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Author:

Annemiek Stoopendaal, MA, Ph.D.

Dept. of Health Policy and Management

Erasmus University Rotterdam

P.O. Box 1738

3000 DR Rotterdam

The Netherlands

office: + 31 10 4088922

mobile: + 31 6 53 906 106

e-mail: a.stoopendaal@erasmusmc.nl or montijn@xs4all.nl

Biography

Annemiek Stoopendaal is an organisational anthropologist, and works as a researcher for the Erasmus University Rotterdam at the Institute of Health Policy and Management.

Table cloths and cupboards. How to understand situated improvements in long term care?

Abstract

This paper attempts to provide an understanding of the embedding of improvements in quality of health care. The question is: what kind of work has to be accomplished to let improvements take place in the everyday life of the care organizations? In the evaluation of the Care for Better program in the Dutch long term care sectors ethnography is used as a methodological tool to analyze which activities are actually carried out in 'Quality Collaboratives'. Due to the lacking qualitative evidence base of improvements in healthcare, it is necessary to better understand and therefore describe how quality improvements are embedded and work out in care practices. Following the improvement project Eating & Drinking, it occurred that to change *routines* and to make changes sustainable, the project teams had to do a lot of unexpected work. For instance, lessons in laying tables were provided, and photographs of a well-covered table were used as instruction. In this paper improvements are considered as improvising processes as *bricolage* along which the *action of translation* takes place. People and materialities, in a symmetrical and reciprocal relation, are thought to be central, but relatively unknown, actors in changing and translating working methods in long term care and *gathering*, *materials* and *training* played a crucial role in the sustainability of the improvements.

Key words: Health care improvement, long term care, quality collaborative, ethnographic methods, Actor Network Theory, bricolage.

Introduction

What kind of work has to be accomplished to let improvements take place in the everyday life of the care organizations? Care for Better, a large quality improvement program for the long term and social care sectors, i.e. care for the handicapped, care for the elderly and home care, was launched in 2005 by the Dutch Ministry of Health. This quality collaborative aims at stimulating sustainable quality improvement that can be spread within long term and social care. In 2006 we started a mixed methods evaluation study analyzing Care for Better (Strating et al 2008). Our evaluation study focuses on providing a better understanding of which conditions on the program and organisational level should be present to realise not only short term improvements in quality of care, but also to sustain and spread results and new working methods. In Quality Collaboratives, organizations from all over the country form multidisciplinary improvement teams that gather in working conferences. They join forces to improve their provision of care by Breakthrough Projects on such different domains as nutrition, prevention of decubitus ulcers, fall-prevention, patient autonomy, behavioural problems and prevention of sexual abuse. Yet, between and after the conferences, back at work, the project teams have to work hard to make the changes come true. What kind of work has to be accomplished in real life in order to improve the quality of elderly care? Getting a grasp on the way this is done is the focus of this article.

To realize more and better understanding of how change occurs and sustains, it is necessary to enter the situation were it takes place and to encounter the people and the enacted materials. A better understanding is necessary because theoretical and empirical grounds underlying the approach of Quality Collaboratives are still limited and especially qualitative research is lacking (Schouten et al. 2008; Mittman 2004). Therefore in depth knowledge and description of the actual interventions and ongoing processes within the program is important (Øvretveit 2002) and alternative conceptualization could be of help in redefining practices of quality improvement (Zuiderent Jerak et al forthcoming). In this paper I will therefore link ethnographic research not only to organizational innovation and change theories (Øvretveit 2002; Ciborra 2002; Freeman 2007; Feldman & Pentland 2003) but, in order to

reconceptualise the complexity of the improvement practices-at-work, also to Actor Network Theory (ANT) (Callon et al 2001; Latour 2005; Law & Hassard 1999; Law 1986). Firstly a theoretical perspective on organizational change is constructed in order to analyze the observations from the shop floors of two organizations for elderly care that took part in the Care for Better program. I will then describe the research methods that were used. The empirical data show what kind of work had to be accomplished to let the improvements take place in the everyday life of the care organizations. Analyzing and repacking the working practices it appeared that *gathering*, *materials* and *training* played a crucial role in the sustainability of the improvements.

Eating & Drinking

> *I join in at the ward called Daisy. Caregiver Gohar feeds one of the patients some yoghurt. Mrs K, eats a sandwich and puts her cup of tea into her glass of apple juice: "Oh gosh, how's that possible?" she asks helplessly. Then Mrs. K seems to forget her sandwich, she stands up and dwells away. Gohar cleans up the table*[1]*.*

Several studies show that a considerable number of patients in elderly care are faced with ill nutrition (Strating et al 2008; Halfens et al 2005; IGZ 2005). Inviting patients with dementia to eat by improving the ambiance and the quality of the food were means to acquire less ill-nutrition, as were protocols to weigh patients regularly. In this regard two specific and SMART goals for the nutrition project, that was called Eating & Drinking (E&D), were formulized and gained: to minimize the prevalence of ill-nutrition and to set up an operational system of signalling clients that do not eat and drink enough (Strating et al 2008; Strating et al 2009; Stoopendaal et al 2009). The E&D project was focused on the overall ambiance around eating and drinking, keeping in mind both the biological and the social importance of meals and drinks. Moreover patient choice, independency and autonomy were important and

[1] Observation notes organization for elderly care 080514 (rural)

substantive underpinning norms and concepts. As Harbers stated *'Food is loaded with meaning'* (Harbers et al 2002).

Breakthrough, collaboratives and sustainability

A typical collaborative starts of with a kick-off meeting, in which teams familiarize themselves with the principles of the 'breakthrough-method'. This method, developed by the Institute of Healthcare Improvement (IHI), is aimed at creating a 'breakthrough' in quality of care through rapid cycles of improvement and feedback. Breakthrough projects are aimed at specific issues as E&D. They start with three fundamental issues: setting aims, establishing measures and selecting changes. The improvement process is structured by the Nolan Model that consists of the three fundamental issues and the plan-do-study-act (pdsa) cycle to test and implement changes in work settings. The pdsa cycle is meant to learn people to work iteratively through planning, trying new ways of working out on a small scale, studying results and acting on what is learned and refine or broaden the changes before starting the cycle all over again (Langley et al 1996; Øvretveit et al 2002:346; Strating et al 2008). In the working conferences program leaders and experts support the teams to pay particular attention to problem analysis, goal setting and measurements.

During one year, organizations from all over the country form multidisciplinary improvement teams, that gather in working conferences. They work together to learn firstly how to analyse their working methods, and secondly how to measure and compare them with best practices and expert knowledge in this particular area. In these face -to -face meetings, project teams also learn how to cope with specific problems by sharing their experiences. Therefore, in the last conferences the teams present images and factsheets of the improvements as 'best practices –to be'. At the conferences I spoke with several members of different project teams and they told me that they felt supported by the structure of the conferences and that they liked meeting other project teams. Moreover, the fact that they were together in a new surroundings with unknown people and nice lunches, worked out as a teambuilding activity. As one of the respondents from the participating project teams stated:

'The care for better conferences were a nice day-trip for us, the head of the medical department once joined, sometimes we went there with eight persons!'[2]

Between and after the conferences the members of the project team were expected to fulfil their task: change has to be realized in their own organizations. Measurements have to be accomplished and analysed, new ideas and knowledge to be told to and adopted by the colleagues at home, new interventions have to be implemented, tested, talked about and adopted, modified or rejected.

Implementing improvements

Project teams then meet the wicked 'implementation problems' that come along with improvements that are based on Rogerian notions of sustainability and spread (Rogers 1995 [1962]; Latour 1987; McMaster et al 1997; Zuiderent-Jerak 2007; Zuiderent-jerak et al 2009). Theories about implementation of innovations and improvements in health care describe these processes either as naturally and smoothly passing processes of diffusion, or as planned, top down initiated processes of dissemination (Greenhalgh et al 2004). In these theories the innovation itself –the best practice- is an unchangeable 'thing', and the involved professionals are expected to act either as innovators who embrace or laggards who resist change (Rogers 1995 [1962]). Studies of improvement processes are retrospective in most cases in which theories, especially Rogers' Diffusion of innovations theory, form a normative and rather compelling perspective (May & Finch 2009). Nevertheless in daily practices of the organizations that joined the care for Better project, these processes worked out to be much more complicated (cf May, 2006). The content of improvement was not always clear and had to be invented and negotiated on the spot. Changes did neither happen plain sailing as the concept of diffusion promises, nor were they very mechanical, controlled and streamlined. On the contrary, following the improvement projects and the teams back at home, the obtained image was more like a messy and contingent puzzle with people,

[2] This was not representative for all project teams. Several teams had difficulties motivating caregivers to join the conferences. In some organizations the lack of personnel was a reason not to join, care had to be continued.

systems, materials and processes (Ciborra et al 2000:2). This is a radical different view and we can maybe better understand how these inherent messy processes work through the concept of *bricolage* (Lévi Straus 1966; Freeman 2007). The anthropologist Claude Lévi Straus contrasted two distinct modes of thought, the engineer and the bricoleur. The engineer, on the one hand, works from scratch, conceptual, top down, planned, understandable and perfect[3]. Whereas the bricoleur, at the other hand, gathers tools and materials during a working process that is imperfectly understood and open for changes. As Freeman (2007) stated: 'Not only are tools selected according to the bricoleurs purpose, but that purpose itself is shaped in part by the tools and material available.' Ciborra (2000) a scholar of implementation and management of information infrastructures also presents an alternative view based on empirical evidence from field studies. This alternative view alters from control to drift-as he chooses to be the title of the book- addressing the complexity of these organizational changes and the puzzling way to deal with them. Ciborra's calls this improvising way of working: tinkering. He attributes power to the situatedness and the fitting in the 'contingencies of the moment'. Inspired by how my observations in the care for better project align with these theories, I consider improvement processes as improvisation, as tinkering or bricolage, with only a little bit of engineering. Indeed, the purposes in the improvement projects were not accomplished but shaped in a process in which, as another striking observation, both people and things were involved.

People and things

Still both bricolage and engineering, even as diffusion and dissemination, are based on the assumption of a central actor. However, studying the improvements happen, I saw no central actor but a lot of actors. There are a lot of different people involved: patients and caregivers of course, but also quality managers, team leaders, relatives and volunteers. But things seem to be of equal importance, the food, tables, napkins, dishes and trolleys. Things

[3] If ever such an engineer would have existed.

play a profound role in the practices I happen to see (cf Harbers et al 2002). In that respect the improvement processes appeared to be more like a collective action of human and nonhuman actors in which a transformation –translation- of purposes and processes takes place, partly planned and partly unexpected, as collective actions of translation (Latour 1987). In this process people and materialities apparently seem to be central and reciprocal actors. The way improvements 'happen' highly depends on local circumstances and on emergent actions, insights and negotiations. Context not only counts (Flyvbjerg 2001:38) but contexts can also be considered as an actor or even an outcome. To form a theoretical perspective on organizational change, which could be of help to analyze and understand these complexities, I therefore link ethnographic research to Actor Network Theory (ANT) (Callon et al 2001; Latour 2005; Law & Hassard 1999; Law 1986). ANT offers a vocabulary to describe the different and messy issues that come along with the unfolding of the improvement processes in organisations. ANT, originated in the field of Science and Technology Studies (STS), emphasizes the performative aspects of ordering the world. Drawing on ANT, people are related in an ongoing negotiation with each other, but also with materials and 'con-texts'. Contexts are shaped and reshape. People and materialities are related actors in a socio-technical web in which each actor forms a nod, and in which a nod is again a network on its own. Actors try to create alignments of interest between themselves and other actors, resulting in an actor -network. Alignment –or social order- can be accomplished through translation. In a social process, according to Callon (1986), the action of translation can be done by inscriptions. Inscriptions are 'material into which it [a meaning, an interest, a value] is inscribed' (Callon 1991), they are the translations of interests in texts, behaviour or materiality's (Monteiro 2000). Inscriptions and translations make action at a distance possible, because they stabilise and standardise the work, so that it can travel across space and time (Latour 1986; Law 1986). As Law (1992, cited by Monteiro 2000) points out: *'Thus a good ordering strategy is to embody a set of relations in durable materials…'* According to Preda (2000) the order of activities can not exclusively

arise out of human-human interactions, it would in that case be necessary to keep them present at any time by permanent monitoring. Human interactions cannot sustain sociality by themselves, they need an additional stabilizing element. Materialities, the simple objects of everyday life, play an important role in the sustainability of ordered action (Orlikowksy 2007). Objects then can, in this perspective, act. They act like mediators, as third parties that can create agreements between different actors or between different networks.

Black boxes, hospitality and routines

Realizing improvements in quality of care, means to adopt and sustain research results and new working methods that are typified-or inscripted- as best practices. Implementing improvements means introducing other or new kinds of working methods. The word new indicates that there are other –old- ways that have to be replaced or reconsidered. Old methods have to be analyzed and problematized but old methods often have become established as routines. Routines often function to keep communities of practice together and by inscribing 'the way we do things around here' they become the fabric of culture and shared identity. To speak in the ANT language of Bruno Latour (1999) old methods are black boxes. They have become matters of fact and their history and internal complexity-the inside of the black boxes-is made invisible by their performative success. The question then is how do working methods, that have become black boxes, change? I intend to draw some theoretical stances on that matter from the work of Ciborra and Feldman & Pentland.

Ciborra (2002) uses the metaphor *xenia* to introduce the concept of hospitality as another perspective on how innovation, the acceptance of new routines, actually take place. He attempts to find other words to describe change processes in organizations, words and concepts that stay close to every day human work. To reframe issues as adopting new working methods, Ciborra introduces the notion of hospitality. This means opening up for the new and unexpected, which can turn out to be either good or bad. To be confronted with a stranger means also being confronted with ones own identity, culture and rituals. '*Hospitality is a first step in accepting the Other*' Ciborra argues but, since the guest is intrinsically

ambiguous, hospitality can also turn into hostility. The way-we-do-things-here have to be reflected and compared with the new behaviour of the stranger. Adopting best practices can be compared with hosting a guest, organizations need to reflect their own practices, while meanwhile implementing the practice that is introduced as a good practice, yet has not been proved to be appropriate in their specific situation. The way-we-do-things-here can be understand as routines that are tangled with history and identity. In organisational change processes, routines are often considered as path dependent and unchangeable, and therefore creating inertia. Feldman & Pentland (2003) challenge this traditional understanding of organizational routines. They reconceptualises routines as both stabilizing sources of sustainability and at the same time, as sources of flexibility and change. Feldman & Pentland define organizational routines as: '*a repetitive, recognizable pattern of interdependent actions, involving multiple actors*.' Drawing on earlier work of Latour, they distinguishes two aspects of organizational routines. Firstly the ostensive aspect that embodies the structure, the abstraction -the principle- and secondly the performative aspect that embodies specific actions by specific people, at specific times and places-the practice. The author show how stability and change in organizational routines are related, even 'mutually necessary', and this explains how endogenous or emergent change can occur. Without an ongoing, situated and improvised performance a routine can not be maintained, without performance the structure of the routine would become meaningless (ibid.) This theoretical position emphasises the practices of involvement and embedding that come along with making improvements sustainable.

Research method

In our mixed methods evaluation study analyzing the national large-scale Care for Better program (Strating et al 2008) we attempt to provide a better understanding if and how sustainable improvements in quality of long term care take place. To obtain a more inside out understanding of quality improvement in healthcare, to 'capture the emergent subtle life or organizations' (Hodson in Brannan, Pearson & Worthington 2007) four ethnographers are at

work to realize ethnographic research next to quantitative research methods. We use ethnographic methods not only to describe, but also to rethink if and how improvement is incorporated in the daily practice of the quality collaborative and in the daily practice of organisations that participated. In this paper, the theoretical framework described above was used to analyse the empirical data, but in an iterative process, the data also influenced the theoretical considerations. Theoretically and methodogically, ANT and ethnography fit, since ANT is more focused on exploring how the social, or in this case improvements, works than on explaining it. To execute research in an ANT like manner is to "follow the actors" through ethnographic research and to examine inscriptions and the way they are made. But following the actors is not as easy as it seams. Who or what exactly is the actor, and were to find the actor? Studying this large-scale program means to look for the appropriate places and times in order to hopefully capture some interesting views of the fluid-like processes that are going on in all participating organizations. In order to write this paper I observed several working conferences in the theme of nutrition, that is called Eating & Drinking (E&D). Furthermore I analyzed two case studies of organizations that joined this specific quality improvement project. The case studies had a layered structure. Firstly the program leader who organized the quality collaborative was interviewed and asked to tell about his experiences with teams from different organisations. I asked him which teams he would nominate as a 'pearl'[4]. We also checked quantitative data on the performance of projects. The observations provide information on the concrete actions undertaken in the pilots of the quality project. In addition, to contribute to the development of tailor-made and situated interventions as of projects as Care for Better, I provide in this paper a conceptual and ontological study of what improvements in long term care mean in the real life situation of the working practices.

[4] From the start we were not so much interested in failure, as this is the 'normal' condition given the lack of sustainable change reported in the literature. It will show however that we did get lots of chances to see 'instructive failure' (cf Pressman, Wildavsky [1973] 1984)

Entering the field

The E&D program leader gave me the names of a few participating organizations that he considered as ‘pearls’ where, to his opinion, change really happened. I selected two organizations to study, one organization was in urban and the other in rural surroundings. The program leader is motivated to improve long term care and especially the state of nutrition of elderly people:

‘It is terrible that people get undernourished’

Undernourishment or malnutrition leads to an undesirable loss of weight and causes a lower quality of life and a higher mortality rate. It delays wound healing, the condition of the skin decreases and it can influence the working of medicines.

The program leader credits caregivers as being idealistic, they want to give good care but they are, as he calls it: ignorantly unable. In addition to the working conferences he contacts the participating project teams after receiving their monthly reports on activities and results. During the project teams are visited twice by the project leader and changes that are difficult to measure could then be discussed. An example of such a non measurable change is the assessment of patients who need their food to be mashed. This should be a regular consideration of caregivers, as the food is more attractive when it is not mashed. Two different risks have to be compared and weighted here, the risk of mall nutrition versus the risk of swallowing the wrong way. These kind of complexities do not hinder the project leader and the teams in trying to reach improvements. Most project teams intend to improve *choice*, *ambiance* and *awareness*. Patients are offered more choice, for example sandwich fillings or different kinds of afternoon drinks. To improve the ‘ambiance’, tablecloths of plastic were replaced by linen, and the awareness of the caregivers for malnutrition increased by weighting procedures that were made possible by the purchase of new scales. As the project leader stated:

‘Change happens by means of small things and subtlety’s’

After contacting the health care organisations I asked the project leader in the organization to allow and enable me to do several observations of the improvement. In this regard it was

relatively easy to see things happening in the E&D project[5]. Although I presumed I could easily join the clients at their lunch or dinner, that seemed out of the question in one of the organizations due to the changes that were realised. According to the new protocol people who were not involved in the dining and would only disturb, were kept out of the living rooms. I started with interviewing the project leaders in an unstructured and open way, followed by interviews with some caregivers or staff members that worked on the project and some that did not. In addition I asked for opportunities to observe the eating &dinking in practice. In this respect the research was modified to the theme, time and place to be.

Different tables: organization 1

In rural surroundings near the sea I visited a 'pearl'. This organization was eager to improve the ambiance around dinner, but they did not succeed until they joined Care for Better. This national project gave them the opportunity to meet other organizations and experts and the project supported the start of a 'breakthrough' project. The executive of the organization chaired the project team. His scope was to facilitate the improvement by purchasing scales in order to accomplish the regular weighting of patients, to control the measurements –weight- and to make small 'change' budgets available to the wards. The other members of the project team were two care managers, one caregiver and one kitchen employee. The project team tried to gather once a month to discuss the progress of the project. They analyzed and improved the procedures to weigh the patients, they bought scales but also water jugs and mugs. They wrote down a code of conduct for the assisting of dinner in the living rooms: moments of silence at the beginning and the end of dinner, no radio and television, no entrance of non participating visitors, appropriate behaviour of caregivers: no sitting on tables, no negative remarks about the food, no throwing away of food before the eyes of the patients. The day structure of the patients was discussed, but they decided to still serve dinner at noon (I will refer to this later), nevertheless patients can choose now between two different menus. Furthermore the project team installed a special committee for mall-nutrition

[5] Compared to improvement projects as preventing bed ulcers or prevention of sexual abuse.

that controls the weighting procedures and outcomes, and a special team to treat patients who have problems swallowing food.

> *Dinner is being served. I take place at one of the two big tables in the living room besides mrs V. She stands up every time 'to clean up a bit' and walks though the door into the special 'Alzheimer garden' where every plant is edible. The moment she is outside she has forgotten the meaning of her wandering. In front of me another neat lady is rumbling the table cloth. Big trolleys come in and the caregiver that fills the plates out of the trolley asks the patients what they would like to eat: 'leek or cabbage?'. The patients do not seem to realize that they can choose. It seems also to be the question if they know what to choose. One of the caregivers tells me that the local food in this part of the Netherlands is potato and leek stew. She asks mrs V if she knows the ingredient of potato and leek stew. Mrs V likes it a lot, she smiles, but she does not know what is in it…*

To choose leek or cabbage is difficult when one can not remember the meaning of these words. Patient autonomy and choice are not simple concepts to accomplish for patients with dementia. Although the intention is right, it doesn't seem to work out. It would have been more easy for the patients to choose when the vegetables were in front of them, at the table so that they were able to see, touch and smell[6].

Apparently however, the aim to create more tranquillity during dinner had an unexpected result. The executive, being the leader of this project, did not feel free any more to visit the living rooms at dinner. This 'lack of proximity' (Stoopendaal 2009) could probably be the reason that the results of the improvement project were not as impressing and close to the purpose as they were in the second organisation I visited.

Different tables: organization 2

> *Dinner is being served in the other organisation. Team leader Ronny shows me how this takes place in several living rooms. I stay at the door mail to avoid disturbance,*

[6] As materialities are an important issue in ANT, the sensorial quality of the materialities are not discussed often.

they rather do not want me to join a table. The quietness is indeed striking. There are a few small tables, several steamy dishes on it, napkins folded nicely. Patients that are unable to eat by themselves are supported personally. Four self-supporting ladies seem to have a nice chat while wining and dining together. One of the patient sits passively in a huge wheelchair but when she smells the aroma's of the dinner, she awakes and asks for some potatoes. Her neighbour serves her. This certainly is a quite unexpected and moving interaction.

Ronny leads me along three other quiet living rooms in this organization which is located in one of Holland's biggest cities. In order to reach tranquillity in the living rooms during dinner the project team decided to close the door, turn off radio and television, and keep out every one that disturbs (doctors, therapists, family and me). At the other hand they needed more help during dinner, so they invited family to give a hand and it is agreed that every employee – also directors, managers and staff- should facilitate whenever it is needed. According to the project leader some relatives were objecting the new ways of serving dinner.

'They thought it was a kind of managerial retrenchment. I told them it came from my mind and asked them to give the idea a fair change. And now they are the greatest supporters I can even think of!'

The project leader is a very enthusiastic manager of a few wards. She has the powerful looks of a head nurse in former times. She initiated the E&D project that gave her the opportunity to realize her vision on ambiance and the ethics of care. She was personally involved and often present in the living rooms. This was, in her opinion, required to shape and institutionalize the practices on the shopfloor.

'We were very often on the wards to give instructions, to observe and to shape the behaviour of our personnel'

Not only caregivers had to be enrolled, but also the family, client council, volunteers and managers. To sustain the improvement, the new working routines were described in the protocols of the internal audits by the quality manager that was involved in the project team. And this inscription or 'plan' did its coordinating job, it worked as an element to enable

managers and caregivers to make sense of both their own and others work (Berg 1999; Suchman 1987). For example the plan enrolls the director of care in this organization, who is held responsible for the sustainability of the results of all the improvement projects.

The making of: choice

Before the Care for Better project started, patients had no other choice than 'to eat or not to eat'. They had no voice in the kind of food nor in the amount of food. Dinner was served as plate service, tables were laid with easy to clean plastic table cloths or plastic place mats. But as patients loose their cognitive and practical competences, it could sometimes lead to situations in which more autonomy is rather painful or even risky.

> *Two elderly ladies and a somewhat younger looking mister B. sit round the table in the living room of the ward that is called Cornflower. All kind of sandwich fillings are on the table, as are chocolate milk and juice. Two caregivers are working between kitchenette and table to lead this breakfast session smoothly. They tell me that, due to the improvement project, the early morning sandwiches are made now- if possible- by the patients themselves. With some help of Samantha-one of the care givers- Mr. B tells me that he lived for a long time in England. I ask him were he lived and apparently this is a too difficult question. 'Somewhere near the middle', he stutters.*
>
> *Mr B. then pours chocolate milk on his plate. Samantha brings him a new plate and a glass of chocolate milk. She tells that these patients need a lot of help and that she has to be alert all the time to exclude risks. Knives and glasses can become dangerous into the patients hands. Making sandwiches is difficult for these patients, they even forget to eat.*

Being confronted with the complexities of every day life in these kind of settings, we probably can conclude that choice is not always the highest aim and that creating more opportunities for patient choice will not in all situations improve care (cf Mol 2008). Even the concept of choice should be situated and individually questioned and adapted. The way choice is shaped has to be aligned with the concept of patient safety. But there are more people,

almost invisibly taking care of the realization of choice. Nancy, one of the members of the project team in the second organization adapted the ict system of communication between kitchen and dinner tables. It took a lot of effort to change the system, but Nancy told me:

> *'Patient choice is priority number one for me. When the patient doesn't appreciate spinach or green beans there should be some thing else on the table, they should have the possibility to eat the vegetables they prefer.'*

When wishes, diets or positions at tables change, Nancy coordinates this by translating the change into the system of ordering the kitchen. Even when a patient prefers to have dinner in the evening, it will be arranged. In her little office, near the kitchen in the cellar, as a bridge between the world of patients and the world of cooks, Nancy does the invisible work (Starr & Strauss 1999) of inscribing choice in the working systems.

Table cloths

> *Mrs V. insists that I get something to eat too. She moves some of her potatoes on my plate and puts a bit of cabbage in her spoon on the tablecloth. The neat lady eats fast and when finished, she goes on eating Mrs. V's potatoes.*

Now, let us discuss the table cloths. Plastic ones are of course the most economical and also the most efficient when chocolate drinks spill or cabbage ends up on it. But times and opinions are changing, and the black boxed choice for plastic table cloths has to be opened. In order to make the tables look more attractive, paper or linen cloths are now supposed to be more appropriate than plastic. The team leader of the second organization studied the possibilities and costs carefully and thoroughly. Her aim was to improve the ambiance but she had to take budgetary limitations into account. She was looking for a justification- to break open the black boxed choice- by testing the plastic table clothes on hygiene: they seemed to be swarmed with bacteria and germs. The paper cloths were in advance due to hygiene and efficiency, however they were costly. The team leader found out that to rent and to wash linen was even more expensive. The acquisition of paper tablecloths then was legitimized and consequently or in addition, crockery and trolleys were replaced too. Using

dishes makes serving different kinds of vegetables and potatoes possible, but at the same time creates a need for appropriate trolleys and several other accessories. As we saw, using dishes allows the patient to choose. So we can conceptualize dishes as mediators between the idea of autonomy and choice and the practice of it. And we can conclude that the dishes do a good job: choice is made tangible by them. As a matter of fact, it became clear that by changing the materialities, they in turn did their work by shaping not only mental frames and the behaviour and practices of the caregivers, but also that of patients and their relatives. Nevertheless, changing materialities alone will not do, training seemed to be necessary too.

Cupboards

In the improvement plan, written by one of the team members, a quality manager in the second organization, I read that clinical lessons were provided. I asked the project leader if she could tell me what the content of these lessons was. Some of these lessons were focussed on the enlargement of competencies to recognize mall-nutrition. The other lessons were focused on practical training, where the caregivers were taught how to serve dinner and how to lay a table. In this organization in urban surroundings young-and scarce-personnel with several ethnic backgrounds have to align their cultural approach and dinner manners with that of elderly people with also different backgrounds. As the team leader stated:

> *'At home people don't lay the table any more. They are used to eat in front of the television.'*

Due to both a generation and a cultural gap and to the lack of education of care givers, it became clear that laying tables had to be trained. And to enact these new routines, inscribing happened in an unexpected way:

> *'We taped a snapshot of a well laid table at the insides of the cupboards.'*

The new routines did not only became incorporated in the in service training, but were also communicated towards the training institutes that take part in the network of this organization.

Timely routines

Since frail elderly people are not able to eat a big amount of food within a small amount of time, it is recommended by the Care for Better experts to spread the moments of consuming food more during daytime. Due to this advice, soup and desert are not served at dinnertime but somewhere during the afternoon. Portions of food are reduced but are offered more frequent. In this organization dinnertime for the patients is at one o'clock pm and at six the patients are offered soup and sandwiches. There is enough time between the meals to have some appetite again. In order to review timely structures, the daily routines of the care givers had to change too. When the patients have dinner one hour later, the lunchtime of the personnel has to be earlier. Changing the daily structures was not as difficult as was expected in advance:

> *'They [the care givers] start their work early in the morning, so having lunch at twelve is an advantage instead of a problem for them'*

In the other organization the timely routines were not changed, breakfast was served at 8.30 dinner at 12 and the evening meal at five o'clock. As Harbers (2002) stated: 'Eating and drinking structures the day and its rhythm. That makes them important not just as nutrition but as events as well'. But E&D does not only structure the day rhythm of the patients, it structures working times as well (Orlikowski & Yates 2002). In organization 2 the day structure of the patients was discussed, but they decided to still serve dinner at noon. Interestingly the argument not to change the times was that '*the patients were used to it'.* Patients were also used to plate service, but that was not brought up as an valuable argument against change. Day structure seems to be a bricolage or gathering of different inscriptions. Changing the timely structures could happen to be no problem, but it can turn out into resistance as well.

Conclusion: unpacking and re -packing

One of the ways to achieve improvements, is by modulating them to the specific situation and problems. But the aims are not unproblematic and fully interweaven in the way care is

provided, in the acting, the structure, the atmosphere, the routines and the materialities. Back into their organizations project members have to translate or 'normalize' their new knowledge to make it understandable and workable (Latour 1987). *Gathering*, *materials* and *training* seem to play a crucial role in the implementation and sustainability of the improvements. Not only are people gathered in working conferences of the quality collaborative, knowledge is gathered too. Knowledge, or inscription, is gathered in the involved experts, in the improvement teams and in the experiences that are shared during the conferences. But we can conceptualize the snapshot inside of the cupboard, the dishes with different vegetables and the dinner tables also as 'gatherings of inscriptions'. These gatherings coordinate new routines[7]. And, vice versa, the new routines will coordinate the gatherings (cf Berg 1999).

Unpacking the action of situating new routines, I felt the need to bring the –human and non human- actors in. And as we can conclude: the devil is in the details. Improvement can come to live by working with all the seemingly small and 'vulgar' things (Garfinkel 1967). The enrolment of big visions of improvements and the often neglected small actions as folding napkins for the dinner tables can work out to become improvements that hopefully turn out to be sustainable. As one of the initiators of the care for better project in one of our interviews with people around the project stated:

'It is not shiny, it's not glossy, it is all about simplicity'

I certainly do agree for the shiny and glossy part, but I do not agree that it is all about simplicity. Indeed it is about small and banal things, but, as the devil is in the details, we can consider these small things as inscripted materialities, complex enough to coordinate action. In order to activate the improvements, project team members with deep understanding of the finest components of the changes and a thorough understanding of both big visions and banal things and all the enrolment and inscription needed in between, are required. In other words: to implement new routines, a large amount of situating work is needed. From this point of view, team members are in a strikingly similar position to that of ethnographers situating their findings. To understand what is needed to be done, change agents have to

[7] Or keep the old timely routines alive.

work inside out, emic, as ethnographers. Just as the implementing of improvement may require many translations of initial improvement plans, so does ethnographic research need to translate what 'good evidence' is to come to good descriptions of care practices. These good descriptions are therefore bound to betray the notions of evidence they may contribute to. A data driven-emic-qualitative and grounded theoretical evaluation of the methodological, practical and local dilemmas of the Care for Better program can help to accommodate future solutions in improving care (Jansen et al 2009). For as Hammersley (1992) stated: '*The purpose of ethnographic analysis is to produce sensitising concepts and models that allow people to see events in a new way. The value of these models is to be judged by others in terms of how useful they find them.*'

The two case studies this paper is based on, provide a better understanding of the context and processes of implementing improvements from a constructivist perspective. As we consider 'deconstruction' necessary for understanding, the aim of our work is to reconceptualise theories of quality improvement that can support the people involved with the ongoing work of improving long term care.

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References

Berg, M.M. 1999, "Accumulating and Coordinating: Occasions for Information Technologies in Medical Work", *Computer Supported Cooperative Work,* vol. 8, no. 4, pp. 373-401.

Brannan, M., Pearson, G. & Worthington, F. 2007, "Ethnographies of work and the work of ethnography", *Ethnography,* vol. 8, no. 4, pp. 395-402.

Callon, M., Lascoumes, P. & Barthe , Y. 2001, *Acting in an uncertain world. An essay on technical democracy,* Massachusetts Institute of Technology, Cambridge, London.

Callon, M. 1986, Some Elements of a Sociology of Translation: Domestication of the Scallops and the Fishermen of St Brieuc Bay. In: Law, J. 1986, *Power, action, and belief: a new sociology of knowledge?* Routledge & Kegan Paul, London [etc.].

Ciborra, C.U. 2002, *The labyrinths of information: challenging the wisdom of systems,* Oxford University Press, Oxford [etc.].

Ciborra, C.U. & Braa, K. 2000, *From control to drift: the dynamics of corporate information infrastructures,* Oxford University Press, Oxford [etc.].

Feldman, M.S. 2003, "Reconceptualizing Organizational Routines as a Source of Flexibility and Change.", *Administrative Science Quarterly,* vol. 48, no. 1, pp. 94.

Flyvbjerg, B. & Sampson, S.L. 2001; 2003, *Making social science matter : why social inquiry fails and how it can succeed again,* Cambridge University Press, Cambridge [etc.].

Freeman, R. 2007, "Epistemological Bricolage: How Practitioners Make Sense of Learning", *Administration & Society,* vol. 39, no. 4, pp. 476-496.

Garfinkel, H. 1967, *Studies in ethnomethodology,* Prentice-Hall, Englewood Cliffs, N.J.

Greenhalgh, T. 2004, "Diffusion of innovations in service organizations: systematic review and recommendations.", *The Milbank quarterly,* vol. 82, no. 4, pp. 581.

Halfens, R., Jansen, M., Meijers, J., Wansink, S. 2005, Landelijke Prevalentiemeting decubitus en andere zorgproblemen. Herziene resultaten zevende jaarlijkse meting 2004. Maastricht: Universiteit Maastricht

Hammersley, M. 1992, *What's wrong with Ethnography?* Routledge, London.

Harbers, H., Mol, A. & Stollmeyer, A. 2002, "Food Matters: Arguments for an Ethnography of Daily Care", *Theory, Culture & Society,* vol. 19, no. 5-6, pp. 207-226.

IGZ. 2005. Kwaliteitsborging in verpleeghuizen en verzorgingshuizen nader bekeken; Onderzoek naar de aanwezigheid van integrale kwaliteitszorg in verpleeghuizen en verzorgingshuizen aan de hand van de uitkomsten van algemeen toezicht van 1 juni 2003 tot 1 juni 2004. Den Haag: Inspectie voor de Gezondheidszorg

Jansen, J.M.F., Foets, M.E. & de Bont, A.'. june 2009, "The contribution of quality research to the development of tailor-made community based interventions in primary care: a review", *The European Journal of Public Health,* .

langley, G.J., Nolan, K.M., Norman, C.L. & Provost, L.P. 1996, *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance,* San Francisco.

Latour, B. 2005, *Reassembling the social: an introduction to actor-network-theory,* Oxford University Press, Oxford [etc.].

Latour, B. 1999, *Pandora's hope: essays on the reality of science studies,* Harvard University Press, Cambridge, MA [etc.].

Latour, B. 1987, *Science in action: how to follow scientists and engineers through society,* Harvard University Press, Cambridge, Mass.

Law, J. 2002, "Objects and Spaces", *Theory, Culture & Society,* vol. 19, no. 5-6, pp. 91-105.

Law, J. 1986, *Power, action, and belief: a new sociology of knowledge?* Routledge & Kegan Paul, London [etc.].

Law, J. & Hassard, J. 1999; 2006, *Actor network theory and after,* Blackwell Publishers, Oxford [etc.].

Levi-Strauss, C.G. 1966, *The savage mind,* University of Chicago Press, [Chicago].

May, C. 2006, "A rational model for assessing and evaluating complex interventions in health care", *BMC Health Services Research,* vol. 6, no. 1, pp. 86.

May, C. & Finch, T. 2009, "Implementing, Embedding, and Integrating Practices: An Outline of Normalization Process Theory", *Sociology,* vol. 43, no. 3, pp. 535-554.

Mittman, B.S. 2004, "Creating the Evidence Base for Quality Improvement Collaboratives", *Annals of Internal Medicine,* vol. 140, no. 11, pp. 897-901.

Mol, A. 2008, *The logic of care. Health and the Problem of patient Choice,* Routledge, London.

Monteiro E. 2000, Actor-network Theory and Information Infrastructure. In: Ciborra, C.U. & Braa, K. 2000, *From control to drift : the dynamics of corporate information infrastructures,* Oxford University Press, Oxford [etc.].

Orlikowski, W.J. 2007, "Sociomaterial practices: Exploring technology at work", *Organization Studies,* vol. 28, no. 9, pp. 1435-1448.

Orlikowski, W.J. & Yates, J. 2002, "It's about time: Temporal structuring organizations", *Organization Science,* vol. 13, no. 6, pp. 684-700.

Ovretveit, J., Bate, P., Cleary, P., Cretin, S., Gustafson, D., McInnes, K., McLeod, H., Molfenter, T., Plsek, P., Robert, G., Shortell, S. & Wilson, T. 2002, "Quality collaboratives: lessons from research", *Quality and Safety in Health Care,* vol. 11, no. 4, pp. 345-351.

Preda, A. 2000, "Order with things? Humans, artifacts, and the sociological problem of rule-following", *Journal for the Theory of Social Behaviour,* vol. 30, no. 3, pp. 269-298.

Pressman, J.L. & Wildavsky, A. [1973] 1984, *Implementation. The Oakland Project,* University of California Press, Berkeley, Los Angeles, London.

Rogers, E.M. 1995 [1962], *Diffusion of innovations,* The Free Press, New York [etc.].

Star, S.S.L., Strauss, A. 1999, "Layers of silence, arenas of voice: The ecology of visible and invisible work", *Computer supported cooperative work,* vol. 8, no. 1/2, pp. 9-30.

Stoopendaal, A., Strating, M., Zuiderent-Jerak , T., Nieboer , A. & Bal, R. forthcoming, "Borgen in praktijk. Het Eten en Drinken traject in Zorg voor Beter ", *Tijdschrift voor Zorg*

Stoopendaal, A.M.V. 2008, *Zorg met afstand: Betrokken bestuur in grootschalige zorginstellingen,* Koninklijke Van Gorcum, Assen.

Strating , M.M.H., Stoopendaal, A.M.V., Zuiderent-Jerak , T., Nieboer , A.P. & Bal , R.A. Forthcoming, "Op weg naar duurzaam verbeteren in de langdurige zorg? Tussenresultaten van het nationaal verbeterprogramma Zorg voor Beter", *TSG* .

Strating, M., Zuiderent-jerak, T., Nieboer, A. & Bal, R. 2008, *Evaluating the Care for Better collaborative. Results of the first year of evaluation*, institute of Health Policy and management, Rotterdam.

Suchman L. A. 1987, *Plans and Situated action. The problem of Human - Machine Communication,* Cambridge University Press, Cambridge.

Zuiderent-Jerak , T., Strating, M., Nieboer, A. & Bal, R. forthcoming, "Sociological refigurations of patient safety; ontologies of improvement and ‘acting with’ quality collaboratives in healthcare.", *Social Science & Medicine,* .