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Staff acting resiliently at two hospital wards

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Abstract

Purpose – The purpose of this paper is to understand how the hospital staff (nurses and physicians) at two hospital wards have coped with everyday work having leaders in conflict or longer periods without one or the other leader and whether the way the staff handled the challenges was resilient.

Design/methodology/approach – Through semi-structured interviews with the staff at the two wards, the authors analysed how the staff were working, if they had cooperation and interdisciplinary cooperation, how they would handle uncertainties and how they coped with the absence of their leaders.

Findings – The staff at both wards were handling the everyday work in a resilient way. The authors argue that to increase the resilience in an organisation, leaders should acknowledge the need to establish strong emotional ties among staff and at the same time ensure role structures that make sense in the everyday work.

Originality/value – This study reports on original work and shows what decision makers could do to increase resilience in an organisation. This paper shows that the organisational context is important for the staff to act resiliently. As leaders come and go, it can be important for the stability of the organisation to promote the staff in acting resiliently independent of the leader situation.

Keywords Health care, Hospitals, Leadership, Management, Organizational performance

Paper type Research paper

Background

Many hospital wards and departments have a team of two or more leaders sharing the leadership responsibility. In this paper, we analyse how the staff react and cope when the leader team is not working as a team or leaders are absent.

We studied multiple and dual leadership in leader teams at departments and wards at Danish hospitals, all in the same clinical specialty. In two of the wards, we found leader teams in which the leaders had challenges. The wards were located in two different hospitals and are referred to as
Hospital 1 and Hospital 2. In one ward, the leaders were in conflict and did not agree on decision processes (Hospital 1). In the other ward, both leaders had, in the past two years, been on leave for varying periods because of illness (Hospital 2) (Thude et al., 2017). Therefore, we found that the leader teams at both wards were challenged.

The aim of this study was to understand how the staff at the two wards with challenged leader teams coped with everyday work and whether the way in which the staff handled the challenges was resilient.

**Acting resiliently**

Organisational resilience is a term used to describe how organisations can adapt to challenging conditions (Sutcliffe and Vogus, 2003). In this context, organisational resilience is relevant as we are investigating whether it was possible for the hospital staff to adapt to the challenging conditions and cope with everyday work.

Historically, the term “resilience” has been used in many ways: to characterise physical materials, to describe how ecological systems can absorb change (Hollnagel, 2018a), as individual resilience, including employee resilience (Britt et al., 2016) and as organizational resilience. In this paper, the focus is on organisational resilience.

Organisational resilience is relevant in health care, for instance, in the rapidly growing interest for resilient health care (Hollnagel et al., 2013b). Although there are many recognized studies of resilient health care (Wears et al., 2015a, 2015b; Braithwaite et al., 2017; Hollnagel et al., 2018), specific studies of organisational resilience in the health sector are relatively scarce (Barasa et al., 2018), and according to Bhamra et al. (2011) “more real world-based research needs to be done [. . .] Empirical research that uses case-based methods focusing on the organisation are currently few and further study here would add to current understanding”. The purpose of this paper is to take a closer look at how, and whether, it is possible for the staff to act resiliently in spite of having challenged leaders.

Resilience is defined in many ways; Vogus et al. (2007) have defined it as “the maintenance of positive adjustment under challenging conditions such that the organization emerges from those conditions strengthened and more resourceful”. According to Weick et al. (2008), resilience is not only about bouncing back but also about using change as an advantage.

The literature on organisational resilience can be divided into two perspectives. One perspective describes resilience as the ability to rebound and pick up where they left. In this perspective, the organisational focus is on coping strategies and to get the organisation to fit in to the new context (Lengnick-Hall et al., 2011b).

The other perspective:

[. . .] looks beyond restoration to include the development of new capabilities and an expanded ability to keep pace with and create new opportunities [. . .]. In this second view organizational resilience is seen as thriving because of the ability to capitalize on unexpected challenges and change (Lengnick-Hall et al., 2011a).

The latest definition of acting resiliently is from Hollnagel (2018b):

*Resilience is an expression of how people alone or together, cope with everyday situations – large and small – by adjusting their performance to the conditions. An organisation’s performance is resilient if it can function as required under expected and unexpected conditions [. . .].*

Further, Hollnagel argues that resilience is not only about recovering from stress but also about being “able to perform as needed under a variety of conditions – and to respond appropriately to both disturbances and opportunities (Hollnagel, 2018b)”.
In this paper, we analyse how the staff are working in a situation where their leaders are challenged and the situation is different from the norm. Therefore, resilience is here used in the sense of adjusting to disturbances and challenging conditions. We do not focus on whether the challenges were used as an advantage to the organisation. Our interviews show that some of the staff did use the situation for their own advantage; however, we do not know if the situation in general made the organisations able to, as Lengnick-Hall et al. (2011a) expresses it, “exploit opportunities and build a successful future”. Therefore, we will use the definition of resilient health care as given by Wears et al. (2015a, 2015b).

Resilient health care can be defined as the ability of the health-care system (a clinic, a ward, a hospital, a county) to adjust it functioning prior to, during or following events (changes, disturbances and opportunities), and thereby sustain required operations under both expected and unexpected conditions.

Using this definition, we assume that “systems work because people are able to adjust what they do to match the conditions or work” (Hollnagel, 2014). In acting resiliently, the system can succeed under varying conditions. (Hollnagel et al., 2013b).

**Methodology**

The staff at the two wards were interviewed using semi-structured interviews (Kvale and Brinkmann, 2009). At Hospital 1, we conducted individual interviews with nurses and physicians for 20 - 30min. The intention was to conduct focus group interviews, but it was not possible for the ward to cope effectively with so many staff absent at one time. At Hospital 2, we conducted focus group interviews with nurses in one group and physicians in another. The interviews lasted for 1 h. The main author translated the quoted material that is used in this article from Danish into English and a colleague verified the translations. The interviews were transcribed in NVivo.

The interviews were originally designed for another study that investigated interdisciplinary cooperation, and therefore, did not have any direct questions concerning resilience.

Some of the questions are however relevant in a resilience context. We asked questions concerning how the staff carried out their work, how they would share responsibility between nurses and physicians, how the cooperation was among staff, how they were communicating, how they would handle challenges and if different professions had a common goal. These questions can be used to cover themes within resilience such as sensemaking and role structure, informal leadership redundancy, prosocial motivation, emotional ties and self-organising. The themes will be explained in the result section.

**Analysis**

The analysis was based on a case-study design, and the interviews were transcribed and analysed in NVivo. The analysis approach was to read through the interview transcripts to identify the themes that emerged and then go back to the literature to find any previous writing on that theme. The literature was also scanned, and the data examined for themes previously identified in the literature and the process was repeated several times. The themes were found by the first author of the paper and checked by the other authors.

Even though the data analysed were not collected specifically for this study, they provide rich information on certain areas related to resilience. However, whether other aspects of resilience played out in the wards is not known, as there were no other data available and the staff were not questioned directly on the subject. This study can therefore only give a limited picture of how the staff acted resiliently.
During the analysis, we found that the following themes recurred in the interviews: sense-making and role structure, informal leadership redundancy, prosocial motivation, emotional ties, self-organising and advice seeking.

In this paper, we will show how these themes increased the possibility to act resiliently at the two wards.

**Context**

Hospital 1 is a regional hospital with approximately 400 beds and small departments, each having few wards. The hospital had reorganised its leader and department structure 18 months before the interviews took place. Earlier the hospital had (in the Danish context) a traditional leader setup, with a nurse in charge of the nurse leaders and a physician in charge of the physicians, and at the department level, a nurse in charge of the staff nurses at the ward level. In the new set-up, the hospital had two health professionals as leaders at both department and ward levels. The two leaders were jointly accountable for the results at the ward and had shared leadership with no specified power differences.

Hospital 2 is a regional hospital with approximately 300 beds and small departments, each having a few wards. This hospital had reorganised its leader and department structure approximately one year before the interviews took place and, similar to Hospital 1, also used to have a traditional set-up. After the changes, the department leadership consisted of three leaders, a chief leader and two deputies. The leadership of the ward consisted of a nurse, who was leader of the nurses, and a physician, who was leader of the physicians.

For both hospitals the changes in the leader set-up was a part of a national organizational change in the health-care sector in Denmark, where acute care centres were established which changed the known patient flows. In connection to these changes, the two hospitals chose to merge certain department and create new departments in an attempt to create better patient pathways. According to internal documents, the leadership set-up was changed because of a wish to create better interdisciplinary cooperation and good continuity of care and treatment. It was not possible to find any documentation for why the chosen leadership set-ups should create better interdisciplinary cooperation.

**Results**

*Sense-making and role structure*

According to Weick (1993), sense-making and role structure are pivotal for an individual to be able to act resiliently. In an analysis of firefighters’ behaviour in a fire disaster, he found that because the firefighters lost structure and became anxious, they struggled to make sense of what was happening and could not make sense of an escape fire lit to save their lives. Weick describes sense-making as contextual rationality and finds that organizational structure can rebuild the sense and provide meaning and order when those involved are faced with large and contradictory demands.

*Hospital 1.*

Analysing the interview data from the staff at the ward with leaders in conflict at Hospital 1, we found that the structure of work was maintained and the staff still knew what to do in the absence of their leaders. One physician from the ward explained:

*I think [the leaders act] [. . .] unprofessionally and it creates disturbance [. . .] ah because, yes, you just need that they [the leaders] are united. And then I think that this causes that you sometimes do what you think yourself, when no one from the top will come and tell you that we should do it like this. Then you might as well do what you feel is the best way. So in some way it gives me a free space.*
In this case, the physician still knew her own role and was good at improvising, which according to Weick (1993) is an important aspect in acting resiliently. The physician used her expertise to improvise, and having knowledge and expertise is an important factor in being able to act resiliently (Weick, 1993). However, another physician explained that because of the leader conflict, critical elements at the ward were not aligned, which sometimes impeded the work. Accordingly, improvisation was not always possible.

The ability of the staff to deal with a crisis situation depends on the organizational structures that have been developed beforehand (Lagadec, 1993). In this case, the physicians and nurses knew their responsibilities and the structure of the hospital and division of labour, so it appears that they were able to continue their work even though the leaders were challenged. A nurse explained: [My leader] doesn’t know anything about patient care [. . .] she can’t follow [. . .] as a leader I do not use her as such, because she has so much else to do and I am just a regular nurse at the department. Instead, I use my colleagues. I miss having a leader who has the energy to be present in the department.

According to Hollnagel (2011), for an organisation to act resiliently, it has to know “what to do, that is how to respond to regular and irregular disruptions and disturbances either by implementing a prepared set of responses or by adjusting normal functioning”. The daily working structures at the ward appeared well established; therefore, physicians and nurses seemed so independent of daily leadership that they could act on their own by improvising or using colleagues for dialogue and coaching. Therefore, we argue that the ward had a well-known and routine structure, and experienced colleagues who knew how to respond to the everyday tasks without their leaders.

Hospital 2.

At Hospital 2, the staff could not see any value in the organisational change; according to the physicians, before the change, their ward had been the best ward within their specialty in the country and now the ward had more staff on sick leave and worse working conditions. It appeared that the staff could not make any sense of the organisational changes and their new role. The physicians explained:

[. . .] earlier we [. . .] well as senior physicians we were a part of the management of the department at that time; that is, we were close to the decisions and we were part of the decisions [. . .]. We got information about economy and so on and we felt we were much more involved. Now everything has been taken to another level [in the organisation] and we are still here and the problem is we have no idea of where we are going. We work very interdisciplinary and we are one of the wards in the country that work most interdisciplinary. And then it is very hard when you get a team of leaders from another specialty [that does not work in the same interdisciplinary manner]. It is very hard to explain to someone who doesn’t have the same mindset. Moreover, the nurses observed:

We feel that we are not noticed in the same way as we were before [. . .] there is much more frustration among the leaders and physicians and because there is more absence according to illness [. . .] I think it is because it is no longer possible to make a decision on your own [. . .] we feel that the physicians are tired [. . .] the mid-level leaders [the leaders of the nurses and physicians at the ward] are on long-term sick leave because of stress.

The leaders and physicians had experienced a change in their roles and their influence in the department, which was unfamiliar and did not make sense to them. In particular, the influence of physicians and leaders at the ward level was diminished during the reorganisation, which had seemingly caused frustration and more sick leave in the two groups. The nurses did not appear affected in the same way.
Stable organisations can fall apart if people are put into unfamiliar roles, some key roles are unfilled, the task is ambiguous or the role system is discredited (Weick, 1993). We only observed the wards in the short term, and the way in which the staff talked about frustrations and sick leave led us to wonder if things would look differently in a long-term perspective. The data reveal information on people in unfamiliar roles and that key roles were vacant because of sickness. Whether the task was ambiguous cannot be conclusively determined from the data. The physicians explained that they did not know where they were going, while at the same time they cooperated well with colleagues and managed their everyday job, which is shown below. Therefore, we consider that the physicians felt confused and excluded on a strategic and developmental level.

Informal leadership redundancy

Informal leadership redundancy is when “slack informal leadership resources are utilized to contain disruptive events” (Johannessen et al., 2015a). According to Schulman (1993a), this slack may involve resources such as time, money and personnel, as well as control – meaning individual freedom to act within the frames of the organisation. Schulman (1993b) also mentions conceptual slack, which allows for divergent perspectives in the organisation:

> This divergence is not about what an organization is doing but about how it is doing it [. . .]
> The foundations of this slack is an institutionalized aversion to what might be termed errors of “aggressive hubris”.

Slack can be planned by the organisation or it can be opportunistic, which means that it is based on informal initiatives (Saurin, 2015). We examined informal slack that was not planned by the organisation and found that none of the wards experienced resource slack. At both wards, the staff felt time pressure and reported that their budgets had been reduced, which was why they did not have resources to hire extra personnel. Nevertheless, we found signs of control and conceptual slack.

Hospital 1

Regarding conceptual slack – having room for divergent perspectives in the organisation – our data indicate that the staff were good at cooperating and listening to each other’s observations and arguments. One physician stated:

> We all individually contribute so that we can get on with the treatment. I would not be able to do without the information from the nurses because it contributes to the picture I need to have of the patient.

Another physician observed that, when the physicians were on call, it was the nurses who received the patients and that:

> We have a lot of conversation about what kind of patient has arrived, then I see the patient and then it might be that we keep the patient for a couple of hours to make observations. And I depend on the observations the nurse makes.

A nurse explained that they had become better at cooperating:

> We depend on each other’s help because everybody is so pressed [. . .] I see us as an octopus having eight arms and we cannot function if one arm disappears [. . .] we cannot do without each other.

The data show that the staff entered into dialogue with colleagues, listened to the observations and used the competencies of other staff members. This provides a picture of the ward having aspects of informal leadership redundancy and conceptual slack.

Hospital 2

At Hospital 2, the physicians explained:
We have some nurses that are incredibly good at working unassisted, which means that I can leave some patients to the nurses [...] and then I say you can follow up and then come to me if it is like this and this [...] we use each other a lot [...] I would not know what to do without the nurses.

We obtain the same picture from the nurse group, as they described: We have a lot of contact to the physicians, we either work together with the physicians where we help in their ambulatories or we do on our own in our nurse ambulatories where we any time can get in contact with the physicians. I think it works well and we can use the physicians if we need to discuss a patient or treatment [...]. We have a very equal relationship to the physicians and we cooperate on equal terms when we are at the consultation.

Again, our data indicate that the staff cooperated and listened to each other’s arguments and used the competencies and resources of other staff. As with Hospital 1, we see this as signs of conceptual slack at Hospital 2.

Our data show that conceptual slack and informal leadership redundancy were present at Hospital 2. Our data indicate conceptual slack at both hospitals. However, we have less information on control slack.

Prosocial motivation
According to Weick and Sutcliffe (2007), mindful organising is a way of being able to adapt to unexpected events and to correct errors, which we understand as being able to act resiliently. Mindful means that “when people act, they are aware of context, of ways in which details differ [...] and of deviations from their expectations” (Weick and Sutcliffe, 2007). Prosocial motivation is an important factor for an organisation to be mindful. When people act prosocially they are “other-oriented”, “meaning that they are motivated to work for the benefit of others and are more receptive to others perspectives and incorporate those perspectives into their work” (Vogus et al., 2014b). In acting prosocially, a person sees his or her action as a contribution to the system, independent of personal interest (Vogus et al., 2014a). The staff in the public sector is often prosocially motivated – or as it is mentioned in the literature on motivation – intrinsically motivated (Georgellis et al., 2011; Bulenes and Van den Broeck, 2007).

Hospital 1
As explained earlier, we found that staff at Hospital 1 listened to each other’s arguments and used the competencies of each other. Further, one nurse explained: “we all want it to work. We are here for the sake of the patient, so it is important that it works in the best possible way”. In addition, a physician explained: I feel that it is a mutual goal [the patient treatment and care]. I think the nurses take responsibility for the patients as much as we do [...] we are a team of physicians and nurses who manage it.

Hospital 2
At Hospital 2, our data indicate that the staff listened to each other and incorporated perspectives of others in their work. A physician explained: We know each other well and know where everybody is, we are easy to get a hold of [...] we have the policy that when our door is open everybody is welcome—and the door is almost always open.

Later, she explained that they were really good at working interdisciplinarily: I know the dietitian here and I know what she can do, so I can tell precisely that it would be
good if she could attend this and this patient. And I can talk to [.] [other professions] and say, I have this and this problem and the patient is like this and this [.] [that is interdisciplinary cooperation].

A nurse claimed:
We feel some kind of responsibility for, I think, that it will work (the treatment and care of the patients). Yes it is some kind of ownership or something [.] so we take care of it [.] we have a really good interdisciplinary cooperation with physicians, physiotherapists, dietitians and so and [.] It works really well [.] we have a task in helping the new physicians who arrives every half year. I think we have a very important role in helping them.

We have the impression from both hospitals that the staff demonstrated strong prosocial motivation for the benefit of the patients.

Emotional ties
Weick (1993) suggests that the development of emotional ties keeps panic under control in the face of obstacles. Close ties permit clearer thinking. Weick also argues that, if formal structures collapses, social ties are what remain to rely upon. In establishing and maintaining social ties, trust, honesty and self-respect must be present in the relation (Weick, 1993). We do not see hospitals as threatening environments creating panic; however, we do argue that the formal structures at the two wards did not work in the way in which they were intended, and social ties might have contributed to the staff being able to do their job.

Hospital 1
The interviews indicate that the staff had developed emotional ties. A nurse explained that it was important to know each other: “For me, personally, it means something that I know [.] what I can say so that they know it is important [.] And also I feel they listen”. Another nurse stated that she found personal relationships important and that colleagues knew about each others’ personal life: I know that for instance he has a son this age [.] his wife is pregnant and he knows about my life and so. We briefly talk about it over lunch but it means that he is a person to me and I am a person to him [.] And we get to know each other so that if I come to him having red cheeks and stiff eyes, and I say there is a [.] [patient] at ward 2 I want you to look at, then he knows it has to be now.

A physician stated:
I really think we have a good relationship [.] and I try when it is possible to have lunch [together with the nurses and the other colleagues] because it means that it is nice and I think it works really good.

Hospital 2
At Hospital 2, the staff found that knowing each other was important. The physicians explained: If you do not know the others there will be a lot of misunderstandings. It is much easier to call someone and ask if they can manage a patient when you know them; that is not easy when they are totally strangers.

Moreover, the nurses explained:
We have to cooperate so that the physicians get the information they need [.] I think it also has to do with that we are a small unit and we need each other [.] we also have good social relationships with the physicians but that might also be because we are a small unit.

The data indicate that, both at Hospital 1 and at Hospital 2, there were tight and differentiated social relations among staff. This might have been because the departments were not very big, so that
everybody knew each other. At the same time, at both wards, the staff appeared keen to know each other.

Self-organising and advice seeking
Laloux (2015) found that self-organising contributes to good results in different industries, in private and public organisations and in different countries. One example of self-organising is a Dutch home-care organisation where self-organising decreased the need for home care per patient, leading to faster recovery and a reduction in acute hospital admissions (Laloux, 2015, p. 90).

We argue that self-organising might provide greater opportunities for the staff to act resiliently because they are closer to reality and because decisions are made where the work is done. In such cases, there is little or no divergence between what Hollnagel (2015) calls work-as-done and work-as-imagined. Not having to consult a leader facilitates adjustments in changing conditions. When they want to make changes or have questions, self-organising staff seek advice and input from affected colleagues and those with expertise. The staff thereby are able to make the decisions themselves rather than have them made by a leader. The two wards we examined were not formally self-organised, but our data indicate that at some points, the staff did work as though they were self-organised (Laloux, 2015). Physicians and nurses can, according to Just and Nordentoft (2012), be defined as professions (physicians) or semi-professions (nurses), meaning that they have had the same education and training and share a professional identity and language. This makes it easier to self-organise and make independent decisions.

Hospital 1
At Hospital 1, a physician explained that instead of waiting for guidance from a leader, she made the decisions herself and that both nurses and physicians took responsibility because everybody had to contribute. A nurse explained that she did not use the nurse leader for advice; instead, she asked her colleagues. Another nurse explained that all the staff worked for the sake of the patient and were good at cooperating.

Hospital 2
At Hospital 2, the staff cooperated and discussed the patients with each other. A nurse explained that the nurses had an equal relationship with the physicians and cooperated on equal terms. However, the staff felt that some of their autonomy had been removed and that it was no longer possible to make decisions on their own in some areas, which led to frustration.

At both wards, the staff cooperated well and sought advice and input from each other. In organising the work within the frames of the ward and seeking advice from colleagues, we see indications of self-organising at both wards. Further, our data from Hospital 2 indicate a wish for self-organising, as the staff were frustrated when the possibility of making their own decisions was removed.

Discussion
We analysed how the staff at two wards with leaders that were challenged coped with everyday work, and whether staff were able to manage the work in a resilient way.

According to sense-making and role structure, which represent the organizational perspective, we found that the staff were able to make sense of their everyday work and the role structure in this work. In some situations, the staff were also able to compensate or carry on with the work in spite of the absence of decisions from leaders.
Self-organising is related to role structure, and we found that the staff helped each other and, to some extent, delegated patient care to each other when they knew that the competencies were present. Because the staff were confident with the role structure and because the structure was open to making own decisions, the staff were able to self-organise and help each other in performing their job.

However, at the same time our data show that when the staff could not make sense of the decisions, they became frustrated, which is consistent with the theory that sense-making is an important aspect of coping with new structures. Further, some staff had a wish to self-organise and were frustrated that it was no longer possible to do so. Other staff missed having a leader close by, and even though they coped with the work, not all the staff were happy to self-organise and handle the job on their own.

In our opinion, informal leadership redundancy, conceptual slack, prosocial motivation, advice seeking and emotional ties link together because they represent the individual perspective in our analysis. We found that all these aspects were present at both wards and the staff valued them and tried to help each other to carry out the tasks. Prosocial motivation also focusses on being motivated by the benefit of others. We found that the staff at both wards were acting resiliently, which might be explained by their motivation to benefit others. Our data indicate that the staff were very much aware of the patients and were motivated by doing a good job nursing and treating the patients. According to the staff, it was only possible to do a good job by cooperating and listening to the arguments and observations of each other. Therefore, we find that being motivated by the benefit of others may explain how the staff can deliver high-quality work and act resiliently under the described circumstances.

Further, we found that there were emotional ties in the staff groups at both wards. According to the staff, personal relations made it easier to cooperate and respect each other. From this perspective, emotional ties strengthened the ability to be other-oriented and work for the benefit of others. According to Weick (1993), emotional ties permit clearer thinking. We found that there were emotional ties at both wards; whereas, in one ward, we found indications of improvising, which indicate clear thinking and resilient acting.

At Hospital 2, our data indicate that the staff were frustrated by being unable to not only make sense of the new structure but also use control slack. The staff had, in the new organisation, lost some of their responsibility in certain tasks and were frustrated that they were not allowed to use their slack of control and the possibility to self-organise. The staff could not make any sense of why these restrictions were made, which led to frustration. Frustration is an aspect that distinguishes the wards, as we did not find the same frustration at Hospital 1. This might be an indicator of how long the staff can act resiliently and is an important aspect that warrants further research. Hollnagel et al. (2013a) argue:

*Health-care organisations and regulators should focus on determining areas of activity that can be routinised and standardised, and understand that other areas are best left for judgements made locally in the situation.*

According to the staff at Hospital 2, more decisions could have been distributed to staff, which might have been beneficial for motivation of the staff.

*Limitations of the study*
As the interviews were conducted for another study, we do not have data in all areas or data on exactly the same themes from the two wards. Therefore, it would be relevant to perform another study, having an interview guide based on questions from the resilience perspective. The study is based on the staff members self-reporting on matters such as interdisciplinary cooperation and how they would handle conflicts. Additional observations would have been valuable to provide more objective data to verify the self-reporting data.

Conclusion
We found that the staff at both wards were handling the everyday work in a resilient way, in spite of the challenges their leaders encountered. The staff at both wards had a role structure that they knew and could fit into, and were using informal leadership redundancy and cooperation, to help each other to complete tasks. The staff were able to self-organise, although some staff had a wish to self-organise while others would have preferred to have a leader close by to use for advice and making decisions. Having strong emotional ties at both wards might have strengthened the cooperation, self-organising and informal leadership redundancy.

We found that the staff at both wards managed their everyday work by cooperating and seeking advice from their colleagues. Therefore, we argue that, even though the leader teams, at the time we performed data collection, were challenged, the established role structures for the everyday work nevertheless made it possible for the staff to continue work. We found that the staff at both wards acted responsibly to ensure the completion of their work and to help each other.

Strong social ties were shown important for the staff to be able to act resiliently. These strengthen the possibilities for cooperation, self-organising and informal leadership redundancy, which are all aspects of acting resiliently.

We found that not being able to make sense of decisions and role structures can lead to frustration, as can reduced autonomy. Frustration may be an important factor in how long the staff can keep acting resiliently.

Therefore, we argue that, to increase resilience in an organisation, it is important to acknowledge the need to establish strong emotional ties in the staff groups and ensure role structures that make sense in the everyday work. Finally, decision makers should be aware that decisions at the strategic level must also make sense at the everyday work level.

Contributing to the literature, the paper shows that the organisational context (sensemaking and role structure, informal leadership redundancy, prosocial motivation, emotional ties and self-organizing) is important for the staff to act resiliently and on a shorter term can support the staff in doing so when their leaders are busy with other matters. As leaders come and go, it can be important for the stability of the organisation to promote the staff in acting resiliently independent of the leader situation.
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