'moving to new positions' and 'walking together'.

Conclusion: The healthcare system consists of multiple interactive systems and subsystems. People working at the micro level need to deliver care under expected and unexpected conditions. For a workplace culture to be effective, staff need to experience being part of a community they can be proud of, as well as being acknowledged as persons contributing to that community. Involvement in decision making and opportunities to verbalise challenges make it possible for staff to make a map that fits the landscape, and thus make better plans for patient care.

Implications for practice:

- Engagement in a project initiated by staff can provide direction for work and better quality of care
- A resilient healthcare system depends on health workers having the opportunity to develop as persons and be part of a community
- Changes in healthcare systems are demanding for both leaders and staff, and it takes time and effort to build resilient systems and cultures

Keywords: Case study, resilient healthcare system, quality of care, workplace culture

Background

Health and social services in Norway have changed since the Coordination Reform in 2012, with its focus on the right treatment in the right place and at the right time (Ministry of Health and Care Services, 2010). The reform was established to improve quality in health services, with the key issues being to improve patient pathways and provide services close to patients' homes (Bruvik et al., 2017). Municipal services were reorganised and relocated, and emergency, reception, rehabilitation and palliative units were established within each municipality.

The critical perspective in this article is how quality of care is maintained alongside such processes of reorganisation and change. As healthcare systems are not simplistic production lines, it is essential for units in an organisation to be resilient. The concept of resilient healthcare (Hollnagel et al., 2015) is used to describe how a system works to adjust its function so that it can sustain required performance levels under expected and unexpected conditions (Hollnagel et al., 2015). The basis of safety is not only to avoid something going wrong, but to ensure things go right (Hollnagel et al., 2015). In a healthcare system, both individuals and teams in the workforce face adversity, and they must try to overcome it without detriment to performance (Bowers et al., 2017). Staff need to identify and meet actual demands and adjust what they do in order to maintain high-quality health services (Hollnagel et al., 2015). This article examines how persons and teams delivering care (healthcare workers and leaders) in a new merged unit worked to sustain required performance levels through changes and disturbances. It highlights discrepancies between work as imagined, encouraged by the wishes of policymakers, and work as done (Hollnagel et al., 2015).

Improving system resilience is an ongoing process of responding, monitoring, learning and anticipating (Clay-Williams, 2015). It is impossible to foresee every eventuality, therefore the system cannot be precisely described, specified, codified, mechanised or controlled (Hollnagel et al., 2015). Practice development methodology suggests workplace learning can be a key strategy for transforming practice. This methodology directs its attention at the micro-system level but requires support from mezzo and macro levels (McCormack et al., 2013).

A healthcare service consist of multiple interactive systems and subsystems that need to adapt to each other (Clay-Williams, 2015). Plans and decisions for the service are made in a sociopolitical system but the required performance is delivered and experienced at the micro level, which is termed 'workplace culture' (Manley et al., 2011, p 1). Discrepancies between plans and reality pose daily dilemmas for healthcare workers; their ability to deliver high-quality care may be affected by constraints on resources such as personnel, expertise, funding and equipment (Kaplan et al., 2012).

Manley et al. (2011) argue that there is a need to pay attention to the culture experienced by patients, users and staff at the interface of care. Workplace culture includes what is learned and shared in the social context, related to the workplace as a microsystem. Insights from this microsystem level can contribute to an exploration of factors that strengthen the healthcare system's resilience. One way of gaining these insights is to involve staff in processes of developing person-centred and evidence-based care (McCormack et al., 2013).

The relationship between the culture in healthcare services and the quality of care is linked to safety and performance (Mannion and Davies, 2018). Organisational culture may indeed lie at the root of many service failings in complex organisations (McSherry and Pearce, 2018). Francis (2013) found that it is a key determinant of what creates a safe healthcare system, defined as a culture of openness and learning where staff were able to voice concerns.

Several studies have found challenges in maintaining quality in healthcare at the micro level after changes at a sociopolitical level. In some instances, patients do not receive the care they require. Nødland and Rommetvedt (2019) found that a lack of beds could prevent municipal services from admitting a patient to the unit best suited to their needs. Patients being discharged from hospitals to

nursing homes are older and have a shorter lifespan than before the Coordination Reform (Bruvik et al., 2017). This has brought different demands than those planned for, as the increased flow of frailer patients places greater demands on the system to ensure they received quality care in the right place (Nødland and Rommetvedt, 2019). Although municipal services took over responsibility for a large number of patients, they saw a very small increase in beds. (Abelsen et al., 2014). The condition of nursing home residents became more complex, requiring increased nurse competence (Glette et al., 2018) and heightening the challenge of maintaining quality of service.

In the case examined here, a unit was established (in September 2016) with rehabilitation and short-term beds 'to help patients/users to be active in daily living'. The municipality had a vision for the unit in which service users and their next of kin would be treated as equally important. Growth, development and thriving should be significant for cooperation between patients and staff. The establishment of the new unit resulted in a transfer of staff and some patients from different nursing homes. This article's authors followed processes in the workplace culture, and the project 'Effective Learning Cultures' (ELC) was planned to strengthen collaboration between the new unit and the university college. It was decided that practice development methodology (McCormack et al., 2013) could support the unit's culture in a positive way and two lecturers from the university college had meetings in the unit. External facilitation helps staff gain awareness of their work and become more able to handle complex situations (Eriksen and Heimestøl, 2017).

The ELC project aimed to develop and maintain a workplace culture that could sustain the required performance levels under expected and unexpected conditions. The researchers realised that staff faced challenges that threatened the quality of care because their work as imagined was very different from work as done (Hollnagel et al., 2015). Bowers et al. (2017) suggest that this is because the collective resources of individuals and teams to overcome adversity have been largely overlooked.

The aim of this article is to explore the experiences of persons in the work culture in response to discrepancies between work as imagined and work as done.

Methodology

A case study was chosen as a research method in order to understand 'the particularity and complexity of a single case, within important circumstances' (Stake, 1995, p xi). The goal was greater understanding of planning and facilitation of quality care in a complex context during the establishment of a new unit. A case study was appropriate, as we wanted to study the unit as unique and complex, embedded in and interacting with the context (Stake, 1995). An effective metaphor for this case is a crystal, which, depending on the angle of the light hitting it, reveals different facets and patterns (Ellingson, 2009). This article describes the ELC project as the case, and the analysis and findings illuminate one facet of the crystal (staff responses to discrepancies between work as imagined and work as done). Engaging crystallisation in qualitative research makes it possible to gain 'a deepened, complex and thoroughly partial understanding of the topic' (Richardson and St. Pierre, 2005, p 963) and to unveil contradictions as well as commonalities (Ellingson, 2009).

Case description

The unit in the case comprises one section with 20 short-term beds and one rehabilitation section with 10 beds. The ELC project aimed to enhance learning in the workplace culture and to involve students, and provided an opportunity for further research on planning and facilitation of quality work in complex contexts. This was done through collaboration between facilitators from the university college and staff delivering care in the unit. Attention was paid to involvement of healthcare leaders and staff in all processes by: actively engaging and involving staff in decisions relating to development; tailoring all activities and plans to the unit; active work with contextualisation of visions and aims; and development of practical solutions for integrating developments into daily work.

The empirical material of this case study was constructed (Alvesson and Karreman, 2001) and captured as part of the collaborative work. The data are taken from workshops, seminars and meetings (see Table 1). The workbased-learning activities were based on principles from practice development methodology, such as involvement, creativity and reflexivity (McCormack et al., 2013). Working towards a common vision was a help in understanding the prevailing situation and identifying issues that needed attention. These processes also had a positive influence on how staff worked with each other, and supported a sense of collective responsibility (Manley et al., 2013, pp 149-150). Figure 1 is a photograph illustrating one creative activity.

Figure 1: Workshop creating a common vision and culture

Participants in the ELC project were the health service leaders group, staff and nursing students in the unit, as well as an external project manager and facilitators from the university college. One activity involved one patient and four next of kin. However, this article concentrates on the experiences of the persons delivering care.

Table 1: Data material and activities in Effective Learning Cultures (ELC) project

Data material	Participants	Number and dates of meetings	Content/programme
Process notes	• First author	• 2017-2019: four	Reflections on changing processes
Notes from kick-off seminar 'Prescribed activity'	• Health workers: (n=22, of which five were 'activity doctors') • Students (n=5) • University college facilitators (n=2) • Next of kin (n=2) • Patients (n=1) • External project organisers (n=1)	• 2018: Feb 1	Information about 'prescribed activity' project by external project organiser
Minutes and notes ELC	One section leader leads two departments; one leader of each unit; one leader in charge of learning and development on each unit and one representative for staff	• 2016: four • 2017: seven	Cooperative work between college and ward. Planning next in practice development in units
Minutes and notes 'Prescribed activity'	• Project group • Activity doctors	2018: four 2019: one	Participant observation, formal and informal interviews
Status from 'prescribed activity: Blob tree sheets (blobtree.com)	• Activity doctors (n=5) • University College facilitators (n=2) • External project organiser (n=1)	• 2018:April 10; June 5; Sept 4; Dec 18 • 2019:March 12; June 12	Each person gives impression of his/her 'position'
Workshop ELC: notes, pictures from creative processes, posters.	• Health workers (n=18) • Leaders (n=4) • University College facilitators (n=2)	• 2016: Nov 1	How can we become 'one house'?
Notes before 'prescribed activity'	• Students with clinical placement in units (n=5) • Leader group (n=5) • Activity doctors (n=5)	• 2019: Jan 22 and 29	Opportunities for activity in the ward
Students' assignments during their clinical placement	• Five year 1 students • Two year 3 students • Two year 2 and 3 year students • One year 2 student	• 2018: four (Feb, April, Oct, Dec)	Students writing about 'prescribed activity'
Student mappings of patients' activities - patients' responses	• Five year 1 students	• 2019: Jan-Feb	Mapping and implementation of activities with patients.
Students' reflections notes on how the project was integrated in the units	• Two year 3 students	• 2019: April-June	Mapping, implementation and writing related to theory on quality improvement.
Informal dialogues throughout the period	• Students • Employees • Leader group	• 2016: May-ongoing	
Focus group (soundtrack) and workshop (notes, pictures from creative processes	• External project organiser (n=1) • Activity doctors (n=5) • Leaders (n=4) • University College facilitators (n=2)	• 2019: March 12	Evaluation of 'prescribed activity' after one year
Drafts, notes ELC	• Facilitators/researchers/authors from University College (n=2/3)	• August 2016 - ongoing	Ongoing dialogues about practice development processes, reflections on facilitation and plans for research
'10-factor' employee survey	• Health workers units	• 2017: April-May	Quality improvement in municipality

The results in this article do not represent outcomes from the ELC project. Rather, the project enabled the systematic collection of data from processes in the workplace as it aimed to overcome discrepancies between work as imagined and work as done.

In the process of working to sustain required performance levels through changes and disruptions, the caregivers became aware of the need for meaningful activities for patients. A subproject, 'Prescribed activity', was incorporated in the ELC project and 'activity doctors' were appointed among the staff. One year after the unit was established, a 10-factor employee survey was conducted in every nursing home in the municipality. This survey was not part of the project presented in this article, but offered insight that was important for the analysis.

Analysis

There has been an ongoing reflection between the facilitators and authors throughout the project period. There has been movement between being immersed in (influencing and being part of) the culture in the unit and holding a more distanced perspective. The engagement in the case was in line with strategies from Ellingson (2009), with a phase of wondering and later making choices as to which facets of the data should be explored/illuminated.

The wondering phase meant asking reflective questions like 'What is going on?', 'How do staff handle the changes?' and 'How can this case represent exemplary knowledge?' (Thomas, 2011). There was ongoing discussion between the authors, reading of literature, presentation to 'activity doctors' from the unit, as well as presentation to researchers in the authors' field. As a result of these processes, discrepancies were discovered between map and terrain, between plans and clinical reality. Examples are presented in Table 2. This allowed more specific questioning of the material, concerning how leaders and staff responded to the discrepancies in order to maintain quality of care.

Table 2: Examples of discrepancies between plans and clinical reality

Aims for quality	Map (work as imagined)	Terrain (work as done)
Physical environment adapted to patients' needs	• Kitchen with coolers and walkers with trays for the patients to find their own food • Open-space solutions, long corridors, no outside spaces	• Frail patients with significant care needs • Many patients had additional diagnoses, such as dementia • The sense of disorientation and restlessness in the unit increased
Having competent staff that can deliver quality person-centred care.	• Planned stay was two to three weeks • Activities suitable for rehabilitation stays • The staff's special competence: rehabilitation and to support the patient's ability to independent living	• Patient stays lasted up to several months • Patients were too frail to move back home or participate in rehabilitation activities, so faced long days of waiting and inactivity • Staff faced new demands, for example, providing substantial help with daily personal care, and handling patients' insecurity and confusion • Few members of staff had competence in caring for persons with dementia • Low score in 10-factor survey question on 'competence to handle challenges'
A resilient workplace culture that can handle unexpected and expected events	• The staff had imagined a continuation of existing practice; they came from two cultures, carrying conscious and unconscious norms, values and attitudes	• 'Us and them' mentality between staff from the two original units • Low score in 10-factor survey question on 'mastery of environment'

The systematic analysis of the data can be described as phases and stages of theme development in a qualitative content analysis (Vaismoradi et al., 2016). As this was a case study, the stages were identified both during the project period and in connection with writing this article. The initialisation

phase was about gaining an overview of the total material, by reading and discussing, writing notes, finding preliminary codes and possible abstractions. In the construction phase categories were used to cluster codes and meanings. A further close reading of the material was carried out and examples developed that represented these labels in the material. In the rectification phase the authors realised that this represented a concrete description of elements of discrepancies in the case. To ensure congruence between the focus of study and the results, the 'self-correcting and cyclic process' was continued (Vaismoradi et al., 2016, p 106) and themes were developed on a higher level of abstraction to illuminate staff experiences and responses. This represents another representation of the findings (Vaismoradi et al., 2016).

Ethical considerations

The study was reported to the Norwegian Social Science Services (59933). All staff and leaders involved in the unit received information about the project and signed an informed consent form. At each workshop, focus group or meeting, everybody in the room was told that the material would be included in the study, and any new staff or nursing students would sign the consent form. Participants could withdraw at any time. The workplace observation and notes from the facilitators and students were carried out in a way that prioritised and maintained the dignity and privacy of the persons involved and no individuals can be identified in the findings.

Results

The staff struggled to 'find their way' as their 'map' – their image about what the work would be like – was not a helpful guide to delivering high-quality care (see Table 2). Staff experiences of orienting themselves are explored below as 'Being left to oneself', 'Moving to new positions' and 'Walking together'. The themes represent variations of experiences that occurred parallel to each other as staff members had different experiences, which varied over time. Some may have recognised mostly one of the three, and the experience of being left to oneself may have diminished as challenges were dealt with over time.

Being left to oneself

In workshops in 2017 staff said there was '*no sense of being a fellowship*' in the merged unit. They experienced that '*each person had to fight his or her own battle*' as there was no sense of common culture and lack of structures to lean on in their daily work. Various reasons for this were voiced.

One was that the staff came from two different units. They held on to their previous routines and ways of doing things and resisted changing them in the new unit. Their impression of the new place was that things were not structured according to the work that needed to be done. It did not seem safe to change a practice that they knew worked: '*Why is the way we did things not good enough anymore?*' As each person had a sense of fighting for herself, the sense of 'them' from the other unit seemed to escalate, with different opinions on '*how things are done around here*'. They said this was like being in '*two camps*'.

Another reason was that staff experience and competence had not been acknowledged in the planning of the merged unit: 'W*e had previous experience with this kind of unit, and knew that serving trays on walkers would not work, but we were not asked*.' Instead, there was a need for competences they did not have, and this meant improvising to care for the patients: '*We do not have the competence to meet the needs of the persons being admitted to the unit, for example persons with dementia*.'

A third reason was a lack of consistent support from leaders. Leaders at different levels in the organisation had to reorganise to address the new demands in the merged unit, and to handle the challenges brought by admitted patients. Handling day-to-day work became very time consuming. At the same time, leaders needed to handle dissatisfaction and complaints from staff, while themselves being in exposed positions without support. The rate of sick leave in the unit was high among both

leaders and staff. Leaders changed roles and some left to work in other places, while employees adopted a position of 'nagging' and expressed a wish for more '*visible leadership, opportunity to be involved, and in general a sense of being seen and heard*'.

This led to a devaluation of all parties involved (leaders, staff, patients and patients' next of kin). The opportunity to live full lives, and have a sense of contributing to something worthwhile was reduced. Some patients and their next of kin complained that their stay did not meet their expectations.

Moving to new positions

These experiences of being left to oneself also triggered reorientation. After having worked together for one year, some staff still expressed concern that they did not work well as a team. At the same time more positive voices were heard, starting to refer to colleagues as resourceful and saying it was a good thing that they had different work experiences.

Throughout this period, facilitated processes had taken place with the intention of developing a workplace culture of learning. For example, a workshop provided space in which each person's opinion and experience were given room and valued. They shared thoughts about their values, and ideas about how they could contribute to the community. A vision emerged and was explored through words as well as visual artefacts. This gave the staff new thoughts about the workplace, about leaders and colleagues, and about their own responsibilities. However, there were still no easy solutions: '*We have worked together on many things, we have started walking, we don't know what will come around the bend, it feels like being in a maze*.' Staff struggled to decide which route to take: "*We have broken a barrier, but what now? What will we do?*" The developed vision was: '*We want high-quality care for our patients – we want a workplace we can be proud of – the best rehabilitation ward in the world*.'

Through formal meeting points between leaders and staff, a common understanding of the daily challenges developed. This lead to changes in routines to meet the circumstances and clearer roles to establish who was responsible for which tasks. Time for learning and development was incorporated in the usual work routine, and reflection groups were established to reflect on patient cases. There were 'get to know each other' events, and dialogues about how the staff could help each other to work together. Activities including a Facebook group and a leisure group organising activities outside work are likely to have contributed to these positive developments.

Recognising signs of reorientation and change made it easier to adjust expectations to the actual situation. Staff oriented themselves towards the future, and to how unexpected situations could be handled. They seemed to accept shared responsibility: '*We are in a nice building and are moving on, but there are many things to handle*.' There was a considerable reduction in sick leave between 2017 and 2019, a clear sign of a positive change taking place in the unit.

Walking together

Taking on a specific project became another element in establishing a learning culture. The unit became involved in the subproject 'Prescribed activity', which aimed to '*improve the quality of life for patients, use staff resources, and include patients' next of kin*'. There was focus on providing activities that suited each patient, and on prioritising activity as one would other prescribed treatment. The subproject was initiated by staff and gave them the opportunity to take an active approach.

A positive energy developed in the workplace: '*This created enthusiasm and joy in our daily work*.' Being engaged in the project was a fulfilment of staff wishes to make things better '*and do what is in the best interest of the patients*'. The project gave them hope of improvement: '*Regaining the feeling of being worthwhile …a project that would enhance the quality of care for the patients*.'

Throughout the project, staff became responsible for development and improvement, and felt their actions could make a difference: '*After we were given roles in the project, things have become better*.' There was a job to be done to tailor the project to the context: '*We needed to make a new menu for activities, we formed the project as it went along and this has made it more suitable for us*.' In this way the project strengthened the workplace culture, and gave new learning opportunities for nursing students – '*a project that made it possible to include the students*'.

Staff saw patients smiling and being happy with the care they received, and expressed pride with successes like '*observing the patient's expression when being able to knit again*'. They could see their wish to contribute to high-quality care being fulfilled.

Discussion

Attention to an organisation's ability to succeed under varying conditions and how this ability can be nurtured and maintained (Hollnagel et al., 2015) seems to be crucial in healthcare services. The findings indicate that discrepancies described in Table 2 had a negative impact on this ability. This discussion focuses on facilitation of positive cycles towards resilience in the light of the three themes above: being left to oneself, moving to new positions and walking together.

Support the system's resilience by empowering persons and the work culture

Unstable and challenging conditions may trigger experiences of being left to oneself, and create a breeding ground for negative attitudes and polarisation between staff members. There is need to encourage positive processes to counteract this. External facilitators can provide opportunities to create awareness among staff about their own work; effective facilitation is a collaborative approach, promoting ongoing communication and assisting the staff in proactive problem solving (Diffin et al., 2018). Eriksen and Heimestøl (2017, p1) suggest it is useful for staff to present a story about 'who we are and what we do'. Staff can become aware of and explore details in their work, as well as gain better understanding of the terrain and plan where to move (Eriksen and Heimestøl, 2017; Dahl et al., 2018). Thus, these processes of empowering persons by helping them become aware of themselves and their own work can be a reorientation towards knowledge of the landscape and finding a way to move to new positions. Contextual factors such as staff culture, patient mix and structural condition will influence the process of knowledge utilisation (Øye et al., 2015).

This kind of facilitation is a way of working with basic assumptions in the workplace culture. Manley et al (2011, p2) argue that skill is needed 'to transform how things are done at the practice level' when this transformation 'requires fundamental changes in mindsets and patterns of behaviour'. Berta et al. (2018) point out that development of human resources influences work attitudes and outcomes. Staff perceptions of their work environment influence how they feel about their work and this in turn influences their work behaviours and performance (Berta et al., 2018). There is a need for meeting places and formal settings in which staff can verbalise concerns (Francis, 2013), influence decisions and become involved in decisions about how daily work is performed.

The findings illustrate that the experience of walking together was a turning point. A sense of being part of a community can come when one's contributions are valued by others, and this can happen in reflection groups and workshops in which all contributions are valued. Such meetings, as well as informal social settings, can strengthen the experience of being a community. Pleasure in sharing common experiences with peers, being and belonging, and collective joy and celebration may be prerequisites to developing effective workplace cultures (Sudmann, 2018).

In this case study, being involved in processes of assessing and describing their challenges led to engagement by the staff. The meetings made it possible to develop a common direction and a sense of being in charge instead of being left in a position of hopelessness. In addition to the ELC project, there were several other measures that contributed to building the resilience of the unit, for example action

plans in response to the 10-factor employee survey, clearer descriptions of roles and responsibilities, and celebrations and social events. The subproject 'Prescribed activity' was one way of staff developing a common direction for their work. It contributed to acknowledgement of each person's competence and efforts, encouraged hope for better quality of care for patients and represented something staff could be proud of as a community.

The findings illustrate that staff did not perform well when they felt left to themselves. Berta et al. (2010) write that demands that are beyond the individual require collective and organisational capacity and support. In person-centred practice, staff need to be innovative and dare to take risks (McCormack and McCance, 2017) but this is hard if you are part of an unstable and insecure environment. Lack of attention to timing and organisational readiness may also hinder processes of development (Øye et al., 2015).

Support the system's resilience by involving all levels

Even with fewer discrepancies between map and terrain (plans and clinical reality), it may not be possible to have a map that fully describes the complexity of the terrain. There is still a need to look for the big picture, informed by several perspectives such as those of patients and their next of kin, healthcare staff, leaders and policymakers.

Even though the organisation is ultimately responsible for delivering high-quality healthcare, those at the 'sharp end' (the staff delivering care) can be blamed if the culture leaves them unable to do their job as they would like to do it. In this case study, what happened at the micro level needed to adapt to the sociopolitical system in which plans and decisions for the service had been taken – 'larger cycles of system change and adaptation… constrain smaller cycles' (Clay-Williams, 2015, p 129). Resilience in a system depends on all levels in that system informing each other and adapting accordingly.

The findings illustrate that staff tasked with delivering the required performance on behalf of the system felt left on their own, uncertain about structures and processes, as well as having a sense of not being acknowledged. A greater degree of involvement in decision-making processes may have given them a clearer picture of the new unit's plan and aims (Hussein, 2016). This would have strengthened their ability to 'be loyal to the vision, and constantly striving for its attainment even during periods of adversity' (Aarseth, 2014, p 23).

Some of the resistance and negative attitudes to change may have diminished if those at the sharp end experienced that their concerns about the quality of care had been acknowledged by persons at the 'blunt end' (management and policymakers). To achieve this, staff need to be given relevant information and be involved in planning processes. A collaborative approach and ongoing communication seem to contribute to the successful implementation of plans (Diffin et al., 2018). If staff are involved in drawing the map they have opportunities to influence priorities and choices. This promotes a sense of shared ownership and responsibility (Dahl et al., 2019).

All levels in the system need to be involved in ongoing processes of responding, monitoring, learning and anticipating in order to be resilient (Clay-Williams, 2015). If resilience is to be analysed, recognised and facilitated, it is important to identify and understand the system and subsystems involved. The map that guides the system in planning and development needs to be based on 'examination of overall patterns, over longer time frames' (Clay-Williams, 2015, p 133).

Manley et al. (2011 p 2) suggest it is useful to 'assess the workplace culture and determine the areas that need action'. There may be a need for persons from different levels in the system to co-create an image depicting the big picture. Involvement and ownership may be strengthened by engaging representatives from different stakeholders in processes of mapping complex projects (Dahl et al., 2019). This kind of cooperative mapping activity may help to promote a shared understanding of the terrain and minimise discrepancies.

Conclusion

A resilient healthcare system needs the ability to adjust its functions in response to changes and disruptions. Exploring experiences of the persons at the micro level can be one way of providing exemplary knowledge about how a unit may develop the ability to sustain the required performance levels under expected and unexpected conditions.

This article shows that in service planning, exclusive attention to practical structures and plans may be detrimental to staff and the workplace culture. Staff, with their competences, values and attitudes, as well as patients with their uniqueness, need to be considered when planning service changes. There is a need to spend time and resources on building cultures and this is an ongoing task if the system is to deliver high-quality care.

It is uncertain whether greater involvement in planning processes for the new unit would have led to less frustration among staff, as adjustment to new working conditions is always likely to be challenging. However, it is crucial to take account of existing knowledge about resilient healthcare systems, and to be aware of the need to work proactively to diminish discrepancies between work as imagined and work as done.

A healthcare service consists of multiple interactive systems and subsystems. The staff operating at the micro level in this case had the responsibility of delivering high-quality care but they needed support from mezzo and macro levels. To promote an effective workplace culture staff need to experience being part of a community they can be proud of, as well as to be acknowledged as persons contributing to that community. Giving them the space to verbalise their views and challenges brings an opportunity to make a map that fits the landscape they are moving in, and thus make better plans for patient care.

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