

Article

Care Descriptions at Work: Textual Technologies from the Standpoint of Care Workers

by

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Abstract

Forms and documents play significant roles in the context of care work for older people. One type of form that care workers use on a daily basis is individual care descriptions (ICDs). An ICD is a text that is written on a piece of paper or on a computer, and specifies the care tasks to be carried out. How do ICDs operate in local settings of care work for older people? Anchored in insights from *institutional ethnography*, I investigate care work practices from the standpoint of care workers in care settings in Norway. In the empirical analysis, I identify and pay attention to two particular ICDs and how they enter the everyday care work practices. The findings indicate that ICDs contribute to standardizing care work practices that are related to changes in the cultural and institutional foundations of the welfare state. Furthermore, ICDs coordinate practices in different ways, and promote several forms of coordination. Hence, when analysing care descriptions at work, awareness of contextual sensitivity is called for. This paper contributes to research on management and power relationships in home care and nursing care work by illustrating different dimensions of textually based coordination.

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Introduction

Care workers are 'located knowers', who use their knowledge to perform their work (Smith, 2005; Quinlan, 2009; Campbell & Gregor, 2004; Rankin & Campbell, 2006). Care work has been described as highly context-dependent and situational, as well as embodied and gendered, requiring a combination of intellectual, emotional and manual labour (Barnes, 2012; James, 1992; Waerness, 1984). Hence, professional discretion is a pillar of care work. However, care workers' discretionary powers are in conflict with the influential modes of governance that seek higher levels of efficiency, accountability and implementation of consumerist logics in the public sector (e.g. Griffith & Smith, 2014; Vaboe & Szebehely, 2012). In Norway, as in other countries, these trends affect and exert pressure on the welfare system, and more so in the field of public elder care (Christensen, 2012; Vaboe, 2009, 2011, 2012; Vaboe & Szebehely, 2012).

Nevertheless, it is not self-evident *how* the management of elderly care work is embedded into actual work. How do 'quality' instruments and time management regimes affect practices of care work? In this paper, I explore this theme from the standpoint of care workers (see Smith, 1987, 2005). I investigate daily work practices from the actualities of care workers at care sites located in the home care services, and in one nursing home, in Norway. To investigate how care work practices at the ground level are related to administrative, institutional and trans-local levels, I examine and compare the use of two particular individual care descriptions (ICDs) in care work. An ICD is a text written on a piece of paper or a computer that specifies care tasks. There are a range of different ICDs in this sector with similar yet distinct functions and institutional logics. Although ICDs differ in purpose, design and support from institutional authorities, they all specify the intentions, expectations and relations between service providers and service users. In the empirical analysis, I have located and attended to texts referred to in interviews, namely the written decision of individual patients ('*vedtak*') in home-based care (ICD1), and the 'Nursing plan' ('*pleieplan*') in the long-term nursing home unit (ICD2). Hence, I analyse the texts 'in action' (Campbell & Gregor, 2004; Smith, 2001, 2006). By comparing different settings, I identify differences in the coordinating effects of texts. These differences are important for developing future research on the relationship between care work (as in front-line social work) and textual technologies. This article contributes to

research on elderly care work and coordinating care work under changing conditions, as it provides insight into the operations and management of care work using the analytical approach of texts in action.

Previous research and the organizational context of care work

The ageing and greying population is becoming an increasing concern for contemporary societies in OECD countries and beyond. The world's share of older people (aged 60 years +) is predicted to increase from 11.7% in 2013 (UN, 2013, xii) to 21.1% by 2050. The accompanying inevitable increase in the need for health- and social care-sector resources has prompted governments to focus on increasing service efficiency and sustainability. In Nordic countries, local governments in municipalities are responsible for providing social care. Municipalities have local autonomy to govern and organize services based on local needs. Thus, there is variation in how elderly care is organized (Jensen & Lolle, 2013; Trydegård & Thorslund, 2010), which results in different combinations of public and private care (Christensen, 2012; Bode, Gardin, & Nyssens, 2011), as well as different degrees of managerialism. For example, in rural parts of Norway, there are strong communitarian values and service provision is pragmatically governed with 'first-hand knowledge about the sparse population rather than by abstracted management ideas' (Vaboe, 2012, 286). However, despite variation, several managerialist ideas have influenced the sector in recent decades, such as importing systems that support purchaser/provider splits and benchmarking, competitive tendering and outsourcing, introducing choice models and providing financial incentives for citizens to become consumers in the market (Szebehely & Meagher, 2013, 241). Marketization processes are ongoing in all Nordic countries. Over time, purchaser/provider models have been developed, the impact of managerialism has increased, and there has been a pragmatic change in the flow of information and communication between the units and care workers (Szebehely & Meagher, 2013; Vaboe, 2011, 2012). Szebehely and Meagher (2013) state that the monitoring process can be distorted and driven by a lack of trust in professionalism, and that the proliferation of rules has unintended and perverse consequences at several levels. Vaboe (2011, 203) explains that on the one hand care work is anchored in the discretionary powers of care workers, which promotes a logic of 'creative justice' by finding just and adequate care solutions for specific individuals and families through open-ended and creative

work that includes tasks to help older people flourish. On the other hand, the purchaser/provider system promotes a logic of 'proportional justice' (Vaboe, 2011, 203), in which care workers' discretionary powers are put under pressure by limits on the use of time, and the standardization of care tasks.

There is a growing research literature on how care workers manage their day-to-day work activities within the current and managerial regimes of care work (e.g. Øydgard, 2018; Hansen, 2016; Allen, 2014; Hirvonen & Husso, 2012; Vaboe, 2011, 2012). Managerialist reforms and the new 'quality agenda' create tensions and pressure on the activities, agency and roles of care workers (Allen, 2014). With reference to the Danish context, Agnete Hansen (2016) investigates care workers' role in the contexts of reforms promoting independence, self-determination and self-care for patients of home care services: 'With these reforms the elderly citizen's body is reconstructed as more resourceful and as possessing more potential than previously supposed, providing a new, cleaner and more optimistic framing of homecare for elderly people, as well as opportunities for homecare workers to renegotiate their occupational identities and the low status of their work' (Hansen, 2016:1092-1093). She found a change in roles from relational caring to *empowering* and *coaching*. Situated in a Finnish context, Hirvonen and Husso (2012) found that in order to maintain their sense of self as skilled professionals within market principles and an economic-rationalistic framing of time, care workers reassessed and adjusted their worker identities. Focusing on the temporal aspect of care work and agency, 'the results reflect the intuitive, habitual and innovative nature of temporality in care practices, but also the constraints posed by the economic-rationalistic temporal structures of public service work that produce the experience of working on a knife's edge' (Hirvonen & Husso, 2012, 351).

Several studies have benefited from institutional ethnography (IE) for studying the system-level coordination of everyday work experiences in the health-care sector (Øydgard, 2018; Quinlan, 2009; Fisher, 2006; Campbell, 2001; Mykhalovskiy, 2001; Rankin, 2001). These studies provide insights into how care work within specific managerialist regimes is done, and how care workers contribute to the maintenance of these regimes. For example, from the standpoint of care workers working in multi-disciplinary health-care teams, Quinlan (2009) investigates the processes that make

up 'knowledge work'. She finds 'that in the course of their collective clinical decision-making, teams' dialogical exchange facilitates the articulation of tacit knowledge and opens up the communicative space for the creation of new knowledge, (...) by illustrating the importance of the social, communicative aspects of the knowledge processes, and in particular, the relationship between knowledge and the social organisation of power' (Quinlan, 2009, 625). Rankin and Campbell (2006) mapped out the specific ways that nursing work has been conceptualized and written up for managing health care. They learned that 'filling in forms is more than a technical task. It draws nurses into the dominant practices of hospital management as its agents' (Campbell & Gregor, 2004, 20). Hence, research has demonstrated that nurses' practices of writing up their work also affect the way they conceptualize their work within their given guidelines.

Analytic approach

This research project draws on insights from IE, which is an empirically driven approach that was coined and developed by the Canadian sociologist Dorothy Smith (1987). This approach is ideal for qualitative research because it is *ethnographic*, and has ambitions to move beyond ethnographic and observable levels by identifying how the institutional and extra-local systems function in concrete, ethnographically approachable settings (Smith, 1987, 2005, 2006; Campbell & Gregor, 2004; Devault, 2008). In IE terminology, people are 'located knowers', with an institutional ethnographer using these accounts of lived experience as a starting point for finding a 'problematic' on which to focus. The IE approach involves exploring a piece of the social world from a particular standpoint – from people's lived experience. An institutional ethnographer is interested in understanding how people describe, explain and make sense of their actions and everyday practices in a specific social order. Theoretically, IE is closely related to (and contributes to) standpoint feminism (e.g. Haraway, 1988). IE also has theoretical similarities with the ethnomethodological approach because they share an interest in 'actualities' and subject-shaped 'accounts' (Garfinkel, 1967). However, IE only takes the analytic level of ethnomethodology as a first step for mapping a chain of actions onto institutional and trans-local relations, which institutional ethnographers coin 'the ruling relations'. In this context, IE relies on a Marxist materialist ontology, in that activities that people

do are embedded and coordinated with others on a large scale (Smith, 2006; Hart & McKinnon, 2010).

A central insight of IE is that the governing of society occurs through abstract symbols and concepts. IE's focus on texts springs from an empirical observation: Technologies of social control and social organization are increasingly textual and discursive (Smith, 2001; see also Foucault, 1972). Text and the textual mediation of social organization are central to empirical exploration into the institutional complex of society, or how the extra-local penetrates the local and concrete level of people's everyday world (e.g. Devault, 2006). Smith suggests that institutional ethnographies are designed to reveal the organizing power of texts by increasing the visibility of how activities in local and everyday settings are coordinated and extra-locally governed (Smith, 2005, 295). As such, IE's focus on objects' ability to coordinate and activate practices is similar to actor-network theory (ANT; Latour, 2005; see also Thompson & Pinsent-Johnson, 2011). ANT seeks to discover how phenomena emerge through networks of people, ideas, objects and practices, and how flows of relations between 'actants' (human and non-human actors) are intertwined. For example, when care workers write a patient report, they are connected with the pen and the paper or the computer. Nonetheless, IE differs from ANT in that the former is fundamentally *people-centred*. In the ontology of IE, the object does not have agency on its own – the text cannot do anything – only people can. Texts are read in specific contexts, and may be interpreted in different ways. At the same time, the replicability of texts is crucial to activating ruling relations. This occurs because:

[T]he recognizable identity of a text from one site of activation to another is integral to the text's distinctive form of coordinating ruling relations, and hence it is also significant for the development of ethnographic practices exploring the social relations extending across, coordinating, and regulating multiple sites and settings of people's work. (Smith & Turner, 2014, 5)

According to Smith and Turner, texts should not be treated as sole objects of research; rather, the aim is to identify and explore how they become activated in specific social settings where people act and interact, and to identify and explore how these texts organize, coordinate, standardize and shape people's everyday life practices: 'Texts only become alive, active, or "occur" as people bring them into place in institutional sequences of action' (Smith & Turner, 2014, 8).

An IE approach to studying the coordination of care work may elucidate specific elements of activating a ruling relation between the welfare state and the individual. Griffith and Smith (2014) state that some IE-inspired studies have often identified chains of action by studying textual technologies, while others have shown that the textual technologies of governance do not always neatly fit with the work of those studied (e.g. Grace, 2014). Standards are used to coordinate activity, and allow the constant coordination of people and things (Timmermans & Epstein, 2010, 83). However, as Timmermans and Epstein point out, there exist many different standards, and they may be implemented in different ways.

This research

This paper reports results from a research project on coordination, cooperation and administration of the user perspective in Norwegian elderly care. To provide a multifaceted view on cooperation and coordination practices, I located my research in one large municipality ('the city', more than 100,000 inhabitants) and one smaller municipality ('the town', less than 10,000 inhabitants) at different care sites: home-based care/care homes (in both municipalities) and two long-term nursing home units ('the city'). In 2013 and 2014, I interviewed care workers, patients and their relatives. In this paper, the care worker interviews are used as the viewpoint and point of entry for the analysis in this paper, as they bridge service users/clients and the ruling discourse (Norstedt & Breimo, 2016).

Care worker interviewees were recruited with assistance from the head of each care site. Ten care workers were interviewed from the home-based care services in 'the city' and 11 from 'the town', while 10 care workers were interviewed at the long-term care facilities. Most of the interviewees were women in their 40s and 50s, and had many years of work experience in the health and social care sectors. The 31 care workers were primarily registered nurses and licenced vocational nurses (LVN), but the sample also included two physical therapists and one occupational therapist. The care worker interviews were conducted in the workplace, during the interviewees' working hours. Although the workers were pressed for time, the management allowed me to spend one hour per interview.

Research inspired by institutional ethnography uses the same methodical principles as much other qualitative research (Campbell & Gregor, 2004). This specific study began with a broad scope, and aimed to learn about the different care environments and groups of actors. In the interviews, I asked ethnographic interview questions (Spradley, 1979) to help obtain deep descriptions and culturally embedded narratives on how the care workers conducted their work. The care workers were asked to describe a normal work day and their typical work tasks, and the interview strategy was to locate topics related to cooperation, coordination and relations with patients. The interviews were not focused on particular ICDs. Even so, when the interviewees discussed and accounted for their everyday work, they referred to specific texts. I discovered different aspects of the care workers' 'problematic' of their lived realities, and I wanted to investigate further how these texts coordinate care work activities and/or shape work practices. At each care site, specific texts that represented ICDs were emphasized when the interviewees discussed their work. The empirical analysis began with identifying specific texts from the interviews about their everyday care work. The aim was to understand how the management of care workers is represented through- and embedded into everyday care work. In the analysis, I address how these texts mediate and coordinate the care workers' practices.

ICD 1: Standardization of care tasks

A normal day for the care workers in the home care services in 'the city' began with a short morning meeting, in which they were given patient lists with descriptions of tasks and the amount of time provided for each patient. They would then rush to their cars and drive off to see their first patients. The number of patients to visit during a day varied depending on the tasks they were meant to perform. Paperwork and other clerical tasks, such as communicating with patients' GPs or relatives, were often completed in the car while driving to see the next patient, during lunch break or in the office after lunch. At times, the list of tasks could not be completed (for example, when responding to alarms and emergency calls), but, in general, their everyday work routines were closely regulated by their patient lists and a document called a 'care description' (ICD1). This document described the care tasks that were to be provided for each patient, and was anchored in a decision ('*vedtak*') administered and ordered by the municipal administration unit for health and care services. The

decision indicates the specific tasks granted to the individual recipient of care from the municipality. *Lena*, a care worker in her 50s explains:

The work is governed by what is on your list. It is written down what we must do – there's not time to be compassionate, really (...). When I started in this occupation, we could sit down and have a cup of coffee and have a chat, and sometimes go outside with them for a walk and those sorts of things. But we can't anymore. Now we do just what we are supposed to and then we leave.

The decision that the municipal administration unit grants a specific service user is meant to produce a pre-given specification of the level of- and particularities of the care work to be provided. For care workers who experienced changes in the occupation over time, there was no doubt that the level of care provided had been higher in the past. Care workers in home-based care services are expected to provide a varied and complex set of tasks, including several medical tasks that require nursing skills, household tasks (such as preparing meals) and compassionate care. At this care site (home care services in 'the city'), the care tasks to be provided for each patient at each visit were precisely described in the care description, and guided by norms set by a municipal administration unit for how long a period of time to use for each task/home visit. According to the interviewees, the norm for giving medication is 15 minutes, toilet visits 15 minutes, showering 20-30 minutes and so on.

'Located knowing' in this setting includes hiding stress and the lack of time for the patient, for example, by taking off one's shoes when entering a home or sitting down and chatting for a minute. All interviewees emphasized that they sometimes felt that they were not able to provide good enough service; it was sometimes difficult to explain to service users or their relatives how the ICD-oriented system worked. When I asked *Randi*, a care worker in her late 40s, how she thought patients felt about receiving help defined by the ICD, she explained:

(sighs)... I think it is frustrating for quite a few of them. (...) They may get frustrated because the care description is so rigid. For example, when a lady asks me, 'Can you turn on a laundry machine and hang up the clothes to dry?', I say 'Can't you manage that yourself?', and she says 'No, my daughter is away', and so on. Then I say, 'But you don't have laundry specified in your care description.' Of course occasionally I do things that I am not supposed to do, but then I must say to them that, 'If this becomes a habit, then we have to apply for a new care description.' 'Do we *have* to do that? It's so much hassle with all these papers I have to sign, why can't you just do it? I have been granted home care, can't I tell you what to do?' So they don't understand. Some of them become (...) frustrated and irritated. And then their relatives may call and say, 'What is this? Can't you just help my mother with this?'

Rand's account implies that ICD-based care work may cause conflict between care workers and patients/relatives. It also illustrates that there is room for manoeuvring, individual judgement and negotiations between care workers and patients and/or their relatives. Still, a recipient of home-based care services may be visited by many different care workers during a given week or month. Indeed, the continuous flow of shifting care workers visiting patients' homes is a problem of home-based care services that has been extensively covered in the Norwegian media. The interviewees explained that when they are not loyal to the ICD, there may be higher expectations from patients, and their colleagues may become unpopular if they provide fewer or lower quality services than the previous care worker. As such, the ICD operates as a tool for care workers to refer to for legitimacy to prevent or defend themselves against criticism from patients and their relatives.

The needs assessment in which the ICD is anchored is based on ongoing evaluation, communication and negotiation between care workers and the municipal administration unit. When care workers believe that the time provided for a task in a specific ICD is too short, they either report to their team leader, or they electronically communicate with the administration unit and request a revision of the ICD to allocate more time to complete the task. In other cases, care workers—or the administration unit—outline the need to downscale the amount of care services provided or time allocated through the ICD. The ICD often needed initial adjustments. In some cases, the ICD needed to be downscaled, for example, when care workers saw that a patient was given more time than necessary to provide specific tasks. It may also require adjustments due to changes in the functional level of the service user.

These practices indicate that the ICD coordinates activities. The ICD regulates and standardizes practices, so that different care workers provide a predictable and similar level of care tasks. Hence, it weakens the discretionary powers of care workers, specifically as related to managing time when providing care. Care workers demonstrate an ambivalence in relation to increased regulations on time management. However, they generally accept the premises for the ICD, and use them to guide the structuring of their everyday work activities. At this care site (home care services in 'the city'), the ICD is an essential tool for regulating and coordinating activities.

In comparison, as an illustration of the municipal variation addressed in the introduction of this paper, employees working in the small municipality ('the town') indicated that the ICD ('vedtak') did not have a strong routinizing effect on their work. Several workers reported an ideal arrangement for the organization of their work, in which they could deliver good care, whereas others problematized the relationship between the ICDs and the level of help they were able to provide to their patients to a greater extent. The ICD was discussed as being in conflict with the levels and types of care tasks demanded by patients and provided by care workers. This problematization was specifically related to the care work provided to older people living in care homes. Care workers explained that the residents' ICDs indicated that they would primarily be able to care for themselves. However, care workers described the residents as frail and the place where they worked as 'a hidden nursing home', which indicated that the ICDs were not in accordance with the need for care—nor in accordance with the level of care—that were provided. Although the ICD was applied in this municipality with a narrative and justification similar to that in 'the city', it did not function the same way. In the home-based care services in 'the town', the care workers did not spend time revising ICDs and communicating with the municipal administration unit.

ICD 2: Detached upward accounting

The work and activities in the long-term nursing home facilities followed routinized intervals. Typical work activities included helping residents wash and get dressed, preparing meals and assisting with eating, organizing activities, writing reports and attending report meetings at the beginning and end of each shift. In contrast with the task-focused organization of the care work in the home care sector, these work tasks were integrated into the rhythm of the nursing home. The care workers with the longest-reaching institutional memory from the sector compared their work tasks to earlier times. They all mentioned that the number of tasks given to them constantly increased; in the past, chefs, cleaners and external laundry services had been at their disposal. These tasks were now included in the care workers' work portfolios.

Other work tasks that interviewees raised in the interviews were paperwork and completing forms, as the interviewees reported an extensive increase in paperwork in recent years. Several different forms were indicated during the interviews, such as

individual plans, action plans, care contracts, care descriptions, care plans and nutrition forms. Some of these forms were described as important tools for securing the safety and well-being of the patients, e.g., to document changes related to nutrition and weight control. However, there was clear frustration in how they talked about these forms. One of these forms was 'the Nursing Plan' ('*pleieplan*'), which I have coined as ICD2. This is a general care description commonly used in both institutional nursing practice and care worker training. When following up on the nursing plan, the care workers are obligated to report on whether or not the patients can manage to clean their own rooms or go to the toilet themselves, etc. As an outsider, the information that the care workers report in the forms appears to be vital for reporting patient's needs to colleagues and management. Yet, in following the 'located knowing' of the care workers, most of this was useless information. For example, whether or not a resident manages to clean his or her room is not vital to report because people who live in Norwegian nursing homes are usually too frail to complete these tasks. The care workers described their work with individual residents as something they needed to adjust according to changing health conditions, which was part of their professional orientation.

In two of the interviews, the nursing plan was misleadingly referred to as the Individual Plan. An 'Individual Plan' (IP) is a rights-based tool for coordinating public services for people who have complex needs (see Breimo et al., 2015). It is a legal term, and the plan is used for patients and service users with complex needs. The plan specifies processes of coordination and follow-up from various care providers. These care workers interviewed explicitly commented that they were confused about the names of the different forms. From an IE perspective, the care workers' confusion related to institutional concepts and texts provides an interesting basis for the actual accounts of the care workers. Care workers are key producers in the production of facts through filling in information in ICDs. Their (lack of) knowledge and/or uncertainties about the legal criteria and functions of specific ICDs affect the production of knowledge through these devices.

Margot, a care worker in her 50s, carefully explained that, in practical terms, they were following up on- and making plans for patients as part of their everyday care

work, but that these practices were not closely attached to the completed forms. As she explained:

I feel that it is used because we are forced to use it. But it is not a tool, really (...) If there are big changes regarding a resident (e.g. his or her medical condition), then we make a brand new plan [(ICD)], right? We throw away the old one and write up a brand new plan.

A colleague of hers, *Marit*, who was in her 60s, elaborated:

We have many plans. We make plans for the residents – action plans. And they are great (on paper)... and we make new plans every year and we write what we will do this year, but it is not easy to follow up on the plans. First, we use a lot of time to make those plans. My impression is that they [the local authorities] think it is important to have a lot written down on paper, it has become an enormous amount of forms and documents over the years... I think it is overwhelming really, with all the different forms we must fill out. (...) But no one controls that what it says on paper is actually done.

Although continually updated by staff, the nursing plan was rarely read by other employees. As *Janne*, a care worker in her 30s commented, the one computer in the unit was often occupied by other care workers updating ICDs:

My impression is that the nursing plan is yet another form that has to be filled in and that it is not used very actively. That's my impression. Of course, I write messages into the journal system (...), but not many of the staff read it. And the thing is, it's not because they don't bother or anything like that, but first of all, there are very few available computers here, and the computer is used by the team leader as well, and when it is available, then they use it for filling in forms, right?

From the care worker's perspective, it is difficult to draw conclusions about the ICDs' functions. There is unnecessary paperwork and a report that is not useful and not integrated into their everyday care tasks. The ICDs were not presented as a tool for ensuring and regulating important aspects of the relationship between the older person and the care worker. At this care site, it was viewed as a bureaucracy-feeding activity that removed the focus from real care work obligations and added to workloads. As a result, the managing functions of the ICD were not well understood at the first line of care.

Concluding discussion

This paper has examined how the management of care work enters into and affects everyday care work practices. The empirical investigation has been anchored in the perspective of care workers at different care sites in Norway: home care services (in two municipalities) and a long-term care nursing home facility. By using 'text in action' as an analytical strategy, I have identified and attended to forms of coordination in

two different ICDs. In this concluding discussion, I summarize the findings relating to care workers' implicit experiences of neo-liberal management technologies, and discuss implications of the use of ICDs.

ICD1 is anchored in decisions made by a municipal administration unit. The effects of this are clearly present in 'the city'. Here, care workers are active co-authors of the ICD, as they continuously communicate changes for revisions in accordance with the patients' changing needs. Interestingly, the care workers in 'the city' indicated that the ICD was an important tool for organizing their work, and that the ICD served purposes related to resource allocation for their respective work units. The interviewees did not problematize the ICD as a regulatory tool. Instead, the ICD was understood as *necessary* for conducting care workers' work. In practice, the ICD ensures that service users are not given more time for care than what has been formally allocated. Thus, the ICD regulates the care workers' work day and the tasks provided for citizens by limiting care workers' discretionary powers. Consequently, ICD 1 is an effective tool for standardizing care tasks (Vaboe, 2011, 2012), and for disciplining care workers (Foucault, 1972).

In contrast, care workers in 'the town' did not report practices related to the ICD as a central part of their everyday care work. Although the ICD could be used as an indicator of provided assistance, it did not have the same powers as a regulatory and standardizing mechanism, and was not as embedded into actual care work. The data does not provide a full answer as to why the ICD was not as effectively institutionalized in 'the town' as in 'the city', thereby rendering it a weaker coordinating and standardizing tool. The ICD stems from the same managerial logic, and was meant to regulate similar work tasks. Firstly, the difference may be related to timing. At the point of data collection, the ICD was only just recently implemented in 'the town', whereas it had received a longer amount of time to be adopted by management and care workers in 'the city'. Secondly, the difference may point to how local actors interpret and negotiate the role of the ICD. In this way, the ICD – a child of the purchaser/provider model – can be adapted and adjusted to different local realities. This is reminiscent of Timmermans and Epstein's (2010) point that standardizations may be subject to contextual variation. More concretely, it may relate to Vaboe's (2012, 282) finding that communitarian values plays an important

contextual frame for managing elderly care work in rural parts of Norway. However, the major municipality merger reform currently ongoing in Norway, where many municipalities will merge into larger ones, may prepare the ground for making managerialist tools more efficient in local services.

In principle, ICD2 may be framed with similar intentions as ICD1, as it aims to secure the coordination of services in accordance with users' needs. However, this was far from the experienced reality at the care site. Care workers in the nursing home did not view the functions and effects of the ICD beyond that it added to the staff workload. Hence, the interviewees viewed the ICD as *unnecessary* and *meaningless* for conducting their care work activities, and the way they talked about the ICD indicated *resistance*. Although it is a practice detached from care workers' professional need assessments, the reporting practices linked to the ICD indicate upwards accounting. By revising ICDs, information is plotted into the municipal administration system, which functions as an accountability tool for the municipal administration.

In an anthology on how the processes related to New Public Management are changing the realities of front-line work, Griffith and Smith (2014) attend to standardization across different local actualities through textual representations. In this line of reasoning, they introduce the term 'institutional circuits', which refers to 'recognizable and traceable sequences of institutional action in which work is done to produce texts that select from actualities to build textual representations fitting an authoritative or "boss" text (law, policy, managerial objectives, frames of discourse, etc.) in such a way that an institutional course of action can follow' (Griffith & Smith, 2014, 12). In this way, the representation of the front-line work is produced and transformed into texts through categories and concepts that pay selective attention to the actualities of that front-line work: 'To become actionable within institutional mandates, our actions must be translated into textual representations standardized across settings to fit the frame(s) of the relevant boss text' (Griffith & Smith, 2014, 14-15).

As Campbell (2001, 230) notes, people rarely understand their individual relations to the health-care system or welfare institution as being 'political' or part of a power

relation. This is also true for nurses and care workers, as they understand their work in relation to their professional competencies. However, the ICDs that entered the everyday work life of the care workers in this study are consistent with specific reporting systems. This indicates that care work is being reported in certain ways in order to produce systems' accountability. From the standpoint of care workers, the comparison in this paper indicates how ICDs operate in concrete care work settings. The textual objectification of care work limits the ability to provide relational care. Textual technologies push care work towards more reporting and less time with patients. Texts provide direction as to what is central to the interaction, but often represents the organizational decision process rather than the client (Campbell, 2001, 240). Consequently, texts guide and generate selective information to produce institutional realities with specific consequences in terms of allocating resources. Nevertheless, this effect is not as evident for ICD2 and ICD1 (in 'the town') as it is for ICD1 (in 'the city'), where the care workers have illustrated their knowledge of how the ICD is connected to resource allocation.

Although variations relating to the specific functions of the two ICDs intend to regulate care practices, they encourage accounting practices rather than actual care work, and belong to the same institutional complex (see also Allen, 2014). Taken together, the different ICDs illustrate different *dimensions* of textually mediated social relations. This analysis indicates that ICDs have distinct and differing functions and consequences. Therefore, to grasp their specific functions as mediators of power, management and ruling relations, it is important to take ICDs and other texts embedded in everyday care work seriously and to study them 'in action', both at different empirical levels of care work and care work management. To learn more about the factual accounts produced at the ground levels of care work and mediated through various ICDs, there is a need for research on what takes place when ICDs enter into higher administrative levels of care work administrations, at the levels above care workers at the front-lines of welfare services.

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