



Tacit practice in care homes

Anne Marie Sandvoll

Western Norway University of Applied Sciences, Førde, Norway
Email: annemsa@hvl.no

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Abstract

Background: Care home practice has been described as complex, even though it might comprise common everyday activities. Research has indicated that nursing staff consider assisting care home residents to be demanding work, much of which remains tacit or is taken for granted. The tacit knowledge that lies behind nurses' work is an important issue to explore and describe.

Aims: To describe tacit care practices and understand the complexity of nursing practice in care homes.

Methods: An ethnographic study was used to gain an in-depth understanding of nursing practice in care homes in a Nordic context.

Findings: Nursing staff appeared to be committed to daily work routines but also reported having to deal with a number of unexpected events each day, some of which were particularly challenging. Dealing with some residents' behaviours could evoke difficult emotions among staff, such as irritation and aversion – emotions that could be difficult to admit to. Despite this, staff seemed to believe they had to manage their responses and offer good care to all residents. Synthesising these findings led to the theme of 'tacit care home practice'. Examples of such tacit practice are described in this article.

Discussion: Staff develop a common habitus of caring, including dealing with unexpected events and behaviours that are sometimes regarded as unpleasant. This habitus is often taken for granted and therefore needs to be explicated and discussed.

Conclusions and implications for practice:

- The statement 'we just do it' suitably describes nursing staff's habitus of caring, which includes dealing with unexpected events and unpleasant behaviours
- Describing these tacit aspects of care can extend our understanding of some previously unarticulated aspects of care home practice
- These findings suggest a need for greater awareness, better communication and reflection in relation to these tacit elements of practice. This could contribute to improved nursing practice in care homes

Keywords: Care home, nursing practice, older people, aversion, ethnography, tacit, habitus

Introduction

This article examines tacit nursing practice in care homes. Tacit knowledge is an important aspect of nursing practice (Benner, 1984; Gourlay, 2006) and most of the literature on the subject in clinical practice is based on Polanyi's (Polanyi, 1966, 1969) and Benner's (1984) conceptualisations of embodied knowledge acquired through experience in practice (Kontos and Naglie, 2009). According to Polanyi (1966), we always know more than we can express and knowledge is tacit when it cannot be articulated. However, the body might know what to do without planning or being aware of it (Benner, 1984). Carlsson et al. (2002) argue that caring does not develop through thinking theoretically but through bodily knowing, and that it becomes an extension of the person who is learning. Tacit knowledge has been described as practical skills, intuition, knowhow and implicit knowledge acquired through practice and experience (Ambrosini and Bowman, 2001).

Care home practice is based on important knowledge that is not always visible to others, or even to the practitioners themselves (Hamran, 1991; Schirm et al., 2000; Olsvold, 2010; Hall and Høy, 2011). It is often described as complex (Rytterström et al., 2009; Heath, 2010), even though it might be regarded as consisting of common everyday activities (Gubrium, 1997). The complexity of care home practice is closely related to the challenges of helping frail and sick older adults with their daily physical, psychosocial and spiritual needs. Previous research indicates that nursing staff consider assisting care home residents to be difficult and demanding work (Diamond, 1995; Foner, 1995; Gubrium, 1997; Owensby, 1997). On the other hand, it represents a practice and skillset often taken for granted (Schirm et al., 2000; Rhynas, 2005). It has also been suggested that staff behaviour is incorporated into tacit routines; they perform tasks that are taken for granted by most people, including themselves (Sandvoll et al., 2012). However, it is important to describe the place of these taken-for-granted tasks in care home practice (Herbig et al., 2001).

These tasks include dealing with others' bodies, bodily functions and excretions – for example, a resident who spits or makes a mess with food. Residents might display annoying behaviours, such as grinding their teeth. Emotions such as disgust, contempt and aversion related to the physical care home work often remain invisible because it is considered taboo to express them. However, these emotions play an important ethical role and shape the social relations between residents and staff (Van Dongen, 2001). For example, Van Dongen questions whether it is always correct for emotions to be concealed from residents and suggests that this issue should be discussed, since care home staff deal with these kinds of behaviours and emotions daily.

However, the way staff deal with unexpected or unpleasant behaviours has so far been a rarely described aspect of care home practice (Widding Isaksen, 1994; Sandvoll et al., 2013, 2015). According to Carlsson et al. (2002) it is a relatively unexplored phenomenon, while Gourlay's (2006) review of empirical studies points to a need for a great deal more research – for example, studies of the function or descriptions of tacit knowledge, in line with the aim of this study. The literature review for this study showed there are several areas of care home practice that remain tacit or taken for granted, suggesting a need for studies to describe these areas; describing them makes them visible to others, who can learn from them. An exploration of care home practice may offer findings that can help guide staff towards a better awareness of their tacit knowledge. Herbig et al. (2001) suggest that incident-based acquisition of tacit knowledge is accompanied by a lack of reflection, so bringing tacit knowledge to the surface could address this and contribute to developing and improving practice (Herbig et al., 2001; Lillemoen and Pedersen, 2015).

Aim

The aim of this study is to describe tacit care practices in order to gain a greater understanding of the complexity of nursing practice in care homes.

Theoretical perspectives

The complexity of care home practice can be appreciated as the ability to complete routine-based work while also dealing with unexpected (including messy) events and/or giving attention to residents' personal needs. Nursing staff accomplish this complex set of requirements using a skillset that either goes unnoticed or is taken for granted. In this study, the theoretical concepts 'habitus' (Bourdieu, 1990) and 'dirt as a matter out of place' (Douglas, 2005) are used for reflection on examples of nursing practice.

Bourdieu (1990) uses the concept of habitus to describe the practical logic of cultural and social practices and the regulation of behaviour. He suggests practice is not guided by sense, theories or regulatory systems but is creative, unpredictable and improvisational (Bourdieu, 1990; Petersen, 1996). Habitus is a collective pattern of thinking or acting, which is often taken for granted within a group (Rhynas, 2005). Bourdieu says members of a group act according to a practical sense, and when asked to describe the rules by which they act are unable to do so. For him, habitus regulates actions without being a product of rules; it makes a group of people act as though 'collectively orchestrated without the action of a conductor' (1990, p 53). Meanwhile, Wilken (2008) depicts habitus as being like a matrix guiding nursing staff through their performance in different situations. Bourdieu's theory of the logic of practice explicates a source of tacit practice that can give practitioners sympathetic and embodied connections with their care recipients (Bourdieu, 1990; Kontos and Naglie, 2009).

Care home staff must sometimes deal with tasks in a way that deviates from normal hygienic practice. In her book *Purity and Danger: An Analysis of Concepts of Pollution and Taboo*, Douglas (2002) gives a possible explanation of why we experience hygiene deviations as 'wrong'. Her definition of 'dirt as a matter out of place' implies two conditions: a set of ordered relations and a contravention of that order. Within this context, dirt is never an isolated event and is always present in a system. As such, she suggests, dirt has been systematically classified as involving rejection of inappropriate elements. Inappropriate things that do not fit in are either ignored or distorted, so as not to disturb the established order. Simply viewing such things that we normally reject might make some individuals feel nauseous, or provoke reactions such as laughter, aversion and shock. Experiences vary, but people try to avoid these stimuli or create rituals around them: if the unclean events or items are not supposed to be there, then we must sort them out; the unclean needs to be held at a distance if order is to be maintained (Douglas, 2002). This is the common way of dealing with dirt in nursing: to isolate the dirty from the clean.

Method

The empirical material for this qualitative study was selected from an ethnographic study (Hammersley and Atkinson, 2007) conducted in two care homes. Some of this study's findings have been presented in three earlier papers (Sandvoll et al., 2012, 2013, 2015) For the current article, the findings of all of the studies have been synthesised to present overall findings.

It is important to explore and describe participants' views of their everyday practice (Hammersley and Atkinson, 2007). In ethnographic studies, the researcher can spend time with the participants, therefore, an ethnographic design was considered an appropriate approach to explore and explicate an area of nursing practice that is accepted tacitly but is difficult to discuss.

The study context was two long-term units in Nordic care homes. Each resident had a private single room with a bathroom, where they generally lived on a permanent basis. In both care homes, a typical morning shift included groups of seven or eight residents, usually from adjacent rooms, being cared for by two nursing aides with a supervising nurse administering medication and helping where needed. Fewer staff worked during the evening and night shifts. All residents of both care homes were frail and living with a variety of conditions. In addition, some suffered from cognitive impairment. Due to their poor health, residents needed assistance with their morning care, during meals and with activities. Most needed wheelchairs for mobility.

To recruit participants, the author held an initial meeting at each care home to inform staff and management about the study. Potential participants were then seen individually and asked to join the study. A total of 45 nursing aides/nurses agreed to participate (24 aides and six nurses from care home 1, and 13 aides and two nurses from care home 2). This sample represented about 70% of the homes' combined nursing staff of 65. The participants were all female, aged between 25 and 60 years.

The regional medical ethics committee (REK West, University of Bergen) and the Norwegian Social Science Data Services approved the study, and it was also endorsed by both care homes. Voluntary, informal written consent was obtained from all participants. The research process emphasised the principles of anonymity, protection from harm and proper data storage.

Data were collected by participant observation, interviews and document analysis over a six-month period in 2008-09 (Sandvoll, 2013). Document analysis of new quality regulations, care plans, White Papers and government proposals was carried out. The quality regulations were part of a quality improvement reform in Norway (Ministry of Health and Care, 1997; Sandvoll et al., 2012). Document analysis was also conducted for background information, or to confirm observation and interview data (Hammersley and Atkinson, 2007). Analysis of the new regulations also inspired the study, to examine how regulations might influence practice (Ministry of Health and Care, 1997, 2003; Sandvoll, 2013).

Participant observation was carried out in residents' private rooms, the kitchen, the living room and the staff room. The researcher spent about four hours in the field each day observing and communicating with participating staff (a total of 160 hours). Field notes were taken during observations and transcribed immediately after each day (Hammersley and Atkinson, 2007).

Interviews were conducted at the end of each observation period with three nursing aides and two nurses in each unit (10 in total) who had become key participants during the observations. The interviews were initially based on an interview guide (Hammersley and Atkinson, 2007), and included themes such as what routines govern the day, staff's familiarity with new regulations and how they knew how to help individual residents. Initial themes, from the preliminary data analysis of the first interviews and field notes, were presented to the participants to explore and validate their importance (Hammersley and Atkinson, 2007). Examples of themes that were investigated further were: work appearing to flow automatically, unexpected events and how staff dealt with annoyances or soiling.

In ethnographic studies, analysis is a continuous process rather than a separate step (Wadel, 1991; Hammersley and Atkinson, 2007). It starts with the literature review and does not finish until the project is complete. Analysis is iterative and circular between theory, hypothesis and data (Wadel, 1991). However, to perform a systematic analysis, the material was analysed in three steps, according to Hammersley and Atkinson (2007).

The first step in the analysis was to read the data carefully to become thoroughly familiar with them. Repeated, detailed reading was necessary to look for useful analytical concepts. These concepts were developed spontaneously based on statements from the participants in their interviews or the field notes; for example, the participants made statements such as 'we just do it' or 'the routines rule the day'. Other concepts were developed by the researcher based on the participants' statements (Hammersley and Atkinson, 2007); for example, 'we just know'.

The second step, a detailed examination of the identified concepts, was undertaken to clarify and deepen understanding of each concept. The process of coding the data was recurrent: as new concepts emerged, the previously coded data were re-read to check for examples of the new concepts (Hammersley and Atkinson, 2007).

The third step involved an interpretation of the relationship between the concepts (Hammersley and Atkinson, 2007). For example, how could it be that staff always knew what to do, even though they had not read any instructions? In this analytical step, different theoretical perspectives, commonsense expectations and stereotypes played important roles (Hammersley and Atkinson, 2007). Relationships between the concepts were identified and three categories were developed:

- 'We just do it'
- Double embarrassment
- Difficult emotions

Striving to be reflexive within a context of having read different theories meant the data began to make sense and a new understanding of nursing practice in the care homes developed.

Furthermore, for this article, the data have been further developed and synthesised to describe overall study findings. How could all findings be interpreted cohesively? As stated previously, the overall study aim was to discover and describe the characteristics of care home practice. During the fieldwork, analysis and writing process, the tacit aspects of care home practice emerged from the dataset. Several of these findings seemed to be important or challenging for staff, so it became important to investigate them further. These data seemed helpful in terms of contributing to and extending our understanding of some previously unarticulated aspects of care home practice. During the synthesis of all findings, a new aim emerged: describing tacit care practices in order to understand the complexity of nursing practice in care homes. The overall theme of 'tacit practice in care homes' emerged during secondary analysis, and the focus of this article is to describe examples of these tacit practices.

Findings

The thematic categories and concepts that emerged from this ethnographic study are presented in Table 1.

Table 1: Main theme – tacit practice in nursing homes	
Category	Concepts
'We just do it'	<ul style="list-style-type: none"> • Commitment to routines • 'We just know'
Double embarrassment	<ul style="list-style-type: none"> • The wrong place • The missing screen
Difficult emotions	<ul style="list-style-type: none"> • Aversion • Consciousness • Commitment

'We just do it'

During fieldwork, the nursing staff often answered, 'we just do it' when asked to describe their actions or why they did something. This response shows how the staff work almost automatically and how aspects of their practice are tacit. The study reveals that staff did not know about the new regulations concerning the fundamentals of care or the associated documentation. The regulations were issued in 1997 and require that all residents receive individual care related to basic needs, have meaningful activities and have the right to participate in decisions concerning their own daily life situation (Ministry of Health and Care, 1997). The regulations were revised in 2003 and the right to participate was strengthened (Ministry of Health and Care, 2003). Even if staff did not follow the regulations, the work seemed to flow automatically throughout the day. Everyone seemed to know the residents well and knew how to help them. Staff said they were not acting based on the new regulations, but were committed to routines. However, findings show that in addition to knowing the residents well, the care staff delivered corresponded to the fundamentals of quality care. Thus, in a way, they follow the new regulations without being aware of doing so. Staff have a strong commitment to a set of routines,

some of which are well known in care homes and obvious to most people. However, some of the daily tasks performed by staff might be regarded as tacit routines – they know each resident well and deliver individual care to them. Even though this was not documented or written anywhere, different nurses delivered the same care to different residents.

For example, one resident had suffered a stroke and was paralysed on one side of his body. He was unable to speak to the staff, but used body language to express what he wanted. For instance, he usually placed his wheelchair by the door to the dining room after meals to convey that he wished to leave the dining room and go to his own room. The staff noticed this and asked if he wanted to go to his room. At night, or during an after-dinner rest, staff helped him to get into bed. In this process, staff performed several important, individualised care tasks, including helping him remove his trousers before getting into bed. Further, they placed a towel on his bed stand, on which they then placed urine bottles because they knew this resident wanted to be independent and did not like one urine bottle to get too full. Thus, staff met the resident's needs for privacy and independence and although the details of these tasks were not written anywhere, all staff knew this important information. However, this is also a good example of something that should be written into a care plan to ensure consistent care for the resident, especially because he was unable to communicate his needs verbally.

Another resident preferred to use her own bed linen at the care home, so staff used her private linen when they changed her bed and her daughter took it home to launder. Although it was not written anywhere, everyone knew this practice and that it was very important to the resident.

Over time, staff get to know the residents well and understand their preferences. Many of the residents like to have routines. For example, some prefer to wake before breakfast, while others want to sleep longer and maybe eat breakfast in bed. These are examples of individual choices that become a set of tacit routines for staff in care homes through familiarity with the residents. This is not visible to others, and is therefore often taken for granted.

The nursing staff act in common because they share the same habitus of care home practice. New regulations are rarely acknowledged among staff and have little influence on their work. This is in line with the concept of habitus, where participants might say 'we just do it'. This is an example of aspects of their practice that are tacit or unconscious and therefore difficult to explain. In one sense, 'tacit practice' might sound like something easily done in everyday care but the fact is that the term represents a significant body of staff experience and knowledge. The staff in this study were highly experienced and knew the residents well. Through working in the care home for so many years, they had developed tacit knowledge, giving them a unique competence for meeting the needs of frail older adults on an individual basis.

Double embarrassment

Several unexpected events occurred during fieldwork and staff are simply expected to deal with these situations as they arise. This study's findings show that they normally did precisely that. This means staff's responses to such events are a rarely described aspect of tacit practice. However, one situation surprised the researcher. The term 'double embarrassment' can be used to describe how staff reacted to an unexpected event late one morning. The situation occurred on a Friday when the staff had nearly completed their morning care routines and were busy checking the residents' rooms and looking ahead to lunch. A resident was seated in the kitchen for a late breakfast, having had a shower earlier. It was a large kitchen, with floor-to-ceiling windows and faced a glass corridor. The nursing staff were busily moving to and from the kitchen, and dealing with other residents in their rooms. The resident sitting at the table lowered his trousers and tried to remove his incontinence pad. A nursing aide rushed over to ask what he was doing. The resident became irritated and waved at the nursing aide to keep her away. Then he stood up, urinated on the floor and continued to undress until he was naked. More staff came into the kitchen, but did not immediately determine how to handle the situation, which had become chaotic, with several staff members making suggestions. One found clean clothes, another

tried to follow the resident to his room, and a third cleaned up the urine on the floor. The resident did not seem to understand the staff members' suggestions and the staff did not seem to understand the resident's needs.

This type of event does not happen frequently enough to be integrated into the habitus of how to react. The situation occurred in the wrong place: it is common to urinate in a toilet behind closed doors and not on the kitchen floor, so the resident's behaviour could be regarded as dirty and uncivilised. It took time for the nursing staff to improvise and resolve the situation as being suddenly confronted with nudity in an open area was probably so alarming that they were unable to use their normal coping skills. To shield or cover residents from being exposed is important in nursing, so naked bodies are usually cared for behind screens – such a screen was missing from this situation. Because this situation occurred in the wrong area and with no screen behind which to hide the naked resident, the staff experienced a double embarrassment. Descriptions of such unexpected events can contribute to a greater understanding of the complexity of care home practice.

Difficult emotions

In addition, the findings from this study show that some of the tasks described as dirty may induce difficult emotions in staff. In this study, difficult emotions included aversion, commitment and consciousness. Staff may be challenged when residents exhibit behaviour that deviates from normal practice, although their daily work includes tasks that most people would consider dirty.

Spitting was reported as the most challenging issue for staff. Residents who might have had a habit of spitting before coming to the care home continued to spit in inappropriate places despite attempts by staff to guide them to spit in a proper receptacle. They might spit on the floor, on their clothes or in their meal. Although staff experienced this as unpleasant behaviour, they dealt with it professionally, for example, by getting a towel to clean the mess or changing the resident's clothes if necessary. Staff also received complaints from the other residents, who were upset if they saw someone spit. In some situations, staff felt their only option was to isolate those with troublesome habits from the others, which was a difficult decision. When they needed to take this action, it seemed to prey on their conscience because they knew the resident's need for activities and social relationships. This type of decision seemed to become a considerable burden for staff over time.

Daily work in the care home also involved annoying behaviours from residents who were agitated, repeated specific words or phrases, actively resisted, yelled or constantly complained. Teeth-grinding is another behaviour that, in close-care situations over time, is clearly something that might irritate nursing staff who listen to it daily.

After several weeks spent observing the morning care for a resident with a habit of repeated teeth-grinding, the researcher wondered how this affected staff. The researcher asked the nursing aide about her experience of providing care for this resident. Initially she answered that everything was fine, but later the same day she came back to talk to the researcher and admitted that it was hard for her, as she obviously got tired of the habit. She said staff sometimes changed residents to get a break from this type of behaviour. This was further discussed during interviews with other nursing staff, who admitted that the resident's teeth-grinding habit was annoying or irritating and was the reason the resident often sat alone. Through such observations, we discovered other signs that it was difficult for staff to admit how behaviours like this affected them. For example, they lowered their voices when explaining their reaction to them. It also took a considerable time before participants in this study felt confident enough to discuss these difficult issues with the researcher.

These findings show that residents with behaviours that deviate from our norms can evoke difficult emotions in staff, such as aversion, and that this can be difficult for staff to admit to. At the same time, they feel a strong commitment to provide good care for all residents, and for them this involves

dealing with aversion to behaviours that most people do not want to see, hear or experience. These are aspects of care that are normally tacit and therefore largely unseen.

Tacit practice in care homes

The findings from this study illustrate that official regulations have little influence when nursing practices are strongly embedded. The work flows automatically across the day and the staff know the residents well. The residents receive individual care and have individual routines, which the nursing staff are familiar with. However, many of these routines are based on tacit knowledge among staff because they are unwritten and do not appear in any care plan. The staff just know how the different residents want their routines arranged and 'just do it'. Without even being aware of the new regulations about individual care, the participants in this study were meeting the demands of each of their residents.

Further, the unexpected event where the resident removed his clothes in the dining area shed light on the complexity of care home practice. Events like this do not happen daily, and even the experienced staff seemed not to know how to respond. It was a challenging situation for them and for the resident. Nudity in an open area made the situation more challenging for staff. Situations related to nudity, especially male genitalia, are difficult for the mostly female staff to discuss, and are most often dealt with tacitly and behind a screen.

Residents' behaviours sometimes evoke difficult emotions. Despite experiencing aversion or irritation related to dirty work, participants in this study tried their best to put their feeling aside and deal with this work. Care home staff experience a strong commitment to the residents so such aspects of care are taken for granted within the group of care home staff. Their commitment to caring requires that they simply deal with such situations as they arise.

The findings from this study suggest that the nursing staff have developed a habitus of caring, which includes a focus on daily routines, as well as on taking care of unexpected events and tasks regarded as dirty. These findings extend our understanding of some previously unarticulated aspects of care home practice. Staff actions seem to flow automatically throughout the day, and staff perform work but are not always able to describe why. Nursing practice in care homes includes elements of knowledge that are not visible to others, or even to practitioners themselves. By synthesising these findings, this study developed the term 'tacit care home practice' as a main theme.

Discussion

The aim of this study was to describe tacit aspects of care in order to gain a better understanding of the complexity of nursing practice in care homes. The descriptions can contribute to an understanding why staff act as they do in different situations. The nursing staff members' own statement 'we just do it' sums up how these tacit aspects, consisting of both knowledge and experience, are accomplished. Nursing staff provide care automatically and simultaneously deal with dirty and unpleasant tasks because they are committed to their residents. These findings are examples of tacit knowledge or how staff come to understand, intuit and know more than they can express (Polanyi, 1966, 1969; Benner, 1984; Ambrosini and Bowman, 2001).

Similar findings have emerged from other studies. Schirm et al. (2000) show how nursing staff learn how to do their work and that they develop a competence that is taken for granted. Other studies have demonstrated that nursing practice is based on common values whereby everyone cares for and has an overview of the patients; these values are also taken for granted (Hamran, 1991; Olsvold, 2010). How is it that the staff in this study came to know what to do in their daily work? To understand this issue, Bourdieu's (1990) concept of habitus may be helpful. He suggests that it is not sense, theories or regulatory systems that guide practitioners, but the practical sense itself, which is creative, unpredictable and improvising. Habitus regulates actions without being a product of rules: it makes a group of people act as though they are 'collectively orchestrated, but without the action of a conductor'

(Bourdieu, 1990 p53). In the two care homes in this study, staff had developed a habitus of caring. This can be related to their education and training and also to the experience developed after working in the care home for several years. The tacit practice described by the staff's strong commitment to the residents can also be related to Bourdieu's theory of the logic of practice, as previously argued by Kontos and Naglie (2009).

This study's findings also show that dealing with dirt has become a part of staff's tacit care home practice. When dealing with behaviours that deviate from normal practice, a common solution is to isolate residents who display these behaviours, for example, during meals (Sidenvall, 1999; Sandvoll et al., 2015). Work in care homes has been categorised as 'dirty work' and care home staff deal daily with work that most people would consider dirty (Twigg, 2000; Jervis, 2001; Stacey, 2005; Lawler, 2006). The feeling of 'dirt' in the situation of a resident urinating on the kitchen floor can be related to Douglas (2002), who defined 'pollution behaviour' as a reaction that condemns any object or idea that is likely to confuse or contradict our classifications. Being confronted with nudity in an open area was probably so alarming that the nursing staff were unable to use their normal coping skills (Sandvoll et al., 2013). We seldom expose ourselves fully; we have doors on our toilets and are embarrassed even to ask for toilet paper, according to Lawler (2006). In nursing, situations related to nudity, and especially the male genitalia, are normally dealt with tacitly and behind a screen (Lawler, 2006). In the situation in this study, the naked male body was at risk of being seen by others because it happened in an open area where guests and others often appear – the screen was missing. This might explain why, once the staff had got over the initial shock, their priority was to get him dressed as quickly as possible and cover his naked body and genitalia. Both staff and residents are vulnerable to deeply rooted cultural norms in such situations; because these are related to embarrassment they are difficult for staff to discuss, even though they have become a part of their practice. However, even though such situations often remain tacit, they can be described and understood through an analysis of ethnographic material.

Although the staff participating in this study experienced aversion or irritation related to dirty or unpleasant work, they tried their best to deal with it, regardless of their feelings. This is in line with Van Dongen (2001) and Lawler (2006), who show that staff feelings about dealing with excrement and sputum, for example, can be summarised by saying it just 'has to be done'. This is probably connected with morality, and with the understanding that all humans are of equal value and the importance of treating all residents equally (Van Dongen, 2001; Wadensten, 2007).

The emotions of staff in such situations were concealed from the residents (Van Dongen, 2001; Lawler, 2006). Similar findings have been reported by Breievne (2014), who found that the most common action strategies when having to cope with bad odours were detachment, silence and a focus on practical nurse procedures. The basic coping strategy was maintaining a blank face to give the patient dignity while removing the cause of the odours as quickly and effectively as possible. These descriptions can help us understand the complexity of care home practice given that, as argued by Herbig et al. (2001), incident-based acquisition of knowledge leads to tacit actions in care situations, without the reflection that could help explain this complexity.

In this study, the staff worked to prevent residents from becoming soiled during meals. They used napkins to protect residents' clothes and made shields for those who made a mess with their food. Food, according to Douglas (2005), becomes dirty when it appears on clothes. This is in line with Sidenvall (1999), who states that staff choose to shield residents who make a mess with their food, and try to maintain control over their own feelings of squeamishness. This might be a way of repressing one's own feelings and keeping a distance from behaviours that provoke aversion (Haidt et al., 1997; Sidenvall, 1999; Simpson et al., 2006). This study's findings also show that keeping residents' clothing clean is important to staff; doing so shows the residents and their families that they are looked after (Rehnsfeldt et al., 2014).

What function or contribution can this study offer? There might be aspects of the nursing staff experience that, if made conscious, could be shared; however, staff always know more than they articulate, as described by Clinton (1998). This is what characterises the challenges posed by tacit knowledge (Polanyi, 1966; Benner, 1984). The restraint of staff confirmed that these aspects were difficult to talk about, which is consistent with previous research (Widding Isaksen, 1994; Lawler, 2006). Van Dongen (2001) also reveals that deeper probing regarding the subject of body work brought staff members' emotions to the surface. There has not been a tradition of discussing these tasks because the words needed to describe the behaviours can themselves be considered disgusting or even vulgar (Isaksen, 2002; Lawler, 2006). This indicates that it is important to reflect on and discuss these tacit issues (Herbig et al., 2001). There is need for better communication and articulation about them, for example, by helping students during their training and supporting practitioners during their daily work. Students could practise such communication during their education and practising nurses might benefit from reflection groups in which to discuss these issues. Previous research shows such groups in care homes have been helpful, contributing to improved clinical practice, as well as to better collegial support and cooperation, and personal and professional development among staff (Lillemoen and Pedersen, 2015). This is in line with Herbig (2001), who developed a method for explication of tacit knowledge and performed a laboratory study, in which nurses had to deal with critical situations. The results point to differences between nurses who successfully resolved the critical situations and those who did not. By appreciative dialogue in facilitation of practice development, Dewar and Sharp (2013) show how their approach helped to liberate, legitimise and share the emotional and tacit elements of work. Methods like this can help staff be more aware of their own tacit knowledge and its impact on their work.

This research into the tacit practices in care homes provides some examples that can help us to explicate and understand the complexity of care home practice, in line with other studies calling for further research to offer descriptions of tacit knowledge (Carlsson et al., 2002; Gourlay, 2006).

Conclusion

Nursing staff often act according to a practical sense and are unable to describe the rules guiding their actions. Participants' own statement that 'we just do it' is a fitting description of how these tacit aspects, built through knowledge and experience, are simply carried out – staff perform care tasks automatically, while dealing with dirty and unpleasant tasks because they are committed to the residents. This article describes examples of tacit care home practice within the context of the theoretical concepts of Bourdieu and Douglas, thereby providing valuable insight into important aspects of nursing care in this setting.

Implications for practice

This study suggests a need for greater communication about and articulation of the tacit aspects of nursing practice described here and elsewhere (Herbig et al., 2001; Gourlay, 2006). There are several likely reasons why these topics are not discussed in nursing, among them being that the tradition has often been 'to just deal with it', because it is something that 'has to be done' (Van Dongen, 2001; Sandvoll, 2013). In addition, there has not been a tradition of discussing certain tasks because the words that would be used to describe them are themselves often considered disgusting or even vulgar (Isaksen, 2002; Lawler, 2006). Students could be encouraged to practise such communication during their education and practising nurses could benefit from reflection groups in which to discuss these issues (Lillemoen and Pedersen, 2015). The descriptions of care home practice here contribute to our understanding of some previously unarticulated aspects of care home practice and may help to give them a language, which may be useful for both students and practitioners. This article shows that tacit knowledge does have its place but nursing home practice needs to be supported by a wider workplace learning framework to maximise the potential for consistently good care in care homes. Greater awareness about the tacit aspects of nursing practice explored in this study may contribute to this.

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Anne Marie Sandvoll (PhD, MSc, BSc, RN), Associate Professor, Western Norway University of Applied Sciences, Førde, Norway.