

# Who knows? Mobilization of Employee Knowledge in Nursing Homes

Stian Bragtvedt<sup>1</sup> 

Ragnhild Holmen Waldahl<sup>1</sup> 

<sup>1</sup>*Nordland Research Institute, Postboks 1490, N-8049 Bodø, Norway*

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**I**n Norway, as in many other countries, professionalized elderly care faces a twin challenge: lack of competent labor combined with disinvestment in elderly care. Furthermore, while the number of elderly people in need of care is projected to rise over the coming decades, politicians are reluctant to commit more resources to the sector. Instead, innovation is seen as the solution. But in the policy debate on these issues, innovation is largely understood to be technological. This paper argues that the experience-based knowledge of assistants, healthcare professionals and nurses working in elderly care is an overlooked resource for innovation. By discussing three ways such knowledge is mobilized for innovation in nursing homes, we show that employee knowledge can help solve problems articulate under a logic of care, but also to solve problems traditionally thought of as belonging to the domain of management.

*Keywords:* Knowledge, elderly care, nursing homes, innovation, logic of care

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## Introduction

In 2019, 1 in 11 people globally were aged 65 and older; by 2050, this ratio is expected to be 1 in 6 (UN, 2019). In Norway, the 80+ age group made up 4.2 percent of the population in 2018, projected to almost double to 8.0 percent by 2040 (Helsedirektoratet, 2018). This poses several challenges for institutionalized elderly care. One is the lack of qualified labor. Another is the economic concern, and the idea of an “elderly wave” threatening the sustainability of the welfare state (Haukelien, 2021). A royal commission tasked with preparing a knowledge base for meeting the future challenges in health care stated that the sector in the future would have to prepare for “fewer employees per patient,” and thus “that health and care services must use personnel and skills much more efficiently than before” (NOU 4, 2023, p. 13). What Nancy Fraser (2017) calls disinvestment from social welfare is thus very much the norm, even in the social-

democratic welfare states in the Nordic region. Even though more and more elderly people are living longer at home and the number of nursing home places has been reduced, nursing homes are experiencing reduced financial room for maneuver and difficulties in obtaining qualified employees. In the following, the lack of skilled labor and financial resources will be referred to as the *twin challenge*.

In Norway, the prevalent solution for addressing the twin challenge involves emphasizing technological innovation, particularly through digitalization, as evident in the Health Personnel Commission's recent investigation (NOU 4, 2023). The discourse mirrors Kovalainen's (2021) observation that proposed remedies for the care crisis predominantly lean toward technological solutions. This article contends that employees' experience-based knowledge is an overlooked source of innovation for solving the challenges. The question of whether the disregard for employee knowledge in elderly care stems from its low status (Liveng, 2007) is outside the scope of this article. There is, however, a marked difference between the scholarly attention given to employee knowledge in traditionally masculine sectors such as manufacturing and the attention given to employee knowledge as a resource for innovation in elderly care.

Innovation is not limited to new technologies or organizational changes but can also arise from "the everyday cultural practices of workers" (Høyrup et al., 2014, p. 77). The starting point of this article is the 'cultural practices' from which innovation might rise, and what this process might look like in the nursing home. The article is structured by the following research question: *How is employee knowledge mobilized as a resource for innovation in nursing homes?* The meaning of mobilize here is to organize or prepare something for a purpose (Cambridge Dictionary), and the purpose we are interested in here is that of innovation. Innovations are solutions to problems. Hence, if innovation drawing on employee knowledge is to be part of the solution to the twin challenge, the problems need to be articulated within the logic of the twin challenge. As we will show in the discussion, employee knowledge is most often utilized to solve problems articulated within a logic of care (Mol, 2008), answering questions that orbit around the quality of care. We will argue that employee's knowledge is an overlooked resource also when it comes to solving problems beholden to a logic of economization, referring here to the economically instrumental rationalities governing the organization of nursing homes (Kovalainen, 2021). The question of how best to perform care tasks

with residents is a problem articulated under the logic of care, while the question of how to have enough employees available at a certain time is a problem articulated under the logic of economization. We will now go on to present the primary theoretical perspectives informing the study, before presenting the Norwegian empirical context and discussing methodology. Then we will discuss the three different ways employee knowledge was mobilized in everyday work in the nursing homes.

### **Theoretical Perspectives**

A central concept in answering the research question is knowledge, and our point of departure is that we know more than we can say (Polyani, 1966). Knowledge has both a tacit and an explicit dimension. There is an ontological barrier between these dimensions (Duguid, 2012) and the tacit cannot be reduced to the explicit. The difference between tacit and explicit can be referred to as “knowing how” and “knowing what” (Lundvall, 2016), and it is the former that makes the latter actionable (Ryle, 1949). To put rules or procedures into practice, we must be experienced in how this is done. Explicit knowledge is not a “self-sufficient base, but a dependent superstructure” (Duguid, 2012, p. 6). The application of explicit knowledge codified in procedures rests on a base of experience acquired over the course of everyday work. The interpretation is not given in the text but depends on the community making the interpretation. In the following, we will use the concept of community of practice (CoP) to refer to this interpretative community, understanding it as “a set of relations among persons, activity and the world, over time and in relation with over [...] communities of practice.” (Lave and Wegener, 1991, p. 98). There is a vast literature on CoP. In the following we draw on Brown and Duguid because we want to highlight the tension and interplay between canonical and non-canonical practices. The tacit dimension of knowledge is typically transmitted by way of examples, by showing how to act with good judgment in unique situations (Josefsson, 1988). Therefore, face-to-face interaction plays a major part in deciding the diffusion of tacit knowledge. It is through mastering the tacit dimension of knowledge involved in a practice that new employees can become members of the CoP (Duguid, 2012). Becoming a knowledgeable employee is thus a question of both acquiring the codified knowledge available through education and in nursing-home-specific procedures, but also (and more

importantly) to acquire the tacit knowledge necessary to put the explicit knowledge into practice.

This view of knowledge formation in everyday work supports an understanding of innovation that is not limited to formal education or research and development but makes work practices into a site where innovation can take place (Lundvall, 2016). Here we shall employ Ellstrøm's (2010) concept of practice-based innovation to describe such processes. Such innovation typically leads to improvements in the way tasks are performed and is defined as "a deliberate, novel, specific change, which is thought to be more efficacious in accomplishing the goals of a system" (Miles, 1964, 14). The key characteristic is novelty, and in the following we adopt what Ellstrøm terms the "low innovation ceiling" (2010), accepting changes as innovation if they are understood to be new in their particular context. Furthermore, "the goals of a system" can be the goals of the Health and Care Department on a municipality-wide level but can also be the goals of the CoP in a particular nursing home. Practices that are taken up collectively can thus be innovations, a better way to do a task that is not collectively adopted is not innovation but an example of individual learning. Furthermore, innovations are not limited to the goal of increasing efficiency or adopting new technology, but may be motivated by different goals, for example improvements in the quality of care. Hence, a new way to perform a care task that is adopted by the CoP can be an innovation. Better working methods can diffuse through the CoP by word of mouth, or they may become part of the organization's knowledge by way of codification.

Practice-based innovations necessarily orbit around work processes, "a set of recurrent actions that are performed with or without the help of tools or machines to achieve a certain result" (Ellstrøm, 2010, p. 30). In the following, work processes and tasks will be used interchangeably. These have two dimensions, one explicit and one implicit. The former designates the way a task or process is codified, regulated, and supposed to be done, what Brown and Duguid terms "the canonical practice" (1991), opposite of the way tasks are done in practice, "the non-canonical practice." As Ellstrøm points out, these distinctions are ideal types, which in the reality of everyday work is intertwined into each other in complex and messy ways.

Innovation is about "accomplishing the goals of a system" (Miles, 1964, p. 14). In our analysis of institutionalized elderly care, we focus on two such systems, or logics:

a logic of care (Mol, 2008) and a logic of economization (Kovalainen, 2021). Knowledge mobilization under the logic of care highlight the relational character of care work. The importance of social relations through which care is given, and the uniqueness of the persons involved in these relations. It understands care needs as situational and temporal (Hoppania et al., 2022), and thus the work of giving care is fundamentally different from the production of goods, whether it is cars or bottles. As Mol (2008, p.47) puts it, the logic of care does not primarily address a three-dimensional physical object such as a body, but something historical, namely the lived life of the patient<sup>1</sup>. The logic of care thus exists in tension with attempts at making elderly care more efficient.

The logic of economization, on the other hand, departs from the fact that institutionalized elderly care is commodified, performed by paid labor. In Norway, it is financed by municipalities and disinvestment in elderly care is taking place. This was also the case in the City where we did our fieldwork, here articulated by senior management in the Health and Care Department:

“That [disinvestment] is part of everyday life. For us here in the City and the entire sector. We are facing big challenges and demands to save money at the same time.”

Simultaneously, the challenge of disinvestment was intertwined into another challenge: a lack of competent labor. Thus, in the City, the primary aspect of economization was one of household management<sup>2</sup>, making the most out of scarce resources, both money and skilled labor. We describe these two logics here because we will discuss how some of the innovations described later pertain to a logic of care, while others pertain to a logic of household management, and what the consequences of this might be.

In discussing the outcomes of employee participation in innovation processes, we will employ the concept of interpellation (Therborn, 1999). Interpellation is an address of ideology directed at individuals. In *The Logic of Care* (2008), Annemarie Mol shows how patients can be interpellated as customers or citizens. In the following we will argue, with Therborn (1999), that interpellation is a double-sided process which involves becoming

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<sup>1</sup> A paraphrasing of Mol.

<sup>2</sup> The use of household management here is inspired by the original meaning of ‘economy’ in Greek, which combines household (*oikos*) and management and dispensation (*nemein*).

a subject under ideology, but at the same time becoming an active subject, qualified for particular roles in society. Hence, an employee at the nursing home accepting the interpellation of an ideology will activate certain modes of reasoning. Certain types of knowledge and attitudes are mobilized, and heuristics for how to achieve certain goals are activated (Lindenberg, 2001). The ideology under which one is interpellated influences how one sees the world: The visibility of the world is structured by the distribution of spotlights, shadows and darkness<sup>3</sup> (Therborn, 1999, p. 18). In this article, we use logics instead of ideology, but the function of interpellation is the same.

### **Empirical Context**

Norwegian health and care services are mainly publicly owned and operated but divided into two separate decision-making lines for the specialist health service (the state) and the primary health service (the municipalities), respectively (Grimsmo et al., 2015). The primary health service includes, among other things, home-based services, and nursing homes. At the end of 2020, there were more than 39,200 nursing home places in Norwegian municipalities. In recent decades there has been a development toward Norwegians living longer and having more severe conditions when moving into elderly care. This increase demands on competence and facilities. As one informant put it: “When I started here [30 years ago] people came here riding their bike when they moved in. Now they are much sicker.” Even though there has long been an awareness of the coming aging of the population, too few nurses are being trained. The shortage of nurses is expected to worsen in the coming years. Nurses in Norway have a three-year bachelor’s degree and healthcare workers have a vocational education.

The three nursing homes that took part in this study all consist of wards with two to three resident groups. There are typically six to eight residents in each group, with common kitchen and living room, and individual apartments with bathrooms. During the day and afternoon, there are usually two employees per resident group, while at night there may be one employee for an entire ward. It varies whether the employees are nurses, healthcare workers or unskilled assistants. The only requirement is that there is a nurse on duty who has medical responsibility on the ward. The employee on duty at each resident group is relatively autonomous regarding how they organize their work.

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<sup>3</sup> Paraphrase of original quote.

### Methodology

This article is based on data generated in a research project concerned with enhancing innovation in elderly care in Northern Norway. The project is a collaboration with two Norwegian municipalities, a city (the City) and a small district municipality (the Island), and a research consortium consisting of Norwegian and Danish researchers. In the City, two out of seven nursing homes were randomly selected for fieldwork and interviews. On the Island it was carried out at the only nursing home. The fieldwork and interviews were part of the project and took place in agreement with the municipality's management and the management at the nursing homes. Table 1 gives an overview of the data.

		Observation	Individual interviews	Group interviews
Island	Two researchers	Two researchers spent one week at the nursing home	- Resident (1) - Manager (1)	- Employees (nurses (2) and healthcare workers (1), assistant (1)) - Managers and employees at the nursing home (managers (2), nurse (1), healthcare worker (1))
City	Two researchers (the authors)	Two researchers spent three days each in each nursing home		- Employees nursing home 1 (nurses, healthcare workers 2) - Employees nursing home 2 (nurses 1, healthcare workers 2) - Managers nursing home 1 - Managers nursing home 2 - Senior managers of nursing home in the municipalities (2)

*Table 1. Data overview. Numbers of persons in parenthesis.*

The fieldwork was carried out by two researchers who spent three to five days each at each nursing home. The researchers stayed in the common areas, mostly, in various resident groups, observing what was going on and taking part in various activities such as singing, setting the table, and talking to the residents. Field notes were made from the observations, as well as notes from shorter conversations with employees and residents. In preparation for observation, we conducted informal talks with managers to prepare fieldwork and get an overview of the nursing homes.

Based on observation and fieldnotes we conducted individual and group interviews with employees and managers from each nursing home. All the interviews were conducted in meeting rooms at the nursing homes. Interviews were recorded, transcribed, anonymized, and coded in software for qualitative analysis, Nvivo.

The field notes and the transcriptions were analyzed through interpretative text analysis within the genre of thematic content analysis (Berg & Lune, 2012). Analysis and interpretation of data consisted of a process where we alternated between inductive and deductive analysis. New readings of theory influenced new readings of data, which in turn influenced new readings of theory.

In addition, we conducted two workshops with employees from the nursing homes, one on the Island and one for the two nursing homes in the City. In the workshop, one of the researchers presented a preliminary thematic analysis of the results from the observations and interviews. Six caregivers participated in the workshop in addition to the entire research team and senior management of the nursing homes in the municipality. The workshops helped to validate the analyses and to spread the results back to the nursing homes (Bradbury et al., 2015).

The data was collected from February 2020 to March 2023. The long period was due to the COVID-19 pandemic, which made it impossible to carry out the data collection. The study has been submitted to the Data Protection Official at the Norwegian Centre for Research Data and they have reviewed the research design, including the consent forms, to ensure the researchers followed the ethical research guidelines.

### **Different Ways to Mobilize Knowledge in Nursing Homes**

During analysis, we developed three different ways employee knowledge was mobilized for innovation. They are distinguished by the level at which the problem to be solved is articulated. In the first type, problems are articulated and solved at the level of the CoP; in the second type, problems are articulated at the level of the organization, in effect the nursing home, while in the third type, problems are articulated at the level of the municipality. The three types of knowledge mobilization are all examples of problem solving, but the level at which the problems are articulated differ – from the setting of everyday work in type one, to the challenges of the nursing home in type two, and the level of the municipality in type three. While the level at which the problems were



articulated differed, the cultural context from which the knowledge was mobilized was the same for all three, and it is from this context we shall begin our analysis.

Field diary:

The time is 07:15 and Guro the manager introduces us at the morning meeting, before they start to discuss the day ahead. The healthcare worker from the nightshift informs it has been quiet. Some residents have been up already to eat and gone back to bed. They talk a bit about procedures and Guro gives credit to the employees for all the deviation reports they are writing. She has been at a meeting at city hall regarding quality indicators. I follow Åse the healthcare worker into one of the three resident groups on this floor and take a seat in the kitchen.

The time that residents get up has a big impact on the flow of work, and when everyone rises at the same time, it is challenging for employees to tend to everyone. Hence, it is therefore important to know what to expect. The quality indicators refer to the set of written procedures for how tasks are performed, and statistics related to various types of incidents, such as residents falling. The short interaction in the morning meeting allows for the exchange of various types of knowledge, with different purposes. And Guro's meetings on quality indicators at city hall have to do with the municipality's attempts to govern elderly care in the City, and thus a need for statistics that can give an indication of its development.

#### *Knowledge Mobilization at the Level of the CoP*

The first type of knowledge mobilization designates the continuous problem-solving taking place during everyday work. While there were written resources giving descriptions for how recurring tasks should be performed, unique situations would continuously arise where caregivers would have to apply good judgment (Josefsson, 1988).

Fieldnotes:

It is morning. A resident has not yet risen. Anne and Trude discuss whether to go in and check on her. Anne wants to, but Trude argues that this has provoked her on earlier occasions and gives reasons for waiting. They discuss between them the pros and cons of entering to wake the resident.

This short exchange of viewpoints illustrates several aspects of everyday work and knowledge exchange in the nursing home. Anne and Trude discuss how to best approach a unique situation, but a unique situation that is still similar enough to other situations to make the experience of the senior and skilled worker Trude relevant. The conversation between Anne and Trude is an example of the interface between individual knowledge and collective knowledge. Trude's knowledge is brought into the situation as a resource to draw on and might be picked up by Anne for use in a later situation. Hence, the knowledge is explicit and disseminated, but in this case only within the CoP. Situations like these were important for knowledge transmission and collective reflection within the CoP, and instrumental in collective processes of knowledge search, trial, and error.

The CoP did not necessarily include all the care professionals at the ward. Experience was important but not enough to become initiated in the CoP, or "well acquainted"<sup>4</sup>, as this interview excerpt illustrates:

Anne: It isn't about the time you have worked here, I mean, some people can work here for twenty years.

Trude: without being well acquainted.

[Laughter]

Anne: It also comes down to what type of person you are.

Linn: I feel that it comes down to personal chemistry, really.

Anne: But you know there is someone that you won't bother to sit down with to discuss an issue.

Trude: But there is a reason for that.

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<sup>4</sup> "Godt kjent" in Norwegian.

Linn: If people are not engaged you don't bother sitting down with them to discuss how to improve things.

The meaning of 'well acquainted' here implies a colleague that it is seen as relevant to have discussions of best practices with, and one that one will potentially listen to in discussions of what constitutes "good" care. The discussion that these excerpts are taken from took place between two veterans at the ward that we came to understand as authorities in the CoP, while Linn had just recently started working there. Still, she was already accepted and understood to be "well acquainted." The diffusion and production of knowledge among the care professionals were both enabled and constrained by the personal chemistry between practitioners.

A way to understand the diffusion of practice-based knowledge among the care professionals is to see them as the tip of iceberg, where the part one can see above the water is the explicit knowledge, while the submerged part represents tacit knowledge. One care professional characterized tacit knowledge this way, illustrating its situational and temporal character:

It is just within us, and in them [residents] too. We know in such a way that we know what to do, what they want and don't want. In that exact moment.

Still, for this knowledge to materialize in solutions to problems, it had to be shared among the members of the CoP. The care professional Marta Anna explained how she had succeeded in getting a patient to eat more:

"[Resident] is very skinny, so we try to get her to eat more, but it is difficult. But one day I got a hunch, so when she turned down breakfast, I just waited for a while, and later put two pieces of bread in front of her, and she ate it all up."

This illustrates how the explicit knowledge, the new way to give the resident breakfast, is dependent on Marta Anna's experience-based, tacit knowledge. Whatever it was that gave Marta Anna a hunch that day is not transmitted, but the new practice that she discovered when acting on that hunch is eligible for diffusion within the CoP.

In the CoP, employee knowledge was mobilized to solve problems articulated by care professionals themselves. The innovations we came across had to do with improving the quality of care in one way or another, whether it was getting a resident to eat enough or deciding when to wake a resident in the morning. The problems and their potential solution were thus beholden to a *logic of care* (Mol, 2008). Another outcome of these processes was the reproduction of the CoP and the role of the care professionals as responsible for the quality of care. As Linn stated earlier, an employee that is a member of the CoP is one that is committed to improving or maintaining the quality of care. Thus, when an employee accepts the interpellation as an invested member of the CoP, they take on a particular set of responsibilities, and at the same time they qualify for a particular repertoire of actions (Therborn, 1999). What these examples illustrate is that innovation and the continuous improvement of the quality of care is not something that has to be introduced to the CoP from the outside but is an integral part of its identity. The first type of knowledge mobilization orbits around solving problems related to the quality of care. The threshold for reflection with colleagues that are ‘well acquainted’ is low, and such reflection was an integral part of everyday work. This type of knowledge mobilization was not written down, and typically dependent on face-to-face interaction. This meant that the new practices invented not necessarily spread throughout the nursing home, but instead were limited to the CoP.

#### *Mobilization by Codification*

Codification of knowledge took place at all the nursing homes we stayed at. An important driver of this development was the quest to ensure ‘quality’ across different nursing homes. This entails systems for documentation and mapping of practices. In addition, the nursing homes in the City participated in a project called “Good Life,” which obliged them to document activities for raising the quality of life for residents. The individual plan (IP) was where all information relevant to the resident was recorded, such as daily routines and how to perform them. A consequence of the nursing homes participation in Good Life was that efforts to improve life quality also had to be documented in the IP. The distribution of medicine and written reports also involved writing, and together this was experienced by healthcare professionals as a push toward more codification. This, in turn, led to resistance and skepticism:

Field diary:

I overhear Une tell Mary that they have to sharpen up when it comes to the Good Life effort, as they were the worst resident group at documenting what they had done. That is damned nonsense! Mary exclaims.

A common view among employees was that Good Life did not change how they worked with ensuring quality of life of residents, but only meant more time documenting this work.

The silent report was another aspect of codification. Earlier, overlaps between shifts were done verbally. The idea behind silent report was that employees instead wrote down the necessary information for the next shift, so they could read on iPads whether there was anything special going on, or if there had been any changes in the routines for how to perform specific care-related tasks. Earlier this had been done verbally. Some employees disregarded the practice of silent reporting and still did a verbal report, arguing that this was a necessary space for dialogue and reflection. Some managers were concerned that silent reporting undermined the development of tacit knowledge:

Rosa the middle manager:

Everyone sits on their own and the culture of sharing knowledge is diminished. Maybe the theory behind it is good, but I still wonder who came up with it, because in the practice it is important that we have these spaces in time where we can talk through things.

This illustrates the tension between the explicit and implicit work processes (Ellstrøm, 2010), and how increasing codification might undermine professional reflection within the CoP. A similar tension existed between the informal, non-canonical practices, and the way they were formally described in the individual plan. Often, the non-canonical practice would develop based on discoveries made in the CoP, without the individual plan being updated.

Anne: You know, when I see she succeeds at getting [resident] to shower, I ask how she does it, and I try it as well. It probably should have been in the individual plan but...

Trine: You never know if it works the next time around. It might work for a month, but then something changes, and it doesn't work anymore.

This illustrates how codification does not happen by itself but is another task that competes for employee's time and focus. The value in terms of efficiency and work performance of codification is thus not given. The employee's solution was to only write down practices that remained useful for a long time or were especially important to have in written form and available to all.

As we have shown, there were considerable barriers to the codification of employee knowledge. Still, when new ways of doing things could be made into a canonical practice by way of codification, it made the new routine available to all employees, and enabled easier access to information for new employees or temps. The problems that codified innovations were solutions to, were articulated under the logic of care and had a goal of improving the quality of care. While the innovation taking place in the CoP was dependent on informal reflection, the collective reflection necessary for codification for the most part took place in scheduled meetings.

### ***Mobilization of Employee Knowledge for Task Reallocation***

During our fieldwork, a project called Task-2<sup>5</sup> was implemented in select nursing homes in the City. Task-2 was a management-initiated effort to reallocate tasks between nurses, healthcare workers and assistants. The project was motivated by the high cost of hiring labor from temp agencies:

Manager: It is the worst of solutions really, very expensive, and short-sighted as well, but we have no choice. We cannot close.

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<sup>5</sup> Name of project anonymized.

The expenditure on temporary nurses had led management to wonder whether they used competence in an optimal way. By using a questionnaire to map how employees spent their time during a typical workday, they discovered that the skilled workers (nurses and healthcare workers) performed a lot of tasks that did not require their level of skill.

Manager: Before nurses could be involved in decorating for Christmas and cleaning windows. That can be nice to do with residents of course, but perhaps their skills are more useful elsewhere, and assistants do the Christmas decorations?

From this realization, management held a three-day workshop involving representatives of the three groups of employers to map all tasks performed at the nursing home in a typical day. The second step was to come to an agreement with employees about the ideal distribution of these tasks among the different groups of employees. Nurses were taken out of the general rotation and instead worked “on top,” meaning that they were not linked to a particular resident group but were available whenever any of the groups needed a nurse. Hence, with Task-2, a sharper line was drawn between tasks requiring nursing competence, healthcare worker competence and tasks that did not demand formal qualifications.

The outcome of the mobilization of employee knowledge in the CoP or through codification was a continuous flow of incremental process innovations, motivated by increasing the quality of care in various ways. Task-2 was a focused intervention aimed at task reallocation to ensure a more efficient use of skills and competences. In the continuous stream of incremental innovations in the CoP, the primary goal was to increase the quality of care, and what was better was judged by the practitioners themselves. In the codification of new canonical practices (Brown & Duguid, 1991), it was still the practitioners who decided, albeit in more formal settings. The goals still orbited around the quality of care, even though it was informed by the national discourse of quality in elderly care. With Task-2, however, the primary goal was not derived from a logic of care, but from a logic of household management. The problem that Task-2 was set to solve was to find better ways to manage the scarce resource of competence.

In the mobilization of employee knowledge for the goal of household management, nurses, healthcare workers and assistants were all addressed as relevant knowers. Their experience-based knowledge was mobilized, not for improving the quality of care, but for finding better ways to manage scarce resources. The practitioners, when participating in Task-2, were interpellated under a logic of household management. That is not to say that the new allocation of tasks was not important but that mobilizing employee knowledge for problems beholden to the logic of household management has the potential to reconfigure the understandings of the roles of nurses, healthcare workers and assistants as well – not only as being responsible for the quality of care and qualified (Therborn, 1999) to speak on problems beholden to a logic of care, but also responsible and qualified to speak on problems beholden to the logic of household management.

In the professionalized nursing home context, the knowledge of nurses and other formal forms of knowledge are often privileged (Dahl, 2017). The involvement of all three groups of employees in contributing knowledge to effectivization efforts has the potential to alter this by increasing the status of the practical knowledge of the professional groups with a lower level of formal education. That nurses now worked “on top” was seen in a positive light by healthcare workers as well, as illustrated in this quote from an informal conversation:

Before, when you worked together with a nurse, they would get called to other wards, leaving you alone. But now we are two people most of the time. [...] And if the nurse on top is free, they can also help out when needed.

Task reallocation resulting from Task-2 was seen as an improvement from a variety of perspectives. The nurses got to spend more time on relevant tasks, healthcare workers had more predictable working conditions and the nursing home had also reduced the need to hire temps.

## **Discussion**

We have shown how employee knowledge was mobilized in different ways and for different purposes at the nursing homes in the City. Some problems were articulated and solved within the CoP, while some solutions were codified into new canonical practices



(Brown & Duguid, 1991). The problems solved from these ways of mobilizing knowledge were beholden to a logic of care (Mol, 2008), with a goal of increasing or maintaining the quality of care. The tendency toward increasing codification existed in tension with the informal form of innovation, and practices such as the ‘silent report’ were seen as undermining informal deliberation and reflection. Still, the codification enabled the wider diffusion of knowledge and formal areas for discussion of practices. Task-2 on the other hand, articulated a problem on a municipal level, namely the lack of qualified labor and costs of hiring temps following from this. To come up with a better way of allocating tasks, the knowledge of all three groups of employees was mobilized. An important aspect of Task-2 was the involvement of nurses, assistants and healthcare workers in problem solving under the logic of household management. This represented a change from the other ways employee knowledge was mobilized, with potential for changing the roles and responsibilities of nursing home employees: from an employee with responsibility for improving the quality of care to an employee with responsibility for both quality of care and household management.

Subjection under an ideology (Therborn, 1999), or under a logic of care or household management in our case, subjects the individual to a certain repertoire of actions and expectations, to particular roles. At the nursing homes in the City, individuals in the role of healthcare workers and nurses were expected to contribute to the improvement of the quality of care. At the same time, these roles also qualified them to make decisions on what constituted improvements in said quality. The more employee knowledge is mobilized for solving problems of household management (like in Task-2), the more questions of household management will come to be understood as not only what employees are expected to contribute to improving, but also what they are qualified to speak about. Hence, an important outcome of Task-2 is the potential changing of the role of nurse, assistant, or healthcare worker, from one of being only seen as qualified to speak on matters under a logic of care, to qualified to speak on matters of household management. It is our view that this would be a step forward in recognizing the knowledge of care professionals and increasing the status of care work.

The purpose of this article has been to highlight the ways employee knowledge was mobilized in nursing homes, and the consequences of this for the way employees understand their roles. A limitation of our investigation is the lack of longitudinal data,

with which we could have investigated how role perceptions of employees changed or not as a result of Task-2 knowledge mobilization. A potential avenue for further research would be to investigate knowledge mobilization in nursing homes in other contexts using the contrast between the logic of care and the logic of household management, to map the extent to which employee knowledge is mobilized for problems of household management in care work.

### **Conclusion**

This paper asks the question of how employee knowledge is mobilized as a resource for innovation in elderly care. We have shown how the CoP continuously develops solutions to problems articulated over the course of everyday work. These solutions either circulate within the CoP or are codified into new canonical practices. Still, these problems are beholden to a logic of care (Mol, 2008), and the main outcome is increasing or maintaining the quality of care. With Task-2, employees were recognized as knowledgeable under the logic of household management, interpellating them as qualified to speak on issues traditionally left to management. A possible advantage of such a decentralization of managerial authority is the solving of problems of household management over the course of everyday work. Such a widening of the responsibility and authority of employees, both skilled and unskilled, could be an important steppingstone on the way to increasing the status of care work, and thus to meeting the twin challenge.

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### About the authors:

**Stian Bragtvedt** is a senior researcher at Nordland Research Institute, Norway. His research interests are public sector innovation, welfare services, knowledge sharing and the labor process.

**Ragnhild Holmen Waldahl** is senior researcher at Nordland Research Institute, Norway. Her research interests are welfare service innovation, organization of welfare services and services for the elderly.