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Review Article

Understanding Missed Nursing Care Using Institutional Ethnography: The Ruling Relations of Post New Public Management

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Abstract

The emergence of New Public Management (NPM) strategies for curtailing the spiraling cost of public spending in the 1980s resulted in major reforms and restructuring of services within Western democracies, particularly the Anglo countries of New Zealand, Australia, the United States, Canada and the United Kingdom. While some commentators argue that NPM has run its course, in this paper we suggest that risk management is now central to the neo-liberal reform agenda of new public management, particularly within the public health care sector in Australia. In making this claim the paper draws on qualitative interviews with twelve nurse managers who worked late and night shifts in one large tertiary public hospital in South Australia. Participants self-selected following an open invitation through the major nurses' union. The focus of the interviews was on missed care, specifically reasons for missed care, using the methodological approach of Institutional Ethnography. In providing an analysis of the interviews we demonstrate the way new scientific approaches to risk management, including digital surveillance, sits alongside NPM to create novel regimes of governance and control over nurse's work.

Keywords: New public management; Missed care; Quality and safety; Audit; Institutional ethnography, Rounding

Abbreviations

AIHW: Australian Institute Of Health And Welfare; A-DRGs: Australian (Refined) Diagnosis Related Groups; ANMF: Australian Nursing and Midwifery Federation; CEO: Chief Executive Officer; DRG: Diagnosis Related Groups; EN: Enrolled Nurse; IE: Institutional Ethnography; ISBAR: Identify Situation Background Assessment and Recommendations; NPM: New Public Management; RN: Registered Nurse; SA: South Australia; USA: United States of American

Introduction

Managing healthcare reform has been a major preoccupation of Western democracies for over fifty years [1]. Whether the health system is centrally funded through the state, primarily market driven, or a hybrid, as is the case in Australia, commentators agree that the major dilemma is spiraling costs within a system that requires balancing the competing interests of the professions (read medicine), the state, and the private for profit sector [2], not to mention rising consumer expectations and a misguided belief that the major drain on costs is nursing labour [1]. Where there is firm agreement is on the need to curtail these costs. Strategies have included a range of structural reforms governing the funding of healthcare, the introduction of industrial agreements determining the way health professionals are reimbursed, and new forms of professional regulation to control the numbers of health professional graduates. Where these reforms are part of the public health sector they are referred to as new public management (NPM) [3]. According to Dent [4], the equivalent set of processes in the USA can be found in the Health Maintenance Organizations. In this paper we argue that the practices of NPM provide new scientific approaches to risk management, including digital surveillance. This in turn leads to missed nursing care.

Emergence of New Public Management

Early work by Ferlie [5] on NPM defined it as the introduction of competitive market-like strategies for modernising public service bureaucracies such as health, education and social services, and public utilities such as water, electricity and telecommunication. The key malaise of these public services was identified as a lack of competition. The key strength of the private-for- profit sector is just this. The claim is that competition generates high levels of efficiency, and productivity through continuous quality improvement and innovation-all necessary to maintain market share. Simulating these mechanisms within the public sector enables it to become more productive and to respond to innovation and efficiency reforms without the long lag time common to large bureaucracies. In the 1980 and 1990s many Western governments set about instigating NPM mechanisms into public sector departments. Examples include outsourcing government services such as public hospitals to private providers or creating quasi-independent entities that operated like private companies but remained subject to government regulation such as the privatization of water and electricity. A further component of the first wave of NPM was a range of workload productivity and efficiency measures. The best known global measure within the healthcare sector is the various forms of case mix prospective payment systems that now determine reimbursement for episodes of care across a range of healthcare services. Case mix measurement

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tools, such as Diagnosis Related Groups (DRG) pre-determine the cost weight, and reimbursement governments or third party insurers are prepared to pay for particular procedures. In order to operate within the parameters of the particular casemix employees must tailor staffing numbers, the organization of their work, and the technologies they access to come in within the cost price [3]. While there has been considerable research on the way micro economic reforms, such as case mix DRGs impact on health professionals, suggestions that nurses have responded to the various NPM reforms through rationalizing, or missing work has only recently surfaced in studies conducted by Kalisch and colleagues in the USA [6-8], and Schubert et al. [9] in Europe. Managing rationed or missed care is now widely recognized in nursing and is a major driver in the reorganization of practice, given the risks that it poses to patient care and safety. In this paper we argue it is a logical outcome of NPM.

Post New Public Management: Risk, Audit and Patient Safety

Some proponents of public sector reform claim NPM has been replaced by post NPM concerned primarily with safety, and quality [10]. Others have suggested it has been replaced by new regimes of power such as digital technologies with their myriad of tools for audit and surveillance [10]. A more accurate analysis is that NPM has joined forces with risk management and the digital technologies to produce new technologies of control [11]. In Flynn's view the capacity of digital technologies to create complex audit systems along with the massive focus on risk, risk management and patient safety has created a heightened workplace culture of distrust. The move to risk management and quality assurance is consistent with the NPM mantra of efficiency and productivity. Without patient safety or effectiveness, productivity and efficiency are meaningless. Accompanying this heightened focus on risk management is a shift in control. The organization of risk management in hospitals is now firmly under the control of managers and Federal and State governments, rather than restricted to the professions. This shift has been achieved by tying public sector funding to particular patient targets, or in cases where services are outsourced, to the establishment of Independent Regulatory Agencies. These agencies while seemingly independent of government are not. They are established through acts of parliament, are dependent on governments for their funding and can be abolished at whim. A number of quality and safety regulatory agencies have been established by centralized governments to take a national overview of patient safety and quality care [12]. In Australia the key agency is the federally funded, Australian Commission on Safety and Quality in Health Care. At local hospital level, quality assurance and patient safety are now major preoccupations for managers allowing them to engage directly with clinicians in how the care of the patient is to be organized [13]. An example might be a pronouncement by managers that team nursing as a model of care is safer than comprehensive, primary or functional task-based nursing [14]. In such a scenario nurses lose the capacity to determine the model of care they think best suits the ward or unit.

Risk Safety and Quality in Healthcare in Australia

Centralized management of quality and safety in Australia began in earnest with the establishment by the Federal and State government health ministers in 2000 of the Australian Council for Safety and Quality in Health Care. In 2011 the Commission identified 10 standards for all public, private, acute and primary healthcare services [15]. These are both guides to internal Quality Assurance and the key standards for achieving the required institutional accreditation. A number of reporting mechanisms are in place. For example, all public hospitals in Australia are required to report on the consumer available My Hospital portal outcomes for particular standards, and a rating system has been designed by the Commission that indicates whether or not health services have met, not met or met with merit particular standards [16] (p 3). The roles of clinicians, patients, carers, the non-clinical workforce, health service managers and state and territory health executives are clearly articulated for all ten standards illustrating the shift from professional control to a shared control with management. For example, Standard 6, Clinical handover, reads, Clinical leaders and senior managers of a health service organization implement documented systems for effective and structured clinical handover. Clinicians and other members of the workforce use the clinical handover system [16] (p 45).This in turn, must be done in conjunction with Standard 1 and 2, which requires patient involvement.

Risk Safety and Quality in South Australia

Although public health services were regionalized under the 2006-2013 Federal Labor government, the management and funding of public hospitals remains the responsibility of the States and Territories. As a consequence, each State has a Safety and Quality Division, where the State-based versions of the national standards are worked out in more detail. For example, the South Australian government 2012-2013 Safety Report is organized around the Australian Commission on Safety and Quality in Health Care 10 point standards [17]. Each of the ten standards has a specific publication to guide health service accreditation, which outlines the relevant legislation and policy, and the actions required. For example, under Standard 6: Clinical Handover, a mandatory policy is provided which supports the use of ISBAR as the clinical handover mnemonic with responsibility for safe handover resting with the CEO, hospital managers of safety and quality, and then clinicians.

The Nursing Response to NPM and Work Intensification

We argue that the productivity and efficiency demands of NPM, along with the shift in safety and quality to managerial control that characterize post NPM has intensified nursing labour, resulting in the phenomena of missed nursing care understood as care that is missed because of the work intensity, or staffing ratios or skill mix does not allow time for the task to be completed [17]. Data for our study comes from qualitative interviews with 25 nurses across two large tertiary hospitals conducted in 2013 where we sought to understand how they managed within the new productivity environment. Permission was sought to interview key nurses, particularly those in middle management, or managing after-hours coordination. These interviews were audio taped, transcribed and put onto the shared drive for team members to read and analyse. Ethics approval was gained from both the Flinders University Social and Behavioural Research Ethics Committee and the SA Health Ethics Committee.

The Analytical Approach

The analytical approach employed for this study was Institutional Ethnography [18] (IE). IE seeks to understand how everyday life, be it within the confines of the family or in the workplace, is subject to power. This power is not overt, but subtlety produced through ruling texts. These may be policies, guidelines, processes for accreditation, statistical evidence that guides funding and staffing levels, or the published outcomes of evidence-based research. Examples of these ruling texts in Australian public hospitals are the various Federal and State policies, procedure manuals, and mandated guidelines. One of the hypotheses of this study is that currently the language of many of these texts focuses on efficiency, productivity, quality assurance, census, patient centered care and safety and quality management. These texts in turn, generate conceptual practices of power in the workplace within a hierarchical system of control; examples include bed-to-bed handover, and rounding. What separates out these textually mediated forms of governance from earlier versions is the increasing capacity for high levels of digital surveillance through audit and the relentless drive towards quality assurance standardization across the state and country.

The foundational ideas of IE come from the work of Dorothy E. Smith a Canadian sociologist interested primarily in feminist analysis of women's everyday lives [18]. She drew on the Marxist notion of relations of production, extending it beyond the way owners, and managers direct control over the labour process of workers, to explore the way in which specific situated texts govern the way work is organized, or to what she referred to as textually mediated practices. IE also draws on Garfunkel's [19] ethnomethodology. He argued we can learn about everyday social life through breaching the taken for granted norms and values of social interaction. Importantly, IE goes beyond classical qualitative approaches, such as phenomenology, symbolic interactionism or grounded theory to suggest that knowledge cannot be known simply through experience, particularly where these experiences present contradictions, or to what Smith refers to as the problematic [18]. Part of the answer lies in examining the power relationships and hierarchies of institutions, often found in ruling texts of policies, guidelines, and legislation. These seemingly benign texts provide the clue as to how an organization operates and where much of the power resides and to how workers must behave. Indeed in most western democracies governance is not directly dictatorial, but benign, manifest in textually mediated social organizations or in discursively organized settings. One example is elective surgery waiting times. These are statistical accounts of the time patients wait for healthcare. Meeting the targets controls the pace of work of many doctors and nurses. The waiting times are set by the Federal government and imposed on state run public hospitals. What is hidden from view is the everyday experiences of doctors in public hospitals who must manage these lists; the plight of these professionals is objectified and reduced to a set of textually based clinical categories established by various medical colleges to ensure that patients have their surgery before their condition becomes life threatening. There is nothing in these texts that reveals how doctors or nurses manage the pressure brought to bear on them to keep lists respectable, or to how patients manage their daily lives while on a waiting list.

The processes used in this study commenced with a first reading of the interviews in order to examine the transcripts for the problem, the stand point of the nurse, identifying missed care, and the social and textual ruling relations. What struck us after reading the small number of the interviews, quoted in this paper, was the nurse's preoccupation with risk, understandable given the interviews focused on missed care. At this point we examined the various practices mentioned in the interviews, tracing them back to their origins in textually based policies, standards and evidence-based practice. This led us to read in the area of safety and quality. Specifically we examined Federal, State and hospital texts (policies, protocols, literature reviews, and standards) dealing with the management of safety and quality. The results are presented below. Firstly, we identify two nurse's textual accounts of working relationships with the medical teams and the impact this may have on missed care. This is followed by an example of NPM on nurses' everyday work where we demonstrate the impact of the policy of rostering skilled and unskilled nurses. In the second section we outline the way in which digital and risk management forms of ruling relations govern nurse's work adding to work intensification. These accounts are not separated from one another, but form a neat web of control over nursing caring labour providing a more nuanced understanding of why some care is missed or rationed.

Missed Care and Ordinary Everyday Team Work

The focus of our research interviews was on missed care. Each interview started out attempting to uncover what these senior nurses believed was missed, and why. One of the issues raised by nurses was the frustrations around interprofessional communication leading to missed care. The two quotes below highlight the pressure on nurses to ensure documentation is adequately completed, or they are informed in a timely manner of the need to do a specific task. In these examples, the text substitutes for verbal communication leading to missed care;

A: Oh definitely, conflicting medical orders, so I'm being told one thing, and I will read the case notes, and that hasn't been documented, so until it gets documented I'm just going to use my common sense as to whether or not we proceed with something you know. If they come and tell me for example, I want that patient to have some Gentamycin but they don't write the drug order up, I then need to okay I'm concerned about this patients antibiotic needs so I've then got to contact another doctor because the home team have knocked off,… but it's things that nurses need to then waste their time on chasing (RN 11).

In coronary care we do a round – well I do personally; I go with the doctors…. And the doctors that we've got, when I can get them how I like to work, when they come on in the morning they come straight to me and we all discuss the patient's, and I tell them anything that's happened over night,… and it's more of a nursing handover I guess, and a bit of what the medical staff had been handing over, but we go through it, and I think they appreciate that, and then we all work together and most of the doctors are pretty good, they'll come and get me.. but they know that I'll get really angry if I find out later "Why didn't you tell me that you – you wrote it in the notes, don't just write it and walk off, or add a drug chart, and then fold it and put it back on the end of the bed at 4 o'clock, so when we do the round at 5:30-6 and pharmacy's closed we find it (RN 19).In both these accounts the

nurse has to apply additional resources and time as a result of lack of communication between nurses and medical staff, although both nurses exhibit a high level of critical thinking and there is also strong evidence of very functional working relationships. In the first, the text is missing, in the second the text is not followed by a verbal reminder. However, our interest is not in the ordinary everyday interpersonal relationships demonstrated in these two accounts, but in how these relationships might be driven by the ruling relations of texts, found not just in the case notes, but also in policies and procedures well beyond the wards. We turn first to the impact of NPM on how nurses think about their work to demonstrate the ruling power of the text.

The Ruling Relations of New Public Management

Much of the robust interprofessional collaboration and critical thinking exercised by experienced nurses in their care of patients and as mentors to junior staff is challenged by NPM processes of flexible staffing, especially the practice of rostering less expensive (read less experienced) staff on after hours when penalty rates mean higher labour costs. A senior nurse argues that care is missed as a result of staffing policies aimed as cost cutting, We've been told that the most senior staff should be (rostered)minimally after hours, no weekends, but that's when I need my most senior staff, that are competent and capable, because when I go home there's no one to fall back on, there's one person that is responsible for the whole of the hospital and that's the person they have to go to if they're in difficulties. So if they're dealing with something else, there's just nowhere else for an inexperienced nurse to go. So if I put somebody that's inexperienced, into that position, that's when we run into difficulties, and lots and lots of missed things (RN 6).

What drives this practice of rostering inexperienced staff on the costly shifts and risking patient care? Under the Medicare Agreements funding to State and Territory governments for public hospitals is partly provided by the Federal government. A major difficulty for the States is to manage the public hospital system on the funding the Federal Government provides. There is adequate evidence that the Federal government has rarely kept to the agreed financial amounts whatever the political party in power [3]. The amount the Federal government does pay the States is a complex formula based on the A-DRGs, along with comparisons made with peer hospitals across the country, as well as some acknowledgement of population and demographic characteristics such as age and Indigenous status [3]. While using standardized funding models based on case mix formula does provide a mechanism for transparency in funding, it also assumes it is possible to standardize medical and nursing care as if all populations are equal and all labour agreements standardized. Standardization of labour wage agreements does not exist; indeed it would be against the NPM strategy of tailoring professional salaries to local conditions through industry specific negotiated agreements, yet this is what is being assumed in the demand to staff according to interstate peer hospitals levels. These measures drive nurse managers to attempt to cut nursing salary costs. The most recent textual evidence for this, for the public hospital sector in South Australia is found in the Deloittes' Hospital Budget Performance Review [20] commissioned by the SA government. This review examined the costs for all major public hospitals in the metropolitan region. The hospital in this study had a yearly nursing cost blow out of $3 million. Factors identified as problematic included high rates of sick leave, a failure to increase the ratio of EN to RNs, and the employment of part-time staff who are eligible for workplace benefits such as education and training, rather than casuals who are not eligible for any educational benefits. This practice alone results in a proportionately higher cost for professional development than if all staff were full-time or casual. Added to this, the report was critical of the 2.5 hours overlap of nursing staff between the morning and afternoon shifts. Apparently 'best practice' indicates that between 30 and 45 minutes is sufficient. However, elsewhere the report notes that the acuity of patients presenting at Accident and Emergency Departments (A&E) categorized at triage levels 4 or 5 has reduced from 57.8% to 51.8% between 2009-2012. This suggests the percentage of presenting patients is sicker, although the number of patients has decreased, primarily a result of reduced beds. The Deliottes' report suggested increased workplace flexibility, but this is not possible under the current industrial agreement. The only strategy available to managers is to manipulate the skill mix, so that the most experienced and costly nurses are rostered on shifts during the standard working hours when penalty rates are not applied and to roster junior, cheaper nurses on after hours, and at nights and weekends. The rostering of appropriate skill mix is not a neutral affair, but one driven by funding policies interacting with industrial agreements [21] (Clause 3.3.3).

Federal Government Target Requirements

The influence of Federal government funding policies goes deeper than skill mix, to impact on how nurses manage daily work on the ward. It extends to unpredictability in patient load. Under the Federal-State agreement hospitals must ensure that patients presenting in A& E Departments do not wait longer than 4 hours for treatment. Targets are set for peer hospitals across the country, and state governments receive or lose incentive payments for meeting these targets [22]. Under the current Medicare agreement the target for 2015 is 90%. The South Australian target for 2012 was 67%, and for 2013, 75% with one of the hospitals in this study achieving 61% in the January to December 2013 period [22]. While this was the best outcome achieved by any public hospital in South Australia it is well below the Federal government imposed Medicare target. As a result of this funding arrangement each evening a census is taken at the hospital to ensure sufficient numbers of categories 1 to 3 patients are admitted within the time frame. The impact of this on how nurses manage their work and on how nurses understand missed care is outlined below: "And we go over census virtually every day, which means emergency have more than 30 patients, every ward then gets a patient, which we go from our 26 to 27, if we don't have a discharge that day, we can remain at that 27 and unfortunately there is another room they can use, so sometimes we're even a 28. They've reigned that in a little bit because of the finances. But we can still be at 27, with no extra staff. And presumably that person from ED is more unwell than anyone else we have on the ward, and they don't get the care that they require because they're the extra (RN 11)".

The Ruling Relations of the Digital Audit

The examples above represent old NPM where work is intensified to meet productivity targets set by government. However, we argue that both the new digital technologies and new mechanisms for risk

assessment have joined forces with the older forms of NPM to create a harsher post NPM. This in turn, intensifies the work. For example, nurses are now expected to anticipate incoming work, and to take a generous approach to accepting patients, even when the patient is not from their specialty or team. When outlier patients are admitted to a ward, missed care is a typical consequence [17]. However, given the requirement for patients to be admitted from A&E within the required 4 hours, it becomes the responsibility of nurse managers to 'fit' patients in wherever possible. Note in the example below patients are assigned as outliers to wards. Nurses report that where patients are outliers they are more likely to miss care [23]. "Yeah the intranet and you can access it and it should tell you any patients that need to come to your unit. So the way we basically manage it after hours, all the wards are meant to keep an eye on the flow board, if they see their patients, under their team name come up, then they should be contacting the coordinator and saying, look I've noticed on the board, I'll take that patient. Then the only time then the coordinator will take over when it gets to the point of, like say coronary care might have, or a particular ward might have 4 beds, but there's none of their patients in ED, they might ring up and say look I know it's not your patient, but can you take this patient or that patient, or you've got a side room and it's the only side room and they're infectious, so can you please take this patient (RN 19)".

The Ruling Relationships of Risk and Patient Safety of Nursing Work

The governance of nursing labour goes beyond the various digital surveillance tools now available to track the flow of patients, record nursing work, or patient waiting times. It is now possible to track the details of patient care, including missed care and critical incidents. The rise in awareness of the impact of risks on hospital effectiveness, as well as efficiency and productivity has led to a national approach to how professionals organize their work. Two examples in South Australia are mandatory use of ISBAR and bed-to-bed handover. We deal with bed-to-bed handover as a culprit in missed care and work intensification. The nurses we interviewed took a mixed view to bed-to-bed handover. When we examined this mandated policy we found an extensive supporting literature on the SA Health Quality and Safety portal [17]. This included an evidence-based literature review on handover [26] (which provided negative support for the practice, and an article by Chaboyer, McMurray, and Wallis [27] dismissing these objections. Both papers were commissioned by the Australian Commission on Safety and Quality in Health Care. Other items included the state-based guide on the National Safety and Quality Health Service Standards (no 6) for clinical handover in line with accreditation requirements, the TeamSTeeps Orientation package, and information on ordering clinical handover resources such as ISBAR telephone prompt sheets, and two Mandated Policy guidelines for clinical handover. Despite the reservations outlined in the Wong et al. literature review [25], the Chaboyer et al. [26] paper, dismisses nurse reservations on bed-to-bed handover arguing that it engages the patient in their care; which in Australia is the first of the ten required standards of the Australian Commission on Safety and Quality in Health Care [16] for all public and private health facilities. Bed-to-bed handover is mandatory in South Australian public hospitals; although it appears to be only done between the early and late shift and not always with doctors or allied health staff available. What we uncovered here is that it has variable impact on patient engagement in their care, requires nurses to think imaginatively about how to convey the information in a way that both involves the patient, but does not violate confidentiality, or alarm relatives, and does not objectify the patient. It certainly limits the information that is exchanged, both for the patient at the bedside, and for the nurse's knowledge of other patients on the ward, and we would argue leads to missed care as the comment below illustrates: The nurses only listen to the bit that they're going to be interested in. So, they're away with the fairies, so when you change the allocation "Oh I don't know those patients" "Well you should have listened" you should know all the patients, that's what you're going to get a handover for. So, in that respect it's quicker, and you only get to know your own patients. The downside is then you don't know any of the other patients (RN 11).

Discussion

The value of institutional ethnography is that it allows the researcher to analyses the particular issues beyond that of the everyday experiences of nurses and others. While the transcripts of the participants provide insights into the how the nurse defines the problem, it does not uncover the fault lines. For example, understanding why care might be missed when the skill mix leaves no experienced nurses on duty on late shifts or weekends has little to do with the quality of graduates, and much to do with the push for work-place flexibility in line with NPM. Why the CEO of this hospital is pushed to achieve such salary savings, and direct nurse managers to roster nursing staff accordingly can be found in the funding agreements between the State and Federal government that leaves the State without sufficient funds to run these hospitals, but bound under law to admit all presenting patients free of charge within a timely manner [23]. It is the contradictions between the policy, the various NPM strategies and the funding arrangements that shape the nurse manager's rostering practices, which in turn, risk patient safety. Likewise understanding why some patients transferred from A&E to an already overcrowded ward might miss out on care is not because nurses are incompetent. It may well be because the patient is an outlier in the ward, or in a ward already full to capacity, with no additional staff. This patient may well have been transferred to the ward in order to beat the daily census, because failure to do so will result in low scores with comparative peer hospitals across Australia, and loss of desperately needed incentive funding if the hospital does not get the patient admitted or discharged within the 4 hour window. Hospitals are required to report this data to state authorities on a monthly basis. States are required to report it to Federal authorities quarterly [16].The close monitoring of hospital quality assurance and risk management by Federal, State and hospital managers represents a new form of surveillance, not because these groups have not always been concerned about safety, but because of the capacity to closely monitor the minute actions of clinicians and the steady drift towards standardization of practice across both the public and private healthcare systems this surveillance generates. Bed-to-bed handover is one example, others include ISBAR, and rounding, and the myriad of clinical pathways nurses and other health professionals are expected to take on. These practices have come from centrally driven decision makers keen to manage the risks and ensure clinical effectiveness, productivity and efficiency. While they may indeed reduce adverse events, they do so, at the risk of increasing the routinization of

nursing work, which in the long run, we would argue, is detrimental to quality patient care and risk reduction. Along with the traditional practices of NPM, and the digital technologies of surveillance, these risk reduction practices form new regimes of work in the post NPM era. In many instances they are presented as change management innovations, or evidence-based initiatives worthy of exploration, and often championed by clinicians. In other instances, they become the recommended requirements of regulatory bodies that provide accreditation- essential for on-going funding- either way they are desperate attempts to manage the contradictions between policy and funding mechanisms, between practice and the text. The difficulty for health professionals is that many of these texts (mandatory policies, standards, evidence-based findings) have the potential to ensure improvements in care, but they also run the risk of reducing the clinician's critical insights through routinization and standardization. Further, where they are an add-on to already existing workloads, they increase work intensity leading to missed or slipped care and [26], produce new regimes and textually based forms of governance over nurse's work.

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