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Medication management in Swedish nursing homes: an ethnographic study of resistance, negotiation and control

Läkemedelshantering på särskilt boende i Sverige: en etnografisk studie om motstånd, förhandling och kontroll

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ABSTRACT

Medication management in elderly care has become a considerable part of the care work. It involves health care professionals, such as registered nurses, formally delegating their tasks to non-professionals, typically care workers. The aim of this article is to explore the medication management in nursing homes for older people. The focus lies on how care workers and residents interact in relation to the medication management routines. Participant observations were made in seven nursing homes, and the analysis of the empirical material applied the theoretical concepts of local routine culture and materiality. The nursing home residents may try to resist or negotiate the medication management routines, express their reluctance in words or actions, ask questions or make demands. While routines produce institutional bodies, acts of resistance and negotiation may strengthen a person's sense of self. Medication management affect the relationship between care workers and residents, by enabling interaction. Looking at medication management as a social phenomenon deepens the understanding of how it affects care work and illustrates that in the context of nursing home care, health care and social care are not separate but rather intertwined.

ABSTRAKT

Läkemedelshantering har blivit en betydande del av äldreomsorgen. Medicinskt utbildad personal såsom sjuksköterskor delegerar sina uppgifter till omsorgspersonalen som ofta saknar medicinsk kunskap. Syftet med denna artikel är att utforska hanteringen av läkemedel på särskilda boenden för äldre personer. Fokus ligger på hur omsorgspersonalen och de äldre interagerar i relation till medicinerna och rutinerna kring dessa. Deltagande observationer gjordes på sju boenden, och det empiriska materialet analyserades genom teorier om 'local routine culture' och materialitet. Resultaten visar hur de äldre kan försöka göra motstånd eller förhandla om läkemedlen och dess rutiner genom till exempel uttrycka sin motvilja i ord eller handling, ställa frågor eller be om mer medicin. Medan rutiner formar en institutionell ordning och ger personalen makt, kan motstånd och förhandlingar till viss del stärka de äldres självkänsla och inflytande. Medicinerna påverkar förhållandet mellan omsorgspersonal och de äldre genom att

KEYWORDS
Medicines; nursing homes; ethnography; participant observation

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mediciner; särskilt boende; social omsorg; etnografi; deltagande observation

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möjliggöra interaktion. Att se hanteringen av läkemedel som ett socialt fenomen fördjupar förståelsen för hur det påverkar omsorgsarbetet och illustrerar hur hälso-och sjukvård och social omsorg är nära sammanflätade inom ramen för särskilt boende.

Introduction

This article will discuss elderly care and the routines of medication management. The administration of medication in health care and in elderly care in particular has become a considerable part of the care work (Bradford, 2012; Feindel et al., 2019; Gransjön Craftman, 2015; Kleinman & Saccomano, 2006; Mitty & Flores, 2007; Plawecki & Amrhein, 2010; Reinhard et al., 2006; Saks & Allsop, 2007; Vogelsmeier, 2011). In addition to the administration of medication (i.e. handing them out), the care workers are expected to monitor the older person's possible difficulty in swallowing tablets, be responsive to any side effects, and document and report irregularities to the nurse in charge. Thus, the management of medication is a complex process that comprises a set of decisions and actions (Kaushal et al., 2001; Kemp et al., 2012). However, there is limited knowledge of how the procedures involved in this process are performed in everyday practice. Despite that medication management is an essential part of elderly care, few studies have been conducted on it and the entailed routines. Therefore, the aim of this article is to explore the management of medication in nursing homes for older people. The focus lies on how care workers and residents interact in relation to the medication management routines.

Context of Swedish elderly care and nursing homes

To understand gerontological social work and social care in Sweden, the context of elderly care must first be described. The provision of care to frail older people – some of society's most vulnerable citizens – is a cornerstone of social welfare, and in Sweden, the care of older people is an integral part of the welfare state (Andersson & Kalman, 2017; Szebehely, 2005). Care for the older persons in Sweden is organised by the Social Service Act, which places the responsibility for the care on the municipalities (290 in all) to provide social care and meet the nursing and housing needs of older people, while the county councils or regions (21 in all) are responsible for the provision of health and medical care. The main responsibilities of social work with older people is to provide living and social services (Forssell & Torres, 2012). The care workers' tasks are not only to give support in everyday life, for instance, with personal hygiene and meals, opportunities for activities, and feelings of belonging but also to give support of a more psychological nature (Dunér & Olin, 2011). The dominant form of social care is with home care services (eight per cent of the population aged 65 or more, and 23% of the population aged 80 or more). Approximately four per cent of people aged 65 or more live in residential care facilities such as nursing homes. In general, the residents are affected by comorbidity, and many suffer from dementia (National Board of Health and Welfare, 2019a). It is the oldest and frailest persons who reside in nursing homes, and the average life expectancy in Swedish nursing homes is six to nine months. Due to failing functions, pain or various diseases, almost every resident uses between one to ten types of medication every day (National Board of Health and Welfare, 2019b).

The municipal provision of long-term care and services for older people is preceded by needs assessments and financed primarily by taxes. Nevertheless, the residents of nursing homes are clients or tenants, not patients, and the nursing homes are administered by legislation concerning the residents' autonomy and participation. The residents have their own rooms or studio with a bathroom and often a kitchenette. A medicine cabinet is also standard in each room. Paradoxically, although the residents pay for the medications themselves, only the care workers and nurses have access to the cabinet. This shows that, even as tenants in their private sphere of their rooms

and studios, the institutional order is manifested by material objects such as the medicine cabinet (Alftberg, 2018).

Care workers employed in nursing homes in Sweden have, in general, a limited education (traditionally secondary school at most). They work closest to the nursing homes residents, providing everyday care, while supervised by a care manager (generally educated in social work) and a few registered nurses who are available for support. Many tasks, including the administration of medication, are formally delegated from registered nurses to care workers. According to the Swedish National Board of Health and Welfare (2004), delegation is required when distributing a task to someone who may not otherwise be allowed to perform it. Health care professionals may only delegate a task if it is consistent with the requirement for good and safe care. Each delegation decision must be documented, and the decision shall be valid for a certain period, with a maximum of one year, or for a specific occasion (National Board of Health and Welfare, 2004). However, the heavy workload of nurses might lead to the delegation of certain tasks to care workers regardless of their skills, and these tasks may not always be carried out in an appropriate manner (Berland & Bentsen, 2017; Bystedt et al., 2011; Gransjön Craftman et al., 2013; Gransjön Craftman et al., 2014; Karttunen et al., 2020).

Gerontological social work and social care has a long tradition in Sweden with a seemingly clear boundary to health care and the field of medicine (Dunér & Olin, 2011). Elderly care in nursing homes is perceived as social care and social work, and not health care (Melin Emilsson, 2009; Szebehely, 2016). But, while the nursing homes and social care fall under the Social Service Act, the administration of medication is regulated by the Health and Medical Service Act. Once delegated, the medication management is performed by care workers, while registered nurses and medical doctors are called in when necessary. As care workers in social services, they lack formal medical competence but are deemed competent through work experience and practical knowledge (National Board of Health and Welfare, 2004). Care workers therefore work both within their usual field of social care and cross over as health care professionals (Bradford, 2012; Gransjön Craftman, 2015; National Board of Health and Welfare, 2006).

According to Moss and Cameron (2004), the Swedish elderly care system contains a hierarchical conflict between two areas of work and knowledge, one more socially oriented and the other more medical in nature. This conflict can be interpreted as part of medicalisation – the societal process where medical explanations gain precedence over social aspects and conditions (Dumit, 2012). The ageing process itself has been subjected to medicalisation by essentially defining ageing as a health and medical problem, including the idea that old age should be prevented by a health-promoting lifestyle and its consequences treated medically (Conrad, 2007). Such notions are based on what Wendell (1996) describes as societal disciplines of normality, including the strive to form and control people and their bodies. The increased use of medication by older people falls in line with this description, but how are we to understand the increasing role of health care within social care and of medication management in nursing homes and everyday care work? To explore the topic further, the article takes its point of departure in routines and materiality as the theoretical framework.

Theoretical points of departure

Care work is organised around routines, and the significance of routines in residential care for older people has been studied from various aspects (Gubrium, 1975; Harnett, 2010a; Magnússon, 1996; McColgan, 2005; Powers, 1995; Repo, 2019). Routines act as a theoretical framework that will help understand the medication management and the interaction that takes place, and within this framework, I apply the concept of local routine culture (Harnett, 2010a). *Local routine culture* is characterised by the ways that its members participate in and maintain routine systems that outline ideals for their behaviour as well as form persuasive logical structures that shape the interpretations and decisions that are considered possible. The members habitually refer to and value routines when

interacting with each other, which reproduces the influence of the local routine culture (Harnett, 2010a, p. 36). Accordingly, the concept provides an understanding of how routines shape the power relations between nursing home care workers and residents. In line with the subject of this article, the routines of medication management involve expected behaviour and ways of interaction between care workers and residents, but these ideal forms of conduct are only made visible when they are disrupted, for example, by resistance. An example of resistance is when the residents do not want to take their medicine and therefore do not follow the expected behaviour.

As Harnett points out, the term 'local routine culture' is an elaboration of the concept of 'local culture' described by Geertz (1983) and Gubrium and Holstein (1997). Culture is a context or system in which social actions are comments on more than themselves and are open for interpretation. Conceptual structures (i.e. a social discourse) influence and form interactions within a particular context (Geertz, 1973). Nevertheless, local routine culture is not a set of rules for behaviour, interpretations and decisions that simply govern its members. Harnett emphasises that routines should rather be regarded as a common knowledge, locally available and locally reproduced, with a set of locally and situationally generated actions that are collectively acknowledged and available to use (Harnett, 2010a, p. 37). In the context of nursing homes, specific routines may differ from one nursing home to another (as well as between welfare systems or countries), but the value ascribed to routines and the endeavour to maintain the local routine culture is the common feature (Harnett, 2010b).

Medication management is not only formed by the local routine culture but also affected by the material *objects* that are part of the routines – primarily the medication, but also the locked medicine cabinet and its key as well as the chart where medicine intake is recorded. Analysing the medications as central objects means using *materiality* as a theoretical perspective. Material objects have the capacity to affect people's minds, emotions and actions by stimulating intentions, interpretations and meaning making. Objects have the power to set the scene and ensure normative behaviour by being ordinary, a part of everyday life and taken for granted (Alftberg, 2017; Miller, 2005). When it comes to medications as objects, Whyte et al. (2002) point out the power of medicine grounded in their capacity to give and take control. Control is part of the relation between the individual and the medication given that medicines take control over bodily symptoms – but one can also become controlled by the medication, for instance, with drug dependency. Moreover, the control concerns relationships between humans, for instance between doctors and patients, or in this article, between care workers and residents. This is illustrated when the care workers administer and have control over the locked medicine cabinet and its content, not the residents. In order for the residents to gain access to their medication, they depend on the care workers. The aspect of control concerns both the actual access to the medication and the non-reflective and accepted 'natural' order of things. The power dimension lies within the trivial and overlooked. Given that medication is a seemingly mundane object but with the power to trigger interaction and affect routines means that it is necessary to take it as a material object into account.

Methods and empirical material

The empirical material of this study consists of ethnographic fieldwork that was conducted as part of an implementation project concerning palliative care for older people in nursing homes (Ahlström et al., 2018; Alftberg et al., 2018). The study comprised participant observations of the care work and the aim was to explore care work and routines in relation to palliative care.

The study was carried out in seven nursing homes in southern Sweden. The nursing homes were strategically selected, reflecting diversity in size and location, as they were a mix of larger and smaller nursing homes and located in rural areas as well as in urban areas. Eight care workers in the seven nursing homes were included. They were selected after contact with the nursing home managers. The managers forwarded a request to the care workers, who then voluntarily decided to be part of the study. In one nursing home, two care workers chose to participate. All participants were

female, 30–64 years old (median 57 years), and had been working as care workers in elderly care for between 10 and 30 years (median 22 years).

The care workers were followed on four occasions (two care workers were followed on two occasions) in their daily work through participant observations (28 occasions in total). Each period of observation lasted 3–4 h (about 110 h total). The observations were made at different times of day, from 7:00 am to 9:00 pm The researcher shadowed the participating care workers in every part of their work. During the observations, informal conversations occurred between the care workers and the researcher, which later were recorded as field notes together with descriptions of the situations that took place at the nursing homes. In practice, this meant that key points were discreetly recorded in writing during the observations and completed field notes were written down immediately after the observations (Gray, 2003).

In order to make ethnographic 'thick descriptions' possible, as in relating human behaviour to its current context (Geertz, 1973), meaningful and extensive details were recorded to illustrate the element of presence and trustworthiness, thus strengthening the descriptive validity (Maxwell, 1992). Following an ethnographic methodology, the researcher strived to be reflective and self-critical during the process of gathering and analysing the empirical material (Gray, 2003). During the observations, the researcher reflected upon how her presence might affect the situations (for instance, it is possible that some participants changed their behaviour because of the presence of a researcher) and critically reflected upon what was the focus of each situation and why. Given that it is impossible to observe and write down literally everything that is said and done, a selection of what was regarded as important and worth recording was made in relation to the aim of the study.

An inductive thematic approach was applied to the qualitative analysis process (Riessman, 2008). The field notes were taken as a whole and scrutinised repeatedly in order to highlight patterns and identify themes. When interpreting the empiric material, two overarching themes emerged: *resistance* and *negotiation*. The themes became apparent as sources of friction in regard to the mundane routines of medication management, either as resistance, where the residents did not want to take their medicines, or as negotiations where the residents wanted more medication or in other ways tried to gain influence over their medicine intake. In the next step of the analysis process, the findings were viewed and interpreted in relation to the theoretical framework but with a theoretical openness that allowed the empirical material to come forward and direct the interpretation. Through the ethnographic method, thoughts and notes from the fieldwork constituted the preliminary analytical reflections, which were processed further in the actual analysis (Hammersley & Atkinson, 2007).

Ethical considerations

The study was approved by the Regional Ethics Review Board in Lund.

Care workers and nursing home residents were informed and gave consent to be part of the research project. Before contacting the residents, there was a discussion with the participant care workers and the care managers because of their in-depth knowledge of the residents' cognitive abilities and their capacity to give informed consent. Solely the residents with the cognitive ability to understand what participation in the project would mean were contacted. Nevertheless, the informed consent was regarded as a process and repeatedly asked for every time an observation took place. The residents were regarded as a vulnerable group, and the presence of the researcher was guided by responsiveness towards their reactions to the observations. Any hesitation or unwillingness to participate was respected. No personal data about care workers or residents was recorded during the observations. In the account of the results, characteristics of the care workers and the residents have been changed or omitted, and they have been given assumed and neutral names to protect their identities.

Findings

The medication management in nursing homes often appeared as trouble-free routine care work. It was the care workers' responsibility to give the residents the right amount of tablets at the right time, as accounted for in the following field notes:

> The care worker, Maria, knocks on the door and enters a resident's room. 'It is time for your medication', she says to Margaret, the resident. 'It is just a small pill this time', Maria says. She unlocks the medicine cabinet and takes out a small plastic bag, where the correct amount of medication is already measured. She takes out a small tablet from the bag and puts it on the table in front of where Margaret is sitting and brings a glass of water to her. Margaret quickly swallows the tablet while Maria signs the drug chart.

The routines of medication management includes many different objects and procedures performed by the care workers, as described. Together the actions and objects form the routine of medication management: the careworkers pick up their key and unlock the medicine cabinet, and control the amount. They then hand the tablet(s) to the resident – either in a plastic cup or a spoon or by placing the tablet into the resident's hand or directly into his or her mouth – and bring a glass of water, checking that the tablet is swallowed. Finally they sign the MAR sheet (Medication Administration Record), which is also called a 'drug chart'. This whole activity occurs as a normal course of events without complications. It is routine care work formed by the demand that medication is to be managed and controlled by the staff, not the residents. The residents were supposed to quietly accept the medication that was handed out to them and no other kind of interaction was expected.

In the following, I describe situations where the medication management was more problematic, and frictions occurred. It is in these situations where resistance and negotiations concerning the medication took place, and the interaction between care workers and residents will thus be highlighted. The point of departure is the field notes from the participant observations, and I have chosen to use longer excerpts in the present tense in order to describe details and to create a sense of 'being there'. This is a common approach in ethnographic research, where culture or context is to be understood *in situ*, with a focus on the individuals using it (Frykman & Gilje, 2003).

Resistance

Medication was often distributed to the residents in connection with meals, such as breakfast or dinner. Meals were always served in the shared dining room, but the residents could choose to eat in their own rooms. During the fieldwork, situations where the residents did not want to take their medication and showed different forms of resistance would sometimes occur. This is illustrated by the following examples:

> The resident, Ruth, is eating her breakfast in the dining room, and the care worker, Karen, crushes her tablets by pressing a spoon against the small plastic bag that contains Ruth's tablets. She then carefully sprinkles the powder from the pills on top of Ruth's porridge. Karen asks for Ruth's spoon and starts to feed her the mixture of porridge and medication. Ruth says no – she thinks it tastes bad, but she nevertheless eats it when she is fed. Karen says that she knows that it tastes bad, 'but just [take] one more spoon'. When all the medication is eaten, Ruth gets her spoon back and she continues to eat on her own.

The routine was clearly to crush the tablets and feed it to Ruth. Ruth's protests were relatively subdued, as she was used to the procedure and knew there was nothing she could do. Her resistance did not change anything, and the routine of handing out medication was followed. In a similar situation, another resident – Robert – gave a much more articulated resistance:

> The resident, Robert, does not want to take his medication when it is time for supper. Linda, a care worker, puts three tablets in his soup so that he can take them with his spoon, but he carefully avoids them when eating the soup. Linda takes his spoon and starts to feed him, and she puts the tablets on the spoon. Robert says no with a loud voice, and when he gets the tablets in his mouth, he spits them out on the table. Linda reacts by putting the tablets back on the spoon and saying to Robert that he must take his medicine: 'It's the doctor's orders'. This

> procedure is repeated several times. The situation is becoming more and more tense. Linda then tries to put the tablets inside Robert's sandwich, hiding them under the cheese. When Robert takes a bite of his sandwich, he discovers the tablets and spit them out again. Finally, Linda gives up, and she puts the tablets in a napkin and then places them in her pocket.

Robert did not want to take his medication, and he was showing obvious resistance. For Linda, the routine of medication management needed to be followed so that Robert got proper care, which included access to his prescribed medicines. From a care worker point of view, it was ultimately for the benefit of Robert's health that this struggle took place – he needed his pills. In the situation, the medication became a central object for the interaction and the control it represents when Linda's expected control over the medication was challenged by Robert's resistance.

Negotiation

A common occurrence in relation to the medication management was negotiation, called upon by the residents as they had objections or wishes that deviated somehow from the routines. One example of this is illustrated in the following field notes:

> A resident, Helen, is sitting in an armchair in her room, and the care worker, Jennifer, sits beside her. Jennifer holds out her hand with four different tablets. 'Well, should I take them? I don't know', Helen says. Jennifer replies that it is Helen's choice. Helen hesitates. 'What do you think?' she asks Jennifer. Jennifer patiently says that it is Helen's choice, but if Jennifer is to give any advice, then it is that the tablets make Helen feel less pain. Helen decides to take the tablets, and Jennifer put them one by one very carefully on Helen's tongue, and Helen drinks a glass of water to swallow them down.

This negotiation between Helen and Jennifer took place over several mornings. What sets this example apart from the others where the residents had hesitations and questions about their medicines was that Jennifer did not seem to mind the temporary interruption of the routine and she did not try to persuade Helen to take her tablets. Instead, the negotiation itself had become part of the routine. Therefore, Helen's questions and hesitations were not treated as a problem but rather was accepted behaviour.

All the examples so far have portrayed the residents as rather passive receivers of medication and even shown how medication sometimes was forced on the residents. Yet, there were several occasions during the fieldwork where the opposite occurred – the residents wanted or demanded more medication than prescribed. In such situations, a negotiation arose between the residents and the care workers:

> John, a resident, is sitting on a couch in the corridor, and when a care worker, Sophia, passes by, John says he wants a tablet with paracetamol. 'Are you in pain?' asks Sophia. John denies having any pain, and the care worker explains to him that he may only receive medication if he is pain. John is being persistent and declares that he could possibly be in pain later, 'Yes, but then you just have to tell us', says Sophia. 'Well, then I'm telling you now', replies John. Sophia answers resignedly that she will be back shortly with some paracetamol.

By being persistent, John obtained the medication he wanted. The tablet he required is a mild pain reliever and a non-prescription drug, which was probably significant for the outcome of the situation. Nevertheless, this was as a situation outside of the ordinary routines of medication management. The routine was that pain relievers were given to residents in pain, while John wanted a tablet preventively. A negotiation took place given that there was no clear routine to handle his request, and therefore, Sophia's control of the medicine was diminished.

Another resident, Betty, had a similar request for more medication, but she wanted a sedative, which, even though it had been prescribed to her, started a negotiation with the care worker, Jessica:

> Betty is calling for Jessica in her room. Betty is feeling anxious, and she asks for a sedative. Jessica checks the drug chart and explains that Betty already had her sedative for the morning and she has to wait until tonight for another one. Instead, she offers a tablet with paracetamol to Betty, but first she has to make a call to the nurse to verify that this is okay. During the call, the nurse asks if Betty is in pain, but Jessica replies that Betty is worried and not feeling well. Giving her another sedative now will mean that it will be impossible to give

another one in the evening because the maximum amount is two sedatives per day. It is decided that two tablets of paracetamol will be fine, and Betty seems satisfied.

The routine of administering Betty's sedatives was firmly established and could not be changed, even when Betty requested more. Instead, the careworker, Jessica, offered another type of medication. It is interesting how paracetamol was used in a situation that involved anxiety and not pain relief, which it traditionally is used for (even though a study by Durso et al., 2015, claims that paracetamol may have an extremely low suppressive effect on all sorts of emotions). Here, any tablet would seem to have had a calming effect, as the medication as an object may have been more significant than the medication itself in this situation. It appeared to be a 'magic object' associated with cure and relief, regardless of its specific area of treatment (Whyte et al., 2002).

When Jessica checked the MAR sheet and then decided to consult the nurse in charge – before giving Betty access to any medicine – it was all part of the routines of medication management. By having control over the medicine, the care worker had control over the situation and could choose to offer another tablet than the one requested – even though the control was somewhat limited and the nurse had to approve the proposal. Thus, the negotiation involved a third party, the nurse with which Jessica had to negotiate her suggestion of paracetamol. The care worker was put in a similar position as the resident – someone who needed to negotiate for the medication.

Discussion

Routines are structured around the organised running of the nursing home and the institutional order, which leaves a restricted amount of choices for the residents (Banerjee et al., 2015; Gubrium, 1975; McColgan, 2005). As has been shown in this article, the residents may try to resist or negotiate the routines, express their reluctance in words or in actions, and make questions and demands.

Previous research highlights the ambivalent nature of institutional routine, both as a safeguard and a threat to integrity (Andersson & Kalman, 2017). Routines risk making nursing home residents into what Wiersma and Dupuis (2010) call 'institutional bodies' – institutional property managed to conform to the structures and practices of the institution and its staff. The residents' functions and needs are meet through standardised routines, which leaves little room for the residents' integrity and wishes. Institutional bodies are made through interactions with care workers, as they enforce routines and thereby reduce the residents' influence over their own bodies (Whitaker, 2010; Wiersma & Dupuis, 2010). The care workers conform to the routines, or rather, the local routine culture and its persuasive logical structures that shape the interpretations and decisions that are considered possible (Harnett, 2010a). In that way, the careworkers in the aforementioned examples followed the routine and took the actions they considered eligible. The routines of medication management are situationally generated knowledge and actions that are available to use, but they may also render other possible actions invisible.

Even though the routines may transform the residents into institutional bodies, there is also room for resistance. This is clear in the example with Robert, while Ruth shows a more silent opposition. Whitaker (2004) points out the silent forms of resistance of nursing home residents, expressed as resignation, adaptation or with a sense of humour. The residents actively try to maintain their identity and struggle to preserve their dignity and sense of self within institutional routines (King et al., 2019; Paterniti, 2003; Pirhonen & Pietilä, 2016). Such struggles seem to be 'condensed' in the actual tablets when it comes to medication management. The medication appears as an object that can be shuffled back and forth between opponents, as in the example with Robert and Linda, but the struggle concerns much more than the medication itself. It is about self-determination and integrity on one hand, and it is about providing what is regarded as proper care on the other. As Backhouse

et al. (2017) illustrate, forced care may occur when the residents refuse or resist care. The care workers directly override resident autonomy with the argument that it is in the resident's best interest or maintains the resident's dignity. Also, to not give (forced) care could be percieved as the care workers neglecting the residents.

According to Harnett (2010b), negotiations may occur when nursing home residents try to influence the routines they are met with. The negotiations are brief, situationally bound, and always temporary exceptions from the institutional order. In Harnett's study, the residents' influence attempts would only succeed if they did not interfere too heavily with the routines and institutional order. Often, the staff adjusted the residents' requests to make them fit into the existing routines (Harnett, 2010b). The aforementioned examples of negotiation seemed to be allowed because they did not overly interfere, or else could be incorporated, into existing routines. Nevertheless, negotiations are important forms of care, in accordance with Pols (2006). The author of this paper argues that a true negotiation has no fixed positions, with one person imposing norms on another. The example of Helen and Jennifer, with the repeated negotiation every morning as part of the routine, could possibly be understood in this way.

Even seemingly trivial and mundane medication has the power to affect the routines and relationship between residents and care workers, and it may increase the inequality of already unequal power relations. Accordingly, one could say that medication management increases the power of the care workers. However, the medicines also give the residents an opportunity to negotiate and possibly affect the care in minor ways – requesting and receiving additional medication is a way to gain a small amount of control, even though it is still very limited.

In sum, the medication management affects the relationship between care workers and residents in different ways. The medication enables social interaction, often from the residents' initiative. For instance, by requesting more medicines, they initiate social contact with the care workers. Given the weight of health care matters such as medication, it is probable that the residents recieve more attention and communication when asking for medicines than if they were to ask for a shower or to take a walk – requests that are easier to dismiss or postpone.

As previous research has pointed out, there is a tension regarding social care and health care; between considering the nursing home as an accommodation or as a medical facility (Dunér & Olin, 2011; Melin Emilsson, 2009; Moss & Cameron, 2004). For the residents, the tension between social and medical orientation can mean different requirements for involvement in everyday life that circulate around promoting autonomy and protecting residents (Wikström & Melin Emilsson, 2014). In this article, the described situations rather show how medical orientation and medication management becomes a *social* practice. Instead of referring to two separate dimensions – health care and social care – medication management involves both. It is both medical and social by the interaction it creates. Looking at medication management as a social phenomenon – people interacting through medicines (Whyte et al., 2002) – deepens the understanding of how it affects care work and illustrates that in the context of nursing home care, health care and social care are not separate but rather intertwined. Certainly, the interaction is affected by power dimensions where the 'organizational culture' (Wikström & Melin Emilsson, 2014) hinders and complicates the residents' control and autonomy. At the same time, medication management makes room for the residents to have at least some influence by creating possible interaction with the care workers. Medication management as a social phenomenon means a shift in perspective. Possible implications for policy and practice in elderly care would be to raise awareness of the relational aspects of medication management as a means to improve the quality of care.

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