“Care is not just about care anymore”
van Wieringen, M.

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Chapter three

"We’re all Florence Nightingales": Managers and nurses colluding in decoupling through contingent roles

Abstract

The present study develops our understanding of the micro-level dynamics of decoupling by addressing how and why various occupational groups, that is, managers and professionals, are involved in decoupling in response to institutional complexity. Our conceptualization of occupational groups’ involvement in decoupling emerges from an in-depth qualitative study of 21 managers and 21 nurses in the Dutch homecare sector, where an increasing business logic alongside a professional care logic necessitates a redefinition of occupational jurisdictions and a repositioning of professionals and managers in relation to nonprofessional caregivers. We contribute by delineating how different occupational groups collude in decoupling in an institutionally complex environment through contingent roles. We show that managers facilitate decoupling through ambiguity regarding multiple institutional logics, and by purposefully abstaining from enacting the business logic in work processes. Nurses in turn deflect institutional pressures by engaging in a classic form of decoupling, that is, complying symbolically with the business logic. We conceptualize how managers’ and nurses’ occupational commitments and jurisdictions, their relative social positions and other situational conditions are integral to how and why they collude in decoupling through contingent roles. As such, we add to the understanding of micro-level mechanisms and conditions of decoupling.

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3.1 Introduction

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(Home-care manager)

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The question of how and why managers collude with nurses in decoupling inspired this study. Decoupling refers to the phenomenon in which organizations adopt a policy or program, but fail to implement related work practices (Meyer & Rowan, 1977). Meyer and Rowan's by now classic thesis, delineating how organizations symbolically comply with external pressures, has been reasserted particularly in studies on organizational responses in institutionally complex environments, where 'there are conflicting institutional pressures' (Boxenbaum & Jonsson, 2008, p. 79; see also Greenwood et al., 2011). Research on the intra-organizational dynamics of decoupling (Bromley & Powell 2012) has focused on the role of power, influence and personal interests of organizational leaders in decoupling (Fiss & Zajac, 2006; Westphal & Zajac, 2001), has revealed the interplay between intra-organizational dynamics and the external environment (Crilly, Zollo, & Hansen, 2012), and has addressed how coordinated decoupling influences the perceptions of legitimacy of lower-level organizational members (MacLean & Behnam, 2010). Professional norms and the claims of occupational groups for control over particular areas of expertise, that is, occupational jurisdictions (Abbott, 1988), have also been related to decoupling practices by doctors (Kellogg, 2011), teachers (Hallett, 2010), and engineers (Sandholtz, 2012). Despite its empirical salience, decoupling remains a relatively under-theorized concept within institutional theory (Boxenbaum & Jonsson, 2008; Greenwood et al., 2011). Further conceptualization is needed to help us understand better what is happening at the micro-level (Sandholtz, 2012), and particularly how decoupling actors engage with, and are influenced by, various institutional logics (Misangyi, 2016).

We address two limitations of the existing literature on decoupling. First, because decoupling has been conceptualized predominantly as an organizational-level response (Binder, 2007), previous research has largely overlooked the various ways in which different occupational groups are concurrently involved in decoupling. In extension, not much is known...
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about what motivates people from different occupational groups and social positions who work in an institutionally complex environment to engage in decoupling (Greenwood et al., 2011; Misangyi, 2016). Therefore, we ask: *How do various occupational groups engage in decoupling when working in complex institutional environments?*

In addressing this question, we join an emerging body of scholars looking at how institutionally complex environments are inhabited by people (e.g., Bévort & Suddaby, 2016; Hallett & Ventresca, 2006). Building on important insights into the relationship between people’s responses to multiple or changing institutional pressures and their (respective) social positions and jurisdictional claims (Battilana, 2011; Bertels & Lawrence, 2016; Currie & Spyridonidis, 2016; Delbridge & Edwards, 2013; McPherson & Sauder, 2013; Lockett et al., 2014), we expand our understanding of the micro-level mechanisms and conditions of decoupling.

Our insights emerge from an in-depth qualitative study of managers and professionals, that is, nurses, in the Dutch home-care sector. As in other sectors (Hallett, 2010; Noordegraaf, 2015), these managers and professionals work in a complex institutional environment in which two very different logics coexist: a professional care logic and an increasingly dominant business logic (earlier referred to as a logic of managed care) (Reay & Hinings, 2009; Scott et al., 2000). The business logic is reflected in increased standardization and formalization as well as a need for transparency and accountability with regard to external funding agencies. Moreover, austerity measures are being taken to curb the rising cost of (long-term) care. As an example, the government now expects informal caregivers, that is, spouses, family or friends of care recipients, to provide particular types of care that were previously undertaken by nurses. This constitutes a change in the institutional environment and alters the jurisdictional spaces of managers and nurses (Abbott, 1988; Evetts, 2013; Thomas & Hewitt, 2011), thus necessitating a repositioning of both managers and nurses in relation to informal caregivers.

Our main contribution is to reveal how different occupational groups collude in decoupling in an institutionally complex environment through contingent roles. Whereas managers facilitate decoupling and engage in that process by being ambiguous in the face of multiple institutional logics and by purposefully abstaining from enacting the business logic in work processes, nurses engage in a classic form of decoupling, that is, through symbolic compliance with the business logic. We conceptualize how the occupational jurisdictions of
managers and nurses, their relative social positions and other situational conditions are fundamental to why and how they engage in decoupling. As such, we increase understanding of the micro-level mechanisms of decoupling and the conditions in which it occurs in institutionally complex environments.

We start by reviewing the literature on decoupling, institutional complexity and social positions. Next, we describe our empirical setting in more detail and delineate our methodology. We then present our findings. We end by discussing how our findings contribute and speak to the existing literature.

3.2 Theoretical background

“Classic” policy–practice decoupling often signifies symbolic management, that is, a failure to implement policy (Bromley & Powell, 2012). Decoupling is then a strategy that is engaged in as a way of enhancing an organization’s chances of survival and legitimacy in the eyes of external constituents (Meyer & Rowan, 1977). Recent research has also discerned means-ends decoupling, referring to the phenomenon in which organizations implement policies but do not achieve their intended outcomes “because the adopted policies are inappropriate” (Wijen, 2014, p. 302; see also Bromley & Powell, 2012). Research on the intra-organizational mechanisms of decoupling has shown how organizational leaders use decoupling as a sociopolitical device to secure their own interests (see Fiss & Zajac, 2004; Westphal & Zajac, 1998), and how their ability to do so depends on the extent of their influence and power (Fiss & Zajac, 2006; Westphal & Zajac, 2001). Decoupling might also occur at the work-floor level. Here it has been found to involve either refusing to enact institutional pressures, or finding ways to avoid doing so, when these are perceived to interfere with occupational jurisdictions (Binder, 2007; Hallett & Ventresca, 2006; Kellogg, 2011). Sandholtz (2012), in his study of how standards are implemented in engineering, focuses on people “on the receiving end of standards” (p. 670). He shows how individual actors engage in decoupling in different ways, depending on the extent to which they perceive their institutionalized occupational jurisdictions to be threatened.

Recently, the notion of decoupling is increasingly re-appearing in research that studies complex institutional environments (see Boxenbaum & Jonsson, 2008 for an overview).
Institutional complexity refers to the enduring existence of multiple institutional logics (Greenwood et al., 2011). Institutional logics are “a set of material practices and symbolic constructions” (Friedland & Alford 1991, p. 248), which include “assumptions, values, and beliefs, by which individuals and organizations provide meaning to their daily activity” and from which they derive “their sense of self and identity” (Thornton et al., 2012, p. 2). Research has shown that institutional complexity may prompt organizations to engage in either decoupling or coupling, depending on what their particular objectives may be (Misangyi, 2016), and that managers may engage in selective coupling of different elements of institutional pressures (Pache & Santos, 2013). While existing research has provided important insights into various forms of decoupling at the organizational level and the role of individuals in decoupling, in this paper we aim to explore in more detail how actors from different occupational groups, working in a complex institutional environment, may be involved in decoupling, and how they engage with and are influenced by various institutional logics. In doing so, we draw on existing research that recognizes that institutions are inhabited by people.

Under conditions of institutional complexity, people may be confronted with the micro-level instantiations of multiple institutional logics. While different occupational groups prioritize different institutional logics, research has also shown that people nonetheless combine multiple institutional logics in their day-to-day work (e.g., Bévort & Suddaby, 2016; Currie & Spyridonidis, 2016; Kraatz & Flores, 2015; McPherson & Sauder, 2013; Reay & Hinings, 2009). McPherson and Sauder (2013) show how actors’ capacity to combine different institutional logics is enhanced when they are operating at the intersection of multiple logics. The authors reveal that, in a drug court, people with different occupational commitments and jurisdictions reached consensus in a decision-making processes by being willing and able to “hijack” logics that others adhered to, and simultaneously pursued their own goals in that decision-making. Reay and Hinings (2009) show how a pragmatic collaboration between interdependent managers and physicians in fact entails an “uneasy truce,” but allows both groups to adhere to the logics to which they are most receptive. Voronov, De Clercq, and Hinings (2013) further show that the ways in which individuals manage institutional complexity are flexible and situated. Individual reactions may vary depending on whom a person is interacting with. As such, research has shown how the manner in which actors perceive and act upon plural institutional logics is determined largely by their own position,
as well as by the institutional demands to which referent audiences are receptive (Delbridge & Edwards, 2013; Dorado, 2013).

Battilana (2011) has more specifically studied the relationship between actors’ position in the field and within the organization in which they work, and their ability to influence the institutional status quo. She shows how organizational leaders have access to considerably more resources for initiating change than lower-level employees, but are less likely to initiate change because the status quo serves their own interests. In a similar vein, Lockett et al. (2014) show how the different social positions of actors influences how they make sense of organizational change and their disposition to take an active part in it. Building on this, Bucher et al. (2016) study how professional groups with different social positions undertake discursive boundary work in response to government initiatives aimed at increasing collaboration between different professions. The authors reveal that high-status professionals seek to maintain their jurisdiction and position, and are well placed to do so. By comparison, lower-status professional groups, and even more so middle-status professionals, discursively challenge the status quo and the concomitant boundaries between professional groups. However, they are not in a position to make any actual changes to existing professional boundaries. Further considering the salience of the relative positioning of different occupational groups, Currie and Spyridonidis (2016) show how mutual adjustment by interdependent occupational groups happens if actors see this is helping them to enhance their own position, and happens provided that higher-status actors do not feel threatened by the institutional logic adhered to by lower-level actors. Finally, Oldenhof, Stoopendaal and Putters (2016) find that middle managers relate to care workers through “professional talk.” This can either serve to empower or disempower those workers, thus affecting their relative position.

To reiterate, previous research has provided valuable insights into the manner in which people manage institutional complexity, oftentimes ostensibly to serve their purposes, and has shown how this is influenced by their social position and their relationship to people who may be receptive to other institutional logics. Mutual adjustment between occupational groups seems to occur insofar as people, in particular those in relatively powerful positions, can pursue their own interests, and as long as their position is not threatened. The question is whether similar dynamics are at play in the process of decoupling. While various organizational actors have been found to coordinate or to actually engage in decoupling, no
one has as yet explored how their response may relate to those of others within the organization. Given that previous research has shown that those who engage in decoupling often do so to serve their own personal interests and/or those of their occupational group, one may well wonder what consequences decoupling may have on the interests and position of other occupational groups within the organization. Besides, as decoupling is ostensibly a rather cautious strategy to avert particular institutional pressures that do not serve one’s own interests, the finding in previous studies that managers are often those who engage in decoupling is intriguing because research on social positions, in turn, suggests that managers are in a better position to initiate institutional change when their purposes are not served. Altogether, these considerations underscore the need for a more complex view of decoupling. However, the literature on decoupling has not yet considered the various ways in which different occupational groups are concurrently involved in decoupling, nor has it addressed what motivates people from different occupational groups and social positions working in complex institutional environments to engage in decoupling. With organizations characterized by instantiations of different institutional logics and composed of multiple occupational groups with distinct social positions and dispositions, it is important to gain insight into how various occupational groups engage in decoupling in an institutionally complex environment. This micro-level focus will advance our understanding of the conditions and mechanisms of decoupling.

3.3 Methodology

3.3.1 Research context

Like other healthcare settings, the Dutch home-care sector has seen a development in which the principle of managerialism has made its way into the organization of caregiving and now co-exists with the principle of professionalism (Thomas & Hewitt, 2011). Following other institutional accounts, we refer to these two principles as a business logic and a professional care logic respectively (cf., Currie & Spyridonidis, 2016; Reay & Hinings, 2009; Scott et al., 2000).

Until the 1990s, a professional care logic was dominant in the Dutch home-care sector. This was reflected, for example, in the prevailing norm that care was provided based on the
needs and wishes of individual clients. Home-care nurses enjoyed considerable autonomy as their professional jurisdiction included assessing and deciding upon the types of help that a client should receive, and organizing and adjusting the caregiving accordingly (Abbott, 1988). Starting in the 1990s, the rising costs of long-term care informed a government-led introduction of a business logic, which brought into caregiving values and practices such as accountability, efficiency, transparency, and standardization (Thomas & Hewitt, 2011). The government set up regional Care Assessment Centres (CACs) to secure an objective and independent process of diagnosing and allocating care. Since then, home-caregiving has been based on “product financing” (Postma et al., 2015). Nurses still assess a client’s care need, but have to do so based on pre-defined, standardized “care packages”. They then have to send a care request to the CAC. The CAC usually allocates the care requested, generally without contacting the client, and provides nurses with care packages that set out precisely what types of care clients are to receive and how much time nurses should spend on caregiving. Once nurses have reported back to the CAC, the home-care organizations which employ them receive an amount of money based on the care packages that have been allocated (Da Roit, 2013).

The Dutch government has also continuously taken austerity measures. In its latest austerity measure, the government cut back on the types of care and support that are funded by means of care packages. For example, meal preparation is no longer considered to be the type of help that nurses should be delivering, and this is therefore no longer reimbursed. Instead, government policies have increasingly pushed informal caregivers to provide help of this kind. Stressing once again the importance of people looking out for each other, the government regards spouses, family, friends, and neighbors as the most appropriate providers of care to those in need. When professional care is eventually called upon, nurses are expected to involve informal caregivers in the caregiving process and to provide support to ensure a continuous role of informal caregivers (Da Roit, 2013). As the number of business-related measures has continued to grow, home-care organizations are now characterized by the instantiation of both the business and the professional care logic. Our case shows how this duality of institutional logics plays out at the micro-level, and reveals how the professional care logic is dominant in guiding the day-to-day practices of both managers and nurses.
3.3.2 Home-care organizations, managers, and professionals

Managers and nurses are employed by private non-profit home-care organizations. Regulated by government laws, these organizations are expected to offer affordable and good-quality care that responds to clients’ needs (Oldenhof et al., 2014). Like other healthcare organizations, many Dutch home-care organizations have merged in an attempt to counter the effects of budget cuts over the past few decades (Postma et al., 2015). This process has resulted in large and hierarchical organizations, and for this study we deliberately selected five home-care organizations with a hierarchical structure of this kind. Within these organizations, communication was largely top-down, and decision-making was centralized. A typical practice which reflected the business logic was the high level of task standardization and task specification in procedures and protocols. Tasks were also differentiated, as they were assigned to “different care workers, depending on required professional capabilities” (Postma et al., 2015, p. 67).

We studied professionals who were providing either personal care or nursing services — that is, second-level auxiliary nurses and registered nurses respectively — and their managers. Personal care services include showering, dressing, and other basic care tasks such as putting on compression stockings or supervising the taking of medication. In addition to supervising auxiliary nurses, registered nurses provide more complex care such as giving injections, dressing wounds, and providing specialized care (e.g. to diabetics). They also have responsibility for requesting care packages and for managing the coordination and overall quality of care. Managers, in turn, are responsible for the functioning of multiple teams of nurses, and as such are indirectly responsible for the quality of care that is delivered. Managers’ tasks relate particularly to the financial management of these teams, including areas such as budget-holding, brokerage, and contracting (Postma et al., 2015).

3.3.3 Data collection

We adopted a qualitative interpretive research approach to address our research question. In-depth interviews formed our most important source of data. Organizational policy documents, setting out the organization’s missions and/or strategies, formed an additional source of data that provided background information and enriched the respondents’ accounts.
Managers of home-care organizations were contacted and informed about the purposes of the study. When they agreed to participate, we were introduced to the nurses. These nurses were contacted by the first author and also informed about the purposes of the study, after which a face-to-face interview was scheduled. Following up on recommendations made by the nurses, the first author also interviewed their managers.

The first author conducted interviews with 21 executive and middle managers and 21 auxiliary and registered nurses. The interviews took place between December 2012 and December 2013, were held at the respondent’s workplace, and lasted between 45 and 90 minutes. All interviews were recorded and transcribed verbatim. At the start of the interview, confidentiality was emphasized so as to encourage respondents to speak freely. The topic list that guided the interviews was designed to acquire information about the individual level, the intra-organizational dynamics and the institutional environment. During the interviews, the following topics relevant to this paper were discussed: occupational background; occupational tasks and responsibilities; the organization of day-to-day work; the frequency and content of intra- and inter-professional meetings; procedures relating to the allocation of care packages; the balance between allocated care packages and actual caregiving; ideas about what constitutes good quality of care; the perceived role of informal caregivers in the caregiving process; and how nurses involved and supported informal caregivers. Interviewees were encouraged to elaborate on their responses.

### 3.3.4 Data analysis

The first author started the data analysis after the first few interviews. Discussions between the authors about interpretations of the data led to some topics – for example, the allocation of care packages and perceptions of the actual time spent on caregiving – being given a more central role in subsequent interviews. More intensive data analysis was undertaken in three stages, during which the authors met several times to discuss the findings, coding decisions and theoretical approach. Coding was done using MAXQDA, a software package for the analysis of qualitative data.


Chapter three

Stage 1: First-order coding

After the interview transcripts had been read several times to ensure immersion in the data, the first stage of data analysis consisted of creating descriptive first-order codes such as “Pointing out the need and areas for creativity” for managers and “Creativity with care packages” for nurses. Our first-order codes made us aware of the considerable number of seemingly contradictory statements by managers or contradictory practices by nurses, which indicated that they were attentive to multiple institutional logics. These intriguing findings informed our second stage of data analysis (Locke, 2011).

Stage 2: Identification of second-order explanatory categories

In this second stage, we moved back and forth iteratively between our data and existing literature on micro-level responses to institutional complexity, decoupling and occupational jurisdictions. For managers, this resulted in second-order explanatory categories such as “Partial conveyance of business demands” and “Trusting nurses’ professional values.” For nurses, examples of categories were “Continuing caregiving as usual” and “Symbolic compliance with the business logic,” which resulted in another second-order category, “Decoupling.”

Stage 3: Identification of aggregate dimensions

In this stage we identified the different yet contingent roles in decoupling, and how these both entailed and enabled the preservation of occupational jurisdictions and positions. The aggregate dimensions we identified were “Facilitating decoupling through ambiguity and purposeful abstention” for managers, “Covert decoupling through symbolic compliance” for nurses, and, applicable to both managers and nurses, “Using situational conditions and social positions to preserve (relative) jurisdictions”. Together, these three aggregate dimensions resulted in what we made into a supra-aggregate dimension: “Working in collusion and contingent roles in decoupling.” Figure 3.1 shows our data structure.

In the findings section below, we provide quotes from our interviews to illustrate our findings. Additional evidence can be found in Table 3.1, which shows the aggregate dimensions, second-order explanatory categories, and exemplars from our data. In translating quotes from Dutch to English, particular attention was paid to retaining the message and tone of the original.
3.4 Working in collusion and contingent roles in decoupling

Our analysis reveals that managers and nurses collude in decoupling through contingent roles. Whereas managers largely facilitate decoupling and engage in it mainly through ambiguity and purposeful abstention from the business logic, that is, negative action, nurses engage in a ‘classic’ form of policy–practice decoupling. We identified how, in doing so, both occupational groups make use of the situational conditions that are inherent to their respective social positions, while taking due care to ensure that the other groups’ occupational commitments and jurisdictions are preserved. We structure our findings around the three aggregate dimensions that we identified: “Facilitating decoupling through ambiguity and purposeful abstention”, “Covert decoupling through symbolic compliance,” and “Using situational conditions and social positions to preserve (relative) jurisdictions.”

3.4.1 Managers: Facilitating decoupling through ambiguity and purposeful abstention

*Partial conveyance of business demands*

Managers’ tasks in the home-care organizations that we studied were to implement externally imposed policy measures and procedures, and to ensure and facilitate the efficient functioning of multiple teams of nurses accordingly. In their accounts, managers indicated how business demands were now inextricably connected to caregiving. As an example, hours spent on actual caregiving in a client’s home for which care packages were received were labelled “productive hours”. All other hours were labelled ‘non-productive’ hours, given that time spent on activities not included within the packages was not reimbursed. To ensure that as much time as possible was devoted to “productive” caregiving, managers kept other activities, such as meetings, to a minimum.

“Money only comes in through the hours that we spend with the client. All the other costs we have to pay for ourselves. So you try to provide as much care as possible and to decrease time spend on meetings, education and traveling because you have to be financially healthy.” (Manager)

However, while managers described the caregiving process using terms such as “production”, “efficiency”, “limits to budgets”, “accountability” and “transparency,” and acknowledged the need for budget cuts in the healthcare sector at large, at the same time they also emphasized
that business demands and the accompanying terminology were externally imposed. They moreover stressed that the demands were too comprehensive and constraining.

“So then you’re squeezed into a format in which you have to deal with these bureaucratic things that nobody wants. I can see it very clearly with the CACs, and also with the government: the number of rules is increasing, despite the fact that they’re saying, ‘We want an environment with a minimum of rules.’ I think this mainly has to do with a transition – I’ve seen that happening quite clearly over the last 20 years, – to a culture in which things are safeguarded.” (Manager)

More importantly, managers realized and expressed the view that many nurses were not at all receptive to financial considerations or efficiency, given their primary commitment to caregiving. As managers themselves shared this commitment to caregiving, they sought to “find solutions” in order to manage the competing demands.

“You really have to look at it as an entrepreneur, ‘how will you manage?’ Care is not just about care anymore, you know? It has a lot to do with finances. We can think that it doesn’t, but it does. We now see what happens as a result of those budget cuts; we have to start finding solutions for that. It is important to remember that finances matter. You cannot just say, ‘I’ll leave that in the background.’ We’re all Florence Nightingales, but that’s not possible anymore.” (Manager)

As a consequence, managers’ instructions to nurses only partially conveyed business demands. They instructed nurses to complete administrative tasks, such as registering and filling in forms, carefully in order to ensure accountability and transparency and also organizational legitimacy. At the same time, managers said that caregiving based on standardized care packages had perverse incentives. Reflecting the professional care logic, they also said that caregiving would be more in line with clients’ needs when nurses had autonomy in care assessment and allocation. It followed that managers deliberately refrained from checking whether nurses’ practices actually reflected the business logic as intended by external constituents like the CAC. Instead of ensuring compliance with business demands, they referred to “grey areas” that allowed for some room for manoeuvre, and by doing so they were showing awareness of the nurses’ occupational commitments. Some managers openly supported “creativity” within the time that was allocated by the CAC.
“When we perform tasks for which we do not receive any money, we are in danger of making ourselves bankrupt. However, in that grey area, it is always possible to do a lot more for the client than people realize.”

Interviewer: Is it? And that creativity is allowed, according to you?

“Yes, that creativity is allowed within the boundaries. I have to set the limits for that.” (Manager)

Preserving the ambiguity of institutional pressures

While nurses were in a position where they had to enact multiple logics, which gave them the tools to deflect conflicting institutional pressures (see below), managers had an equally deliberate strategy for managing institutional complexity. They preserved a degree of ambiguity regarding the various norms and practices inherent to the different institutional logics. This showed, for example, in views expressed about the increasing role of informal caregivers, and, in particular, in the question of who should enforce and organize informal caregiving. Besides, managers had reservations about the increasing formalization of the role of informal caregivers because of financial considerations. Whereas informal caregiver participation in the caregiving process was appreciated when it supplemented professional caregiving, managers expressed unease about informal caregivers taking on tasks that had formerly been assigned to nurses. That is, managers were anxious about a possible trade-off between professional and informal caregiving, resulting in a decrease in the number of hours allocated to professional caregiving. Relatedly, time spent on supporting informal caregivers was also regarded by managers as ‘unproductive time’. The involvement of informal caregivers therefore represented a threat to the organization’s budget.

“Finances are important to everyone. Obviously, you think it’s important that an informal caregiver does something. However, when that is deducted from your hours [of caregiving], then you have another problem. So you have to organize things in another way. So yes, [informal caregiving is] important, but also worrying.” (Manager)
### Table 3.1 Aggregate dimensions, second-order explanatory categories and exemplars from data

<table>
<thead>
<tr>
<th>Aggregate dimensions</th>
<th>Second-order explanatory categories</th>
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<tr>
<td><strong>Facilitating decoupling through ambiguity and purposeful abstention</strong></td>
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<td>Managers</td>
<td>Partial conveyance of business demands</td>
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<td></td>
<td>We have to realize, time and time again, that we’re working with money from the community. Too often, I see people who think, “I just put more people on it, because it was necessary,” whereas I think, “I can only spend money once I know I’ll earn it back.” That’s no rocket science. That’s generally not how people see it, but they should. Creativity is killed, as a result of accountability and efficiency requirements. On the one hand, I understand that we need to cover for safety and quality. On the other hand, this will limit creativity and also cost reductions in care.</td>
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<td>Preserving the ambiguity of institutional pressures</td>
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<td>Sometimes, you get a small care package, while the client needs more care. Then you have to deliver more than the care package and consider what is possible and what isn’t. And that is kind of difficult, because you want to deliver very good care, but there are also rules you have to deal with. We always look at, “what care is needed” instead of “what is the care package” [...] For example, preparing a sandwich or making the bed. These things aren’t part of the care package, but you can’t say, “I showered you, I injected insulin, but I can’t prepare you that sandwich.” I don’t think that people should be dependent on their neighbours. [...] I’m not sure whether that would be a good thing.</td>
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<td>Covert decoupling through symbolic compliance</td>
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<tr>
<td>Nurses</td>
<td>Symbolic compliance with the business logic</td>
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<td>Obviously, we are able to fill in the those hours somewhat differently, but there are limits to this. [...] Then you sometimes run into a situation in which you have to be creative with the time that you did get, and that you run into the limits of what you can do time-wise. You tend to go play with the possibilities you have with requesting care packages.</td>
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<td>Continuing caregiving as usual</td>
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<td>I just think it is important that you deliver care according to clients’ needs instead of care based on standards. When sandwiches need to be prepared, it’s quite common here in our team that we’ll try to do it.</td>
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(continued)
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<tr>
<th>Aggregate dimensions</th>
<th>Second-order explanatory categories</th>
<th>Second-order explanatory categories</th>
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<tr>
<td><strong>Managing</strong></td>
<td>Purposefully alternating between engagement with work-floor level and willful ignorance</td>
<td>Trusting nurses' professional values</td>
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<td></td>
<td>Well, I do have to make clear to people the importance of careful registration. It is related to what kind of budget you get. If you don’t, you can shake it.</td>
<td>Nurses, most of them, just want to provide sincere care, have contact with clients; according to their [professional] norms and values. Yet this is sometimes hindered by production norms, the pressure on rules and bureaucracy.</td>
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<td>There are employees who, when time allows, go to the market and buy a nightgown for a client. I don’t say anything about that.</td>
<td>Let nurses just handle it by themselves. [...] I trust nurses’ professional skills, they see things right away, like clients getting skinnier. They don’t need a scoring list for that. However, we’ve become protocolized so much that humans disappear from the picture.</td>
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<tr>
<td><strong>Nurses</strong></td>
<td>Claiming dedication and jurisdiction by distinguishing</td>
<td>Making use of situated knowledge and conditions</td>
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<td>[An important element of good quality of care] is that people can stay in their own homes. We try to keep them there as long as possible. [...] That’s basically what we do, “home-care”: we have to make sure that people can stay in their home.</td>
<td>When I estimate that care delivery might take a bit longer, because someone is a bit slow, for example, then I request another type of care package. You tend to get handy in it: you’ll make sure you have an overview of all possible diagnoses, so as to be able to substantiate why you need more time.</td>
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<td>I happen that we call a daughter or a son, and that they do not respond, also not to letters in which we ask them to contact us. It can be quite a hassle at times. Sometimes informal caregivers say, “That’s your job, you’re there most often.”</td>
<td>[T]hey have these kind of schemes, the CAC: when you assist someone with showering, you get an x-number of minutes. I think it was 30 minutes. “Dressing” is 10 minutes, or something like that. Adding this up will give you a number of minutes or hours, and that is the time we can use: that is the care package.</td>
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<td>Well, considering [the role of] informal caregivers: when the informal caregiver resides with the care recipient, we generally are there to relieve informal caregivers so they can go outside. We’re there to watch the care recipient. That’s what you generally see: informal caregivers are in it till their heads.</td>
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More importantly, managers did not consider it to be their role, nor part of the nurses' role, to involve informal caregivers. It followed that they were hesitant regarding who could be held accountable or who was responsible for the quality of care or help given by informal caregivers.

"[T]o what extent do you as a professional caregiver have an explicit role in involving informal caregivers in caregiving? For example, in the case of disturbed relationships?"

These are ethical discussions that we are currently having. In my opinion, it's very limited, because you can't look at the situation in depth. However, these are dilemmas that we will encounter.

(Manager)

Managers also recalled situations in which informal caregivers were not always willing to take on tasks and responsibilities. When tasks were to be assigned to informal caregivers and nurses encountered unwilling caregivers, the organization could run into trouble because it had a responsibility and obligation to provide care. At the same time, managers realized that nurses would feel responsible for their clients' well-being and would take on these non-reimbursed tasks, if need be in their own time, if informal caregivers failed to do so.

In sum, managers clearly questioned aspects of the business logic. By conveying the business logic to nurses only partially, and sometimes symbolically, and recognizing its incompatibility with the professional care logic, managers were purposefully ambiguous and facilitated decoupling.

### 3.4.2 Nurses: Covert decoupling through symbolic compliance

Symbolic compliance with the business logic and continuing caregiving as usual

While nurses enacted some of the practices of the business logic in their day-to-day work, it did not necessarily mean that they were receptive to its values. Instead, nurses were particularly disparaging about the values of the business logic as these were considered to hinder the delivery of the best possible quality of care to people in need, which is one of the core values of nursing. It followed that the practices associated with the business logic were enacted in a different way to what was intended and were not aligned with its values. With creativity tolerated by managers, nurses engaged in decoupling by complying symbolically with the process of requesting and allocating care, because actual caregiving deviated from the care packages that were allocated. As the empirical example in Figure 3.2 shows, nurses...
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requested particular care packages but delivered other types of care in the time allotted to them.

“Sometimes I know that unplanned care might be needed. So then I know that if I only request ‘dressing [in the morning],’ this client eventually might need more because of her mental or physical limitations. So then I request ‘dressing [in the morning]’ and ‘undressing [in the evening],’ although I know we only visit her in the morning, just to have some space. [...] Then you can provide care at the client’s pace.” (Nurse)

Regardless of whether specific care or support was allocated by the CACs (see Figure 3.2), decoupling enabled nurses to continue caregiving as usual, and ensured that they had relative autonomy in care delivery. That is, by decoupling nurses continued to provide the types of care or support they thought to be indispensable for clients and ensured that they had enough time to do so. The nurses’ strategy indicates that they were very much aware that they could not officially spend more time with a client than had been allocated, which is why they looked for covert ways to build in more time.

“Sometimes someone does not want those compression stockings but just needs to talk to someone, or whatever. Well, the way to get [time for that] anyway is by requesting ‘compression stockings’ or ‘medication.’” (Nurse)

3.4.3 Using situational conditions and social positions to preserve (relative) jurisdictions

Our findings indicate that both situational conditions, such as nurses working out of sight of managers, and the tasks and responsibilities expected of nurses or managers because of their position in the organizational hierarchy (Battilana, 2011) were key to how both groups were involved in decoupling. We show how nurses’ and managers’ roles in decoupling as well as their use of situational conditions and social positions were contingent, and were essential in facilitating the role of the other group in decoupling and retain respective occupational jurisdictions.
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Figure 3.2. Empirical example of care need, care allocation, and actual requesting and actual care given

"We're all Florence Nightingales"
Managers: Purposefully alternating between engagement with the work-floor level and willful ignorance

While it might be considered an inherent characteristic of managerial roles that managers should alternate between engagement and non-engagement with practices at the work-floor level, the accounts given by managers in our study revealed that strategic considerations were informing their engagement or non-engagement. By deliberately engaging or not engaging with those at the work-floor level, managers maintained their position in relation to nurses and underlined their own and the nurses’ occupational jurisdictions. As part of their social position, that is, in carrying out their supervisory role, managers exerted influence over the amount of time nursing teams spent in meetings, including both how often such meetings were held and how efficiently they were used. Unlike caregiving, these meetings were held in the office and managers used this situational condition to make periodic checks on these meetings. Managers would not attend every meeting, though. Instead, about once every two months they would ‘claim’ and preside over a meeting, and would enact their supervisory role by announcing measures and policy changes or mediating in a conflict within a team. In addition, when they had concerns about the efficiency of the meetings and the relevance of the topics being discussed, managers sometimes paid a surprise visit and checked on the meetings.

With regard to their relationship with nurses, managers, on the one hand, made sure that nurses understood that if they betrayed the trust placed in them, severe measures would be taken, saying “then I’ll make sure you don’t get away with it.” On the other hand, they stressed that contact with nurses was informal, ‘my door is always open’, and emphasized their faith in nurses. This faith seemed essential because teams of nurses often worked from various locations in the neighborhood they served. This situational condition, and the fact that managers had no direct oversight of what nurses actually did in clients’ homes, also enabled them to conveniently distance themselves from practices by nurses. Besides being physically distant from the work-floor level, managers often also distanced themselves from it rhetorically, or literally turned a blind eye. By so doing, they deliberately confined themselves to their own occupational jurisdiction, while allowing nurses to continue caregiving as they saw fit. As this (chapter’s opening) quote illustrates:
“When you look at the policy that describes what types of care can or cannot be given... I notice that employees think, ‘Whatever, I’m doing it anyway,’ or ‘I’ll continue doing it.’ So things are done that are officially not allowed [anymore], but I do understand it. It may be false to say it like this, but ignorance is bliss...” (Manager)

By sometimes pretending not to know about nurses providing other types of care than that which had been set out in care packages, managers strategically made light of their colluding role in decoupling.

**Managers: Trusting nurses’ professional values**

Similar to what Oldenhof et al. (2016) found, our data indicate that managers would engage in professional talk in the enabling sense. That is, managers were likely to emphasize nurses’ skills and sense of responsibility, and trusted that they would adhere to professional values:

“I think that if we could just go back to spending time on caregiving, there would be a better quality of care and no overconsumption of care. Nurses aren’t educated that way. [. . .] They haven’t been educated, to put it bluntly, to force care down someone’s throat. Not at all. The incentive for production is in the system, and therefore we have to fill in all these forms. I think that the domain of caregiving should be given back to nurses. Those that are working here, really, I don’t need to tell them anything about their profession. What they want is to be facilitated in practicing their profession.” (Manager)

Several managers somewhat nostalgically called for “giving caregiving back to nurses.” In doing so, they were referring back to the time when nurses had autonomy over care assessment and delivery. It followed that managers granted nurses a rather extensive jurisdiction in addition to supporting their jurisdictional claims rhetorically. By assigning themselves a facilitating role, managers underscored their sympathy with nurses and the goals and values that nurses were pursuing:

“You really have to say to the client – and that is where we, or actually nurses, go astray – ‘I am here to do my thing, and then leave, ‘byeee.’ That’s what it comes down to. However, the people who have chosen to go into caregiving are all Florence Nightingales: they go in there with their heart.” (Manager)
Managers said that they consciously and gladly left caregiving to nurses since nurses knew perfectly well how this should best be done. When considering the boundaries of nurses’ jurisdictions, managers nonetheless also indicated that nurses were sometimes treading a thin line between professional and unprofessional behavior, that is, doing too much for a client or getting personally involved. Interestingly, our findings indicate that the managers were also involved in blurring the line between these two types of behavior.

To conclude, by purposefully alternating between engaging with and turning a blind eye to the practices on the work floor, managers were for the most part using situational conditions and their social position relative to nurses as means of preserving their own jurisdiction. They also paid due respect to nurses’ jurisdictional claims and occupational commitments, and showed how they largely shared the commitment to caregiving. It followed that managers facilitated decoupling by nurses at the work-floor level and hence were colluding in this practice.

*Nurses: Claiming jurisdiction and dedication by distinguishing*

Decoupling by nurses was implicated by jurisdictional claims and by the fact that they believed their dedication to clients differed from that of informal caregivers. By distinguishing themselves from informal caregivers, nurses problematized the involvement of informal caregivers, questioning their capabilities and commitment. By portraying and treating informal caregivers as co-clients rather than co-caregivers, nurses established their own position and caregiving role vis-a-vis that of informal caregivers. That is, nurses continued to take on tasks that were officially allocated to informal caregivers and legitimized this by framing it as an effort to relieve informal caregivers who might be in need of support themselves, particularly partners who could be almost as frail as the actual client. The tasks that nurses did allocate to informal caregivers were the kinds of help that were clearly complementary to professional care, such as social outings, and tasks relating to the social bond between the client and the caregiver.

“[Informal caregivers] can do many things: groceries, cleaning, but also just making life a bit more pleasant, so to speak. They can go for a walk with someone in a wheelchair or just have a chat, social activities.” (Nurse)
When the division of tasks was clear, nurses would often appreciate informal caregiver involvement. Despite such satisfactory cases, nurses tended to emphasize occasions where the involvement of informal caregivers had proved problematic:

“I actually think it’s quite disappointing. We also encounter many problematic relationships with family members, people whom you’d not want to ask to do informal caregiving. I mean, really, in such a way that you think, ‘This is not supportive in any way,’ in the worst case, that is.” (Nurse)

Also, when an informal caregiver, for example, took charge of caregiving supplies such as bandages but forgot to stock up with new ones, nurses considered this to show a lack of commitment to caregiving. As nurses were hindered in their caregiving when they found themselves without the supplies they needed, it also felt to them like a personal failure in delivering a good quality of care. Unwilling to compromise on the quality of care, after incidences of this kind nurses would generally take over tasks and continue doing them themselves. Likewise, when they had to make a great effort to get family members involved to clean the house or do groceries for a care recipient, this gave them grounds to denigrate the involvement of informal caregivers and present themselves as devoted caregivers.

So with children [of clients], there’s always one who does the most, while the rest hardly do anything; generalizing it a bit. . . Often the family doesn’t bother to inquire about caregiving. They think: “caregiving is what you [nurses] do, I don’t have any clue whatsoever”. It’s not an easy group to reach. (Nurse)

In fact, nurses hardly ever met with caregivers to discuss and fine-tune shared caregiving, seeing this as an additional task that was difficult to include as part of day-to-day practices with already (too) tight schedules.

**Nurses: Making use of situational knowledge and conditions**

An important aspect of the decoupling strategy used by nurses to alleviate the pressure of tight schedules was their use of situated knowledge and situational conditions that were inherent to their role and to their position in the organization, at the intersection of the business and professional care logics. Not only would nurses assess care, they were also responsible for both the administrative duties associated with requesting care and the actual delivery of care. The essential ‘tool’ that they used was their detailed knowledge of how to
request care. That is, they knew precisely what types of care would be allocated, what types they could reasonably fit together, and how to frame the care request. This enabled them to avoid being questioned by the CAC. In this way, nurses strived to limit their engagement with CAC administrators to just an inconvenient formality and to preserve a degree of autonomy.

In addition to their situated knowledge, another critical situational condition for nurses’ decoupling practices was their independence in caregiving. While nurses kept the CAC at a distance as much as possible, the CAC itself was remote from caregiving practices in that it hardly ever checked on actual caregiving. In a similar vein, nurses’ caring practices largely happened out of sight of managers and were seldom discussed with them as long as the organizational finances remained healthy. Consequently, nurses were able to provide the types of care and support that they deemed necessary in a client’s home, regardless of what care packages had been allocated. In fact, by ensuring administrative consistency, nurses were able to align their decoupling practice to managers’ formal demands for cost-efficiency, and the jurisdictions and positions of both occupational groups were preserved. However, despite seemingly being aligned to the cost-consciousness that some managers had hoped to convey to nurses, the nurses’ strategy was essentially informed by an effort to deliver the best possible quality of care for clients.

3.5 Discussion

In this paper, our aim was to increase our understanding of the micro-level mechanisms and conditions of decoupling. Our micro-level focus enabled us to identify how two occupational groups have contingent roles and collude in decoupling in an institutionally complex environment. We also showed how occupational commitments and jurisdictions, relative social positions, and other situational conditions are integral to how this collusion takes place. We now discuss how our findings contribute to previous research, and suggest some directions for future research.

3.5.1 Contingent roles in decoupling: Social positions and jurisdictions

Our study contributes to the understanding of decoupling as a response to institutional complexity. We have provided valuable insights into the micro-level mechanisms and
conditions that enable decoupling. Whereas previous research has studied the decoupling practices of one occupational group at the time, we extend this literature by revealing how the social positions and jurisdictions of different occupational groups within an organization result in contingent roles in decoupling, and are integral to how decoupling takes place. Unlike research which shows that managers ensure tight coupling or recoupling (Hallett, 2010), look for compromises (Oldenhof et al., 2014), or engage in coordinating decoupling (MacLean & Behnam, 2010) or symbolic management with regard to external constituents (Bromley & Powell, 2012; Westphal & Zajac, 1998), our research demonstrates that managers largely colluded in the decoupling practices. Specifically, we show that because managers deliberately chose not to provide strict guidelines regarding the business logic – that is, they took what can be seen as negative action (cf., Currie & Spyridonidis, 2016) – this in fact entailed the enactment of the professional care logic. In a similar vein, the fact that managers turned a blind eye to the decoupling practices of nurses meant that the professional care logic was perpetuated. In this sense, the manner in which managers enacted both the business logic and the professional care logic through negative (and positive) action in their day-to-day work seemed purposefully ambiguous, and designed to leave the nurses room for manoeuvre. In turn, nurses used this room for manoeuvre to creatively combine the different logics through decoupling in their everyday work.

This leads us to (re)consider how people with different social positions in the organizational hierarchy (Battilana, 2011) influence whether and how micro-level practices reflect different field-level logics. We explicate how the manner of enactment of distinct institutional logics in an actor’s everyday work is inherent to their social position (Lockett et al., 2014). We make explicit that, when presented with tools and conditions that allow them to be creative in combining different logics, actors eventually adjust their practice and thus reduce the incompatibility and tensions between disparate logics. We show that, more than managers, relatively low-status professionals were able to “use” institutional complexity because of their social position at the micro-level intersection of multiple logics (McPherson & Sauder, 2013). Hence, nurses were in the best position to blur logics (Currie & Spyridonidis, 2016), and this enabled them to reshape and adjust their work practices to fit with local demands (Kellogg, 2011) and professional values. Managers in turn used their social position to purposefully refrain from interfering with these practices at the work-floor level, and thereby allowed such practices to take place.
Taking this further, we found that managers and nurses, while dealing individually with institutional complexity, recognized the importance of the occupational jurisdiction of the other group in addition to preserving their own. Such mutual adjustment between actors mirrors findings from earlier research in institutionally complex settings (Currie & Spyridonidis, 2016; McPherson & Sauder, 2013; Reay & Hinings, 2009). These findings also resonate with recent conceptualizations of manager–professional relationships that go beyond describing these relationships in terms of tensions and clashes (see Evetts, 2013; Olakivi & Niska, 2016; Reay, Goodrick, & Hinings, 2016). The contribution of our study is that it shows a different dynamic in terms of who is adjusting to whom, and how. Oldenhof et al. (2016) show that middle managers relate to care workers in either an empowering or a disempowering way, and manage the relative positioning to this group in the process. Currie and Spyridonidis (2016) demonstrate how mutual adjustment is uneven in the sense that it exists by virtue of positional gains for higher-status managers, and doctors in particular. Our study renders visible a different mutual adjustment between managers and subordinate professionals. In our case, managers tended to close in on the lower-status, subordinate, professional group, as shown most directly by the efforts that they made to preserve the jurisdiction and position of nurses, and by the fact that they colluded in decoupling and in the enactment of the professional care logic.

We speculate that, had managers enforced strict compliance with the business logic, they would probably have elicited resistance from nurses, which might eventually have obstructed organizational functioning. As such, managers helped to facilitate the professional work of nurses as well as the proper functioning of the organization in a meaningful way (McPherson & Sauder, 2013; Noordegraaf, 2015; see also Olakivi & Niska, 2016). Through decoupling, nurses in turn preserved both the occupational jurisdiction to which they felt entitled, and their relative position with regard to informal caregivers. They also preserved their subordinate social position in the organizational hierarchy, while the interests and social position of managers were (indirectly) preserved through co-implication. Either way, our research underscores the relevance of studying the influence of people at the work-floor level and on the frontline of organizations. We suggest that future research should focus more closely on the influence that is exerted through (seemingly) mundane tasks, and also study the potentially powerful position of people on the frontlines of organizations in other settings.
3.5.2 Quietly colluding in decoupling: Interests and commitments

Besides intra-organizational mechanisms and social positions, the relative distance of external constituents such as the CAC was an essential situational condition for the particular way in which decoupling took place. This helped nurses to use a control mechanism, which had been designed to ensure disclosure and transparency, to engage in concealed practices to preserve their autonomy. We speculate that openness about nurses’ practices would probably have led to closer surveillance by external constituents (Levay & Waks, 2009). Consequently, managers and nurses clearly had an interest in keeping the decoupling covert (Bjerregaard & Jonasson, 2014), which added a manipulative flavour to their decoupling practices. Concurrently, it was by means of this decoupling that the CAC and clients, two important referent audiences, were both satisfied. This resonates with Misangyi (2016), who suggests that decoupling (as well as coupling) in institutionally complex environments may be informed by multiple intentions that are inherent to different institutional logics. Following this line, we suggest that it depends on the institutional perspective of actors, and the perspective of referent audiences, as to whether decoupling is seen as a manipulative device or a strategic solution to solve tensions that result from institutional complexity (Misangyi, 2016, Sandholtz, 2012; see also Olakivi & Niska, 2016). An important limitation of our research was that we only studied managers and nurses, and not clients who received their services. However, our findings suggest that clients’ care needs and requests are an important – but clearly not the only – antecedent of decoupling practices. We suggest that a fruitful avenue for future research would be to study the relationship between professionals and the recipients of decoupled services, and to consider the role that service recipients may play in decoupling.

Either way, managers and nurses exhibited a blinkered view regarding the potentially positive aspects of the business logic, such as the (proposed) increasing role for informal caregivers (Allen, 2004). Likewise, they did not respond in a proactive manner to either the societal need for budget cuts or the associated changes to the caregiving process. Our findings suggest that their failure to do so was informed by the values of the professional care logic, namely to provide care in the best possible way. Building on the finding of Wright, Zammuto, and Liesch (2017) that emergency specialists engage in rather ‘open’ efforts to preserve their professional values, we speculate that decoupling may be an alternative way in which lower-
level professionals preserve their professional values. If this idea were to be explored further in future research, this might provide an explanation of decoupling that goes beyond (personal) interest-based explanations of decoupling (Westphal & Zajac, 2001). It would also increase our understanding of the various strategies that professionals may engage in to maintain the values of their profession at the organizational frontline, and would indicate the extent to which they are able to do so. Importantly, our study underscores the significance of an emerging and promising body of literature that (again) takes heed of the role of values in explanations of institutional processes and dynamics (see Kraatz & Flores, 2015; Wright et al., 2017). This may be particularly important in professional settings, where people are socialized into, and committed to, particular institutionalized role values (Wright et al., 2017). We suggest that future research should focus on institutionally complex environments in which the values, interests, positions and jurisdictions of different professional and occupational groups are contested, and should study whether and how values are conducive to institutional activity.

Given that we studied managers and professionals in one particular setting, we need to consider the boundary and scope conditions of our findings. Teachers and social workers are relatively low-status professionals who are having to contend with business imperatives and limited resources that may impede them in enacting their own professional logic. We suggest that these conditions, including the high level of public scrutiny involved, and in particular the nature of the service delivered to (highly) dependent or vulnerable recipients, may motivate these professionals to engage in decoupling practices and may also encourage managers to collude in such practices. By comparison, when we consider professionals in cultural industries, where aesthetic and business logics often co-exist, we suggest that the motivations and mechanisms for decoupling that we identified are less likely to occur, because these logics are considered to be dichotomous rather than oppositional, and are balanced in order to achieve artistic legitimacy and recognition (see Voronov et al., 2013). In creative industries where professionals are producing experiential goods such as classical music (Glynn, 2000) or theatre (Eikhof & Haunschild, 2007), we speculate that professionals may engage in decoupling for the purposes of personal fulfillment. Given the absence of a dependent and vulnerable service recipient, and due to their focus on sales and profit, managers may eventually come into conflict with professionals (e.g., see Eikhof & Haunschild, 2007; Glynn, 2000) instead of colluding in decoupling. Professionals in law and accounting in...
turn are generally receptive to a business logic, and collusion in decoupling between different people in the organizational hierarchy presumably is less likely to revolve around a professional logic. Then again, given the salience of the business logic in these organizations, individual professionals may nonetheless engage in quiet decoupling informed by a professional logic, that is, they may make an effort to respond to the requests of clients who are dependent on their services—for instance, in pro bono cases. As such, as mentioned above, the role of service recipients as potentially influential antecedents of decoupling practices by professionals seems a fruitful direction for future research.

An important limitation of our study is that we interviewed our respondents at a single point in time. The limitations of this “snapshot” are that our study does not provide any insight into whether decoupling was a temporary strategy, as others have suggested (MacLean & Behnam, 2010; Oldenhof et al., 2014). Additionally, we did not address how the strategies of managers and professionals may have changed over time (Raaijmakers et al., 2015). Future research could take a longitudinal approach and examine whether decoupling may be an initial response to perceived threats and ambiguity stemming from institutional change (Greenwood et al., 2011), and whether subsequent responses are as contingent as the one we identified. This is particularly relevant in the light of recent changes to the Dutch home-care sector. Home-care organizations are increasingly being restructured in order to realize flat organizational structures, without the tiers of middle management that are now said to be redundant. In these organizations, nurses work in self-managed teams. Although this gives them greater autonomy, as managers are even more at a distance, nurses are still confronted with and confined by care packages, the formalization of informal caregiver involvement, and efficiency requirements resulting from continuing budget cuts. Consequently, these conditions are fascinating in light of the mechanisms and conditions for decoupling that we identified. That is, the conditions ostensibly prompt and facilitate decoupling practices.