Received: 16 March 2019 | Revised: 21 May 2019 | Accepted: 25 May 2019

DOI: 10.1111/jonm.12806

ORIGINAL ARTICLE

WILEY

Safeguarding the patient in municipal healthcare—A hermeneutic focus group study of Nordic nursing leadership

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Abstract

Aim: This study illuminates the meaning and purpose of clinical presence in nursing leadership in municipal home care from the first-line nurse manager's own perspective.

Background: Being a first-line nurse manager in the context of home care is demanding due to demographic changes and an ever-increasing number of elderly suffering from chronic diseases. Leading in this context entails leading from a distance because patients live and receive care in their homes. First-line nurse managers express the importance of clinical presence. However, there is a paucity of studies from home care of the meaning and purpose of presence. The theory of caritative leadership and the model of caring in nursing leadership served as the starting point for this study.

Methods: Hermeneutic abductive approach using a purposive sample of three semi-structured focus group interviews with 11 first-line nurse managers in home care in three Nordic countries.

Result: This study shows that first-line nurse managers described the meaning and purpose of their clinical presence in home care as safeguarding the patient by taking overall responsibility for care, securing the patients' voices, building and maintaining trustful relations, and securing a sensible economy.

Conclusion: Our findings indicate that clinical presence serves the purpose of taking the overall responsibility for care and safeguarding the patient. Presence is perceived a necessity to verify staff providing the best possible care. First-line nurse managers acted metaphorically as a shield to protect patient care, which is the main concern in their leadership. The findings add new knowledge to the significance of caring in nursing leadership and the theory of caritative leadership.

Implications for Nursing Management: First-line nurse managers need to be clinically present in order to safeguard the patient and to fulfil their threefold responsibilities for the patient, the staff and the economy. This study might also contribute to the political discussion concerning why nurses has to be first-line nurse managers and cannot be replaced by economists.

KEYWORDS

caring, caritative leadership, clinical presence, hermeneutics, municipal home care

1 | INTRODUCTION/BACKGROUND

Nurses have a long tradition of leading health services (Nightingale, [1860], 1969). Nursing includes an expectation of advocating for the patient, voicing responsiveness and integrating an acknowledged professional responsibility for the patients' needs (Vaartio, Leino-Kilpi, Salanterä, & Suominen, 2006). Cook (1999) defines nursing leadership as a direct involvement in clinical care, constantly influencing others to improve the care provided. Leading involves influencing development of shared values, vision and implementation of planned goals, and overall effectiveness (Feather, 2009). In this article, the nurse leaders are the leaders working closely with patient and personnel, often with a tripartite responsibility for personnel, finances and patient care. We use the term first-line nurse managers (FLNMs) or leaders for these individuals.

First-line nurse managers in formal positions are a part of the health care system managing the largest group of health care staff, the nurses (Aitamaa, Leino-Kilpi, Puukka, & Suhonen, 2010). The nurses are perceived by FLNMs as their most important resource (Vesterinen, Isola, & Paasivaara, 2009). Complex and constantly changing work situations characterize the work environment of the FLNMs (Karlberg Traav, Forsman, Eriksson, & Cronqvist, 2018). The leaders' responsibilities include safeguarding daily care, developing nursing care, facilitating a good workplace environment and keeping the budget balanced (Athlin, Hov, Petzäll, & Hedelin, 2014). Their workday is filled with tasks such as meetings, scheduling and organizational issues (Ericsson & Augustinsson, 2015). First-line nurse managers have considerable influence given the designs and responsibilities of their roles. Therefore, they require a relational approach to achieving a preferred future and ideally a shared vision with their team (Cummings, 2012). Even though FLNMs understand and emphasize with the nurses' vision of professional care, they perceive ideal patient flow and adhering to budgets as more important (Skirbekk, Hem, & Nortvedt, 2017; Solbakken & Bondas, 2016). First-line nurse managers are crucial to the success of patient care and play a critical role in articulating the uniqueness of nursing in complex, corporatized health care systems, safeguarding the best quality of care and caring for the patients (Bondas, 2003; Boykin & Schoenhofer, 2001; Nyberg, 2010; O'Connor, 2008). Nursing leadership is correlated with patient outcomes such as patient satisfaction and adverse events (Cummings et al., 2010, 2018; Solbakken & Bondas, 2016; Wong, Cummings, & Ducharme, 2013). Good leaders help produce good care and poor leaders produce poor care (Scully, 2015).

There is a need for stronger conceptualizations of nursing leadership that clearly defines leadership practices affecting those who lead (Avolio, 2007; Rosengren, Athlin, & Segesten, 2007).

In the Nordic countries, a political shift towards municipal health care is seen, and several large health care reforms encompassing care for elderly has been implemented. Traditionally, FLNMs were nurses. Lately, being a nurse or having another health care profession is no longer required. An increased focus on economy and efficiency, based on the ideals of New Public Management, has initiated a debate whether replacing nurses with economists as first-line managers is more beneficial.

The services are mostly organized, managed and financed by the municipalities (Nylenna, 2014). Nordic municipal home care is mostly organized as one or several organizational home care sectors within the community, based on the patients' geographical residence. Each sector has their own staff consisting of nurses, nurse aids and other formal caregivers and has one leader. The leader is located in the sector's main office. The shifts start and end at this office, but nursing care is provided in the patient's home. Individuals with extended-care needs, formerly residing in institutions, are now receiving treatment and care in their own homes (Holm & Angelsen, 2014; Strandås & Bondas, 2017). According to Rudolfsson, von Post, and Eriksson (2007), FLNMs struggle to maintain focus on the patient in hospital settings. Leading in home care entails leading staff at a distance. First-line nurse managers themselves are distant to patients and their relatives, which challenges clinical presence and thus the FLNMs risk losing sight of the actual nursing care under their responsibility (Solbakken, Bergdahl, Rudolfsson, & Bondas, 2018).

This study is based on the theory of caritative leadership that originates from the motive of caritas that is seen as the altruistic and lasting idea of caring. The motive of caritas might give strength and provide a deeper meaning to the whole culture within the health care organization (Bondas, 2003). The theory of caritative leadership is derived from the concept of humanistic caring and service to humanity. Its main tenet is ministering to the patient, contributing to an existential awareness of personal and professional meaning and purpose, which creates a more caring work environment. When caring is connected to administration, ministering to the patient is implemented in leadership and directed to foster an organizational culture based on an ethos of caring. The caritative leader will need a combination of management and leadership competencies as well as competencies in caring and nursing sciences. All these competencies are needed to provide the patient with the best care possible with a minimum of bureaucracy (Bondas, 2003, 2009; Peterson & Bredow, 2013).

In the first phase of the research project, we developed a tentative theoretical model using metasynthesis (Solbakken et al., 2018). The findings indicated that caring in nursing leadership is a conscious movement between five metaphoric, relation-based “rooms” in the leader's “house” of leadership. The rooms are: The “patient room”, where nurse leaders try to avoid patient suffering through their clinical presence; the “staff room”, where nurse leaders trust and respect each other and facilitate dialogue; the “superior's room”, where nurse leaders confirm peer relationships; the “secret room”, where the leaders' strength to hang on and persist is nurtured; and finally the “organizational room”, where limited resources are continuously being balanced. If the “rooms” are not given equal attention, movement stops, symbolizing that caring in leadership stops as well (Solbakken et al., 2018). This movement is further understood as FLNM's clinical presence where presence means meeting patients, relatives, and staff in their everyday context thus *not* as nurses participating in daily care. It is evident from the metasynthesis study that

clinical presence is a prerequisite for a caring leadership. Previous research did not provide insight on clinical presence in nursing leadership in home care.

2 | AIM

The aim was to illuminate the meaning and purpose of clinical presence in nursing leadership in a municipal home care context from the FLNM's own perspective.

3 | METHOD

A qualitative, hermeneutic approach inspired by Gadamer and described by Fleming Gaidys and Robb (2003) guided the study, where interpretation is described as a nonlinear process by going back and forth from parts to whole to get an expanded understanding of the whole and widen meanings of the parts (Table 1). This is also described in the hermeneutic spiral for gaining understanding (Gadamer, 1989). The study has followed an abductive logic where the questions emanated from reflections on the findings from the previous metasynthesis and our wonder based on our experiences (Råholm, 2010).

3.1 | Participants

A purposive sampling of Nordic FLNMs responsible for overseeing first-level nursing services in home care was chosen, as the empiric foundations for our tentative model were studies from the Nordic countries (Solbakken et al., 2018). In this study, we therefore, decided to gather data from the Nordic countries. Even if the included countries are comparable regarding the rights of the citizens to receive public health care, we chose three different countries to maximize the nuances forming first-line management. The inclusion criteria were (a) Nordic nurse leaders working as first-line nurse managers in municipal home care, (b) work experience more than one year, (c) fluent in a Scandinavian language and (d) voluntary participation.

Eleven first-line nurse managers volunteered to participate in three different focus groups from units of various sizes in municipal health care in Norway (focusgroup1), Finland (focusgroup2) and Sweden (focusgroup3). Leaders in focusgroup1 and focusgroup3 were full-time leaders, but those in focusgroup2 had shared positions made up of 20% management and 80% nursing shifts. Seven participants had taken part in courses in nursing or administration, but none had master's degrees in nursing/caring sciences or administration. Their mean age was 50.3 years (33–61 years), experience as nurses 22.9 years (3–37 years) and experience as leaders 13.3 years (1–34 years). All participants were female and working in the same municipality in each country, but not all at the same location (Table 2).

TABLE 1 Description of Fleming's four phases

Phases
1. Find the meaning that expresses the text as a whole.
2. Investigate every single sentence to understanding its meaning.
3. Relate every sentence or section to the meaning of the whole to expand the meaning of the text as a whole.
4. Identify the passages that seem to be representative of the shared understandings between the researcher and participants.

3.2 | Data collection

Data were collected in three focus group interviews (FGIs) between February and May 2018 and took place in undisturbed rooms at the participants' workplaces, lasting 3–4 hr, including breaks. The recommended number of focus groups in order to gain data varies (Hennink, Kaiser, & Weber, 2019), but should consist of four to twelve participants (Krueger & Casey, 2009). Focus group interviews were chosen to collect qualitative data that would not emerge using other methods due to the aspect of interaction between participants and the collective activity in the group. Focus group interviews are used for the explicit exploration and exploitation of such interaction in a research process (Kitzinger, 1994). Focus group interviews are carefully planned discussions in a non-threatening environment, created to obtain the participants perceptions on pre-defined area of interest. Group activity was important for obtaining the participants' varied perceptions and experiences that are possibly triggered by the other participants' descriptions (Kitzinger, 1994; Orvik, Larun, Berland, & Ringsberg, 2013). Another argument for choosing focus groups was that we were interested in the shared experiences of the participants as leaders in an everyday context, and the topic was not regarded as sensitive that could have required individual interviews.

However, we modified the traditional FGI by not strictly following the structure of our interview guide and including different open-ended but also clarifying questions based on our theoretical perspective. An initial presentation of each metaphoric room from the model was followed by questions such as: “What do you think of this description?” and “Is anything missing?” Follow-up questions could be: “Can you add some examples?” and “Why is this important?”.

TABLE 2 Characteristics of the eleven participants

Age	Gender	Profession	Additional education	Time practicing as nurse	Time practicing as leader	Percentage of time resources available for administration
33–61 years Average: 50.3 years	Female	Nurse	None: 4 Nursing: 3 Administration or leadership: 4	3–37 years Average: 22.9 years	1–34 years Average: 13.3 years	FG1: 100% FG2: 20% FG3: 100%

We used the same interview guide in all FGIs, with small adjustments made according to interesting findings that needed to be explored in the next interview. We also invited a hermeneutically oriented dialogue of storytelling, listening and probing for clarification when new issues emerged. The participants knew each other and easily followed up on each other's comments. Each participant contributed as much information as she wanted.

Two researchers were present, RS and AK. The first author (RS) presented the topics of interest and facilitated an open atmosphere, acknowledging contradictory comments and maximizing interactions between the participants. The assistant moderator (AK) observed and documented the group dynamic and body language in field notes and occasionally summarized discussions (Karlsson & Lerdal, 2008; Kvale, Brinkmann, Anderssen, & Rygge, 2015).

3.3 | Data analysis

The FGIs were audio-recorded and listened through, and the first author transcribed and began the analysis directly after each FGI. Our data consisted of 248 A4 pages that were transcribed verbatim and additional field notes. The next step was to highlight the meaning of each passage, constantly comparing and contrasting within and across the FGIs, going from the whole to the parts using a reflective process, creating and naming subthemes and finally finding the overarching theme. Finally, we identified and organized the subthemes into themes and named them (Fleming et al., 2003). The analysis was based on rich and varied data from all the FGIs and analysis continued until no new meanings emerged.

RS and AK performed the analysis separately. Thereafter, both participated in the interpretation process through dialogue with each other and in dialogue with the text. TB verified and contributed new perspectives.

Scientific curiosity and a reflective ethical attitude guided this study. RS, AK and TB are experienced, qualitative researchers and nurses. Only RS and TB are former FLNMs in municipal home care and had a previous understanding of the work of nurse leaders, however, quite a long time ago. RS and TB could identify with the FLNMs in their challenging workdays with multiple demands and had experience on how to handle them. AK helped us to keep the distance we needed to a phenomenon familiar for RS and TB, and asking questions. We knew the home care settings of our different countries.

3.4 | Ethical considerations

The Norwegian Centre for Research Data approved this study (NSD: 59117). All participants received written and verbal information about the study, signed an informed consent sheet and were ensured their right to withdraw from the study.

4 | RESULTS

The interpretation of the FLNMs' descriptions led to an understanding of the meaning and purpose of clinical presence that is to safeguard the patient and enhance the best possible care based on the following four themes: taking overall responsibility for care, securing the patients' voices, building and maintaining trustful relations, and securing a sensible economy.

4.1 | Taking overall responsibility for care

Having the overall responsibility for quality of care, staff and economy was described as demanding and sometimes even overwhelming. All the FLNMs proclaimed a need to be present in the homes as a part of safeguarding and caring for the patients. Leadership in home care settings meant leading patient care at a distance because patients live and staff work in their homes. All FLNMs expressed confidence in providing good services. However, they must rely on the information received from the staff even though it is sometimes contradictory. Staff present differing perceptions of the reality in the field, resulting in uncertainty to the FLNM. First-line nurse managers expressed an inner conflict between trusting the staff's comments and a need to oversee the care:

> I feel quite confident that it is good what they do…but you never know. It is only what you hear. You have to see it with your own eyes. (Focusgroup2-7)

However, one leader expresses:

> I would prefer to be less with the patients. (Focusgroup2-7)

Many homes are old and not designed for older people with health issues. First-line nurse managers intended to defend both the patient's and the staff's dignity by seeing with her own eyes. One leader said:

> You know what? You should not tolerate this. This home is not acceptable to work in. This is not right. I am also responsible for the safety of the staff. (Focusgroup1-1)

Participants in two focus groups were full-time leaders; in the third, the leaders had shared positions consisting of 20% administrative time and 80% clinical nursing time. In the two groups, the leaders themselves mostly initiated the clinical presence. In the third group, the leaders also emphasized clinical presence even if this was not by choice and resulted in performing administrative work in between clinical obligations or in their spare time.

4.2 | Securing the patients' voices

The responsibility for quality of care belongs to the FLNMs. Having a personal relation to the patient seemed essential for the leaders. This means securing their voices by communicating with the patients to plan care, based on the patients' care needs and wishes. Two of the municipalities conduct annual surveys to gain insight into patient satisfaction. The leaders stated that meeting the patients and

their relatives and listening to their comments were important to get an overall impression of the care. They received valuable input on how things are working and what ought to be improved. Therefore, it seems that a prerequisite to safeguard the patient is being connected to the patient by meeting them personally. One FLNM stated that her motivation for being out in the homes was:

> I need to know the patients I am responsible for, and what needs they have. I always strive forward to improve care. The responsibility for quality of care lies on us. (Focusgroup1-1)

For some patients, for example, those suffering from dementia, the relatives may try to speak on behalf of the patient and ensure the patient's involvement in care. All FLNMs described good experiences with meeting relatives, but only one FLNM routinely participated in the admission meeting with new patients and their relatives.

> I always introduce myself when new patients arrive. I need to have a face…. (Focusgroup3-9)

> Meeting the patients enables me to hear them describing their needs as a way of securing their voice in care planning. (Focusgroup1-1)

First-line nurse managers mostly initiated meetings when needing additional information.

Another aspect in the context of home care is patients' living in their own homes or in the homes of their relatives. Sometimes this means that home care services and relatives have a shared responsibility for the patient. This requires thoughtful planning for predictable health care service.

> I have high focus on user involvement. For extended-care needs, I need to hear a little bit about what is important, right, for the patient and for you. What are your needs, and what do you want us to assist with? (Focusgroup1-1)

The FLNMs describe a tight connection between the well-being of the staff and the care given to the patients. Taking care of the staff is a way of caring for the patient. As one leader said:

> …when you take good care of your staff and we are having a good atmosphere amongst us-it will affect patientcare positively. (Focusgroup2-5)

Employees might also have mutual conflicts, which are perceived to affect patient care negatively. The FLNMs may intervene fast and determined to protect the patient, as one of the leaders described:

> Do you know that you are at your workplace and that you are adults? None of you get to work with the patients now. Go home both of you and call me when you have decided what you want to do! Do you want to work, or do you not want to work? (Focusgroup3-11)

First-line nurse managers' ability to handle such conflicts presupposed support from their superiors.

4.3 | Building and maintaining trustful relations

All the FLNMs prioritized sitting down with their staff on a regular basis, at least once a day. They saw themselves as facilitators of a good working environment. Their vision was an atmosphere characterized by safety, flexibility, well-being, high job satisfaction and rare sick leave. Even if the meetings are mostly informal, they are consciously used to build a caring culture in the unit.

> It is important to be "on the same wavelength" as the staff even if we do not always see things the same way. I ask their opinion before I make decisions, therefore it is important that they dare to come forward with it. I do not want to be an authoritarian leader; I want the staff to trust me. (Focusgroup2-7)

Having an "open-door culture" seemed important. It was connected to the leaders' availability to the staff, through which they intend to build trustful and personal relations where confidentiality is crucial. Leaders from FG1 in particular said this relationship extended to facilitating and participating in private social events, ranging from small meals to making staff trips abroad possible. The purpose was to strengthen mutual relations, which they could benefit from at work.

> Both the staff and I learn to know each other from another side. (Focusgroup1-2)

Nevertheless, most FLNMs drew the line between personal and private relations, for example, excluding friendship on social media.

A tight relationship between good working environment, job satisfaction and good services delivered to the patient was highlighted. Sometimes employees have conflicts with the patients and/or their relatives that could result in denied access to the homes and hinder patient care. One leader described:

> Knowing the patient and staff enables me to participate in discussions and reflections on good professional solutions for the patients. (Focusgroup1-2)

First-line nurse managers' ability to delegate was described to serve two purposes; to give the staff interesting tasks and to prevent their own burnout due to heavy workloads. Knowing the staff meant finding each person's strengths and weaknesses. Relationships helped the leader to find a balance between delegating and mastering for each individual. First-line nurse managers had to be clear on their expectations and dare to trust that delegated tasks will be accomplished. The

FLNMs were aiming at an equal workload, but were afraid of being unfair. Even if most employees wanted their own area of responsibilities, some are not suitable to delegate to. One leaders describe challenges related to delegating like this:

> There are always those avoiding responsibility for anything. They focus more on themselves than on the patient. (Focusgroup2-8)

Good relations to the staff enabled the FLNMs to assess competence needs, facilitate courses to close knowledge gaps based on individual needs and furthermore demand high quality in patient care.

The FLNMs described their unique ability to influence patient care based on their own perception and found it easier to guide their staff by being a role model when caring for a patient. As nurses, they have the competence to give the staff practical guidance or professional founded verbal advices depending on the situation. They saw themselves as role models for knowledge-based practice but expressed a humbleness from not always knowing everything.

> Trustful relations to the staff makes it easier to highlight areas of improvement and dare to discuss it with them or show them how to do. (Focusgroup2-6)

> It is important that you are being a role model and try to show that this is how I will have things done. (Focusgroup1-5)

4.4 | Securing a sensible economy

Budget overages are mostly related to unforeseen things related to staff administration, for example, education or sick leave. Knowing their unit by being present and thereby being able to influence decisions and give directions convinces them that their department's money is being spent sensibly. Even if budgets are exceeded, they can argue for the money spent. Patient care is always the first priority. Administrative work is of secondary importance, but this is also subsumed under the vision of better care. A well-led unit with a satisfied staff and patients will result in financial economy.

First-line nurse managers are responsible for the accounts, and they stated that there is a strong focus on keeping the budgets balanced.

> Ultimately, it is all about money. (Focusgroup1-4)

First-line nurse managers described a cleverness in juggling between budget posts due to cover the extra money consumption. A difference between the focus groups was seen in how burdensome the leaders experienced the economic pressure. The FLNM needs support from superiors and politicians to cope with this pressure, which was most evident in FG3. However, all participants expressed a solid confidence in their decisions never to jeopardize the patient care in their attempts to stay under budget.

> We meet many situations where we must consider hiring in extra people. If the employees say that "We are so busy, and we need more people," while I think only some adjustments needs to be made. I must be able to explain why we have spent so much money on extra staffing. (Focusgroup1-4)

Additionally, government requirements are imposed and require staffs involvement, resulting in a need for extra staffing and thereby increased expenses without additional funds. Nevertheless, they were unanimous: the patient and the staff are their main concern. Everything they do as leaders, they do with the goal of the best possible care for the patient.

> We are responsible for good and safe care. (Focusgroup3-11)

> The patients and staff come first. Finally, the economy. (Focusgroup3-10)

5 | DISCUSSION

The present study offers an understanding of what is the meaning and purpose of clinical presence for nursing leadership in municipal home care. Clinical presence was perceived as a necessity to safeguard the patient by taking overall responsibility for care, securing the patients' voices, building and maintaining trustful relations and finally securing a sensible economy.

Safeguarding the patient is the overarching theme that explains the meaning and purpose of clinical presence, where best possible patient care is the FLNM's main concern. The FLNMs did not want to jeopardize patient care to save the economy or the staff, even it meant exceeding budgets or firing staff. Due to insight from their nursing education, FLNMs acts metaphorically as a shield to protect patient care.

First-line nurse managers' job descriptions in the Nordic home care consist of a threefold responsibility: to the patient, the staff and the budget. A focus on budgets combined with a constant lack of time due to multiple demands often provides the framework for caring in leadership (Lindberg, Persson, & Bondas, 2012). First-line nurse managers often have a balanced budget as their main priority (Skirbekk et al., 2017; Solbakken et al., 2018). This study further confirms that NLs juggle simultaneously their three priorities: staff, patients and budget. However, protecting the patients' needs and providing the best care possible was their main concern.

The home care context challenges the FLNMs because patients live and staff work in the patients' homes. An organization consistently practicing caritative leadership also focuses caring for and nurturing those who are led (Bondas, 2003; Solbakken et al., 2018). Nevertheless,

personal conflicts that might affect patient care are stopped decisively to protect the patient. This study suggests that FLNMs' presence enables them to build relations with their staff in order to foster a caring and supportive work environment by supporting and praising the staff's work. They want to maximize the development of their staff by knowing their strengths and weaknesses, their need for personal and professional development, being in line with the theory of caritative leadership (Bondas, 2003). Nevertheless, our main finding is that FLNMs' clinical presence enables them to see things with their own eyes, not relying only on the staff's comments, as a way to verify or oversee patient care. This brings a new dimension into caritative leadership (Bondas, 2003) and the theory of caring leadership (Solbakken et al., 2018), because the need for overseeing patient care can be interpreted as mistrust. Alternatively, it might be an expression of their nursing profession influencing leadership because they are nurses who have a desire for excellence in practice (Sørensen & Hall, 2011).

Even if patient involvement is emphasized in governmental documents and regulated by law, there were no established forums for FLNMs' regular patient meetings. All leaders described being torn between relying on the staff's descriptions and a need to see things for themselves to make decisions in the demanding context of municipal healthcare. These findings are in line with Rudolfsson et al. (2007) and Strandås and Bondas (2017).

The themes in this study describe the meaning of clinical presence. The themes match and deepen findings established from the metasynthesis (Solbakken et al., 2018); the patient's room, the staff's room, the superior's room, the leader's secret room and the organizational room. In this model, movement is not understood as verifying, but a way of creating an atmosphere of trust and respect combined with the prevention of patient suffering. This study adds to our understanding of the drives and motives for this movement, in an abstract sense, that is, safeguarding the care of the patient by clinical presence. Our findings show that it is difficult for the FLNMs to reconcile the tension between their own professional integrity and economic requirements. In addition, staff constitute an informal influence that supports the hiring of personnel resources and restricts the flexible use of personnel, which is in line with Danielsen and Hertel (2018). Our findings indicate that FLNMs' presence enables them to influence and oversee money consumption, related to FLNMs' own conviction when arguing for reasonable spending. Limited budgets were never allowed to jeopardize patient care, even if it meant exceeding their budgets. Administration is seen as a part of enabling the patient care as also described in the theory caritative leadership (Bondas, 2003, 2009, 2018).

The first-line managers educational background is not insignificant when being the leader working closest to the patients and the staff. The professional background of the leader has an impact on what he or she observes when being clinical present due to the professional lenses they are wearing. Nurses are educated to identify threats to patient care safety. First-line nurse managers being proactive in their presence, in a positive meaning, may enable them to identify and take action together with the staff to prevent adverse events, alleviate patient suffering and build caring cultures that are based on shared values (Bondas, 2003). Our findings indicate that everything the leaders did served the purpose of safeguarding the patient. This coincides with the ideal of caritative leadership, whose focus is alleviating patient suffering, and is typified by human mercy and whose main principle is ministering to the patient (Bondas, 2003).

5.1 | Limitations

To enable the reader to follow our interpretation, detailed descriptions are offered, including citations (Fleming et al., 2003). Abduction shows in the shift to dialogue/FGI as a hermeneutic spiral (Alvesson & Sköldberg, 2008). We reflected on our preunderstandings using conference calls throughout the entire process of this study. Further, the validity of findings was strengthened through the involvement of two authors in the interviews and analysis and by the validation of the findings by the third author. The caritative leadership theory (Bondas, 2003) and the model of caring in nursing leadership (Solbakken et al., 2018) guided this study; nevertheless, we strived to hold this theoretical perspective in abeyance. An ethical reflection and scientific curiosity guided this study.

A sample with only women can be a limitation, but most FLNMs are women and therefore are representative of this position in the three Nordic countries. Further research is needed to increase transferability into other contexts and cultures even though our coverage of three participating countries gives a broad perspective and strengthens the findings.

Focus groups enable powerful insights through participants descriptions, communication and interaction within the group to generate data. It is a less intrusive than, for example, fieldwork or participatory observations. The leaders knew each other and interacted freely, still participants might have hided social “incorrect” or atypical perspectives for their colleagues and the researchers (Halkier, 2010). A longitudinal study adding interviews and observations is needed to gain a deeper understanding. This study is limited to the FLNMs' perspectives and offers the potential for qualitative understanding.

6 | CONCLUSIONS

Our findings indicate that clinical presence serves the purpose of taking the overall responsibility for care and safeguarding the patient. Presence is perceived a necessity to verify staff providing the best possible care. First-line nurse managers acted metaphorically as a shield to protect patient care, which is the main concern in their leadership. The findings add to the understanding of the meaning of caring in nursing leadership and the caritative leadership theory.

7 | IMPLICATIONS FOR NURSING MANAGEMENT

First-line nurse managers need to be clinically present in order to safeguard the patient. To fulfil their threefold responsibilities for the

patient, staff and economy, clinical presence is needed. This study might also contribute to the political discussion concerning why nurses need to be first-line nurse managers and cannot easily be replaced by economists.

ACKNOWLEDGEMENTS

The authors would like to thank the nurse leaders who participated in this study and their organizations.

ETHICAL APPROVAL

The Norwegian Centre for Research Data approved this study (NSD: 59117). All participants received written and verbal information about the study, signed an informed consent sheet and were ensured their right to withdraw from the study.

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How to cite this article: Solbakken R, Bondas T, Kasén A. Safeguarding the patient in municipal healthcare—A hermeneutic focus group study of Nordic nursing leadership. *J Nurs Manag*. 2019;27:1242–1250. https://doi.org/10.1111/jonm.12806