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Municipal Chief Nurses' Experiences of Navigating Within Their Assignment

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Abstract

Municipal primary healthcare in Sweden has been criticised for being inefficient. Within this branch of healthcare, municipal chief nurses (MCNs) hold an overarching responsibility for patient safety, but they lack authority and mandate over financial resources and resource allocation. The overall aim of this thesis was to explore MCNs' experiences of fulfilling their patient safety responsibilities within municipal primary healthcare.

Study I was a qualitative descriptive study. Data were collected through 15 semi-structured interviews with MCNs, and the results were analysed using qualitative content analysis. *Study II* was a cross-sectional total population study conducted through a web-based survey among all MCNs in Sweden. The data were analysed using descriptive statistics and thematic analysis.

The findings show that MCNs perceived their own competence as insufficient for the role, which may negatively impact patient safety. Additionally, the unclear role influenced the conditions under which the MCNs carried out their responsibilities. MCNs perceived their organisational placement as important for obtaining the mandate necessary to influence decisions.

In conclusion, clarifying the MCN assignment and strengthening healthcare competence within municipal primary healthcare is essential for providing MCNs with the necessary prerequisites to effectively fulfil their responsibilities and ensure patient safety.

Keywords: decision-making, leadership, municipal chief nurse, municipal primary healthcare, patient safety.

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List of articles

This thesis is based on the following studies, which are referred to in the text by their Roman numerals.

I. Reinikainen E, Kihlgren A, Norell Pejner M & Windahl J. Municipal chief nurses' responsibilities and decision-making to ensure patient safety in municipal healthcare: a qualitative descriptive study. BMC Nurs 2025;24:636.

II. Reinikainen E, Kihlgren A, Norell Pejner M & Windahl J. Conditions required for patient safety within municipal primary care: a cross-sectional study of municipal chief nurses' perspectives. Submitted to *BMC Primary Care* 2026-01-30.

Reprints were made with permission from the respective publishers.

Abbreviations

MCN – Municipal chief nurse

1 Introduction

Municipal primary healthcare has taken on an increasingly important role in addressing the needs of an ageing population and individuals with complex health conditions. At the same time, the organisation of municipal primary healthcare has become more fragmented, involving multiple providers and complex governance structures. Within this context, the municipal chief nurse (MCN) has an important role in ensuring patient safety. Despite the significance of this role, the MCN position has received limited attention in research.

My interest in studying the MCN role emerged during my work as an MCN, when colleagues reported having different conditions and possibilities to fulfil their responsibilities. These experiences highlight a significant knowledge gap regarding how MCNs fulfil their statutory responsibility for patient safety.

Previous evaluations of municipal primary healthcare, particularly following the COVID-19 pandemic, have highlighted challenges related to organisational and professional conditions. However, little is known about how MCNs' mandate, authority, and organisational context influence their ability to fulfil their responsibilities. My research therefore aims to increase understanding of the conditions that shape the MCN role, and to contribute knowledge that may support the development of safer and more effective municipal primary healthcare.

2 Background

2.1 Organisation of elderly care

Traditionally, elder care in Sweden was a family responsibility. Families who were unable to care for their older relatives were referred to the poor relief system. Care was provided on a voluntary basis, and was often administered by the Church (1). In 1734, a law was enacted stating that every parish (later municipality) was required to establish and maintain a poorhouse (2). However, the transfer of responsibility for the care of older people from the Church to the parish took more than a century. The Poor Relief Regulation of 1871 stipulated that poor relief should be financed through municipal taxation, thereby assigning responsibility for the organisation of care for older people to the municipalities.

In 1918, the municipalities were given responsibility for providing residential homes for older people in need of care. For those requiring healthcare services, responsibility was assigned to the county councils (later the regions), which were tasked with providing such care (3).

Home-based healthcare and social care became established during the 1960s. Special residential facilities were designated for older people with more extensive care needs. The role of home care services was later strengthened through the Social Services Act (4), while home healthcare was reinforced in the Health and Medical Services Act (5). This development enabled individuals with greater healthcare and social care needs to continue living in their own homes.

Division of responsibility between municipalities and regions created some difficulties in coordinating healthcare and social care. The Swedish Elderly Care Reform (6) (known as *Ädelreformen*) aimed to strengthen coordination and collaboration between the organisations

responsible for the care of older people. As part of this reform, the municipalities assumed responsibility for certain healthcare services (municipal primary healthcare), including services provided by registered nurses.

According to the Social Services Act (7), the municipalities are responsible for providing special housing for older people and for promoting good living conditions through healthcare and support services. The Health and Medical Services Act (8) stipulates that the municipalities are responsible for providing healthcare services for older people. Consequently, the municipalities assumed overall responsibility for older people in need of both healthcare and social care. Responsibility for medical treatment, however, remained with the regions (6, 9). The MCN position was established to ensure compliance with patient safety requirements within municipal primary healthcare (6).

Since 2018, Swedish healthcare has been undergoing a transition towards person-centred and integrated care. This means that primary healthcare is intended to serve as the hub of the healthcare system, making healthcare more accessible to citizens. Patients are expected to play a more active role in decisions regarding their healthcare, which should be coordinated and tailored to individual needs (10). However, the Act on System of Choice in the Public Sector (11) has contributed to a fragmented healthcare system with multiple providers. Similar reform processes have taken place in other Nordic countries, where healthcare systems have undergone organisational changes aimed at improving coordination and delivering healthcare closer to patients' homes (9, 12, 13).

2.2 Municipal chief nurse

Each municipality is required by law (8) to appoint an MCN. The MCN role was introduced to replace the previous arrangement, in

which a designated physician within the former county council system was responsible for maintaining and developing patient safety.

The MCN role is regulated in the Health and Medical Services Act (8) and the Health and Medical Services Ordinance (14). The assignment includes overarching responsibility for patient safety within municipal primary healthcare through development of guidelines for medication management, delegation, documentation, incident reporting, and contact with physicians. Following delegation from the municipal political leadership, the MCN is also responsible for reporting serious adverse events to the Health and Social Care Inspectorate (15). The requirement for serving as an MCN is to be a registered nurse (14). However, the legislation does not specify the extent of the decision-making authority held by the MCN in carrying out this assignment.

In addition to the statutory responsibilities of the MCN, duties may vary between municipalities depending on the size of the municipality, its organisational structure, and access to healthcare expertise. As municipalities are self-governing (16), other factors may also influence the MCN role, such as political governance and priorities within healthcare and social care. The increasing shift of healthcare delivery from hospital settings to patients' homes creates complex demands on patient safety, for which the MCN holds responsibility (17).

In smaller municipalities, the MCN may be the only person with healthcare expertise in a managerial position, which may result in the role being expanded to include a wide range of responsibilities beyond those defined in legislation. For example, the MCN and the operational manager may be the same individual.

Within healthcare services, a designated operational manager must be appointed. The operational manager holds overall responsibility for

ensuring that the service meets patients' needs regarding continuity, coordination, patient safety, and security. There are no formal requirements for the operational manager to possess healthcare competence. However, if such competence is lacking, decisions concerning patient care and treatment must be delegated to a person with the necessary competence to ensure patient safety (8).

The delineation of responsibilities and decision-making authority between the MCN and the operational manager of healthcare services is not always clear. The MCN role exists only in Sweden. In several other European countries and in North America, operational managers also hold responsibility for patient safety (18-20). While the operational manager is responsible for personnel, finances, and healthcare delivery within the organisation, the MCN holds overarching responsibility for patient safety (8). This entails systematically planning, directing, and monitoring activities to ensure compliance with quality-of-care requirements, as well as preventing adverse events and engaging in continuous risk management (15). A prerequisite for safe patient care is close collaboration between the MCN and the operational manager (21).

2.3 Patient safety

Globally, substantial efforts are being made to strengthen patient safety within healthcare systems. Patient safety is defined as "the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum" (22). Despite ongoing efforts to improve patient safety, more than 134 million adverse events are reported worldwide each year, of which approximately 3 million results in death (23). These adverse events vary in nature, but the most common include medication management errors, complications associated with surgical procedures, and healthcare-associated infections (22).

Achieving a high level of patient safety also requires a person-centred approach in which patients are given opportunities to participate and are provided with adequate information regarding their care. Particularly in home healthcare, safe care is highly dependent on the engagement and active participation of both patients and their relatives (24).

Approximately 80,000 patients in Sweden are affected by healthcare-related adverse events each year, and around 1400 of these events result in a fatal outcome (25). The objective of Sweden's national action plan for increased patient safety is that no patient should experience a preventable adverse event. An understanding of how different factors within healthcare systems interact is essential for patient safety work. In addition, patient safety is influenced by factors beyond the direct control of healthcare services. Within municipal primary healthcare, for example, the provision of care services may affect the safety of individual patients (26).

Most deficiencies in patient safety can be attributed to structural and organisational factors. Leadership plays a central role in ensuring a high level of patient safety by establishing and maintaining a strong patient safety culture (22, 26). Patient safety culture is defined as the shared values, attitudes, and behaviours that emerge through the commitment of both management and healthcare professionals to prioritising safety over competing goals (27).

Patient safety is promoted through compliance with laws and guidelines, as well as adequate staffing levels within the organisation (28-30). Conversely, when leaders fail to ensure these conditions, patient safety may be compromised (28, 31). Leadership competence in healthcare is another factor that promotes high levels of patient safety (24, 29, 32-35).

2.4 Competence in healthcare

Competence is highly relevant to the role of the MCN. An MCN holds overall responsibility for ensuring patient safety, including ensuring that healthcare is delivered by personnel with adequate competence. Competence implies that employees have the capacity to perform specific work tasks satisfactorily in particular situations (36). It also refers to employees possessing the appropriate education, knowledge, experience, skills, and attitudes required to carry out their work in a manner that promotes patient safety (26). In healthcare, competence development occurs through both clinical experience and advanced education. This progression takes place across five distinct stages, from novice to expert. In the final stage, the nurse has developed the ability to recognise patterns and to make sound and deliberate decisions in complex situations (37).

Healthcare is becoming increasingly complex, with more advanced treatment methods and a growing number of people living longer with chronic conditions. This requires healthcare professionals to use their expertise to develop more innovative solutions and to engage patients in their own care. It also requires the skill of navigating a fragmented healthcare system (38). Services that integrate healthcare and social care require leaders to have the competence to navigate different regulatory frameworks, to balance risks, and to foster a shared culture of learning within the organisation (39). In order to understand patients' needs and make appropriate healthcare priorities, it is necessary for decision-makers to possess competence in healthcare practice (40).

Similarly to other countries, the Nordic nations are undergoing reforms that involve shifting healthcare provision from hospitals to settings closer to patients' homes (9, 12, 13). Through collaboration

among patients, relatives, and social services, it becomes possible to deliver healthcare interventions in the individual's home. However, this places greater demands on competence regarding the care environment and its impact on patient safety (17, 41). Primary healthcare is intended to be coordinated according to individual needs.

2.5 Theoretical framework

The organisational theory by Mintzberg (42) was selected as the theoretical framework for this thesis, as it describes how healthcare organisations have historically been shaped by professions possessing expertise and decision-making authority within their respective fields. Mintzberg (42) argues that decision-making within a professional bureaucracy is governed by laws and regulations as well as by professional expertise. Professionals may experience a sense of power and control over their own work, as their expertise within the field often exceeds that of centralised management (42). At the same time, the complex organisational structures of municipalities, characterised by competing interests, challenge operational efficiency and a coherent understanding of the organisation's assignment (43).

Mintzberg (42) describes organisations as comprising five configurations. This framework may help explain how MCNs navigate between different configurations within municipal organisations.

Strategic apex – According to Mintzberg (42), this consists of those holding the highest administrative responsibility within the organisation. In municipalities, politically elected decision-makers ultimately bear responsibility for ensuring patient safety; however, they often lack specific expertise in this area. Consequently, the

operational responsibility for ensuring high-quality care is delegated to operational managers and MCNs (44, 45).

Middle line **–** This level consists of those responsible for ensuring that services comply with applicable requirements and guidelines. These functions also play a central role in communicating information from the operating core to the higher levels of the organisation and from top management to the operating core (42). Within municipal primary healthcare, this level is represented by operational managers in accordance with the Health and Medical Services Act. Patient safety efforts are facilitated by a clear organisational structure in which decision-making authority is well defined (28, 46, 47).

Operating core – The operating core consists of the personnel who perform the day-to-day work required for the organisation to achieve its objectives (42). Within municipal primary healthcare, the operating core includes professions such as registered nurses, physiotherapists, occupational therapists, dieticians, assistant nurses, and care assistants. These professionals work under two separate legislative frameworks: the Health and Medical Services Act (8) and the Social Services Act (7).

Technostructure – This configuration consists of staff functions such as legal advisers, development managers, and other roles responsible for the planning and control of organisational activities (42). Within municipal primary healthcare, these responsibilities are assigned to the MCN, who holds overarching responsibility for patient safety in accordance with current legislation (8), including ensuring and monitoring that healthcare services comply with patient safety requirements.

Support staff – Support structures provide the organisation with services such as IT solutions and payroll administration (42).

2.6 Rationale

There is an extensive global effort to strengthen patient safety. The majority of adverse events occurring within healthcare are rooted in organisational and structural factors. Research shows that leadership competence is of crucial importance in promoting patient safety. In complex healthcare situations, additional demands are placed on leaders' competence and their ability to manage patient safety challenges.

As part of the reform of services for older people in Sweden, the role of the MCN was established with responsibility for ensuring patient safety within municipal primary healthcare. The MCN holds a leadership position with a certain degree of decision-making authority regarding patient safety. However, the role does not include financial or personnel responsibility. Consequently, the practical implementation of guidelines depends on the competence of operational managers and the organisation's prioritisation of patient safety.

The organisational structure within municipal primary healthcare may be described as fragmented, contributing to deficiencies in the care of older persons, some of which fall within the MCN's area of responsibility for patient safety. At the same time, there is a lack of clear regulations defining the organisational position of the MCN and the mandate required to fulfil the assignment. The profession therefore calls for greater clarification of the MCN's role within the organisation, as well as of the decision-making authority associated with the function.

In summary, the conditions under which MCN professionals carry out their assignment to ensure patient safety within municipal primary healthcare remain insufficiently researched. The profession

has called for a greater scope for action and increased clarity regarding the assignment.

3 Aim

The overall aim of this thesis was to explore MCNs' experiences of fulfilling their patient safety responsibilities within municipal primary healthcare. To achieve this aim, two studies were conducted.

The aim of *Study I* was to explore MCNs' experiences of the obstacles and possibilities for decision-making to secure patient safety in municipal healthcare.

The aim of *Study II* was to explore MCNs' experiences of the conditions to fulfil their patient safety assignment within municipal primary care.

4 Methods

4.1 Design

Study I used a qualitative descriptive design to gain a deeper understanding of the MCNs' experiences. Data were collected via semi-structured interviews.

Study II used a cross-sectional design in which both quantitative and qualitative data were collected via a web-based survey. The study was conducted as a total population survey.

An overview of the studies is presented in Table 1.

Table 1. Overview of the participants and research methods in Studies I and II.

Study	Aim	Sample	Data collection	Data analysis
I	To explore MCNs' experiences of obstacles and possibilities in decision-making to ensure patient safety in municipal primary care	MCNs (n=15)	Semi-structured digital interviews	Qualitative content analysis
II	To explore MCNs' experiences of the conditions required to fulfil their patient safety responsibilities within municipal primary care	MCNs (n=190)	Web-based survey	Descriptive statistics and thematic analysis

MCN: municipal chief nurse.

4.2 Data collection

Participants in *Study I* were strategically selected to ensure variation in the level of experience as an MCN. The inclusion criterion required participants to have worked as an MCN for at least two

years. Based on these criteria, 15 participants were recruited through a network of MCNs across municipalities in one region in Sweden.

The MCNs were contacted by e-mail, provided with written information about the study, and invited to participate. Two MCNs did not respond to the invitation, and so two additional MCNs were contacted; both of these agreed to participate. Data were collected through individual semi-structured interviews. Due to national restrictions regarding physical interactions in Sweden during the COVID-19 pandemic, the interviews were conducted digitally.

An interview guide was used, including open-ended questions about experiences working as an MCN, possibilities and obstacles in fulfilling responsibilities, decision-making mandates, and organisational placement. The interview guide was pilot tested in interviews with three MCNs who had consented to participate. All questions were considered relevant and comprehensible by the MCNs; therefore, no alterations were made to the interview guide, and the pilot interviews were included in the main study. Data saturation was reached after 15 interviews, as little or no new information emerged from subsequent interviews. The interviews were recorded using a tape recorder and thereafter transcribed verbatim.

In *Study II*, all municipal registrars in Sweden were contacted to obtain the contact details of their MCNs. All MCNs (n=333) were then invited to participate in the study through a separate email containing information about the study and informed consent. The inclusion criterion for participation was being employed as an MCN in a Swedish municipality.

A questionnaire was developed by the research group using a web-based survey tool. The questions were based on the findings of *Study I* and on the researchers' own experiences of the MCN's responsibilities

and decision-making authority in ensuring patient safety within municipal primary healthcare.

The initial version of the questionnaire contained 34 questions, comprising 20 open-ended and 14 closed-ended items. The closed-ended questions also allowed respondents to provide comments in free-text format. Ten of these questions offered yes/no response options, with the possibility of adding unlimited comments. The open-ended questions likewise had no word limit, enabling respondents to freely describe their experiences.

Five randomly selected MCNs from different regions of the country were invited via email to participate in a pilot study of the initial version of the questionnaire. All five agreed to participate, and four completed the questionnaire within the three-week response period. The pilot study aimed to assess the wording, clarity, and relevance of the questions, to identify any missing or redundant items, and to estimate the time required to complete the survey.

Comments from the pilot study indicated that the survey contained a large number of questions and that the many open-ended items made it time-consuming to complete (ranging from 40 minutes to 2 hours). Based on these comments, five questions were revised to improve comprehensibility, and a further seven questions were removed. These questions concerned MCNs' additional assignments, engagement with current research, reasons for applying for MCN positions, and the proposed new legislation. Consequently, the final version of the questionnaire was reduced from 34 to 27 questions.

4.3 Data analysis

The data in *Study I* were analysed with qualitative content analysis (48). Each author individually read through the transcribed interviews multiple times to gain a deeper understanding of the

content, which was then collectively discussed on several occasions. Sentences or paragraphs with similar meanings were extracted and condensed into meaning units. Next, the condensed meaning units were assigned codes that captured their central meaning. The codes were compared for similarities and differences and organised into six subcategories. These subcategories were subsequently grouped into three categories, which were used to interpret the results. One theme emerged, illuminating the underlying meaning of the meaning units, codes, subcategories, and categories. Although the process is described linearly, the analysis involved a back-and-forth movement between different parts of the text. Examples from the data analysis are presented in Table 2.

Table 2. Examples of the data analysis with coding, subcategorising, and categorising of the interview data.

	Example 1	Example 2	Example 3
Interview text	"The role of MCNs is not particularly regulated, and what is outlined in the healthcare regulations represents only a small portion of our actual responsibilities. Our role varies significantly across different municipalities, and the nature of our assignments differs because there is no standardised regulation." (MCN 12)	"The further down you are in the organisation, the more difficult it becomes to make decisions and to have the courage to implement changes. Conversely, if you are higher up, such as just below the Head of Social Services, it is easier to accomplish certain tasks to ensure patient safety." (MCN 2)	"There is a lack of genuine understanding of healthcare. I have to fight hard for patient safety and healthcare issues." (MCN 4)
Meaning unit	The assignments of MCNs vary, causing confusion and affecting their decision-making authority. The role of MCNs is not fully regulated.	The possibilities and decision-making mandates of MCNs are influenced by their organisational placement and their collaboration with management.	A limited understanding of healthcare issues makes it challenging for MCNs to explain patient safety within the organisation
Code	An ambiguous assignment	Organisational placement	Knowledge of healthcare is lacking within the organisation
Sub-category	Different interpretations of the assignment	Organisational placement affects patient safety	Competence in the organisation
Category	Unclear role and understanding of the assignment	Impact of organisational level on decision-making mandate	Knowledge, competence, and experience in patient safety work.
Theme	Navigating decision-making to ensure patient safety		

MCN: municipal chief nurse.

In *Study II*, background variables were analysed with descriptive statistics presented as frequencies (n), percentages (%), means, and medians. Qualitative data were analysed with thematic analysis following the six-phase approach of Braun and Clarke (49). The first

author (who is also the author of this thesis) began the process by familiarising herself with the data through repeated readings of all responses to the open-ended questions. Initial notes were made to capture preliminary impressions and identify meaningful aspects of the text related to the aim of the study. In the second phase, the data were systematically coded. The first author highlighted segments of text relevant to the research aim and assigned descriptive codes to these excerpts. All codes and supporting quotations were organised in a structured coding document.

During the third phase, codes were grouped according to their conceptual similarity. These preliminary groupings were discussed among all authors to ensure that interpretations were grounded in the data, and potential themes and sub-themes were then drafted.

In the fourth phase, the authors jointly reviewed the themes by returning to both the coded data and the full dataset to ensure that the themes were coherent, internally consistent, and meaningfully distinct from one another. Through this process, one overarching theme, two themes, and five sub-themes were identified (Figure 1).

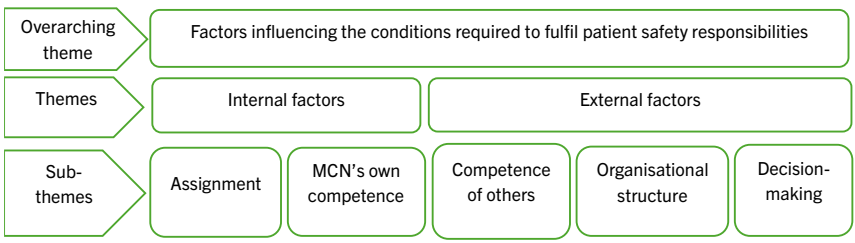

Figure 1. The overarching theme, themes, and sub-themes that emerged from the data in Study II.

4.4 Ethical considerations

The studies were approved by the Swedish Ethical Review Authority (registration numbers 2021-01862, 2022-04546-02, 2022-07330-02). They were performed in accordance with the Swedish Act concerning the Ethical Review of Research involving Humans (50) and the ethical principles outlined in the World Medical Association's Declaration of Helsinki (51). Participation was voluntary, and informed consent was obtained from all participants prior to data collection. Participants in both studies were informed about the purpose of the study, their right to withdraw at any time, and how confidentiality or anonymity would be maintained. The participants' identities in *Study I* were known only to the interviewer. To ensure confidentiality during data handling and analysis, each participant's interview transcript was assigned a code number.

All collected data were handled securely and used solely for research purposes, in order to ensure the protection of the participants' integrity and privacy. Recorded interviews were stored in a locked safe, separate from the code list. Only the research group had access to the research data.

Two of the researchers had previous working experience as MCNs, providing them with a good contextual understanding. The remaining two researchers did not have such backgrounds, which contributed to analytical variation within the research team.

As the role of MCN is a female-dominated profession, with few men in the field, the gender of the respondents was not reported in order to maintain anonymity. Gender was not considered relevant to the outcomes of the studies.

5 Results

In *Study I*, 15 MCNs from 12 municipalities were interviewed. In *Study II*, the overall response rate was 57% (n=190), with response rates for individual questions ranging from 53% (n=101) to 100% (n=190). Participant characteristics for both studies are presented in Table 3.

Table 3. Background data for the participants in Studies I and II.

Variable	Study I	Study II
Specialist nurse degree	60% (n=9)	54% (n=102)
Education in leadership	67% (n=10)	70% (n=132)
Median time working as a municipal chief nurse	6 years	5 years

The overall results from both studies show that several factors affected the MCNs' experiences of navigating within their assignment in municipal primary healthcare. These results are presented below in terms of two categories: *the professional level*, including competence and role clarity, and *the organisational level*, including organisational placement and relationships. Both of these factors affect the outcome of patient safety in municipal primary healthcare (Figure 2).

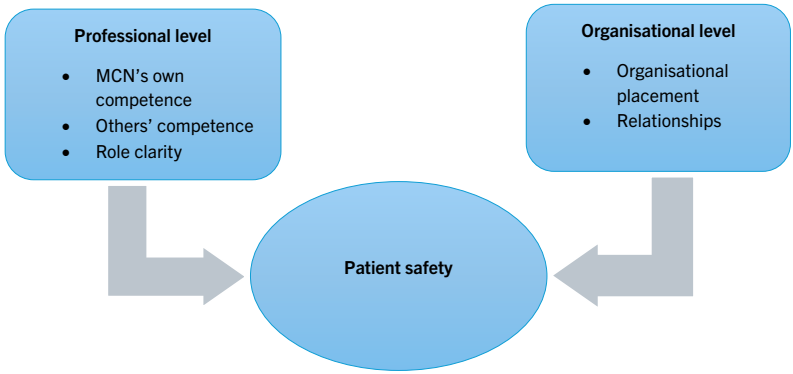

Figure 2. The overall findings of the thesis.

5.1 The professional level

The MCNs' competence and experience were essential for fulfilling their responsibilities. Important areas to master were leadership, municipal primary healthcare, laws and regulations, and organisational aspects of healthcare and municipalities. Their competence and prior experience instilled confidence in others, enhancing their reputation as trustworthy and reliable. This credibility earned them a mandate from management and first-line managers, providing better opportunities to fulfil their responsibilities.

Overall, 43% (n=77) of the respondents reported lacking the competence they considered necessary for the MCN assignment, while 20% (n=36) were unsure and 37% (n=67) considered themselves adequately competent (*Study II*). Among those who reported lacking competence, the areas identified were largely similar in both studies: a need for additional knowledge of healthcare legislation and leadership, as well as specialist nursing education.

The MCNs also perceived that the healthcare competence of others influenced their ability to carry out their assignments and exercise their decision-making mandate within municipal primary care. Organisational competence, in turn, referred to management's lack of knowledge and understanding of the MCNs' responsibilities. In many municipalities, first-line managers were perceived to have limited or no healthcare education or experience. The MCNs emphasised that managers' healthcare competence was important, as it enhanced their understanding of what is required to provide patient-safe healthcare.

When no one in a leadership position had healthcare education, the MCNs were often assigned responsibilities and decision-making authority that extended beyond their statutory role. They believed that operational managers with healthcare education would be better equipped to contribute to the development of healthcare and patient safety within their units. However, some MCNs viewed the absence of such expertise in leadership positions as an opportunity, as it allowed them greater autonomy and enabled them to carry out their work more independently.

The description of the assignment and the MCNs' interpretation of it were important factors influencing how the MCNs experienced their ability to carry out their responsibilities. Municipal management played a key role in defining the MCNs' responsibilities, resulting in different interpretations of the assignment across municipalities.

According to the MCNs, management was unsure how to effectively utilise the MCN role. The MCNs' assignments were ambiguous, which they found problematic. They experienced uncertainty regarding their responsibilities as well as the scope of their assignments and decision-making mandates. Some MCNs viewed the lack of clarity in their role descriptions as an opportunity to

independently shape their own assignments. Despite this, the MCNs expressed a desire for a more regulated mandate and clearer role descriptions to ensure consistency across municipalities.

Experiences of the MCN assignment varied considerably. Thirty-three per cent (n=60) reported that the assignment was clearly and well articulated in the current legislation. In contrast, 42% (n=76) considered the assignment to be unclear and in need of more explicit regulations (*Study II*). The MCNs indicated that their role varied between municipalities due to differing local interpretations and levels of competence, highlighting a need for clearer regulation.

5.2 The organisational level

The MCNs' organisational placement varied across the municipalities. Participation in management teams also varied, depending on the respondents' organisational placement. The MCNs described how being positioned at the administrative level, directly under the head of administration, provided greater possibilities to influence healthcare matters and facilitated their involvement in strategic decision-making related to healthcare and patient safety. Having a strong decision-making mandate, in turn, enhanced their capacity to fulfil their responsibilities effectively.

Working near the management team facilitated the MCNs' healthcare development work and eased communication when healthcare and patient safety issues needed to be discussed. It was also useful when explaining the consequences of identified shortcomings to the management team. MCNs who were placed at lower levels within the organisation experienced challenges in relation to this. For example, when their organisational position was located under a first-line

manager, they were effectively responsible for reviewing or overseeing their own manager's work.

Self-confidence and clarity regarding the MCN's role were highlighted as important for fulfilling the assignment. At the same time, the MCNs reported uncertainty regarding the extent of their decision-making authority, which meant that it was seldom exercised and consequently limited their scope for action. They experienced difficulties in delineating the boundaries between the responsibilities of operational managers and those of MCNs. When asked about the extent to which they used their statutory mandate, three respondents were unsure of what mandate they actually held in their role as MCNs. One MCN felt that their decisions were not questioned by others.

When others had confidence in the MCNs, their reputation as trustworthy and reliable professionals was enhanced. Their credibility earned them a mandate from management and first-line managers, providing better opportunities to fulfil their responsibilities. This enabled the MCNs to receive support in their work and invitations to management team meetings, allowing them to participate in and influence decisions related to patient safety in municipal primary healthcare.

The MCNs reported that healthcare providers almost always or quite often followed their decisions within the statutory areas for which MCNs are responsible. However, they also noted challenges in reaching all staff to communicate current decisions and guidelines. According to the respondents in *Study II*, one of the greatest obstacles to fulfilling their assignments concerned shortcomings in compliance with the Patient Data Act; 15% (n=29) stated that healthcare providers quite rarely or very rarely adhered to these regulations (Table 4).

Table 4. Healthcare providers' compliance with decisions in the statutory areas for which municipal chief nurses are responsible.

Response options → / Statutory areas ↓	Always	Quite often	Quite seldom	Very seldom	Never
The patient receives safe and appropriate healthcare of good quality	27 (51)	69 (130)	4 (7)	0 (0)	0 (0)
The patient receives the care prescribed by the physician	54 (102)	46 (86)	<1 (1)	0 (0)	0 (0)
Medical records are kept in accordance with the Patient Data Act	27 (51)	58 (109)	14 (27)	1 (2)	0 (0)
Delegations are compatible with patient safety	36 (67)	55 (103)	7 (14)	2 (4)	0 (0)
There are appropriate routines for medication management	72 (136)	26 (49)	2 (4)	0 (0)	0 (0)
There are appropriate routines for incident reporting	68 (129)	28 (53)	4 (7)	0 (0)	0 (0)
There are appropriate routines for contacting a physician when the patient's condition requires it	75 (142)	24 (46)	<1 (1)	0 (0)	0 (0)

Data are presented as n (%), indicating response frequencies and proportions for the question "To what extent do you consider that the organisation complies with your decisions in the following areas?"

5.3 Summary of the results

Overall, the results of this thesis show that professional and organisational factors influence MCN's experiences of navigating within their assignment.

The most prominent finding was that the MCNs did not always possess sufficient competence to fully carry out their responsibilities and thereby ensure patient safety within municipal primary healthcare. Moreover, the organisation's collective competence in healthcare was limited, which further affected patient safety. A lack of competence contributed to an unclear role when the organisation's understanding of the MCNs' assignment was insufficient. Finally, organisational positioning and relationships were considered to be crucial in ensuring that the MCNs had the authority required to influence decision-making in matters relating to patient safety.

6 Discussion

The overarching aim of this thesis was to explore MCNs' experiences of fulfilling their patient safety responsibilities within municipal primary healthcare. Below, the findings are discussed in relation to Mintzberg's organisational theory, using four of its five organisational levels as the analytical framework: strategic apex, middle line, operating core and technostructure (42). The fifth component, support staff, is excluded from the analysis, as it was not examined within the scope of the present thesis.

6.1 Strategic apex

Based on Mintzberg's organisational theory (42), the findings of this thesis suggest that positioning an expert function close to the strategic leadership strengthens its authority and capacity to influence organisational development. Involvement at an early stage of the decision-making process increased the MCNs' opportunity to influence strategic decisions before they were finalised. On the other hand, the MCNs' competence and experience affected their ability to make decisions concerning patient safety, irrespective of their organisational placement. Having access to the strategic leadership provides insight into the organisation's overall assignments, while support from senior management enhances the legitimacy of decisions and change initiatives. Such a position also facilitates the allocation of resources and reduces the risk of important issues becoming stalled at the middle management level (42).

Across both studies, the MCNs described organisational placement as crucial for their scope of action and ability to fulfil their responsibilities. Previous research has demonstrated that a clear organisational mandate has a positive impact on patient safety, by facilitating a more effective implementation of guidelines in daily

practice (46). Research further suggests that an understanding of the organisational decision-making processes and distribution of mandates contributes to a strengthened patient safety culture (28, 29, 47, 52).

At the same time, the findings indicate that the MCNs lacked a clear decision-making mandate. This lack of mandate may create underlying organisational deficiencies that could contribute to adverse events if they are not identified and addressed in time (53).

In municipalities, politically appointed decision-makers ultimately bear responsibility for ensuring patient safety; however, they often lack specific expertise in this area. Consequently, the operational responsibility for ensuring high-quality care is delegated to operational managers and MCN professionals (44, 45). Proximity to the political leadership within the strategic apex provides better opportunities for a functioning decision-making process (42).

6.2 Middle line and operating core

In contrast to the strategic apex, individuals positioned at lower organisational levels, such as within the middle line or operating core of a bureaucratic structure, tend to operate with less authority and a more limited mandate. Individuals in the middle line play a central role in communicating information upward within the organisation to the strategic apex (42). Within municipal primary healthcare, this includes the operational managers in accordance with the Health and Medical Services Act.

Healthcare is regulated through legislation and evidence-based practice (8, 15). Decisions affecting the content of healthcare and patient safety should therefore be made by individuals with appropriate professional competence, in accordance with Mintzberg's

(42) theory of professional bureaucracies. Overall, managers' and MCNs' limited understanding of the assignment may contribute to different interpretations of the responsibilities in patient safety work within municipalities. Patient safety efforts are facilitated by a clear organisational structure in which decision-making authority is well defined (28, 46, 47). Moreover, patient safety work is prioritised to a greater extent when registered nurses hold leadership positions (40), highlighting the importance of professional competence in managerial roles. In municipalities, however, operational managers often lack the professional competence of healthcare.

An ambiguous decision-making mandate may impede systematic patient safety efforts and may be associated with deficiencies in organisational governance and the allocation of responsibilities. The operating core consists of the personnel performing the day to day work required for the organisation to achieve its objectives (42). These professionals work under two separate legislative frameworks — the Health and Medical Services Act (8) and the Social Services Act (7) — and they often only have competence in one of these areas. The delineation of responsibilities between MCNs and operational managers regarding healthcare services is not always clearly defined within municipalities. Clear lines of responsibility are a fundamental prerequisite for the identification, analysis, and management of patient safety risks (54).

An unclear role disrupts the balance between the organisation's fundamental components, creating uncertainty regarding responsibilities and decision-making authority (42). Consequently, it becomes difficult to determine who is responsible for specific tasks and decisions, from the political leadership that delegates responsibility to the MCN to the operational healthcare manager who is responsible for implementing working methods.

The findings of this thesis indicate that the MCNs perceived their scope of action and decision-making authority as being largely based on personal knowledge, experience, and professional trust rather than on formal authority. They frequently lacked the mandate required to implement the working methods they considered necessary to ensure patient safety. This is particularly relevant since effective leadership in professional organisations requires that decisions are made close to the professional expertise. It also requires organisations to enable a genuine scope for action, even when formal mandates are limited.

The MCNs often needed to navigate the organisation by building relationships and developing networks in order to fulfil their assignment and gain legitimacy. This may be understood as an expression of informal power, exercised as a complement to formal structures in complex organisations (42). However, such informal processes may both support and constrain patient safety, depending on the extent to which they promote transparency and organisational learning (29, 31).

6.3 Technostructure

The technostructure is the part of an organisation made up of experts who develop systems, guidelines, and procedures to standardise and improve work performance. A higher organisational position for experts provides greater authority to develop organisation-wide policies and guidelines, and facilitates the implementation of change in collaboration with managers across the organisation (42).

The findings of this thesis indicate that the MCN occupies a position that resembles the technostructure, functioning as an expert role without formal organisational authority. Furthermore, although the nursing profession holds formal responsibility for leading nursing practice and the MCN represents the highest professional nursing

expertise within municipal primary healthcare, the role often lacks the formal organisational mandate required to exert strategic influence effectively. This discrepancy between professional expertise and formal authority may limit the MCN's capacity to coordinate organisation-wide development and implement change, despite the role's recognised professional legitimacy.

Mintzberg (42) describes how the decision-making mandates within organisations do not always align with professional competence, particularly when administrative functions are granted greater influence than the professional core. In relation to patient safety, this lack of mandate can create a gap between responsibility, competence, and the actual capacity to influence, thereby risking the weakening of both patient safety culture and practical patient safety work (24, 55). Based on these findings, positioning MCNs within the strategic apex may provide them with the mandate required to fulfil their assignment effectively. The ambiguity in their roles creates a grey area surrounding mandate and authority, requiring the organisation to rely on mutual adjustment as a primary coordination mechanism. As a result, important decisions risk being delayed or left unresolved.

Another prominent finding was that the MCNs perceived their own competence as insufficient to fully carry out their mandate and thereby ensure patient safety in municipal primary care. This indicates a structural issue whereby professionals, represented in this context by MCNs, may lack the competence, authority, or organisational conditions required to fulfil their responsibilities effectively. At the same time, government inquiries have highlighted insufficient healthcare competence, a lack of protective equipment, and limited continuity within municipal primary care. These factors negatively affect both individual patients and patient safety (56). Furthermore, access to healthcare competence within municipal

primary healthcare has been found to be inadequate, including at the strategic management level (57).

When professionals perceive deficiencies in competence development, role clarity, or organisational support, the decentralised model risks becoming dysfunctional. This could lead to misalignment between organisational structure and professional mandate (42). When MCNs' responsible for patient safety perceive their competence as insufficient, this may undermine the legitimacy of the role and increase the risk that the responsibilities are not fulfilled satisfactorily. From a patient safety perspective, this entails an elevated risk of adverse events (58, 59).

Leadership in healthcare requires relevant clinical and organisational competence in order to identify and manage patient safety risks and to promote safe care (12, 24, 60). A functioning governance structure is a central component of systematic quality improvement, in which the healthcare provider is responsible for continuously developing and ensuring the quality of care (8, 54). At the same time, complex leadership assignments require organisational support in order to be carried out effectively (39, 61).

In addition, leadership experience has been shown to strengthen both confidence and the ability to act in leading roles (60, 62). The respondents in the present thesis did not reflect on how their own competence influenced patient safety. Possible explanations for this may include the perception of the MCN role as a career pathway and as providing opportunities for influence. At the same time, managers' limited understanding of the assignment may contribute to competence requirements not always being clearly defined or adequately applied.

Ultimately, a paradox emerges in which the MCNs carry extensive legal and professional responsibility for patient safety, yet are not always provided with the organisational conditions necessary to influence decisions related to it.

6.4 Methodological discussion

In S*tudy I,* the qualitative approach of Graneheim and Lundman (48) was considered appropriate for investigating the MCNs' experiences and gaining a deeper understanding of their function within municipalities. Although one interview was brief, the richness and detail in the content of the analysed material were well suited to the aim of the study. A strength of the study lies in the rich and nuanced data acquired from the interviews. Having open-ended questions and the opportunity for the participants to orally describe the studied phenomena gave the authors valuable nuanced information from different perspectives.

In *Study II*, thematic analysis as described by Braun and Clarke (49) was considered the most appropriate method for examining the role of MCNs, given the limited previous research on this topic. The method offers a systematic and flexible way to identify, analyse, and interpret recurring patterns in the empirical material. By analysing similarities and differences in the participants' statements, key themes that answer and relate to the research questions were identified. The method is particularly suitable as the aim was not to develop a new theory, but to describe and interpret recurring patterns in the participants' experiences.

The questions were divided into thematic areas to make it easier for the respondents to stay focused on different themes (63). One advantage of thematic analysis is its transparency. The analysis process was accounted for step by step, from data collection and coding to the

development and review of themes, which strengthens the credibility of the study and makes it possible to follow and assess the analysis (64). Through systematic coding work, the risk of arbitrary interpretations was reduced while the analysis remained close to the empirical material. The method enables a balance between data-oriented descriptions and analytical interpretations, which provides a rich basis for answering the research questions (49).

The dependability of the studies is strengthened by the consistency and stability of the research process over time, and by the clear documentation of all stages of the process. Results in both studies were discussed among all authors and verified through consensus, thereby strengthening the transparency, confirmability, and credibility of the findings (64).

Transferability in *Study I* was supported by purposive sampling, including participants with relevant professional experience and diverse backgrounds within the profession. Although the study had only 15 participants, rich descriptions of the participants, study context, and findings enable readers to assess the applicability of the results to similar settings. The aim was to generate an in-depth understanding of the phenomenon.

Transferability in *Study II* was enhanced by inviting the entire population of MCNs working in Swedish municipalities to participate, thereby providing all eligible individuals with the opportunity to contribute their experiences. More than half of the target population (57%) responded to the survey, resulting in a large and geographically diverse dataset. The use of open-ended questions generated a broad range of experiences and perspectives, increasing the likelihood that the identified themes reflect issues relevant to the profession across the Swedish context. Nevertheless, as participation

was voluntary, the possibility of non-response bias cannot be excluded. The results of both studies are similar, which strengthens the transferability (64).

Due to the COVID-19 pandemic, data collection in *Study I* was conducted via digital interviews. It is difficult to assess the extent to which the digitally conducted interviews may have negatively impacted the interaction with participants, compared to face-to-face interviews. However, the information the MCNs provided was rich, and they seemed to feel free to discuss their work.

7 Conclusion

This thesis shows that adequate competence among MCNs is essential for fulfilling their statutory responsibilities within municipal primary healthcare. The role requires not only extensive clinical experience, but also competence in leadership, legislation, and organisational factors. Without sufficient competence, MCNs may have limited ability to identify risks and influence organisational decisions that are critical for maintaining safe and high-quality healthcare.

The findings also indicate that the MCN assignment remains insufficiently defined, resulting in considerable variation in how the role is interpreted and implemented across municipalities. Such ambiguity may weaken the MCNs' mandate and create uncertainty regarding their responsibilities and authority.

Therefore, there is a need to clarify both the scope of the MCN assignment and the competencies required for the role. Establishing clear national expectations regarding qualifications, responsibilities, and organisational prerequisites could strengthen the MCN function and provide more consistent conditions for promoting patient safety across municipal primary healthcare.

7.1 Clinical implications and future perspectives

The findings of this thesis have important implications for clinical practice and the organisation of municipal primary healthcare. Clearly defined competence requirements, role descriptions, and organisational mandates for MCNs are essential to support the conditions for fulfilling their responsibility for patient safety. Strengthening healthcare competence at the organisational and management levels within municipalities may further enhance the conditions required for MCNs to exercise their responsibilities and contribute to safe, high-quality care.

Future research should explore the association between MCNs' competence and patient safety outcomes to provide further evidence of how competence influences the quality and safety of municipal primary healthcare. In addition, exploring the perspectives of other key stakeholders, including heads of municipal administration and representatives of government authorities, could provide a broader understanding of the organisational conditions that influence the MCN role and its contribution to patient safety.

8 Svensk sammanfattning (Swedish summary)

Den kommunala primärvården har kritiserats för bristande effektivitet och patientsäkerhet. Medicinskt ansvarig sjuksköterska (MAS), är en central funktion för att säkerställa att vården är säker. MAS har det övergripande ansvaret för kvalitet och patientsäkerhet. Trots detta ansvar har MAS ofta inte mandat att påverka beslut om ekonomi, resurser och organisation. Det kan göra det svårt att genomföra de förändringar som krävs för att förebygga vårdskador och förbättra vårdens kvalitet.

Syftet med denna avhandling var att undersöka hur MAS upplever sina möjligheter att ta ansvar för patientsäkerheten inom den kommunala primärvården. Avhandlingen bygger på två studier som har utförts genom dels intervjuer med 15 MAS från olika kommuner i en region i Sverige, dels genom en webbaserad nationell enkätundersökning där MAS från alla Sveriges kommuner bjöds in att delta.

Resultaten visar att att det finns brister i den kompetens som MAS har och behöver för att fullgöra sina uppdrag för patientsäkerheten. Eftersom rollen kräver både klinisk erfarenhet och kunskap om lagstiftning och ledarskap kan brister i kompetens påverka möjligheterna att fullgöra uppdraget och därmed också patient-säkerheten. MAS uppdrag ofta är otydligt och förutsättningarna att utföra uppdraget varierar mellan kommuner. Den organisatoriska placeringen för MAS har stor betydelse för möjligheten att påverka beslut och driva ett systematiskt patientsäkerhetsarbete.

Slutsatsen i avhandlingen är att MAS uppdraget bör förtydligöras, samt hälso- och sjukvårdskompetensen bör förstärkas inom kommunal primärvård för att ge MAS nödvändiga förutsättningar för att effektivt kunna fullgöra sina ansvar och säkerställa patientsäkerhet.

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Additional file 1

Questionnaire regarding municipal chief nurses' experiences of the conditions required to fulfil their patient safety responsibilities within municipal primary care, and the response rate per question.

Questions	Frequency (%)[1]
Age	189 (99)
Sex	190 (100)
Do you have a specialist nursing degree?	189 (99)
What is your highest level of education?	188 (99)
In which year did you obtain your nursing degree?	189 (99)
Do you have any leadership training? Please comment.	190 (100)
How long have you worked as a municipal chief nurse?	188 (99)
What percentage of your employment is dedicated to your responsibilities as municipal chief nurse?	190 (100)
What is your organisational affiliation?	186 (98)
What title does your immediate manager have?	188 (99)
How many inhabitants live in the geographical area you are responsible for?	186 (98)
Are you the only municipal chief nurse in the municipality?	189 (99)
According to the Swedish Health and Medical Services Ordinance (2017:80, Chapter 4, Section 6), the municipal chief nurse is accountable for the areas listed below. To what extent do you consider that the organisation complies with your decisions in these areas? • The patient receives safe and appropriate healthcare of good quality • The patient receives the care prescribed by the physician • Medical records are kept in accordance with the Patient Data Act • Delegations are compatible with patient safety • There are appropriate routines for medication management • There are appropriate routines for incident reporting • There are appropriate routines for contacting a physician when the patient's condition requires it	189 (99)
What is your opinion of the description of the municipal chief nurse assignment in current legislation?	180 (95)
Do you have a written assignment description/job description?	190 (100)
To what extent do you use your statutory mandates?	188 (99)
What factors influence the decision-making authority you have in the various statutory areas included in your assignment as a municipal chief nurse? Please provide examples of opportunities and obstacles to making decisions.	165 (87)
Describe any additional mandates you must make decisions regarding within your assignment as a municipal chief nurse.	134 (71)
Are you part of any management group(s)?	189 (99)
Do you participate in meetings where decisions about healthcare at the municipal level are made?	189 (99)
How does your organisational placement/affiliation affect your ability to fulfil your assignment as a municipal chief nurse? Please describe opportunities and obstacles.	172 (91)
What competency requirements do you believe should exist for the assignment as a municipal chief nurse?	174 (92)
What aspects of your own competence and experience do you consider necessary to perform your work as a municipal chief nurse?	174 (92)
Do you lack any competence that you consider necessary for the assignment as a municipal chief nurse?	180 (95)
Is there healthcare competence in the organisation where you are placed as a municipal chief nurse?	188 (99)
How does the competence of other individuals in the organisation affect your mandate to make decisions in your assignment as a municipal chief nurse?	165 (87)
Is there any additional information you consider important for the decision-making mandate of municipal chief nurses within elderly care?	101 (53)

[1] Total number of respondents: N=190.