Power Dynamics and Knowledge Sharing: Towards Quality Holistic Dementia Care

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ABSTRACT

This research explored knowledge sharing among the diverse professionals involved in dementia care. Ageing is an inescapable process in everyone's life. The ageing process is, however, often accompanied by health and welfare challenges, which require support and attention. A major challenge requiring urgent attention is the increasing prevalence of dementia. Dementia is characterised by the impairment of some brain functions, including memory, understanding and reasoning, which slowly render sufferers incapable of independent living.

Consequently, people living with dementia require specialist care that utilises knowledge from disparate groups of aged care experts to make holistically informed decisions to maximise client well-being. Integrating different paradigms of knowledge from diverse professionals involved in dementia care presents a challenge due to the temporal and geographical separation of professionals who often work between facilities and on different schedules. In addition, the professionals and experts have different care responsibilities and expertise. Time and space, as well as differences in responsibilities, make integrating diverse and fragmented knowledge related to holistic client management challenging.

The reality is that knowledge is power and, therefore, understanding the power impediments which affect the integration of the diverse knowledge resources in the dementia care system is a valuable area of study. As such, this research stands to inform dementia care providers and ultimately help advance constructive and holistically informed dementia care practice.

The research explored the challenges of managing diverse knowledge resources and the associated power dynamics involved in knowledge sharing amongst dementia care teams. This was achieved by examining the knowledge sharing methods among experts, the influence of power dynamics on the knowledge sharing process and how social capital contributes to the relational dynamics among teams of professionals in ways that can either assist or inhibit the sharing of knowledge. The goal of the research was to elucidate the barriers and opportunities for collective knowledge sharing that contributes to holistic dementia care.

THESIS DECLARATION

I, Oluwafunmilola Oreoluwa, certify that this work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

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_____February, 2018

Oluwafunmilola Oreoluwa

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GLOSSARY

Knowledge: Knowledge is a resource applied by social actors in an attempt to solve problems. It can be mostly contextual, as it is bound to its use, and its user within an organization. Knowledge is something people do as part of their everyday activity connecting what individuals know and what they do in practice.

Knowledge management: Knowledge management is referred to as the process of creating, sharing, using and managing the knowledge and information of an organisation. It is a multidisciplinary approach to achieving organisational objectives by making the best use of knowledge

Knowledge sharing: Knowledge sharing refers to the provision of information, ideas and skills to others to ensure collaboration in solving problems, creating new ideas and implementing policies and procedures

Collective knowledge: Collective knowledge is defined as the aggregate of various individual professionals' knowledge that develops into a shared collective knowledge resource, is an area that requires further research

Social capital: Social capital is defined as the sum of the actual and potential resources embedded within, available through, and derived from the network of relationships possessed by an individual or social unit.

Power dynamics: Power dynamics refers to the influence each individual has on personal knowledge or knowledge they have access to or power over and how this influence affects the level of knowledge that is shared.

Holistic care: Holistic care is care that encapsulates evidence, knowledge, practical information and expert opinion.

Power Dynamics and Knowledge Sharing:
Towards Quality Holistic Dementia Care

(1) INTRODUCTION

1.1 Thesis background

The research reported in this thesis contributes to our understanding of knowledge sharing and the influence of power dynamics on the sharing process among care professionals involved in residential dementia care. There is a group of diverse health care professionals who provide valuable knowledge in the care of dementia patients; individually they make distinct contributions to the portfolio of dementia care requirements (Kümpers 2005). A platform of understanding was required to inform theory and knowledge sharing practices among these care professionals. Integrating different paradigms of knowledge from diverse professionals involved in dementia care, however, presents a challenge due to the temporal and spatial separation of the professionals involved. In addition, the diverse professionals who are considered expert due to their academic qualifications and experiential knowledge have various care responsibilities and experiences which make knowledge-sharing and holistic patient management challenging.

The different care responsibilities, disparate knowledge perspectives and the fact that some care professionals work across a variety of locations requires a platform to integrate diverse knowledge perspectives to achieve quality holistic dementia care. Further to the challenge of integrating diverse and fragmented knowledge sources for optimal dementia care, is the idea that such knowledge is intimately and inextricably connected to people's occupations, which could create a challenging power dimension when it comes to sharing important care information. Hence, the research problem guiding this thesis was:

Research problem: *To understand knowledge sharing and power dynamics in among teams of care professionals involved in residential dementia care.*

The purpose of this research was to examine and raise understanding about the influence of power dynamics on the process of sharing valuable care knowledge among the various professionals involved in dementia care. Furthermore, by developing an understanding of the dynamics and challenges of knowledge sharing among the teams of diverse care professionals

involved in dementia care in residential facilities, this research seeks to contribute to the body of knowledge on the provision of quality holistic care through good collective knowledge sharing. This chapter sets the scene for the body of work presented in this doctoral thesis; discussing the key issues, research problem and outlining the theoretical background that helped address the research problem.

1.2 Significance of the research problem

The research problem centred on understanding knowledge sharing and power dynamics in individuals who belong to different professions involved in the care of dementia clients. This was towards achieving knowledge from different perspectives. The creation of valuable knowledge has hence been established as a precursor to achieving competitive advantage and effectiveness by a number of authors (Nahapiet 1998; Ipe 2003; Cai, Goh, Souza and Li 2013). There is a shift in emphasis from tangible assets to intangible knowledge-based assets that are superior when addressing spontaneous and novel situations that are likely to occur while providing care to dementia clients.

Diverse care professionals have intangible knowledge that contributes to achieving holistic dementia care. Individually each professional can only solve an aspect of a dementia client's care requirement. This is because each professional have their area of specialisation and rely on other professionals' expertise and knowledge to provide holistic dementia care. Patient centric care involves contribution from diverse experts; such as, care from; general practitioners, nurses, dieticians and psychologists. Knowledge is, therefore, defined here as an interpretive resource based on prior information, experience, learning, expertise and insight. Knowledge is an intangible asset that develops as a result of certain mental activities undertaken by individuals. Knowledge is, hence , closely bound with people's self-worth and occupations, thus sharing such knowledge does not come without challenges (Ipe 2003).

To achieve knowledge sharing among care professionals that provide care to dementia clients, knowledge management processes can be useful in integrating knowledge from diverse experts. Knowledge management is the process of creating, sharing, using and managing the knowledge and information of an organisation. It refers to a multidisciplinary approach to achieving organisational objectives by making the best use of knowledge. This knowledge may include databases, documents, policies, procedures, and previously un-captured expertise and experience in individual workers.

Among the barriers to knowledge sharing is the fact that individuals often view knowledge as power (Gordon & Grant 2005). However, while various studies have identified knowledge as a source of power, limited studies have examined knowledge sharing within dementia care teams, particularly from the perspective of the influence of power dynamics. In addition, research on how social capital can be leveraged to improve relationships in dementia care teams to ensure knowledge sharing has received little attention (Nahapiet & Ghoshal 1998, Anand,Glick and Manz 2002). The influence of power dynamics on the knowledge sharing process in care teams and how social capital can be leveraged to improve inter-group relationships were the focus of the research.

The research problem concentrated on four key issues:

(1) quality holistic dementia care

(2) knowledge sharing in dementia care

(3) influence of power dynamics on the knowledge sharing process

(4) the leveraging of social capital.

A theoretical exploration of the key issues and their importance to the research problem is discussed and justified below.

1.2.1 Importance of quality holistic dementia care

Global population ageing is a major challenge which has far reaching implications for many countries as they seek to provide quality care to the elderly. Ageing is likely to put unsustainable pressure on public spending, with particular concerns about rising health costs and the ability of the health system to serve the increasing numbers of older people needing care. This will ultimately result in the pressing need to facilitate effective knowledge sharing across the professional care team to meet the demands presented in the healthcare system.

The increase in the ageing population is the result of remarkable improvement in life expectancy and a fall in the mortality rate due to advanced medical services and health care facilities. The ageing of the post second world war baby boomers in many developed countries has contributed to the disproportionate number of elderly citizens in increasing need of care (Australian Institute of Health and Welfare 2016).

In addition, the increase in longevity results in a raise in diseases associated with ageing, many of which require constant care and professional management. One such disease is dementia which has been identified as the third leading cause of death and disability in the world, as well as Australia (WHO, 2016; Australian Institute of Health and Welfare 2016). Because dementia is a progressive, irreversible and permanent cognitive deterioration, it is feared by many people as they age (Australian Institute of Health and Welfare 2016). The condition is characterised by the impairment of some brain functions, including memory, understanding and reasoning, which slowly renders sufferers incapable of independent living (Barrett 2013). This results in dementia clients requiring extensive care from different care professionals as their capabilities and independence are slowly compromised. The direct implication for the healthcare system, government agencies and informal carers is the need to ensure dementia clients receive holistic care.

1.2.1.1 Defining quality holistic care

An estimated 413,106 Australians currently have dementia, of whom 93% are over the age of 65 (Australian Institute of Health and Welfare 2016). Dementia's prevalence doubles every five years after the age of 60, and dementia was been declared a public health priority (WHO 2012). It is evident that a crisis is emerging for which countries may require an effective system of care to address the medical and social needs of this large, ailing group (Australia's Institute of Health and Welfare 2014; WHO 2012). Furthermore, projections reveal an increase in the population of dementia clients at the advanced stage of the condition (WHO 2014). While the onset of dementia can be managed by community care staff and informal carers (family members), the population of dementia clients with advanced stages of dementia require capabilities that can only be effectively provided through institutionalised care (Brodaty and Low 2006).

The rapid growth in the number of the elderly affected by dementia and the need to provide quality care has resulted in different practice guidelines in the bid to achieve quality dementia care. Different recommended practice models are being suggested and keep evolving due to the complex nature of the disease and new discoveries (Pond 2011, Australia's Institute of Health and Welfare 2014). Consequently, a comprehensive definition of quality dementia care has so far been elusive. A standard practice to synchronise the various care pathways to dementia management from the symptom stage to the late onset of dementia has therefore been a topic of much discussion (Pond 2011).

An attempt to define quality holistic care suggests that it is care that encapsulates evidence, knowledge, practical information and expert opinion (Pond 2011). This explanation implies that the sum of these attributes results in the provision of holistic dementia care. From the definition of quality holistic care, it can be argued that there is a need for care professionals to share valuable knowledge in the care of dementia patients. However, due to the peculiarity of different dementia cases, rigid adherence to developed care practice guidelines has been discouraged to ensure each case is handled uniquely, based on the available evidence relative to the case requirements (Australia's Institute of Health and Welfare 2012). The manifestations of dementia in clients are different; and each client requires one-on-one speciality care. This indicates that the

process of knowledge sharing on a case-by-case basis because it affects the delivery of quality care to dementia clients requires further research.

A review of the literature on quality dementia care reveals that holistic dementia care can be achieved through collaboration and effective knowledge sharing among care teams (Kümpers 2005). Care teams in the dementia care context have been identified to include: specialist medical areas (e.g., general practitioners, geriatricians, and psychiatrists), allied health practitioners (e.g., dieticians, dentists, physiotherapists) and carers (e.g., formal carers – personal care assistants and informal carers – family members) (Daniel, Neale, Isaacs Sodeye and Landinez 2013). These professionals possess diverse knowledge perspectives and dispersed attendance at institutionalised care facilities. Hence, this complex care relationship will clearly require coordinating the various professionals in the care teams from different settings to achieve quality care.

Fundamental to the issue of coordination is the challenge of integrating the disparate, disperse and unique knowledge about dementia clients from all participating stakeholders, as the availability of relevant evidence about dementia care is dependent on the collaboration of the different professionals involved in each dementia care case (Kümpers et al. 2006). The process of sharing dispersed knowledge among dementia care teams is thus important in achieving quality dementia care. However, only a few studies have provided empirical insight into how knowledge is shared among care teams involved in the care of dementia patients focused on best practice knowledge (Kümpers , Mur, Hardy, & Maarse 2006; Janes, Sidani, & Cott 2008).

While these studies contribute to best practice knowledge in the dementia care context, how diverse knowledge is shared among dispersed care providers was not addressed. In addition, the possible influence of power on the sharing of best practice knowledge was not explored. Kümper et al.'s 2006 research on knowledge transfer in the dementia care context only addressed sharing among specialist and generic services in a given context, not among transient workers. Kümper et al.'s research context is England and the Netherlands, addressing knowledge sharing and not the effect of power dynamics on this process. Based on these considerations, this research was

conducted to advance the process of knowledge sharing and the influence of power dynamics from the perspective of care teams involved in the care of dementia clients and how quality holistic dementia care can be achieved.

1.3 Theoretical background

To achieve quality holistic dementia care through informed knowledge sharing, an examination of the literature in three areas – knowledge sharing, power and social capital – is required. The issue of knowledge sharing and power has received some attention by scholars (Liebowitz 2007, Coopey 2010), and a few of these studies have applied these areas to the healthcare sector (Doering 1992; Currie 2006). Most of the previous studies on the relationship that exists between knowledge and power indicate that power serves as a barrier to formal knowledge sharing.

There appears to be a paucity of research on power acting as a facilitator to the informal sharing of knowledge. This research explored the positive and negative influence of power dynamics on the knowledge sharing process. This will add to the body of knowledge on how power can contribute to the sharing process. Furthermore, the question of how knowledge sharing occurs in dispersed and diverse care teams and the influence of power dynamics on this process remains unexplored. A brief theoretical exploration of research on knowledge sharing and the influence of power dynamics on this process is examined below. The role of social capital in this interaction is also examined. This exploration is based on the research questions presented below. This leads to the methods and methodology and how this study can contribute to practice and theory.

Three questions guided this research to help explore the research problem and inform understanding of the role of social capital and power dynamics on the knowledge sharing process among teams of experts involved in dementia care. The following chapters of this thesis will provide a detailed review of literature focused specifically on each research question, to introduce

the general theoretical background of the key issues. This section presents that background, highlighting a summary of gaps in extant literature on the identified research questions.

1.3.1 Research question one

RQ 1: *How do the diverse members of care teams share knowledge in residential dementia care?*

This research question addresses the first key issue, an exploration of the dynamics of knowledge sharing among health care professionals. Literature on the locus of knowledge in health care and the mechanism of knowledge sharing among dispersed and diverse care professionals was reviewed. During the preliminary investigation of the literature, the issue of where knowledge is found, knowledge creation, types of knowledge and the dynamics of sharing knowledge among dispersed care teams were theoretically identified as the key contributors of knowledge sharing in care teams. Consequently, literature on these three areas was explored to address the first research question.

1.3.1.1 Knowledge in health care

The literature suggests that the involvement of disparate and dispersed professionals in the aged care system, and the significance of achieving collective knowledge, cannot be over emphasised (Clarke 2003). Identifying the origin of knowledge is pertinent to discovering the types and dimension of knowledge that exist in dementia care. Understanding the origin of knowledge would assist with the coordination of knowledge that requires integration, sharing and diffusion in the dementia care setting.

Knowledge can be either tacit or explicit (Polanyi 2015). **Explicit knowledge** is a representation of routines and information stored in patients' case folders, regulatory documents, administrative processes and procedures that guide the aged care system. This form of explicit knowledge can be accessed and utilised by all participating stakeholders involved in different aged care institutions and this has been termed rationalised knowledge (Ipe 2003; Chiu, Hsu and Wang 2006). However, while some explicit knowledge can be easily accessed, some is strictly context-specific, embedded and professionally perceptive. Explicit knowledge requires individual or

expert interpretation. This suggests that explicit knowledge is embodied knowledge which requires technical knowledge to interpret in practice (Ipe 2003; Chiu et al. 2006). An example of embodied knowledge in practice is the knowledge that comes from training as a general practitioner or a nurse and interpreting cases in accordance with procedures and experience gained from training. This involves applying knowledge acquired from training to novel situations, to make diagnoses or treat dementia patients.

Tacit knowledge, on the other hand, is cognitive. It is difficult to consciously articulate because we may not be aware of what we know, and when we try to communicate this knowledge in verbal and written form, it poses a difficult task (Nonaka 1994). Tacit knowledge is likely to require interaction and a level of rapport between individuals for it to be elucidated because it is difficult to articulate. This suggests that tacit knowledge is individual to a particular professional. This knowledge, according to Blackler (1995), is embrained and encultured, and the dimensions of knowledge are used to solve novel and unique tasks in a particular context.

Encultured knowledge in dementia care aligns with the shared stories and languages that develop over time due to interactions with individual dementia patients. Indeed, family members, carers and care professionals involved in constant interaction with particular clients will have the tacit knowledge about historical events or idiosyncrasies that can help in treating patients on a case-by-case basis. *Embrained knowledge* is a combination of tacit and explicit knowledge. This entails applying mental abilities and judgments to a situation. This is personal knowledge that is difficult to separate from the individual. It is also the knowledge applied based on assumptions from previous experiences. While this has an explicit dimension based on previous ideas, the individual cannot be separated from the application of the task.

It can be argued that the interactions between the different types and manifestations of knowledge in the health care setting may contribute to collective knowledge; and the nexus of these knowledge bases is important in achieving quality dementia care practice. It is evident that the sometimes personal nature of knowledge across professional boundaries makes it difficult to share, diffuse and acquire this knowledge from all the stakeholders involved in dementia care.

This indicates a need to engage various care teams in interactive sessions that will mediate the institutionalised boundaries and ensure knowledge is shared across professional and organisational boundaries.

1.3.1.2 Mechanism of knowledge sharing

Individuals develop novel ideas and techniques through continuous sharing and learning. It is therefore important to share ideas, skills and techniques to inform quality and effective service delivery as the process of sharing these ideas may help organisations achieve collective knowledge. According to Widén-Wulff and Ginman (2008), collective knowledge is the most secure and strategically significant kind of organisational knowledge. However, the personal nature of some knowledge types requires adequate collaboration between health care professionals in dementia care.

Knowledge among care teams involves knowledge sharing across professional and organisational boundaries. Research has explored the mechanisms of sharing knowledge across boundaries from the brokering and repositories' perspective (Widén-Wulff et al. 2008). This involves bringing together actors under a brokering relationship where a broker coordinates different professionals' knowledge and codifies, distributes, and makes it accessible to others in the relationship.

This approach, however, has some limitations. Knowledge, according to Blackler (1995), is what we do and not what we have. It is therefore situated in practice and doing and involves participation and interaction. Externalising personal knowledge in codified expressed form, therefore, involves initial interaction among stakeholders involved in dementia care. Externalising personal knowledge is especially important in the professional boundaries that exist among health care professionals, where face-to-face interaction is rare due to the transient nature of the attendance of some experts in the care facilities who seldom have opportunities to share crucial patient knowledge in a face-to-face exchange. Sharing personal knowledge through conversations may hence result in articulating knowledge otherwise lost in routine and practice.

The second limitation identified with knowledge brokering is in the institutionalisation of professional boundaries. This involves hierarchical and formal attributes that define each profession and organisation; this can serve as a barrier to knowledge sharing because of the lack of informal interaction, since formalisation of the sharing process limits the free flow of knowledge and willingness to share (Widén-Wulff; et al. 2008). It can be argued that knowledge sharing among dispersed and diverse care professionals requires a platform where participation and interaction occur in order to provide quality service to each dementia patient.

1.3.1.3 Knowledge integration and relational dynamics

The collective expertise of those involved in the care of dementia clients in residential aged care forms dynamic capabilities required by the organisations to deliver informed dementia care. Dementia clients require care for various issues handled by diverse experts. These collectives of experts contribute specialised capabilities that address spontaneous issues that arise when dealing with dementia clients. These capabilities exist as component knowledge, which is knowledge that relates to parts rather than a whole, in teams, across boundaries, in different forms and at different levels. According to Phillips (2000) and Koeglreiter, Smith and Torlina (2006), component knowledge resides in transient and multidisciplinary teams that have diverse expert knowledge perspectives. To integrate these knowledge components that reside in different professionals and in diverse forms, relational dynamics through interaction between professionals may become necessary.

Expert knowledge in this context is therefore not necessarily governed by formal hierarchy, since knowledge exists across the hierarchy and within individuals who are not necessarily bound by organisational structure (Mechanic 2003). While studies have identified difficulties involved in sharing knowledge amongst disparate professionals, the same issues have been identified with professionals working within the same organisation and within the same profession (Phillips 2000; Koeglreiter et al. 2006). Indeed, Koeglreiter et al (2006) proposed that while knowledge exists in groups, these groups are sometimes separated by boundaries and knowledge perspectives. They suggest that implementing virtual and face-to-face communities of practice will help bridge the gap between professionals.

Phillips (2000) and Koeglreiter et al. (2006) reiterated the importance of collective sharing, stating that collaboration not only transfers existing knowledge among organisations, but also facilitates the creation of new knowledge and produces synergistic solutions. Bridging the relational gap that exists between disconnected individuals and groups may potentially encourage effective sharing of different knowledge types as this is important for quality holistic dementia care (Ipe 2003; Wang & Noe 2010).

Hence, this doctoral study explored the social dynamics involved in knowledge sharing in teams, and reveals how health care professionals interact in the process of developing their collective knowledge for informed care. Understanding this process serves as the bedrock to acknowledging the shared knowledge resource for optimum care in residential aged care facilities.

1.3.2 Research question two

RQ2: *What is the influence of power dynamics on knowledge sharing among members of care teams?*

A variety of power bases was explored to investigate this question, examining how power bases manifest themselves during knowledge sharing, and the various influences they exert on the sharing process. Areas of literature explored included power as a resource, relational dynamics and social power bases, and the social dimensions of power.

1.3.2.1 Power as a resource

There are arguments about the relationships between knowledge and power, and it has been argued that power does not necessarily go with status or hierarchy, since people regarded as having low status in organisations have resources that are valuable, which gives them some level of power (Foucault 1980; Hekkala & Newman 2013). A correlation has been made between power, status and the knowledge sharing process. Knowledge is linked to power due to the competitive edge it brings to individuals and organisations (Gordon & Grant 2005). However little empirical research has been done on the direct influence power dynamics has on knowledge sharing in the dementia care context. In this context, power dynamics refers to the influence each individual has others and how this influence affects the level of knowledge that is shared.

In previous research, power has been viewed as a means of influencing individuals, due to hierarchical stances. Individuals in elevated positions in a hierarchy are viewed as having knowledge because they have position power. This has nevertheless been argued to be a myopic perception that is not necessarily accurate (Peiro & Melia 2003). The perception that position power is equivalent to having knowledge prevents individuals who have tacit knowledge without position power from seeing themselves as possessing power. People in this category are oblivious to the power they possess due to the control culture (Lukes 1974).

Lukes (1974) introduced the idea of the social relationship structure to explain the interaction between people in control and people in possession of skills and knowledge that have been submerged in the power play. This makes the concept of informal relationships/network relatable to informal power. Due to the informal work system, knowledge eventually becomes distributed at every level. There are, however, limited studies on the manifestation of informal power in organisations, and indeed, the knowledge sharing process that occurs between professionals.

Expanding on the concept of informal power, Foucault (1980) stated that since power is viewed as the possession of new truth, it cannot be exerted due to position alone, but only as a result of having knowledge that is essential to operations. It is impossible to exert genuine power without possessing the relevant knowledge. People lower in an organisation's hierarchy than the nominal leaders can therefore possess power that can be to their strategic advantage (Haugaard 2000) when they know things others in the hierarchy do not know.

According to Foucault (1980), power in the strategic sense is knowledge in manifestation and not due to either possessing power or position; but as a result of possessing requisite knowledge that is needed to achieve effective service. It can therefore be argued that knowledge is required to possess power.

Building on Foucault's study on power (1980), Flyvbjerg (1998) and Haugaard (2000) have improved on the definition of power as it relates to knowledge sharing in the 21st century. Haugaard (2000) has noted that it is the era of empowering workers at all levels as a necessary strategy for organisational effectiveness. Organisations need to examine whether reinforcing

dominance encourages knowledge sharing or whether dispersing the dominance regime will improve knowledge sharing (Gordon & Grant 2005). To persist in believing that only those in positions of power have knowledge will leave important knowledge necessary for quality care untapped.

Status and power influence the relationships that exist in organisations and ultimately dictate with whom knowledge is shared. These factors have been identified as barriers to knowledge interaction. While a correlation has been made between power, status and the sharing process; little or no empirical research has been done on the direct influence power dynamics has on knowledge sharing in dementia care.

1.3.2.2 Relationship between power and knowledge

The knowledge-based view suggests that an organisation's capacity to create continuous knowledge serves as a competitive advantage and ensures organisational effectiveness (Ipe 2003). Knowledge is, however, dynamic due to the involvement of diverse actors in different functional and professional areas (Lam 2000). It is important to combine knowledge from different actors to inform treatment plans for dementia clients (Inkpen 1996; Wang & Noe 2010; Yu et al. 2013).

Studies addressing knowledge sharing among professionals involved in dementia care view knowledge as vital to achieving informed practice. However, the success of achieving knowledge sharing among professionals depends on certain human behaviours and antecedent operational factors. Intellectual ownership needs to be addressed in advance, for example, as experts may have reservations about disclosing knowledge due to fear of losing their intellectual competitive edge. What counts as relevant knowledge is mostly socially situated and those who possess such power enjoy autonomy; this promotes status and power (Mclaughlin & Webster 1998). This growing specialisation of knowledge involves a complex structure where technical knowledge and knowledge gained by personal experiences are required to achieve competitive advantage.

Knowledge is contextual in nature; it is thus a common feature in an organisation's power and politics discussion (Wang & Noe 2010). While some literature has referred to the pitfalls involved in the power play that exists in knowledge sharing, how power dynamics influence this

process has not been explored. Hekkala and Newman (2013) define power as an individual's control over resources that is manipulated to gain an edge. However, Foucault (1980) posits that the existence of power produces new knowledge, which he described as *new truth*.

The struggle for power between individuals in an organisation can thus affect the knowledge sharing process, when power play is involved, which implied that the relationship between knowledge and power is important for organisational effectiveness. Knowledge sharing is relational (Heizmann 2011) and based in daily interactions. According to (Foucault 1980), power exists in relations that are constantly producing activities, including the sharing process. Therefore, for effective knowledge sharing in care professionals in dementia care, a constructive relationship between knowledge and power is essential for more collectively informed practice.

1.3.2.3 Relational dynamics and social power

The extent to which actors view themselves as connected to other actors and identify to a common goal refers to the concept of relational dynamics (Chiu 2006). On the other hand, social power is referred to as the power to control a resource or an individual (Henderson 1994). Social power bases have been conceptualised broadly as formal and informal power bases. Examples of formal bases are: legitimate/position and reward power and examples of informal bases are: referent, expert and information power. The process of controlling resources and individuals is influenced by relational dynamics and social milieu (Chui 2006). The issue of control comes as a result of the importance attributed to knowledge. Individuals with competitive knowledge therefore view the knowledge they possess as valuable and a source of power.

Power has been defined from different perspectives by different authors. It has been conceptualised from the domination and resistance perspective (Foucault 1980). Dominance indicates an individual's intention to control another individual, a resource or a situation. Further to the mainstream management theory, other authors view power as formal legitimate authority Gordon and Grant (2013) have therefore defined power as the potential ability of an agent to influence a target (Raven 1992).

The concept of the agent and target in the dementia care context refers to individuals with position power or expert knowledge as *agents*, and those over whom these individuals want to

exert authority as *targets*. The notion of the source of power has been explained in various ways, most of which have resulted in an overlap of definitions (Raven 1994; Henderson 1994; Foucault 1982).

These distinctions are all based on Raven and French's (1992) six power bases which are; *legitimate, expert, referent, reward, information* and *coercive power*. These power bases have been further classified into distinct perspectives: *informal and formal, individual and group power, direct and indirect, influence versus authority, personal and impersonal, and harsh and soft* (Mechanic 2003; Peiro & Melia 2003). These classifications help provide an understanding of the different manifestations of power in the knowledge sharing process. These classifications proved important to this research as they capture the effect of the power bases on the sharing process among teams of experts.

The literature suggests that power has been mainly viewed from a formal perspective (Chiu 2006), that is, in the belief that individuals with legitimate positions in the organisation's hierarchy are the only ones with power. This perspective is gradually changing, however, with organisations beginning to draw additional knowledge from outside the organisation. The involvement of diverse and dispersed experts in the provision of care to dementia clients presents a new dimension to the issue of power. The diversity of professionals working across different aged care facilities is not necessarily bound by organisational structure. Many of these professionals are bound by the ethics of their profession and informal relationships that develop through occupational communities.

This group of dementia care experts consists of professionals who have permanent placements in aged care facilities, along with those whose expertise is shared by more than one aged care facility and whose attendance is transient. From the specialist medical areas (e.g., general practitioners, geriatricians, psychiatrists), to the allied health practitioners (e.g., dieticians, dentists, physiotherapists) and carers (formal carers and informal carers – family members), this diverse group is sourced from different organisations or independent practices, while others are employees of residential care facilities, clients' families and volunteers (Verbeek, Meyer and Leino-Kilpi 2012, Daniel et al. 2013).

Professionals involved in the care of dementia clients consist of those bound by organisational structure and influenced by formal power bases and those who are external to the aged care facility and bound by other professional relationships. It can be argued that due to the diverse nature of the members in the care teams that the professionals had both an informal and formal relationship with the organisation. The existence of formal and informal ties in this context further supports the importance of exploring the influence of power on these relationships and how knowledge is shared.

Knowledge is distributed in a much broader sense among care teams; defying the stereotyped vertical barriers to accommodate horizontal and vertical flow of knowledge in a formal organisational setting (Cecez-Kecmanovic 2004). Teams of care professionals are drawn from different knowledge perspectives, different organisations and locations. The dynamics of knowledge presents a dilemma in relation to achieving collective knowledge and because of the power issues involved in these relationships. The manifestation of power in the knowledge sharing process among care teams is thus not necessarily targeted at those holding positions in an organisations' hierarchy. Any member who has expert knowledge in a critical area may be viewed as having a source of power (Mechanic 1962; Boonstra & Bennebroek 1998).

With this in mind, the following two important issues require further study. Firstly, much research has focused on the manifestation of power due to position power or medical dominance based on the perception that those with position power necessarily possess knowledge. This assumption is referred to as *veiled authenticity* (Manias & Street 2001; Sturdy & Fineman 2001). Veiled authenticity has been defined as the perception by an individual or a group that position power equates to having expert knowledge and therefore can exert power over resources (Manias & Street, 2001). To better understand who has power in organisations, it is paramount to explore the different power bases that exist among teams of and how these power bases influence and contribute to the knowledge sharing process in the dementia context.

Secondly, informal power, such as referent and expert power based on interpersonal relationships, knowledge and social support, is present in individuals across the care continuum,

and the implications of these relationships on knowledge cultivation in the care team requires attention. Formal power bases appear to have received significant attention compared to informal power bases. Diverse teams are not just formal organisations, but also informal due to the involvement of professionals who are not bound by the organisational structure and procedures. It is possible that informal power bases affect the knowledge sharing process in teams involved in the care of dementia clients. The issue of power in informal organisations' knowledge process requires further research as the arrangement has received limited attention. Given the evidence of the effect of informal relationships on the knowledge sharing process, it can be argued that research on relational issues affecting this process would be beneficial.

The importance of power as a relational issue is due to the fact that power is a function not only of the extent of the control of information, persons and instrumentalities, but also reflects the importance of the various attributes that characterise the individual (Munduate & Bennebroek 2003). These attributes manifest as informal generators of power. Examples include such attributes as charisma and referent power, categorised as informal power bases which coalesce around individuals with appealing attributes.

It is common for informal power bases to operate outside the structured lines of communication (established organisational reporting lines), developing an avenue for shared practice through informal interactions Mechanic (2003) based on individual attributes that manifest during individual interactions. This informal communication may help care teams create shared understanding and common practices which translate into informed quality practice.

Power in this doctoral study was considered to be an element of a dynamic social process affecting behaviour, knowledge exchange and individual interaction. This perspective is different from many studies of power because it brings to light the influence of attitudes, behaviours, and social interaction on how power affects the achievement of required goals.

1.3.3 Research question three

RQ3: *How does social capital contribute to the relational dynamics in care teams and effective knowledge sharing?*

The research for this thesis explored the literature on structural capital achieved through network ties, relational capital which manifests through relationships and shared languages, agendas and narratives as the basis for cognitive capital. The examination of literature in these areas will give an understanding of the role social capital plays in the knowledge sharing processes among teams of experts.

1.3.3.1 Knowledge in teams and social capital

The knowledge sharing strategy employed by an organisation is determined by the complexity of their operation and the knowledge base. Knowledge in care teams is fragmented due to the involvement of various specialists. Kümpers et al. (2005), in their analysis of integrating specialist knowledge in the health sector have proposed the care pathway in achieving integration in the process involved in caring for clients with complex needs.

The care pathway, according to Kümpers et al. (2005), involves defining the goal, task allocation and making the required connection between the different care organisations and the professionals involved. While the steps involved have been enumerated, no definite process of how this can be achieved has been highlighted. Knowledge sharing in a fragmented setting involves consistent interaction and exchanges between actors with diverse kinds of knowledge to ensure they build some form of rapport. Rapport invariably enhances knowledge sharing and may result in actualising the concept of the care pathway (Inkpen 1996).

Collaborative efforts in the knowledge sharing process are key features in the management of organisational knowledge, as individual knowledge can only be effective in actualising organisational effectiveness if it moves from the individual level to the group level and ultimately gets absorbed into the organisation as a whole. Knowledge sharing, according to Ipe (2003), involves distribution of knowledge across the board in every setting. It entails individual knowledge being absorbed, disseminated and used in teams. To achieve this feat the cooperation of individuals is required due to the conscious nature involved in sharing. Levinthal and March (1993) proposed that sharing of knowledge owned by different actors enhances decision making in ways that cannot be achieved by a single individual.

Due to the tacit nature of experiential knowledge, knowledge sharing across boundaries is affected by different internal and external dynamics. Sharing knowledge across boundaries can be limited based on the transient attendance of professionals, organisational policies, time constraints and shift patterns. Hence, interaction in informal organisations is required to enhance the learning process. In addition, organisational sharing and learning is a key factor of organisational knowledge (Daft & Huber 1986). They therefore have a symbiotic relationship, as learning that occurs at the individual level is too narrow and will defeat the purpose of sharing (Nonaka 1995; Berkes 2009). Group-sharing and multi-level sharing are therefore prerequisites for effective decision-making.

The concept of individual and multi-level sharing, according to Mezirow (1996), enhances knowledge transfer and sharing, which can be explained using social learning theory. Social learning involves learning and sharing knowledge through a cognitive process that takes place in a social context and is effective through face-to-face interaction, communication and observation.

Social learning has three major learning and sharing processes: firstly, experiential learning, which is a process of creating knowledge by-doing (Mezirow 1996); secondly, transformative learning, involving an individual's perceptions and cognitive experience, and which can be shared through communication (Mezirow 1996); thirdly, the iterative reflection that occurs through shared experience and ideas. According to Berkes (2009), these three learning processes have emerged as a means of decision making in a collaborative environment. Furthermore, Nonaka (1995) reiterated this in his study of the creation of knowledge through the interaction between the single-loop learning (where explicit knowledge is put in practice) and double-loop learning (where individual fundamental assumptions are questioned).

This invariably occurs in an environment where there is interaction between individuals in an organisation or network and this process helps to change behaviours and enhance social capital. Knowledge sharing in teams therefore revolves around actors' ability to reflect on their behavioural patterns; as it affects how they relate and interact with people to form collaborative

knowledge sharing. Without a platform for collaboration, access to an individual's knowledge will be impeded and limited.

The argument about social learning theory and learning theory was important to this research because the concept of social interaction and face-to-face communication contributes to the sharing process in teams. These are therefore useful theories to apply in encouraging knowledge sharing among groups of professionals.

A systematic review of evidence from diverse care settings in different countries has revealed a need to improve communication and interaction between skilled health professionals to ensure delivery of high quality dementia care (Kümpers et al. 2005). However, further research is required on how to enhance specialists' ability to acquire new behavioural skills that will aid the process of interaction to ensure quality holistic dementia care.

As knowledge sharing studies have shown, the biggest challenge of knowledge sharing is changing people's behaviours and handling expectations from the knowledge exchange process (Ruggles 1998). Social capital is defined as the sum of the actual and potential resources embedded within, available through, and derived from the network of relationships possessed by an individual or social unit (Bourdieu 2011). Social capital is based on relationships and according to Hsu and Lin (2008) can serve as a means of achieving knowledge sharing in care teams. The process of building relationships ensures participants exhibit different skills and techniques in front of other individuals, and communicate with one another to ensure knowledge is disseminated (Wu, Lin and Lin 2006).

Studies have proposed that social capital ensures that the knowledge sender and receiver go through the knowledge sharing process based on intensive interaction requiring some level of trust (Wu et al. 2006; Hsu 2008). Knowledge can only become dynamic when it is circulated; otherwise such knowledge is static and cannot benefit the organisation. However, knowledge sharing among groups of professionals experiences the challenge of social and physical location boundaries that serve as a constraint on building relationships between professionals (Heizmann 2011). Communication and relationships between individuals are therefore essential to enhance

knowledge sharing, which aids behaviour, shared vision, goals and commitment. Power dynamics can however hamper this process, and that is why it is crucial to examine its influence on the knowledge sharing process and how to leverage social capital phenomena to alleviate any power play.

1.4 Method and methodology

The ontology that guides this research is *critical realism* (Lings 2008). Critical realism posits realist ontology, that is, the existence of a world independent of the researcher's knowledge of it (Miller and Tsang. 2010). This is achieved by having a holistic view of the realities that exist in the study context and studying the individual's view of the social world in which they operate as it relates to nuances like language, meaning and behaviour to inform the knowledge sharing process (Crotty 1998; Lings 2008).

Epistemology provides a philosophical background for deciding what kinds of knowledge are legitimate and adequate. Succinctly, epistemology deals with the sources of knowledge**.** Therefore, due to the peculiarity of this study's research problem, and the questions posed for the project, the epistemology of this research was based on the interpretive approach viewed from a phronesis perspective. The interpretive approach posits that research starts from the position that our knowledge of reality, including the domain of human action, is a social construction by human actors and that this applies equally to researchers. The interpretive approach is also based on interpreting and understanding relationships through observations and interviews

This research utilised a qualitative approach to examine power and knowledge in dementia care teams and thus sought to develop theory from data collected through the use of an ethnographic approach. An ethnographic approach stresses the importance of observing participants in a particular context (Easterby-Smith 2008). An ethnographic approach is the scientific and social description of peoples and cultures with their customs, habits, and mutual differences. This approach was important to this research because it allowed the researcher to observe human behaviours over a period of time. The methods used in this ethnography research are participant

observation and interviews. This research therefore used the combination of participant observation and semi-structured interviews.

Participant observation allows the researcher to observe the subtle manifestations of power in the knowledge sharing process. This informed the proposed conceptual framework in order to develop a grounded empirical model. In addition, semi-structured interviews were conducted to identify issues that participants found relevant to addressing the research problem.

Four major independent aged care facilities were used as case studies. Care teams with care professionals belonging to different professional groups who provide care to dementia clients were observed and interviewed. These four aged care facilities belong to the same corporate organisation but were independently managed by different service managers. The difference in management style, location and care teams in these four facilities revealed similar or contrasting results to ensure theoretical replication (Wilson 2010). In addition, Wilson (2010) stated that multiple case studies would answer 'why and how' questions, which required different perspectives and experience.

Data collection using the combination of ethnography, semi-structured interviews and participant observation helped the researcher to investigate the research problem from two different perspectives and also provided a platform to verify results. An ethnographic approach has been argued to have a tendency to be influenced by the researcher's feelings, therefore, combining this approach with semi-structured interviews helped give credibility and validity to the result (Lings 2008). Interview questions were based on the key research issues: quality holistic dementia care, knowledge sharing, power dynamics and social capital.

Data analysis involved digital recording of participants' interviews and subsequent transcription of audio recording for analysis with the use of *Nvivo* qualitative research software. Key themes were identified during the coding process and emerging themes were noted. The evidence identified in the various themes was interpreted according to its relevance to the research problem and questions. The coding and interpretation of the interviews helped identify links between the key themes; this informed the development of the emergent framework.

1.5 Outcome and contributions of this thesis

The overall aim of this research was to understand how collective knowledge in care teams could lead to the development of key competencies and ultimately holistically informed care practice. This research contributes to the illumination of these important theoretical connections. A number of theorists have conceptualised power in relation to the existence of structure and control at an organisational level and the inherent behaviour that exists between different actors (Gordon & Grant 2005; Hatch 2013). Studies on the relationship between power and knowledge have, however, highlighted the insufficient coverage of power within the knowledge management literature and suggest a need for empirical study (Gordon & Grant 2005).

This research contributes to existing theory by linking social relationship theories with the interaction between power and knowledge sharing processes. The practice-based view of knowledge suggests knowledge is embedded in practices and is context-based (Heizmann 2011), which implies knowledge is tacit. Tacit knowledge is embedded in an individual's personal experiences and is difficult to codify; it is therefore personal and mobile in nature (Lam 2000). Knowledge exists at different levels in the organisation, but the intrinsic involvement of individuals requires a platform to ensure it becomes absorbed across teams.

The coalition of actors has been identified as an effective way of achieving effectiveness based on the organisation's ability to align the shared goals of all stakeholders (Haas 1990). In retrospect, knowledge sharing between individuals has been viewed as an easy process. However, more research in the field has revealed the fact that knowledge can only be shared if individuals are willing to divulge skills they regard as personal and deem a source of power (Ipe 2003). The research context is the aged care, dementia health sector in Australia where there is a growing need to align the knowledge of health professionals in this field to ensure quality informed practice care. In doing so, it will advance knowledge sharing at different professional levels, taking into cognisance the power dynamics involved in the knowledge sharing process.

This research is exploring knowledge sharing from the power dynamics perspective which is subtle and cannot be quantified but manifests during social interaction. Investigating the effect of

power dynamics on knowledge sharing in dementia care teams will contribute to theory by addressing the relationship between knowledge sharing, power dynamics and how social capital can be leveraged to improve relational activities between teams of disparate professionals.

In addition, understanding how power issues influence the integration of the diverse knowledge resources that exist in the residential aged care system can contribute to more informed care providers, and ultimately further the practice of quality holistic dementia care. Therefore, to help address the research problem, this research took an ethnographic approach to experience firsthand the power display among team members.

1.6 Structure of the thesis

This thesis is divided into six chapters. In the **first chapter**, the background of the research project, context of the research, research problem and questions are highlighted and discussed. The **second chapter** provides a comprehensive literature review, develops the propositions and builds on the theoretical framework presented in Chapter One. The **third chapter** outlines the methods and methodology that guided the empirical investigation process. The **fourth chapter** presents the empirical findings and analysis of the case evidence. The **fifth chapter** discusses the empirical findings and how they relate to the overarching research problem and propositions. In conclusion, the **sixth chapter** gives a general overview of the theoretical findings and how this project contributes to practice and the existing body of knowledge; the chapter concludes with suggestions for future research.

(2) LITERATURE REVIEW

The exploration of the literature presented in this chapter provides a sound theoretical understanding of the research problem,

> *To understand knowledge sharing and power dynamics in among teams of care professionals involved in residential dementia care.*

In doing so, collections of literature corresponding to each of the research issues were examined to deliver an effective understanding of current thought on the knowledge sharing processes in care teams and the influence of power dynamics on those processes. To this end, literature was explored in the areas of:

- knowledge sharing, to help understand the knowledge sharing process in teams of care professionals involved in the care of dementia clients

This is followed by investigation of the literature on

- power dynamics

followed by an examination of research on

- social capital.

This chapter is structured around three research questions designed to address each research issue. The research questions are:

RQ1: *How do teams or groups of disparate professionals **share knowledge** in residential dementia care?*

RQ2: *What is the influence of **power dynamics** on knowledge sharing among the different professionals in care teams?*

RQ3: *How does **social capital** contribute to the relational dynamics in care teams and effective knowledge sharing?*

The first section of this chapter is guided by the research question: *How do teams or groups of disparate professionals **share knowledge** in residential dementia care?* It informs the issues of

knowledge sharing in the dementia care context by exploring literature through four different avenues:

- locus of knowledge
- typologies of knowledge in health care system
- knowledge sharing in teams
- approaches to sharing and transferring knowledge.

In doing so, the following theoretical foundations of knowledge are presented and their relevance to the project is discussed:

- individual and collective knowledge sharing
- typologies of knowledge
- social structures that enable knowledge sharing.

In the second section of this chapter, the issue of power dynamics is addressed through the research question: *What is the influence of power dynamics on knowledge sharing in care teams?* This section explores:

- the different power bases
- how these power bases manifest during knowledge sharing
- the various influence on the sharing process. Areas of literature explored includes, power and knowledge sharing, social power bases, professional power and social dimension to power.

The third section of this chapter informs the issue of social capital, by exploring: *How does social capital contribute to the relational dynamics of a care team toward effective knowledge sharing?* The literature investigated dealt with:

- network ties through structural capital
- relationships through relational capital
- shared languages, agendas and narratives as basis for cognitive capital.

The examination of literature in these areas was to give an understanding of the role social capital plays in the knowledge sharing processes among groups of experts.

Following this review of the literature and the theoretical interpretations of literature with respect to the research problem which was *to understand knowledge sharing and power dynamics in among teams of care professionals involved in residential dementia care*, three propositions and a theoretical framework were developed to illustrate the relationships between the research issues and guide the empirical investigation. The propositions for this research are presented in the final section of this chapter. This will provide an overview of how social capital can be leveraged to facilitate knowledge sharing, given the influence of power dynamics.

2.1 Knowledge sharing

Knowledge is an important resource to organisations (Ipe 2003; Nonaka & Konno 2005; Wang & Noe 2010). This has led to an exploration in the literature of how knowledge can be managed and shared. To harness the full potential of collective knowledge resources, there need to be processes in place in organisations to share, transfer and leverage knowledge that exists at individual, collective and organisational levels.

In the case of residential dementia care teams, knowledge among dispersed and diverse professionals is fluid and dynamic in nature (Nonaka 1994). This is due to the involvement of transient and multidisciplinary professionals who provide care to dementia clients. Organisations relying on teams of care professionals such as these, therefore, need to become learning organisations to ensure knowledge is shared among key individuals if they which to achieve a comprehensive body of collective knowledge, skills and competences. Creating an avenue for members of the care team to learn and share knowledge can contribute to professionals involved in the care of dementia clients having a shared vision and understanding of treatment plans for clients (Sinkula 1997; Chow 2008).

Knowledge sharing refers to the provision of information, ideas and skills to others to ensure collaboration in solving problems, creating new ideas and implementing policies and procedures (Wang & Noe 2010). A number of management theories have explored the significance of knowledge as a competitive advantage (e.g., Ipe 2003; Chiu et al. 2006). There is, however, limited literature on how knowledge is shared among diverse and disparate care professionals.

In addition, collective knowledge, for the purpose of this research defined as the aggregate of various individual professionals' knowledge that develops into a shared collective knowledge resource, is an area that requires further research. The research contributes to the literature by informing these gaps on the locus of knowledge, typologies of knowledge and approaches to knowledge sharing, and thus will help to address the research question: *How do diverse care teams of disparate professionals share knowledge in residential dementia care?*

The literature review process sought to inform this broader question with specific reference to care teams that provide support to dementia clients. A summary of knowledge sharing issues investigated and corresponding literature examined is presented in Table 2.1.

Table 2.1 Knowledge sharing issues and corresponding area of literature explored

Research Issue	Theoretical Background	Key Authors
Knowledge Sharing Issues	Locus of Knowledge	Nonaka (1994)
		David and Fahey (2000)
		Polanyin (2012)
		Lam (2000)
		Grant (1996)
		Blackler (1995)
		Nahapiet and Ghoshal (1998)
		Dosi, Nelson and Winter (2000)
	Typologies of Knowledge	Duguid (2005)
		Webster et al. (2008)
		Nonaka (1994)
		Hara and Foon Hew (2007)
		Blankenship and Ruona (2009)
		Holdt Christensen (2007)
		Blackler (1995)
	Approaches to Knowledge Sharing	Blankenship and Ruona (2009)
		Waring et al. (2013)
		Leathard (2004)
		Krackhardt and Hanson (1993)
		Wenger and Snyder (2000)
		Nugus et al. (2010)
		Scott (2006)

2.1.1 Locus of knowledge

According to Kümpers (2005), quality dementia care requires ensuring the team of care professionals involved in the care of dementia clients share their different knowledge perspectives. Identifying where these different knowledge perspectives are situated among individuals and stakeholders involved in dementia care, and the organisations that they work with, can provide an understanding of the type of knowledge present among the teams and how to share such knowledge.

Knowledge exists in individuals, groups and at the organisational level (David & Fahey 2000). There is a need to explore the relationship between the different knowledge perspectives that exist in individuals, groups, and at the organisational level among those involved in dementia care. This is important because there has to be interaction between these three levels of knowledge to harness the whole knowledge that exists in a particular context (Kimmerle & Cress 2010). The interaction between different knowledge perspectives is hence important to achieving holistic dementia care (Kümpers 2005). A review of the literature suggests divergent views among researchers about where knowledge exists in organisations and what level of interaction is necessary to achieve effective knowledge sharing (Felin 2007; Kimmerle & Cress 2010).

People have been identified as key sources of knowledge about the provision of quality holistic dementia care. Indeed, individual knowledge is personal in nature, and referred to as tacit knowledge (Nonaka et al. 2000). Individual knowledge has been referred to as something people own because knowledge is intrinsic to their personal understanding and interpretation of phenomena. It is, however, useful to note that knowledge can also be seen from the perspective of what people practice (Blackler 1995).

The perspective of knowledge as a personal possession owned by individuals and an action in practice emphasises the personal nature of individual knowledge. From these two perspectives, this research adopted the position that individual knowledge is what people think and what they do, given the fact that it is gained through experience and interaction with work processes. Individual knowledge can therefore be viewed as a personal attribute, which is difficult to

understand and separate from the individual. Knowledge in this personal context requires interaction between individuals to become collective knowledge, as much individual knowledge is tacit in nature and requires members of a team to interact; communicate and reflect on ideas to achieve collective knowledge sharing. Consequently, achieving collective knowledge may require a convergence of diverse knowledge from individuals to attain a collective knowledge perspective and provide holistic dementia care.

Individual intrinsic knowledge, according to Polanyi (2012), is referred to as tacit knowledge. Tacit knowledge, also according to Polanyi, is knowledge that can only be exchanged through interaction between individuals. Tacit knowledge has also been defined as 'that part of an organisation's knowledge which resides in the brains and bodily skills of individuals' (Lam 2000, p. 2). The definition given by these two authors gives an understanding of individual knowledge in the tacit form that can be shared through interaction. This was important to this research, as having an understanding of the type of knowledge individuals possess contributes to the understanding of how such knowledge can be shared to become collective knowledge.

Inherently, organisations and teams of care professionals are made up of different individuals and interaction between them generates knowledge that can ultimately become collective knowledge. According to Grant (1996), the existence of organisational knowledge is dependent on individual knowledge in creating, sharing and transferring knowledge. This connotes the importance of each individual knowledge perspective to attaining collective knowledge.

The contribution of different knowledge perspectives from individuals is therefore important in achieving collective knowledge. From the review of different theories regarding the significance of individual knowledge by various authors, it can be argued that knowledge from individual care professionals in care teams would form part of the locus of knowledge in a dementia care organisation. Individual knowledge, therefore, serves as a critical element of the team and the organisation's knowledge base.

There have been conflicting perspectives on the locus of knowledge. There are two schools of thought about the locus of knowledge, the individual and the collectivist. The collectivist school

of thought proposes that knowledge exists at the organisational level. From the collectivist perspective, knowledge is a social phenomenon that is different from the aggregation of knowledge in individuals (Nahapiet & Ghoshal 1998). Building on this definition, Dosi, Marengo and Legrenzi (2000) state that knowledge is not a function of the combination of individual knowledge, but exists as an attribute of the organisation. According to this perspective, knowledge is embedded in an organisation's routines, culture and documents; this form of knowledge is explicit and easily codified.

These arguments suggest that knowledge at the team and organisational level is a result of the exchange and integration of diverse individual knowledge. This perspective about the locus of knowledge views knowledge as a combination of collective knowledge and individual knowledge. Conversely, the individual school of thought views collective knowledge as a convergence of individual knowledge which goes through the socialisation process from tacit knowledge to externalised explicit knowledge stored in the organisation's repositories.

While the differing perspectives diverge in their understanding of the locus of knowledge, recognising the fact that collective knowledge is generated from individuals indicates a point of agreement about the locus of knowledge. From the arguments about the locus of knowledge in an organisation, it can be appreciated that it is important to harness all the knowledge that exists in an organisation, irrespective of the level, as this is important in achieving quality and effective service delivery (Janes et al. 2007).

For the purpose of this research, collective knowledge was identified as the aggregate of individual and organisational knowledge that evolves from the interaction that occurs between individual, collective and organisational knowledge in the dementia care setting. From the review of the literature, it can be argued that in order to explore the relationship between individual, collective and organisational knowledge in the dynamic care teams of residential dementia facilities, further research is required to generate a model to synthesize knowledge situated at individual, group and organisational level to achieve collective knowledge. This research was required because limited studies have explored the integration of these levels of knowledge as the knowledge base of an organisation.

It can be argued that the aggregate of knowledge from the individuals in the group of disparate care professionals, as well as the knowledge embedded in organisational routines, practice and procedure, makes up the locus of knowledge available to the care teams in residential dementia care facilities. From this position, knowledge from the diverse and dispersed individuals and organisational knowledge are cardinal to the success of quality care. Awareness that the application of routines, procedures and processes is dependent on individual interpretation and the application of organisational knowledge (Daniel et al. 2013), brings a recognition that knowledge is a convergence of individual and organisational knowing that needs to be cultivated to achieve collective knowledge. Hence, appropriately identifying the locus of knowledge in dementia care is crucial to understanding and articulating where knowledge resides in an organisation.

2.1.2 Typologies of knowledge

Knowledge is seen as a resource applied by social actors in an attempt to solve problems. It is hard to remove knowledge from its context, as it is bound to its use, and its user within the organization (Blackler, 1995). Knowledge is not something people have, but something they do, with practice connecting knowing with doing (Blackler, 1995; Gherardi, 2001, Gherardi & Nicolini, 2000; Lave & Wenger, 1991).

The importance of involving disparate and dispersed professionals in the aged care system and the significance of achieving collective knowledge cannot be over emphasised. In addition to identifying the origin of knowledge, it is pertinent to identify the types and dimensions of knowledge that exist in teams of dementia care professionals. Identifying the types of knowledge and knowledge perspectives that exist among care teams can assist in understanding what is required for effective integration, sharing and diffusion of knowledge in the dementia care setting.

Knowledge is broadly classified into explicit and tacit forms (Collins 2010). Explicit knowledge is knowledge that is codified and articulated; it is sometimes referred to as ‘know-that’ knowledge (Duguid 2005; Webster, Brown & Zweig 2008). Explicit knowledge in dementia care

is frequently represented in routines and information stored in patients' case folders, and regulatory, administrative processes and procedures that guide the aged care system. These forms of explicit knowledge are accessed and utilised by all the teams involved in different aged care institutions. Different authors have conceptualised explicit knowledge from different relevant perspectives.

An example of such perspectives is rationalised knowledge and coordinated knowledge (WEISS 1999; Holdt Christensen 2007). These perspectives will further help in the identification of the types of knowledge used in practice and how this knowledge manifests in the interactions among the various professionals in dementia care teams. Explicit knowledge has been referred to as *rationalised knowledge* (WEISS 1999). Rationalised knowledge includes templates and processes required to accomplish a task. Examples in the dementia care context are the policies, statements and procedures involved in the daily activities codified to guide the operation of residential homes. These types of rationalised knowledge are articulated for aged care facilities and can be accessed from anywhere and by anyone in the aged care system.

Explicit knowledge that is context specific has also been referred to as *coordinating and book knowledge*, due to the overarching policy and procedural nature of such knowledge (Hara & Foon Hew 2007; Holdt Christensen 2007). These types of knowledge are documented information and knowledge that serves as a guide to the care of dementia clients. However, while some explicit knowledge can be easily accessed, some is strictly context-specific and requires interpretation by an expert in the field (WEISS 1999).

The interpretation of information stored in repositories requires the application of embrained knowledge, defined as abstract, conceptual and theoretical knowledge gained through formal education (Polanyi 2015). Information documented in organisational repositories may mean different things to different professionals depending on their area of expertise. Dementia clients' medical history stored in an aged care plan, for example, will only make sense to a doctor or medical specialists who possess the embrained knowledge to understand the information in the plan and can conduct the necessary health procedures.

Embedded knowledge, alternatively, is wrapped up in an individual's ability to undertake specific tasks. It is the skills, know-how and capabilities that enable the worker to engage in a task without thinking, because it has become second nature. An example of embedded knowledge in the dementia care context is seen in nurses performing routine checks on clients' vital signs because the activity has become a normal care practice routine. Embedded knowledge is required to give action to embrained knowledge in specific contexts. There is likely to be constant interaction between embrained and embedded knowledge in dementia care practice (Blackler 1995).

This argument is based on Blackler's (1995) interpretation of embrained knowledge as knowledge with heavy emphasis on training and qualification. Hence, professional training and qualification form a key part of an individual's embrained knowledge, because embrained knowledge comes as a result of personal interpretation of what has been taught or explored in books peculiar to a given profession.

An example of embrained knowledge is the knowledge that comes from training as a general practitioner or a nurse, while the application of the knowledge to diagnose and treat or react in novel situations is reliant on embedded knowledge. While embrained knowledge is largely explicit, it also has a tacit dimension due to the need to apply embedded knowledge to different scenarios.

According to Argyris (1993), Blackler (1995), and Argote and Ingram (2000), such experiences occur through double-loop learning, which are experiences that can be explicit or tacit in nature. Embrained knowledge from the double-loop perspective is, therefore, also applied, based on assumptions from previous experiences. Consequently, contrary to the notion that explicit knowledge is easy to codify, some explicit knowledge requires individual interpretation and needs interaction among care teams to achieve collective knowledge. Hence, to achieve collective knowledge there needs to be a convergence of explicit, embrained knowledge and tacit, embedded knowledge.

Tacit knowledge is difficult to consciously articulate, because it is difficult to explain intuitive knowledge and learned behaviours that are automatically displayed in particular situations (Polanyi 1997). Trying to communicate this knowledge in verbal or written form is difficult. It is a type of knowledge that requires constant practice and interaction, along with rapport between individuals for it to be elucidated.

Tacit knowledge is personal, individual and context specific. According to Blackler (1995), it is embodied and encultured, that is, the individual understands their role in an organisation and is able to function appropriately in the value system, shared beliefs and rituals of the culture of the organisation. Embodied and encultured knowledge are personal and socio-cultural in nature (Blackler 1995). Encultured knowledge in dementia care aligns with the shared stories and languages that develop overtime due to interactions with individual dementia patients.

Family members, carers and care professionals involved in constant interaction with particular clients will possess tacit knowledge about historical events or idiosyncrasies that can help in treating dementia clients on a case-by-case basis. Experienced carers will also exhibit explicit, as well as tacit, knowledge of their roles in caring for a dementia patient. Clearly, they must have knowledge of the concept of dementia and the formal ways to care, but each carer will also possess important tacit knowledge derived from experience and personal attributes.

This is exemplified in Blackler's (1995) analogue of individuals being told explicitly how to operate computers or machines, while tacit knowledge achieved through constant use of the machines, allows them to idiosyncratically improve the operation due to their personal cognitive abilities and experiences. This entails applying mental abilities and judgments to a situation.

According to Hara and Foon Hew (2007) and Holdt Christensen (2007), knowledge in this form is a combination of an individual's professional training and personal experiences gained through practice. From this premise, it can be argued that while embodied knowledge is tacit, it goes from a continuum of being initially explicit from manuals and procedures, to becoming tacit from continuous practice and internalisation. From the review of the literature on tacit knowledge, it is apparent that tacit knowledge is personal and socio-cultural in nature and difficult to separate

from the individual. It can therefore be argued that the interactions between the different types and manifestations of knowledge in the health care context are what make up collective knowledge, and are thus important in achieving quality care.

With regards to converging knowledge that exists in organisations, it is important to note that each type of knowledge cannot work independently of the others. Understanding the role of each knowledge type displayed by care teams reveals the different knowledge perspectives, and how each knowledge type contributes to holistic quality dementia care. Indeed, Pisano (1994) proposed that to effectively utilise an organisation's knowledge and information, it is essential for all the knowledge types to work together as collective knowledge. It can be argued that based on the typologies of knowledge, individuals with tacit knowledge work in organisations that are guided by regulated policies and procedures. Therefore, there is interaction between knowledge in its explicit form in qualifications, policies and procedures, and tacit knowledge that is personal to each individual, which has been gained through experience, but is not readily codified or easily transmitted.

For tacit knowledge to be useful, it needs to be available in a form where others can access it and learn from those who possess it. Conversely, explicit knowledge that exists in an organisations' documents can only be interpreted in ways based on individual understanding in a given context towards achieving a definite purpose.

Indeed, Blankenship and Ruona (2009) have further stated that the type of 'knowledge in use' will inform the knowledge sharing method employed, as this depends on the degree of tacitness or explicitness. Moreover, individuals can improve on knowledge in its explicit form by combining explicit knowledge and tacit experiences or assumptions to create new knowledge through the double-loop learning process. This process, according to Nonaka's knowledge spiral, is where a higher realm of new knowledge is created and disseminated for the organisation's common goal (Nonaka 1994). Consequently, it can be argued that the collectivist premise of knowledge in organisations being mainly organisational knowledge devoid of individual knowledge is debatable. The knowledge resource in organisations is the sum of all existing

knowledge types being used by individuals and that exists in organisations' documents in the form of policies and procedures. Identifying the types of knowledge in the dementia care context is important in the process of harnessing available knowledge that will assist care teams to provide quality holistic care to dementia clients. From the review of the literature on the typologies of knowledge, a summary of findings is illustrated in Table 2.1.

Table 2.2 Typologies of knowledge

Knowledge type	Author	Manifestation
Explicit knowledge	Duguid 2005	Know-that or Know-what
	Brown & Duguid 1998	Information shared in repositories
	Webster et al 2008	Regulations and administrative processes and procedures
Rationalised knowledge	Weiss 1999	Templates, procedures, policy statements
Coordinating and book knowledge	Holdt Christensen 2007	Context specific. Policy statements and procedures
	Hara & Foon Hew 2007	
Embrained knowledge	Polanyi 2015	Acquired through formal education. Specific to professional activities ad require expert and personal interpretation
	Blackler 1995	
Tacit knowledge	Polanyi 2015	Cognitive and personal context specific knowledge
Embedded knowledge	Polanyi 2015	Individual skills - know-how used to perform a specific task without thinking because it has become second nature.
	Blackler 1995	
	Horvath 2000	
Embodied knowledge	Blackler 1995	Applying mental abilities. Continuum of explicit to tacit knowledge. Example is following instructions in manuals and from continous use and practice it becomes tacit knowledge
	Polanyi 2015	
Encultured knowledge	Blackler 1995	Shared stories, culture and languages
Cultural/professional knowledge	Hara & Foon Hew 2007	Combination of individual professional training and personal experience
	Holdt Christensen 2007	

2.1.2.1 Knowledge sharing and knowledge creation

The process of knowledge sharing has a direct effect on the creation of new knowledge. The whole essence of knowledge sharing is to ensure that other people have access to knowledge from individual experts and the organisation's systems and repositories, which in turn could help in solving problems and improve services. In the aged care context, the entwining of knowledge from diverse care professionals gives new and unique insights to the management of dementia patients (Kümpers et al. 2005).

From the discussion on the interaction between tacit and explicit knowledge, Nonaka's (1994) spiral knowledge process resonates the interaction between tacit and explicit knowledge. This knowledge development process, according to Nonaka (1994), is enriched through the socialisation, externalisation, combination and internalisation (SECI) spiral process (Figure 2.1).

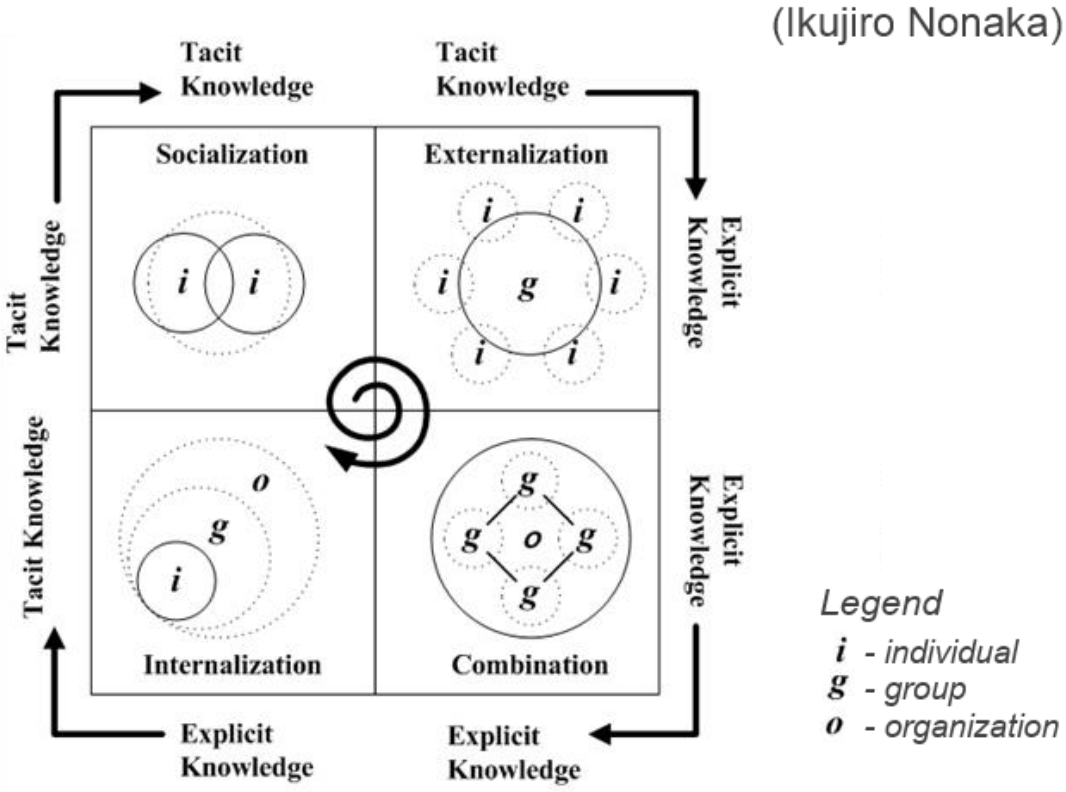

Figure 2.1 SECI model of knowledge dimensions (Ikujiro Nonaka)

Socialisation is defined as the process of learning tacit skills through observation, imitation and practice (Nonaka 1994). This process generates tacit knowledge in the individual learning from the expert, and thus the tacit-to-tacit process occurs. The tacit knowledge gleaned from this interaction is converted to explicit when the learner documents or codifies information and disseminates this to others (tacit-to-explicit).

This process is referred to as **externalisation** and serves as the point of understanding the processes involved in the know-how enough to document it or make it explicit (Nonaka & Konno 2005). In the dementia care context, this serves as the process of producing the patient's case files and ensuring that this knowledge can be viewed by all stakeholders.

Documenting new knowledge and making it available to others is the process of **combination** which involves the explicit-to-explicit continuum. The availability of explicit knowledge to other individuals in the form of procedures or operating manuals serves as a basis for combining explicit knowledge with personal tacit knowledge to develop new novel ideas, which in turn results in **internalised** knowledge.

It can, however, be argued that Nonaka addressed the interaction between knowledge from the perspective of different functional/professional headings without taking into consideration knowledge sharing between disparate professionals (Hong 2012). This suggests that Nonaka's model is based on the assumption that individuals involved in the knowledge sharing process work from the same organisation, professional group or have shared agendas, understanding or goals.

It is evident that there is a need to explore how and if the SECI process of knowledge creation and sharing works in dispersed teams of care professionals in the dementia care context. It is important to explore the process of knowledge creation and sharing in care teams that provide care to dementia clients because of the involvement of diverse and transient professionals in the care model who sometimes operate in different shifts and in different aged care facilities.

Nicolini, Gherardi and Yanow (2013) proposed that the knowledge sharing process among groups of professionals is socially constructed in activities embedded in different contexts of knowledge work. They further argued that instead of conceiving of items of knowledge as reified objects that can easily be acquired, processed, transferred, spread and stored across different geographic domains and organizational contexts, the knowledge-as-practice approach emphasizes the members' participation in 'situated material and semiotic activity mediated by a plurality of artefacts and institutions (Nicolini et al. 2003).

Nicolini's et al (2003) argument differs from Nonaka's (SECI) spiral approach because it takes teams' geographical, professional and organisational differences into consideration. This contrary opinion to the knowledge spiral process reveals that there is a need for further research to explore how the knowledge creation process works in disparate and dispersed teams. This is important to

this research because it informed an understanding of how various types of knowledge are shared among diverse and geographically separated care teams and how this helps in providing quality holistic care.

It can be argued that knowledge that exists within teams of care professionals in the dementia care industry is created through the integration of tacit and explicit knowledge with knowledge embedded in systems, processes, experiences and insights. The arguments against the limitation of Nonaka's spiral model shows the intricacies involved in integrating knowledge from care teams to achieve quality holistic dementia care. This is because of the issue of knowledge being sticky (Von Hippel 1994) and hence requires further investigation.

Knowledge is seen as sticky due to it being personal, context based, and difficult to separate from the social or practical situation (Koeglreiter, Smith & Torlina 2006). From these assertions, there appears to be a need to explore how knowledge sharing can be coordinated, given the diverse and dispersed care teams involved in caring for dementia patients. This is because knowledge is distributed between individuals, organisations and groups. Regardless of the knowledge typologies and manifestations of knowledge in different contexts, the value attributed to knowledge can only be beneficial if it is shared among individuals to become useful collective knowledge.

The examination of typologies of knowledge illustrates the personal nature of knowledge across professional boundaries which can make it difficult to share, diffuse and acquire knowledge from all the stakeholders involved in dementia care. This indicates a need to engage various professionals in interactive sessions that will mediate the institutionalised boundaries and ensure knowledge is shared across professional and organisational boundaries.

2.1.3 Approaches to knowledge sharing

The review of literature suggests that knowledge sharing between employees, within and across professional and organisational boundaries, generates collective knowledge (Kimble, Grenier and Goglio-Primard 2010). However, for this to happen, organisations require a social structure that supports knowledge sharing (Blankenship & Ruona 2009). Social structure, according to

Blankenship and Ruona (2009), is the patterned aspect of the relationship that exists among individuals in organisations. An organisation's social structure is important to the knowledge sharing process because it is difficult to separate individuals from their social context, as this is where interaction that facilitates knowledge sharing occurs (Koeglreiter et al. 2006). Social structure has been further defined as relationships between different entities or groups, or as an enduring and relatively stable patterns of relationships (Scott 2006). From the various definitions of social structure highlighted above, for the purpose of this research, social structure was defined as the cognitive or institutionalised relationships in place in dementia care facilities to help foster knowledge sharing among expert care teams.

Social structure has been conceptualised from the formal and informal perspective (Scott 2006, Blankenship & Ruona 2009). Formal social structure is concerned with formal organisations and the idea that organisations are grouped according to functional and hierarchical stances. Formal organisations are guided by rules, regulations and organisational structure. An informal social structure, however, evolves spontaneously during interaction between individuals in an organisation. It is not guided by formal rules or norms and is determined independently of positions in the organisation (Scott 2006).

An overview of the concept of social structure has shown that the structure in place in an organisation determines the approach to knowledge sharing and the type of knowledge shared (Tsai 2002). It is therefore worth noting that the social structure in place determines how tacit or explicit knowledge is shared. Organisations need to devise methods that will enhance knowledge sharing to suit the structure in place in the organisation.

The personalised and spontaneous nature of tacit knowledge encourages its transfer in an unstructured and informal setting. Sharing tacit knowledge requires regular interaction and observation between individuals to help the transfer of implicit knowledge. Tacit knowledge, therefore, requires informal avenues to encourage knowledge sharing.

Conversely, explicit knowledge is mostly embedded in an organisation's documents and is guided by formalised rules. Explicit knowledge is aligned to formal social structure, policies and

procedures. The social structure in place in the dementia care context is especially important, given the shift pattern in place and the existence of specialists who provide services to more than one aged care facility. Their attendance at the aged care facilities is therefore transient (Kümpers 2005).

An overview of literature on the social structure in place for knowledge sharing in organisations revealed some current compelling structures in place to enhance the knowledge sharing process. While a number of structures were reviewed for the purpose of this research, the structures discussed below have been delineated from others because they are directly related to the health care industry. In addition, they involve diverse and dispersed professionals and the process involved in integrating knowledge from all stakeholders.

These social structure perspectives are discussed with special emphasis on the approach to knowledge sharing. Secondly, the type of knowledge and dimensions of knowledge being shared are explored under each structure. Thirdly, the organisational boundaries and membership in each structure are explored to capture all professionals involved in the different structure and how they share knowledge. Lastly, the degree of formalisation in each social structure is examined to help determine if knowledge is being shared in a formal or informal social structure.

2.1.3.1 Knowledge brokerage

Knowledge brokerage is the act of using brokers, technologies and objects to facilitate knowledge sharing among experts. An example of knowledge brokerage in practice is the facilitation of knowledge sharing and transfer through technology transfer. This is achieved with the use of information systems. According to Wang and Noe (2010), knowledge brokerage bridges the structural holes between unconnected professionals and facilitates the coordination and alignment of knowledge between communities.

The advantage of knowledge brokerage to the knowledge sharing process is recognised through contributions from professionals across communities of practice and articulation and documentation of knowledge by diverse professionals caring for dementia clients. This approach

to knowledge sharing conceives knowledge as explicit in nature and aims to codify and store knowledge in repositories (Waring, Currie, Crompton & Bishop 2013).

The knowledge brokerage process is facilitated by a defined organisational structure. Knowledge garnered from contributions by different care professionals is embedded in organisations' documents with the help of brokers. Brokers are actors who have a formal position of serving as knowledge coordinators who gather knowledge from different professionals across professional and organisational boundaries in a particular context and store such knowledge in an explicit form available to all stakeholders.

The purpose of having a knowledge repository is to ensure expert teams from different sites can have access to updated information and knowledge about issues to guide their decision making process. An example is seen in an aged care facility tasked with a project where knowledge and expertise from different subject matter experts is sought through the creation of a network system where knowledge is collated and documented at no cost to the organisation.

The knowledge brokerage method develops a knowledge repository where new knowledge perspectives from different care professionals who are separated by distance and professional boundaries contribute to knowledge, techniques and ideas. The codified knowledge resonates with what has been referred to as *book knowledge* by Hara and Foon Hew (2007), *coordinating knowledge* by Holdt Christensen (2007) and *embrained knowledge* by Blackler (1995). It can be argued that due to it being embedded in an organisation's documents, the knowledge is available to all participants in the community and therefore is collective in nature.

While this knowledge sharing process is useful in achieving a knowledge repository, it has not properly addressed the process of sharing tacit knowledge among various professionals, or the creation of a holistic knowledge resource. In addition, researchers have identified the challenges faced by brokers wanting to access, share and support tacit knowledge which is practice-based, personal and can only be shared through interaction (Nicolini et al. 2003; Duguid 2005).

Knowledge in its tacit form requires interaction between the holder and potential recipients for it to be articulated and shared. The process of interaction among professional and organisational boundaries requires a platform for knowledge sharing. Brokers have been shown to have trouble getting different professionals to share with others from different professional groups due to the lack of shared language, mutuality and shared agenda (Wang & Noe 2010). The reluctance of professionals to share knowledge is also emphasised by professional legitimacy and power (Wang & Noe 2010), as diversity in membership, structural hierarchy and power creates barriers to sharing knowledge. These issues affect the knowledge sharing process due to the lack of opportunity to develop rapport with others from different professional headings and different organisations, which would facilitate the process of sharing. This is as a result of knowledge being gathered by a broker and represented in explicit form for dissemination.

Knowledge brokerage has also been criticised based on unclear measures to determine who serves as a broker or knowledge coordinator. Literature on the review of the role of brokers and the process of knowledge brokerage suggests a political undertone to allocating the position of a broker or a knowledge coordinator (Currie et al. 2013). This has brought to light the influence of power dynamics in relation to the institutionalised structure of knowledge sharing.

It can be argued that while the knowledge brokerage process captures explicit knowledge sharing among health care professionals across professional groups and organisational boundaries, there is a need to expand the scope from capturing knowledge in its explicit form to also harnessing tacit knowledge through relationship building avenues. In addition, there is a paucity of research on power issues connected to the issue of professional legitimacy and the allocation of the role of the broker, or knowledge coordinator, among dispersed and diverse teams of care professionals in the dementia care context.

2.1.3.2 Interdisciplinary collaboration

Knowledge sharing among all stakeholders in the health care industry has been at the forefront of research (Janes 2008; Meyer 2017). A person-centred care approach to patients' care has been recognised as a catalyst to improved service delivery in the health care system and specifically in

the dementia care context (Kümpers 2005). This approach involves collaboration and integration of experiences, knowledge and skills from all stakeholders involved in the care process (Koubel & Bungay 2008).

The success of this approach, however, requires interdisciplinary collaboration, which involves knowledge sharing among all care teams involved in dementia care. Interdisciplinary collaboration in the dementia care context is a process that brings together groups of individuals who contribute their own special and unique skills and knowledge to the creation of a cohesive care plan for the patient (Leathard 2004).

Interdisciplinary collaboration is achieved through case conference meetings. Case conferencing has been defined as a formal meeting that provides opportunities for both transient and disparate health care professionals to communicate, share knowledge about patients and document specific care plans for patients (Nugus, Greenfield, Travaglia & Westbrook 2010). The case conferencing results in interactions among professionals and this generates a wealth of tacit and explicit knowledge about the patients. This is because the process of achieving explicit knowledge (documented care plans) arises from the interactions that occur between individuals through the articulation process (Nonaka 1994), which also brings about the production of encultured knowledge through collective understanding (Blackler .1995).

This has been referred to as object-based knowledge, which is derived from collective experience in dealing with customers or patients in a particular context (Holdt Christensen 2007). Given that the mark of a well-functioning interdisciplinary team is the ability to harness different knowledge types from the diverse stakeholders involved in dementia care, this suggests that interdisciplinary collaboration is important to achieving collective knowledge due to the existence of avenues to interact and share knowledge.

Implementing interdisciplinary collaboration provides numerous benefits:

- effective communication among different and dispersed health care professionals
- constant interaction during case conferencing that builds rapport among the professionals involved in the care of patients

- relationships help facilitate quick and effective decision making concerning the clients' treatment plan (Jansen 2008)
- reduce the overall cost of repeated consultation.

The whole process of collaboration among care teams involved in the care of dementia clients helps build an understanding and respect for each other's expertise and this will in turn assist knowledge sharing. Although a collaborative and interdisciplinary team approach to knowledge sharing has been agreed to be beneficial Klein (2017), the process of achieving such approach have received limited attention among care teams in the dementia care context. Conversely, challenges have been identified about the use of case conference meetings to facilitate the knowledge sharing process among care professionals (Nugus et al. 2010).

Literature has revealed issues of professional dominance as a barrier to achieving this level of collaboration (Nugus et al. 2010). According to Nugus et al. (2010), general practitioners have been observed taking control of case conference meetings, which has hampered participation, and knowledge contribution by other members of the group. This is due to the belief that general practitioners possess superior knowledge and therefore tend to have major, if not the only, contribution at meetings (Nugus et al. 2010).

This assertion about general practitioner behaviour may defeat the process of achieving collective knowledge, which involves a convergence of knowledge perspectives from different care professionals through collaboration. Indeed, if the purpose of implementing interdisciplinary meetings is to achieve shared vision, appropriate skill mix, mutual respect and trust for colleagues from other professional groups and a perspective of equality, then professional dominance impedes this laudable vision.

In addition, the formal dimension to interdisciplinary collaboration introduces the issue of authoritative and hierarchical structures, which, according to Jansen (2008) and Leathard (2004), diminishes professional autonomy. This reveals a need to achieve a balanced level of participation, communication and contribution from all stakeholders in achieving knowledge sharing and ultimately quality dementia care.

A further review of the literature suggests that, despite the possible barrier that professional dominance poses to achieving interdisciplinary collaboration, limited research has been done to address this issue. The evidence indicates that there is a need to explore the influence of professional dominance (power) on the process of collaboration. It was anticipated when planning this research that investigating the process of interdisciplinary collaboration and how it facilitates knowledge sharing among care teams in the dementia care context would help address the influence of power on the sharing process suggested by literature and how these processes can be fine-tuned to improve the sharing process among experts.

2.1.3.3 Informal networks

An informal network is an avenue by which to share knowledge; this is achieved by building relationships created through interactions. Informal networks have therefore been defined as a set of relationships, personal interactions, and connections among participants, viewed as a set of nodes and links, with its affordances for information flows and helpful linkages (Bodin & Crona 2009).

An informal network evolves from collective thought processes (Krackhardt & Hanson 1993). It involves the distribution of information through an organisation's 'grapevine', sourced from different employees. Knowledge and information are shared in informal circumstances. An example presents in employees discussing knowledge about the clients during lunch breaks or over a cup of coffee in the staff room. This avenue provides an informal way of sharing knowledge through storytelling and sometimes information gleaned from organisation's documents in its explicit form can also be shared faster through informal networks.

According to Krackhardt and Hanson (1993), an informal network is a fluid arrangement where attendance is voluntary, and practitioners are either members of a particular profession or from diverse professions. Membership therefore cuts across professions, where colleagues from diverse professional groups communicate through social ties. It is worth noting that these professionals have diverse knowledge perspectives, but the informal network provides avenues to

share diverse knowledge and expand on how these different knowledge perspectives contribute to quality holistic dementia care.

This suggests that knowledge sharing by way of informal networks can be classified as encultured knowledge, which is a representation of collective thoughts (Blackler 1995), or know-how (Blankenship & Ruona 2009). The knowledge is documented in a repository that highlights experts or information in a particular context, as well as tacit (personal) knowledge. The resultant knowledge of the informal network is usually tacit know-how.

Informal networks help in the knowledge sharing process due to the interactions that occur between employees from different professional groups and across hierarchical levels. It appears that organisations are beginning to place value on this social structure as a means to manage knowledge, and it has been suggested by various authors that managers need to harness the various social links involved in informal networks to help understand how to further manage knowledge (Krackhardt & Hanson 1993; Blankenship & Ruona 2009; Nugus et al. 2010).

Identifying the membership and process involved in informal networks in organisations, according to Krackhardt and Hanson (1993), will help managers discover how knowledge can be shared faster through social links. Given the nature of informal networks, the involvement of managers may ultimately hinder the flow of information. This is because there is a tendency to make the whole process formal once a structured process is in place, which may reduce activities, such as unplanned and unstructured conversations amongst employees where knowledge is articulated and shared. Furthermore, the review of literature on informal networks suggests that due to the informal nature of membership, with no structure involved, there has so far been limited research on exploring whether power dynamics influence the knowledge sharing process in informal networks.

2.1.3.4 Communities of practice

Communities of practice (CoPs) are an informal avenue for sharing knowledge among dispersed and diverse care professionals through continuous interaction and communication. Communities of practice differ from interdisciplinary collaborative teams because they are self-organised,

informally structured, and therefore informal in nature. Communities of practice have been defined as a self-organised professional community aimed at situated practice, knowledge sharing and learning from the dimensions of mutual engagement, joint enterprise, and a shared repertoire of resources (Wenger & Snyder 2000).

The success of a CoP is based on interaction between the members of a team that has been established over time through relationships of mutual engagement that help to shape the group's practice, purpose and build a sense of rapport. Communities of practice are not just an aggregate of individuals that come together, but professionals that have a sense of belonging in a particular community guided by a particular cause (Soubhi et al. 2010). The purpose of a community of practice is the major driving force that binds the members together.

In the dementia care context, the purpose for sharing knowledge and exchanging information is hinged on providing quality care to dementia patients. This, in essence, forms the joint enterprise or shared agenda that drives care professionals to share knowledge (Amin & Roberts 2008). The sharing and transfer of knowledge helps to develop practice routines, shared language, stories, professional jargon peculiar to the context of interest and techniques. Indeed, during these interactions different perspectives of knowledge are shared, which evolve into the assimilation of new techniques, skills and ideas.

It can therefore be argued that knowledge sharing and knowledge creation serve as the overarching agenda for casual interaction in communities of practice where professionals interact on a regular basis to share ideas, knowledge, experience and skills that develop into a shared repertoire. Communities of practice have been known to encourage the free flow of information and encourage learning and sharing among professionals with shared domains of interest. This is due to the facial and social familiarity woven into the routine of shared work which can trigger social learning and tacit knowledge (Amin & Roberts 2008).

The knowledge of members from different communities of practice takes various forms, but ultimately knowledge is mostly shared in its tacit form. An example is knowledge shared by general practitioners or dieticians where they share experiences and stories that combine what

they have learnt from their years of academic training and their personal experiences with patients. This suggests that members of a community of practice attempt to articulate tacit knowledge during these meetings, knowledge which has gone through the internalised process (explicit to tacit) and socialisation process from tacit-to-tacit to produce what has been referred to as *professional knowledge* by Holdt Christensen (2007) and *embodied knowledge* by (Blackler 1995).

Sharing tacit knowledge requires close social proximity among members of the community due to the need for situated learning, which involves socialisation and imitation. Communities of practice have, however, been studied from a face-to-face interaction dimension and virtual interaction dimension. Therefore the option for virtual interaction exists. Virtual communities of practice, unlike face-to-face communities of practice, refer to knowledge interaction between a group through discussion boards without necessarily having regular face-to-face contact (Dubé et al. 2006).

It has been suggested that virtual communities of practice (VCoP) help encourage community collaboration on the go. This is achieved through online discussion boards and other online facilities (Dubé et al. 2006). While the importance of virtual communities of practice in facilitating knowledge sharing among dispersed professionals is obvious, Amin and Roberts (2008) suggest that bridging the boundaries between different professionals and dispersed professionals requires an avenue for them to build rapport and a sense of interdependency with other professionals in the group.

In addition, shared agendas, language, symbols and routine are developed during continuous face-to-face interaction. It is therefore apparent that face-to-face interaction is important at the initial stage of a CoP as it helps to establish rapport and a shared agenda that can be transferred to virtual interaction. Essentially, it is likely that using a combination of face-to-face CoP and Virtual CoP to share knowledge among dispersed and diverse professionals could generate some useful results. The concept of CoPs is important to the care of dementia clients given the fact that

ideas, skills and knowledge from a dispersed group is required to achieve quality holistic dementia care.

The members of a CoP are individuals from different professions whose interaction is devoid of institutionalised practice. These communities are not limited to a particular organisation or profession, as they attract individuals with diverse and different skills and experiences. Review of the literature about CoPs in the dementia care context suggests that CoPs consist of interactions between members from different health care communities of practice coming together to contribute to health care agendas (Lathlean & Le May 2002; Addicott et al. 2006; Amin & Roberts 2008).

An example is seen in CoP groups in dementia care across Australia where diverse groups of care professionals meet virtually and face-to-face periodically to discuss trends, knowledge and techniques on how to provide care to dementia clients. This gives an indication that different CoPs and avenues for informal collective thinking that cut across interdisciplinary professions exist. The unstructured nature of knowledge sharing amongst different CoPs therefore has the potential to ameliorate the difficulties of sharing knowledge in highly structured organisations.

According to Krackhardt and Hanson (1993), knowledge sharing is easier and quicker in informal settings due to the network of relationships formed across functional and divisional boundaries. This is important to the process of knowledge sharing among diverse and dispersed care teams as it points to the availability of a social structure that encourages informal knowledge sharing.

Conversely, a review of the literature suggests there is limited research on the influence of power dynamics on the knowledge sharing process in CoPs (Contu & Willmott 2003; Mørk et al. 2010). This is important due to the need for interaction among heterogeneous professionals in CoPs and the possibility of diverse power issues that may occur due to the importance of knowledge as a resource. The literature indicates that the issue of power is important due to the existence of interaction among professionals from different organisational settings and professional headings, which can give rise to conflicting stakes in regards to allegiance to professions or organisations. Consequently, it can be argued that further exploration is required to address the influence of

power on knowledge sharing in informal social structures. The current research was important to because of the involvement of different professionals in the care of dementia clients. The summary of findings aligned to the key focus areas is represented in Table 2.3.

Table 2.3 Key characteristics of organisational social structures that enable knowledge sharing

	Knowledge Brokerage	Interdisciplinary Collaboration (IDC)	Informal Networks	Communities of Practice (CoPs)
Purpose	Collect and distribute knowledge or information	Sharing knowledge to inform quality service delivery	Gathering information and passing to members of team	Knowledge development and sharing unique experiences
Types of knowledge shared	(1) Externalised knowledge (Tacit and Explicit)	(1) Externalised knowledge (Tacit and Explicit)	(1) Encultured knowledge	(1) Tacit knowledge
	(2) Book knowledge	(2) Encultured knowledge	(2) Know-how	(2) Embodied knowledge
	(3) Coordinating knowledge	(3) Object based knowledge	(3) Tacit knowledge	(3) Professional knowledge
	(4) Embodied knowledge			
Boundaries	Across different organisations and professions	Across professions	Across professions	Across professional and organisational boundaries
Degree of formalisation	Formal	Formal	Informal	Informal
Membership	Team	Personal and impersonal	Team	Team

Blankenship & Ruona (2009); Nugus, Greenfield et al. (2010); Wenger & Snyder (2000); Waring, Currie et al. (2013); Nonaka (1994); Amin & Roberts (2008)

2.2 Formal and informal knowledge sharing

From the review of the literature on the social structures in place for knowledge sharing, it is apparent that knowledge sharing can be achieved through formal and informal structures (see Tables 2.1 and 2.2). A formal approach to knowledge sharing involves structured and organised meetings, teams and storage of information in repositories. The approach is highly structured, mostly designed by management, and allocates people and resources to organisational tasks and roles. Formal knowledge sharing requires coordination by an individual who has been given the authority to do so or who assumes a place of authority or power over other individuals. The formal approach to sharing is important in ensuring knowledge is available and shared in its explicit form.

However, the structured nature of formal knowledge share is understood to limit the free flow and articulation of tacit knowledge, because the formality of the rules and procedures reduces the interaction between the experts. In addition, the literature suggests that the power dynamics in the formal and structured setting discourages the development of personal rapport and encourages the tendencies of individuals to hoard knowledge (Contu & Willmott 2003). However, considering the suggested influence power dynamics has on formal opportunities to share knowledge, limited research has explored these issues (Contu & Willmott 2003).

A review of literature suggests that an informal approach to knowledge sharing is the social dimension involved in the sharing process (Chen 2016). It is an unstructured, casual and incidental knowledge transfer that occurs during interaction between individuals. An informal social structure helps to disseminate tacit knowledge through continuous interaction and communication among professionals (Chen 2016) The ties among individuals in informal structures facilitate rapport and trust, which, in turn, help motivate individuals to share knowledge (Wang & Noe 2010).

The knowledge shared in informal settings is usually a combination of tacit knowledge and explicit knowledge that has been converted into tacit knowledge by individuals through the internalisation process (Nonaka 1994). Essentially, this form of structure encourages connections

that help to build shared agendas and a sense of belonging amongst diverse professionals, who gain the confidence to share knowledge among their colleagues. The existence of successful informal groups is important in organisations, because, when individuals are looking for a solution to a problem, they usually turn to their colleagues and not to knowledge repositories (Wang & Noe 2010). Many of the skills and much of the knowledge that employees use to perform their tasks are, therefore, not from the formal repositories provided by the organisation, but depend on a mixture of knowledge from informal and formal interactions.

Organisations are a network of informal social relationships, as well as a hierarchy of formal tasks and authority relations. The informal organisation can, however, enhance organisational performance because a substantial amount of knowledge exists outside the confines of organisational structure. Hence, harnessing power and knowledge in informal organisations can be an avenue for organisations to achieve collective knowledge.

From the foregoing on the advantage of informal relationships, in considering knowledge sharing in an aged care residential setting, there is a requirement to consider the informal organisation in terms of transient workers who work across different aged care facilities and how they share their knowledge with those inside the host organisations, and the structure in place. Transient staff pose a dilemma. Firstly, knowledge is shared in a formal structure, with which they may not be familiar. Secondly, sharing knowledge informally among disparate groups of care professionals requires trust and rapport, which are difficult to build in a transient population, however expert.

These are difficult circumstances, and it is apparent that using a hybrid of social structures in the knowledge sharing process among care teams would be required to facilitate knowledge sharing. A combination of structures at different knowledge sharing stages is seen in the use of CoPs to facilitate the informal process of building a shared language, shared repertoire, mutuality and joint enterprise (shared agenda) among professionals. This can be combined with formal structures, such as knowledge brokerage and interdisciplinary collaboration to ensure that tacit knowledge gradually becomes explicit knowledge for easy access by professionals who cannot meet face-to-face due to boundary issues. The use of these two approaches is likely to ensure a convergence of different typologies of knowledge and therefore contribute to the knowledge sharing process and ultimately the provision of quality holistic dementia care.

Based on the analysis of the literature, the first proposition for the study was:

Proposition 1: *Knowledge sharing among diverse and disparate dementia care professionals is likely to involve a unique combination of institutionalised elements and emergent social structures relative to each unique care situation and to the various experts involved.*

2.3 Power dynamics

This section explores the influence of power dynamics on knowledge sharing among professionals. The literature informing this research issue was concerned with power bases, the influence of power on the knowledge sharing process and power manifestations. These theoretical areas contributed to the understanding of how power dynamics influence knowledge sharing among professionals and therefore informed the second research question: *What is the influence of power dynamics on knowledge sharing among professionals in care teams?*

A summary of the areas of literature explored in relation to the influence of power on the knowledge sharing process are highlighted in Table 2.4.

Table 2.4 Power dynamics and corresponding area of literature explored

Research Issue	Theoretical Background	Key Authors
Power Dynamics	**Power and Knowledge Sharing** Social Power Bases • Legitimate Power • Coercive Power • Reward Power • Expert Power • Referent Power • Information Power	• Mechanic (1962) • Jayasingam, Ansari et al. (2010) • J. Boonstra and Bennebroek Gravenhorst (1998) • Munduate and Bennebroek Gravenhorst (2003) • Raven (1992) • Raven, Schwarzwald et al. (1998) • Follett and Graham (2003)
	• Power in Teams • Social Dimension to Power Dynamics	• Nugus, Greenfield et al. (2010) • Jansen (2008) • Contu and Willmott (2003)

2.3.1 Power and knowledge sharing

Power and knowledge are not seen as independent, but rather as inextricably related. According to Foucault (1982), knowledge is an exercise of power and power a function of knowledge. This suggests that knowledge serves as a competitive advantage, as those with different knowledge are seen to possess power (Krackhardt, & Hanson 2003). On the other hand, knowledge sharing requires regular interaction and communication between individuals and its success is highly dependent on the willingness and ability of individuals who hold the knowledge to share their knowledge.

Since individuals perceive knowledge as giving them a level of power and superiority (Wang & Noe 2010), they are often reluctant to share it. A review of the literature on knowledge sharing suggests a need to explore the influence of power on the knowledge sharing process, given the value of knowledge to individuals and organisations (Kümpers 2005). Knowledge sharing, and factors that influence it, is especially important in the dementia care context due to the uneven distribution of power and knowledge because of the involvement of diverse and dispersed professionals in the care of dementia patients.

Power is a term that has been defined from different theoretical perspectives. One such definition was from Marx and Weber, who conceptualised power as social relationships that exist between a plurality of actors, with some of the actors possessing the ability to ensure orders are carried out without resistance (Clegg 1994). Building on Weber's definition, a number of authors have defined power in relation to one's ability to influence another due to one's access to valuable resources (Raven 1992; Boonstra 1998).

Research reveals that the concept of power encompasses the idea that power is the resources one person has available that enable them to influence another person to do what that person would not have done otherwise (Raven 1992). Definitions also suggest that power is the ability to mobilise resources (Sabiston & Lascbinger 1995). A broad definition of power has also been provided by Boonstra (1998), who defined power as affecting emotions, opinions and behaviours of interest groups in which inequalities are involved with respect to the realisation of wishes and interests.

The definition of power has, however, evolved in recent studies, and one of the recent definitions suggests power is an act of withholding or manipulating valuable resources and ultimately exercising control of such resources ahead of others (Hekkala & Newman 2013). Given the behavioural nuances attached to the manifestation of power in the knowledge sharing process, there is a constant overlap of definitions given to power, depending on the context. From the review of different definitions given for power, and for the purposes of this research, power was defined as the influence each professional in the care team had on the knowledge sharing process due to individual behaviour and resources available to them, and how this affected quality holistic dementia care. The various approaches to defining power are paramount to understanding the influence of power on knowledge sharing. It was therefore important to refer to the definition as it aligned to the context of this research.

For the purposes of this study, influence was defined as a force one person (the agent) exerts on someone else (the target) to induce a change in the target, including changes in behaviours, opinions, attitudes, goals, needs, and values (Raven & Schwarzwald 1998). It is important to note that the target can also be an agent because, according to Rind and Kipnis (1999, pg. 151), 'we cannot expect to change other people without also causing changes in ourselves'.

Furthermore, emphasis has been laid on the interchange of roles between an agent and a target, as agents (A) who have power over targets (T) are not only those incumbents holding positions of authority over a particular person, but any member in a given context who benefits from any source of power (Raven et al. 1998). According to Mechanic (1962), irrespective of an individual's position, everyone at some point will require a resource from another person and will therefore take the position of a potential agent or target of influence. This was important in the context of this research because dementia care often involves geographically dispersed health care professionals, professionals separated by patterns of shift work (an attribute of some aged care facilities), and specialist healthcare workers who work across different facilities.

In addition, in the review of the literature on knowledge sharing, it was established that all members of the care team, irrespective of their position, have either tacit or explicit knowledge that is useful to another member of the team or the organisation (Kümpers 2005). This suggests that in the dementia care context an agent and a target can be in the same care team and exchange roles depending on who requires particular information or knowledge at any time. It is therefore important to note that every individual in the care team, irrespective of their profession or position, might possess valuable resources that are important to the provision of quality holistic dementia care and therefore serve as a source of power.

2.3.2 Social power bases

A number of power typologies and frameworks exist and these power types have evolved from different theoretical perspectives. However, from the review of literature, Raven and French's (date) typology on power seems to be the most prominent, and it aligns with the current research context. Indeed, a number of authors who have studied power, have based their exploration on French and Raven's typologies French and Raven's power typologies distinguish how an agent(s) can influence a target(s) using the following power bases: *legitimate, position, coercive, reward, referent, expert* and *information.* A review of each power base was conducted for the study based on the following perspectives: how each base affects knowledge sharing among care teams and how each base is manifested in practice.

2.3.2.1 Legitimate position power

Legitimate power is based on formal structures, whereas organisational structure is defined, hierarchical and dependent on an individual's position. Legitimate power has been defined as the perception by a target that an individual who is regarded as an agent has the legitimacy, position and authorised power to influence his or her actions and ensure compliance (Jayasingam et al. 2010). The source of influence in legitimate power is based on the structural relationship that exists between the agent and the target. It can thus be argued that power that comes from a hierarchical position or authority in an organisation serves the interest of the organisation and the agent involved.

The use of legitimate power on the knowledge sharing process is exemplified in Barley and Orr's (1997) study of how copier technicians' practices were controlled by an agent with position power with the intention of enforcing standardised and predictable procedures and discouraging technicians' local knowledge and embodied improvisational skills. This was done by providing a set of explicit procedures and enforcing strict compliance, thereby discouraging the use of tacit knowledge by the technicians (Contu & Willmott 2003).

In such a situation, the agent exercised their legitimate position power to influence the knowledge sharing process among the technicians. This is a formal use of legitimate power, which has a negative effect on the creation and sharing of tacit knowledge, while promoting strict adherence to explicit knowledge. Adherence to explicit knowledge and the formal use of power may ultimately affect an organisation's documented (explicit) knowledge, since tacit knowledge which might inform the process of creating new knowledge would be discouraged because of the reduction of informal interaction.

The manifestation of legitimate power through its influence on an action due to the position held in a particular context has been known to produce negative relationships between agents and targets (Byrne & Power 2014). In fact, Jayasingam and Ansari (2010) argue that managers can no longer rely solely on position power to influence targets, as they will only haphazardly respond to orders to share knowledge. This approach will only elicit knowledge that professionals are willing to share and not the whole knowledge available to them. It appears that managers require a level of rapport with individuals (targets), as well as and expertise in the subject matter to help facilitate knowledge sharing.

Conversely, some research has found that legitimate power has had positive effects on knowledge sharing (Krackhardt & Hanson 1993; Lettice & Parekh 2010). This conclusion is based on the use of the managers' authority to expose people from one profession to people from other professions in the hope of expanding informal network ties and encouraging knowledge sharing (Krackhardt & Hanson 1993; Lettice & Parekh 2010). According to Jayasingam et al. (2010), the method of

using legitimate power to enhance knowledge sharing involves managers interacting with targets on the same level, thereby building a trust relationship. This suggests that legitimate power should not be the sole mechanism of influence owned by an agent, but that a hybrid of power bases will help to gain a higher level of influence on knowledge sharing in a group.

Hence, while legitimate power has been viewed from a formal and negative perspective, it can be argued that through interaction and a combination of other power bases, such as expert or referent power (discussed below) with a legitimate power position; legitimate power tends to have a positive influence on knowledge sharing. Viewed from an informal perspective, legitimacy and positivity are associated with the presence of relationships.

This assertion about the positive effect of legitimate power is, however, contingent on individual attitude and definite context (Jayasingam et al. 2010). When the exercise of legitimate power exerts a positive effect on the sharing process, the results facilitate voluntary tacit knowledge sharing, as well as explicit knowledge sharing if they are complemented with other power structure. Studies on the positive influence of legitimate power on the knowledge sharing process are, however, limited and restricted to interactions between professionals within an organisation. It can therefore be argued that further research is needed to explore how legitimate power can be used to enhance knowledge sharing among dispersed professionals.

The use of a collection of power bases by managers with legitimate position power was reviewed in the literature related to health care. The results suggest that the implementation of legitimate position power has a negative effect on knowledge sharing. In the health care context, general practitioners are perceived to have authority power because they are usually high up in the organisational structure; this perception is based on their level of education and the esteem accorded to the profession. General practitioners therefore have a tendency to take charge at case conference meetings, while other professionals with less education take a back seat with hardly any opportunity to contribute (Leathard 2004; Jansen 2008; Nugus et al. 2010). The reluctance to share or contribute to discussions at case conference meetings can ultimately have far-reaching

effects on knowledge contribution from other health care professionals as it discourages the free flow of information. It is therefore important to explore how legitimate power can be evenly distributed in such a way as to facilitate equitable knowledge contributions from the variety of participating experts, irrespective of an individual's position in the organisation.

2.3.2.2 Coercive power

Coercive power stems from the perception that one individual has the right to enforce an action through threats or disapproval. Coercive power has been defined as the belief or perception that an individual with position power has the ability to inflict punishment, dismissal and threats on another individual (Jayasingam et al. 2010). It is important to note that for coercive power to be effective, the target needs to believe that the agent has the right and position power to enforce the threats presented.

Coercive power has been conceptualised from the impersonal perspective and the personal perspective. According to Raven et al. (1998), impersonal coercive power involves threats that can be argued to be tangible and physically seen by everyone, but does not affect an individual in a personal way. An example is seen in a threat of dismissal from a position or the threat of a low performance management score if an individual fails to abide by an organisation's knowledge sharing initiative.

A review of Raven's (1998) early work on power revealed another perspective to coercive power, which reinterpreted coercive power to include personal manifestations. Indeed, Raven et al. (1998) redefined coercive power to include personal coercion where intangible attributes are used to coerce an individual to comply to a directive. This is indicative of an agent's threat to disapprove or dislike an individual for non-compliance to a particular directive.

The use of coercive power is closely tied to formalised procedures, and this is what gives one individual the legitimate right to enforce a sanction on another individual. These procedures usually outline the repercussions of disregarding a directive; this power base is therefore linked to organisational hierarchy and the control system. It can be argued that coercive power is formal in nature and can be linked to the existence of explicit resources, which are connected to organisational procedures and not the use of tacit resources to exert power.

A number of studies on coercive power have argued that the use of coercive power is effective in enforcing legitimate power in order to achieve a goal (Raven et al. 1998; Jayasingam et al. 2010). Further research has shown that the use of oppressive actions often labelled as power is more likely to be because of lack of power. This assertion, according to Jayasingam et al. (2010), is based on the premise that a manager with legitimate power does not require any form of coercion to get the job done. It can be argued that an individual with a hybrid of legitimate power and coercive power, known to possess superior expertise, and well respected for key attributes, will not struggle to exert authority through coercion.

Exerting power forcefully can be linked to a leader's ineffectiveness and inability to achieve delegated duty. Forceful exertion of power through the use of coercive power was exemplified in Raven et al.'s (1998) study of nurses who used coercive and legitimate power because they felt insecure about their position in the health care system. According to Jayasingam et al. (2010), using coercive power to enforce knowledge transfer can serve as a barrier to generating and encouraging a learning and knowledge environment.

Therefore, using force or threat of punishment can discourage professionals from sharing their unique and personal knowledge, or have at most superficial influence on the target. Coercive power may therefore have a negative influence on knowledge sharing and should be discouraged. The influence of coercive power on the knowledge sharing process among dispersed and disparate professionals may impede the flow of knowledge and ultimately affect the provision of quality dementia care to clients.

2.3.2.3 Reward power

The influence of reward power on the knowledge sharing process is dependent on what motivates an individual. Reward power is based on the target's belief that the manager has the ability to provide them with desired tangible or intangible rewards (Jayasingam et al. 2010). The influence of reward power can therefore be impersonal and formal, based on tangible organisational rewards or benefits. This form of reward can only be accessed if the agent has the authority to determine who gets a reward and who does not get a reward. On the other hand, reward power

can be personal and subjective if the reward being offered is in the form of personal, intangible approval from someone whose approval is important to the target (Raven 1992).

The influence of reward power on individuals is an area of debate in the research literature. One theoretical perspective argues that reward power has a manipulative effect on the knowledge sharing process (Amar 2002), and therefore disables rather than enables knowledge sharing (Politis 2005). This suggests that using reward power as a tool to ensure knowledge sharing behaviours in individuals will not necessarily produce the right kind of attitude to sharing knowledge within a team.

On the other hand, according to Raven et al. (1998), the ability of an agent to use reward power to influence a target's decision to share knowledge is useful, and not manipulative, if the target really values the reward. In the dispersed dementia care context, where professionals do not work within the same organisation, there may be limited reward incentives that can be used to encourage individuals to share knowledge. Reward power can have a positive effect on knowledge sharing, therefore, depending on what motivates an individual, and the opportunities to reward the target or to bring individuals together for sharing knowledge.

Mapping out what motivates individuals to share knowledge determines the effect of reward power on their knowledge sharing behaviours. Expectancy theory emphasises the need for organisations to relate rewards directly to performance and to ensure that the rewards provided are those rewards wanted by the recipients (Lunenburg 2011). Expectancy theory helps to explain an individual's motivation to perform. It is based on the idea that people believe there are relationships between the effort they put forth, the performance they achieve from that effort, and the rewards they receive for their effort and performance (Lunenburg 2011). Building on the expectancy theory of motivation, organisations need to relate rewards to what motivates each individual. This is important because every individual is motivated by different elements, either intrinsic or extrinsic.

Intrinsic motivation involves doing something because it is inherently interesting or enjoyable (Ryan & Deci 2000). While limited empirical research has been conducted on the influence of reward power on knowledge sharing in the dementia care context, extant literature on intrinsic motivation suggests that employees choose to share knowledge as a way to help develop personal relationships with peers, as this serves as a means of interaction and learning from colleagues (Wang & Noe 2010).

On the other hand, it has been argued that extrinsic elements also determine an individual's willingness to share knowledge. Extrinsic involves doing something in expectation of a tangible reward (Ryan & Deci 2000). While some professionals perceive the promise of a pay rise as demeaning and manipulative, some professionals share knowledge to either get the extra extrinsic benefits of public recognition, incentives and/or the sense of being regarded as an authority in their field, as expert, or having information power (Ipe 2003).

This suggests that reward power can have a positive or negative influence on knowledge sharing, depending on what motivates an individual to share knowledge. It can be argued that reward power may help facilitate the knowledge sharing process and adopting a reward culture in organisations can serve as an incentive to sharing knowledge.

2.3.2.4 Expert power

Expertises, and indeed knowledge, are important factors in discussing the issue of social power. Expertise is important to achieving quality and effective service delivery, as having expertise in a particular context, simply put, gets the job done. Expert power has been viewed from the perspective of a target's belief that someone in authority can provide special knowledge in a given context (Munduate 2003). A review of the literature has, however, revealed a progression from expert power solely owned by people in authority to include everyone with valuable and unique knowledge (Mechanic 1962; Raven, Schwarzwald et al. 1998; Jayasingam et al. 2010).

With this in mind, expert power has been defined as power owned by individuals who possesses valued skills, knowledge, experience or judgment that others need and do not possess themselves

(Jayasingam et al. 2010). Indeed, access to this unique expertise is not necessarily dependant on the formal structure of an organisation because, irrespective of an individual's position in an organisation, they possess expertise useful to achieve the goal of the organisation.

According to Mechanic (1962), the informal social structure of an organisation kicks in with the existence of expert power when employees at all level have valuable skills, information and expertise that are useful to another person or the organisation. This informal network disregards the structured lines of communication with the intention of developing an avenue for shared practice through informal interactions.

In the health care context, this informal communication may help groups of professionals create shared understanding and common practices which can develop into quality dementia care. In addition, it can be argued from the foregoing that expert power is context based. It is therefore apparent that among care teams involved in the care of dementia patients, each professional has expertise needed by the other.

A general practitioner is an expert in the practice of medicine. An aged care nurse is an expert in the care of ageing clients. A personal care assistant is an expert who possesses tacit knowledge and important information particular to each patient due to their role of providing personal care. All levels, types and social construction of skills and expertise need to be considered in the issue of the influence of power dynamics on the knowledge sharing process, as every professional has expertise and knowledge that gives them expert power. This forms the positive aspect of expert power.

Conversely, another theoretical perspective has been offered by Raven et al. (1998) who notes that care professionals in positions of influence can generate negative attributes in individuals or subordinates. It has been argued that expert power can also be disregarded because care professionals often act in response to their personal desires (Boonstra & Bennebroek, Gravenhorst 1998) and to their own advantage, using their expertise for personal gain (Raven 1992; Byrne & Power 2014).

Individuals who have power associated with their perceived position in the organisation need to realise the importance of having expert power or a combination of expert power and position power to facilitate any form of influence (Jayasingam et al. 2010). This is important because individuals who have expert knowledge in an organisation tend to expect that those among the top hierarchy possess superior expert power and should be able to guide them based on their expertise.

Individuals like general practitioners, who are perceived to have position power and expert power, can use the combination of the power bases they possess, both formal and informal, to influence and mentor other professionals and not discourage them from sharing knowledge that will benefit the shared agenda. The process of inspiring every professional in a team to share knowledge irrespective of his or her position in an organisation resonates with the concept of empowerment.

2.3.2.5 Empowerment

The concept of empowerment brings the issue of specialisation to light because it addresses the concept of redistribution of power by ensuring every individual's knowledge and skills are harnessed and recognised. Empowerment is defined as a process whereby individuals learn to see a closer correspondence between their goals and a sense of how to achieve them, and a relationship between their efforts and life outcomes (Mechanic, 1991). Another useful definition of empowerment views it as an intentional, ongoing process centred in a context, involving mutual respect, critical reflection, caring and group participation, through which people lacking in equal shared valued resources gain greater access to and control over those resources (Wilkinson 1998).

Empowerment, according to Follett and Graham (2003), is aimed at preventing an uneven distribution of power that causes power domination or a perceived monopoly of expert knowledge. The concept of empowerment involves the decentralisation of authority to encourage contributions from all employees. In practice, empowerment helps organisations in terms of people management. The hierarchical authority that limits everyone's involvement because of

expertise tied to position power is discouraged and greater emphasis is based on empowerment through the utilisation of every employee's unique expertise (Wilkinson 1998).

The definitions of empowerment suggest that it may facilitate employee commitment, a willingness to share knowledge across the board and a high possibility of positive power influence. This suggests that empowerment can result in flexibility of operation, which relies on every employee's skills, knowledge and expertise to achieve quality service delivery. Increase in specialisation and the existence of expertise in every professional may assist in boosting the confidence of care teams at every level, and make every employee important in the achievement of quality service.

The concept of empowerment therefore reveals the importance of ensuring every professional in the care team is respected because everyone possesses a level of expertise, either in the tacit form of personal knowledge or the explicit form of information power. However, not all these professionals have legitimate power and this may affect the importance given to the skill, knowledge or information they possess (Mechanic 1962).

According to Edelman,Bresnen and Newell (2004), legitimate power is determined by the organisational structure and the reporting lines in place in an institution. Consequently, the literature suggests that organisations require a knowledge audit where knowledge possessed by different professionals is identified and, even more specifically (Wilkinson 1998), a knowledge repository identifying subject matter experts to help access knowledge quickly and empower all employees across the board. This will ensure every professional's expertise is harnessed in the knowledge sharing process.

2.3.2.6 Information power

The nature of information power is such that the information an agent presents to a target can effectively cause a change in the decision making process. Information in the context of this study included knowledge about a patient's history, knowledge of norms and procedures, knowledge about who the expert in a particular field was, knowledge about what triggers a particular behaviour in a dementia patient, and knowledge about the treatment history of a dementia patient. Information power leads to internalised and lasting changes in the target's beliefs, attitudes, or values (Munduate & Bennebroek Gravenhorst 2003). Compared to other

bases of social power, the changed behaviour resulting from information affects a target permanently, and once the knowledge or information is shared, it becomes available in explicit form to all parties involved (Raven 1992).

Information power has been viewed from both direct and indirect perspectives (Raven 1992). Direct information power involves an individual's direct control or access to information that can cause a permanent change in another individual. In practice, changes caused by information power have been noted to usually be positive changes (Raven 1992) in the behaviour of the target after the information has been received.

In the case of indirect information, this occurs when information is passed to a workplace superior in an indirect form. An example of indirect information power was illustrated by Raven et al. (1998) where a nurse informed a general practitioner that she observed that a particular treatment seemed to have helped another patient treated for the same ailment. The influence of this indirect information usually causes a positive change in the general practitioner's treatment pattern due to the nurse's additional information.

It is important to note that not all information power is linked to position power since important information exists at every level in an organisation (Mechanic 1962b). Every employee has potentially important information that can help in actualising quality service delivery. Access to unique and important information gives an agent information power over the target irrespective of the position of the agent (Mechanic 1962).

It can be argued, therefore, that contrary to the bases of power previously discussed, information power is independent, both of the position of the agent and the agent's relationship with the target, and is instead based on the perceived relevance and validity of the information. The knowledge sharing process in dementia care is important, given the involvement of so many diverse and disparate health care professionals. Every care team has information which arises from their interactions with each patient. This is information that could make a lasting positive impression on decisions about treatment to enhance quality care.

2.3.2.7 Referent power

Unlike other social power bases, referent power evolves from a target's acceptance of an agent. Acceptance of the agent, according to Jayasingam et al. (2010), is based on the ability of the agent to influence the target through loyalty, respect and admiration of the agent's leadership style. The influence of referent power is not necessarily based on position power or tangible resources, but on intangible resources that are only recognised by the individuals who have been influenced (Jayasingam et al. 2010).

Referent power was therefore defined in the current study as the aspiration to be like a person respected due to attributes considered worthy of emulation. Referent power can be experienced because of the characteristics a person possesses. For example, it can be based in a manager's approach to dealing with subordinates in a way which endears the manager to them. Referent power has been known to lead to private acceptance by the target by enabling him or her to maintain a satisfactory relationship with the agent and see him- or herself as similar to the agent on certain relevant dimensions. This manifestation of referent power has a positive influence on an individual's behaviour, (Raven et al. 1998) due to the fact that the character that a target admires in a person makes the target adhere to instructions given by the agent.

However, Jayasingam et al. (2010) have argued that referent power does not necessarily influence knowledge sharing behaviours since individuals with expertise are independent people who decide when to share knowledge and with whom. Corresponding with the uncertain influence of referent power on knowledge sharing, referent power can also have a negative effect on individuals when people imitate not only good attributes but also bad. Imitating bad attributes can affect the perception of the target and ultimately have a negative influence.

An example of how referent power can have a negative effect on knowledge sharing in the dementia context can seen in a well respected nurse hoarding information from some particular individuals when, from her perspective, their work does not require such client information. Her perception can influence those who respect and value her opinion, who fails to investigate whether the individuals who have been excluded actually do require the information.

The review of the literature suggests that limited research exists on the influence of referent power on the knowledge sharing process, especially among the members of teams. It can be argued that it is important to both research and practice to explore the influence of referent power on the knowledge sharing process because knowledge sharing involves constant interaction among individuals, and attitudes can serve to either encourage knowledge sharing or discourage knowledge sharing.

2.3.3 Power in teams

The previous sections explored literature on the influence of different power bases on knowledge sharing among individual professionals. However, due to the involvement of different professions in the care of dementia patients, a review of the influence of power on knowledge sharing among professional groups was deemed necessary, given the growing tendency for organisations to draw additional knowledge from outside the organisation and from multidisciplinary professionals (Wang & Noe 2010).

In the dementia care context, care teams in residential aged care facilities are made up of a multi-disciplinary professional group of care professionals consisting of members from specialist medical areas (e.g., general practitioners, geriatricians, psychiatrists), allied health practitioners (e.g., dieticians, dentists, physiotherapists) and carers (formal carers and informal carers – family members) (Verbeek et al. 2012; Daniel et al. 2013). These different occupational groups maintain their power structure within the organisation and even in informal groups (Mechanic 1962), so working in a team with different professionals has the potential to bring about competing interests and ideas.

Furthermore, the nature of the interactions between diverse professionals in dementia care suggests that there are power dynamics issues. According to Nugus et al. (2010), the professional diversity that exists in care team results in fragmented understanding, which generates power plays amongst these diverse groups. This, according to Nugus et al. (2010), is because each profession possesses a repertoire of knowledge that gives them a sense of importance, power and

influence. This suggests that there is a need to explore the influence professional power has on the knowledge sharing process among the members of care teams.

The contribution of different professionals involved in the care of dementia clients highlights the intricacies involved in sharing knowledge in the midst of divergent structures. It should be noted that the power process among professionals is characterised by negotiation and an exchange of resources (Mechanic 1962). Resource exchange in this context refers to the sharing of skills and knowledge required to achieve a shared agenda among all stakeholders. However, in the light of the importance of knowledge in achieving quality service, it has been argued that, depending on the context, some professionals' skills have more influence on decision making than others (Mechanic 1962; Jansen 2008).

Indeed, Jansen (2008) has argued that the importance placed on a professional's skills or knowledge in a particular context brings about professional dominance, meaning that one profession among a multi-disciplinary professional group assumes a leadership position or exerts a major influence on decision making (Jansen 2008; Nugus et al. 2010). In the dementia care context, the review of the literature revealed that general practitioners usually take the lead in decision making (Jansen 2008; Nugus et al. 2010), although it must be noted that professional dominative power is not restricted to a particular profession in the health care context. Professionals from various professions also have the tendency to display some subtle level of power.

This leads to what has been referred to as competitive power. Competitive power, according to Nugus et al. (2010), involves a particular profession or member of a profession dominating others. This resonates with legitimate or coercive power, in the sense that a particular profession or member of a profession dominates others due to perceived formal authority given by the organisation. This perceived authority has been linked to the level of pay, decision making power and the importance accorded to the role of the profession in the final work process (Jansen 2008). This suggests that the professional whose expertise is most valued in the decision making process

is likely to possess expert power. This engenders a sense of superiority among the members of the profession.

According to Nugus et al. (2010), competitive power discourages knowledge sharing among care professionals because it discourages other professionals from sharing their unique and valuable knowledge. Therefore, although every member of a team possesses some form of expertise needed by others, opportunities to share valuable knowledge are rare or not pursued.

From the collaborative perspective, teams have been known to collaborate in arriving at solutions to shared agendas. An example was outlined by Nugus et al. (2010), whose empirical evidence revealed diverse health care professionals using collaborative power to achieve collective knowledge. Collaborative power involves equal participation in decision making and employees evaluating their own performance to hold themselves accountable to team members (Nugus et al. 2010). It can be argued that some professionals, irrespective of their perceived professional power or the respect accorded to their profession, encourage equal participation in knowledge sharing meetings (Nugus et al. 2010). This is exemplified in some general practitioners operating 'collegially facilitated' case conference meetings (Nugus et al. 2010, pg. 5).

A collegially facilitated case conference meeting involves responsibilities and discussions shared by every member with no control from a perceived dominating leader. In the dementia care context, collegial facilitation involves equitable representation from medical, allied health workers, auxiliary employees, clients, family members and everyone involved in the care of a client coming together to contribute their expertise without any one professional or individual making all the decisions. A collegially facilitated meeting therefore involves sharing power or authority with individuals seen as colleagues; this aligns with the concept of individual empowerment.

This is very important to the knowledge sharing process amongst professionals because it encourages open communication and can ultimately have a positive influence on providing holistic quality service. Dementia care is such that no professional can work without the

contribution of other professionals in delivering quality care (Kümpers 2005). Hence, it is useful for health care professionals to get to the point where collaboration and respect for contributions from all professionals involved in dementia care is sought and valued.

This is also important and relevant to management practice as inter-professional relations are fast becoming important in the work place (Nester 2016). It can therefore be argued that while limited research has focused on the influence of individual power plays in the knowledge sharing process, the issue of the professional powerplay has received less attention. Thus, empirical research is needed to examine the influence of power on knowledge sharing, both at the individual level and at the group/professional level.

2.3.4 Professional hierarchy

The knowledge relationship between care professionals appears to be dynamic. From one perspective, there are professionals who promote a collegially facilitated case conference meeting involving every member of the collective with no perceived hierarchy. Conversely, Freidson (1970) proposed that in professions like medicine, there is a monopoly of knowledge, power and treatment pathway over the techniques and competences required to address peculiar dementia issues in practice and in a given domain. Professional power, status and hierarchy limit the flow of knowledge and collaboration between different care professionals. This result in some professionals, and by implication knowledge domains, positioned as having higher status than others. Within the healthcare sector, the dominance of doctors over other clinicians (Freidson, 1994), specifically the ongoing subservience of nursing and other allied healthcare professionals to doctors, is likely to hinder any effort to mobilize knowledge across boundaries. For example, the act of professional hierarchies and more clinically bound knowledge-brokerage activities and meetings confined to discussions and interactions between doctors excluding other collectives of experts.

Professions operate as part of an interdependent system Abbott (1988), whereby the activities and developments of one group necessarily impact upon, and are constrained by, other groups within the system. Processes of knowledge sharing may be contested between professions, and are tied up with issues of power, status and control. Example is seen in the stratification based on the importance placed on particular professions. To define stratification in this context, stratification may mean doctors taking greater leadership and decision-making responsibility than other care professionals and not encouraging contribution from others, with power moving upwards within the professional hierarchy. Examples are doctors who exercise control over case management meetings and are not opened to suggestions from other professions (Freidson, 1988, 1994).

2.3.5 Social dimension to power dynamics

The previous sections explored the different power bases, their influence on the knowledge sharing process among different professionals, the power/knowledge resource manifestation and the type of knowledge shared. The review of the literature on the influence of power on the knowledge sharing process revealed that power is exercised both formally and informally.

Using measurement instruments different from French and Raven's (1994) power sources, revealed two dimensions of social power. Formal power is a role characterised socially and impersonally determined, rather than a personal one. On the other hand, informal power is a personal characteristic, connected to personal competencies, background, and experiences (Raven 1994). Furthermore, formal power is based on structural power sources related to hierarchical position, while informal power is based on personal power sources not necessarily associated with formal structures.

Formal power structures can be recognised as:

- legitimate position power
- reward power
- information power
- coercion power

while informal power can be grouped as expert and referent.

There is, however, an overlap in the case of referent and information power, according to the review of the literature. These two power bases manifest under informal power, as well as formal power bases. The review of the literature revealed that various researchers assert that legitimate position power manifests in formal settings and has a negative effect. However, the current research diverged from this opinion, influenced as it was by the results of Jayasingam et al. (2010) and Krackhardt and Hanson's (1993) study.

Jayasingam et al. (2010) and Krackhardt and Hanson (1993) argue that managers using legitimate position power to facilitate informal relationships between and among individuals to encourage knowledge sharing contribute to the knowledge sharing process and therefore have a positive effect on the sharing process. Based on the argument that legitimate power can be used to facilitate knowledge sharing, combining legitimate position power with other forms of power is likely to encourage knowledge sharing without negative influence. This leads to the second proposition:

Proposition 2: *The combination of formal and informal power bases is likely to have a positive influence on the knowledge sharing process among the members of care teams.*

Power influences the relationships among professionals who work together in the same and different organisations. The influence of power on the interactions between team members ultimately determines who shares knowledge with whom and the motive behind sharing knowledge among colleagues or across professions. Different types of personal power have a major influence on the knowledge sharing process. However, there needs to be more exploration and empirical research on each type of power and how it affects knowledge sharing, either positively or negatively. The relationships between power bases and knowledge typologies have been analysed and summarised in Table 2.5.

Table 2.5 Key representation of power bases, manifestations, influence on knowledge sharing and social structure

Bases of social power	Manifestations/Differentiation	Influences on knowledge sharing	Social structure	Knowledge/Power resources in display
Legitimate power	Formal (Position Power)	Positive	Formal social structure Interdisciplinary collaboration and knowledge brokerage	Explicit
	Informal	Negative		Tacit
	Reciprocity			
	Dependence			
	Equity			
Coercion power	Personal	Negative	Formal social structure	Explicit
	Impersonal			
Reward power	Impersonal	Positive	Formal	Explicit
	Personal	Negative	Informal	Tacit
Expert power	Positive	Positive	Informal	Tacit
	Negative	Negative		
Information power	Direct	Positive	Formal	Explicit
	Indirect		Informal	Tacit
Referent power	Positive	Positive	Informal	Tacit
	Negative	Negative		

Jayasingam, Ansari et al. (2010); Byrne & Power (2014); Lettice & Parekh (2010); Raven (1992); Raven, Schwarzwald et al. (1998); Mechanic (1962)

2.4 Social capital

The third research issue explores the role of social capital and the influence of power dynamics on the knowledge sharing process among diverse professionals in dementia care. The literature informing the issue of social capital is presented through the three facets of social capital: structural, relational and cognitive capital (Nahapiet & Ghoshal 1998; Anand et al. 2002). It is worth noting that although these three perspectives have been interpreted in different ways by social capital researchers, they are interrelated and combining them will result in a more informed understanding of collective social capital.

Social capital has been conceptualised from different perspectives; this has therefore resulted in diverse definitions depending on the authors' context. It has been defined as the aggregate of potential resources linked to institutionalized relationships; or membership of a group based on mutual acquisition, which provides each member of the group collectively owned capital (Bourdieu 2011). Indeed, Anand et al. (2002) view social capital as those features of social organisation, such as relationships, trust, norms, shared agendas and networks, that can improve the efficiency of society by facilitating coordinated actions.

Another useful definition is Nahapiet and Ghoshal's (1998) definition. Social capital was defined as the sum of the actual and potential resources embedded within, available through, and derived from the network of relationships possessed by an individual or social unit. These definitions suggest that one of the main focal points of social capital theory is that people gain tangible and intangible resources at the individual, group and organizational level through social interaction and connections with others.

Social capital is characterized by the major attributes of social ties, relationships, trust, norms, shared language and shared narratives (Nahapiet & Ghoshal 1998). These attributes are important in achieving knowledge sharing among groups, because knowledge sharing involves relationships that exist within social structure and networks. Relationships foster trust that helps people draw closer to one another and facilitates knowledge sharing, and the need for shared

agendas that ensures participation towards a common goal. Social capital therefore encompasses social interaction, trust and shared vision, which, from the review of literature on sharing knowledge, are preconditions for knowledge sharing. The previous sections of this chapter discussed how an organisation's social structure affects the process of knowledge sharing among individuals and groups and at an organizational level. Building on this review of the literature on the effect of organisations' social structure on knowledge sharing, this section explores the role of social capital in the knowledge sharing process among care teams.

Three social capital dimensions are examined: network ties that exist through structural capital; relationships that are formulated through relational capital; shared languages and narratives that form the basis of cognitive capital. Collectively, these three dimensions of social capital contribute to our understanding of the interactions and relationships that facilitate the knowledge sharing process among group members and so help inform the third research question: *How does social capital contribute to the relational dynamics in care teams and effective knowledge sharing?*

Table 2.6 Social capital issues and areas of literature explored

Research Issue	Theoretical Background	Key Authors
Social Capital	Structural Capital	• Krackhardt and Hanson (1993) • Chang, Huang et al. (2012) • Díez-Vial and Montoro-Sánchez (2014) • Bourdieu (2011)
	Relational Capital	• Chang, Huang et al. (2012) • Díez-Vial and Montoro-Sánchez (2014) • Bourdieu (2011)
	Cognitive Capital	• Chang, Huang et al. (2012) • Díez-Vial and Montoro-Sánchez (2014) • Bourdieu (2011)

2.4.1 Network ties through structural social capital

Structural capital describes the network connections that exist between individuals and groups. Indeed, social capital theory is directly concerned with relationships as a resource to ensuring collaboration among individuals (Anand et al. 2002) . Nahapiet and Ghoshal (1998) opined that there is a direct correlation between social and intellectual capital since intellectual capital in the form of knowledge possessed by individuals requires a platform for interaction for knowledge sharing to take place. *Social capital* describes such a platform, pointing to the relationships among individuals and their shared vision (Díez-Vial & Montoro-Sánchez 2014). Consequently, social capital encompasses both the relationship structure of teams and the knowledge resource needed to form collective knowledge that will help create a competitive advantage for organisations.

Social capital relates to relationships between various actors in a group (Nahapiet & Ghoshal 1998). In relation to care teams, aged care professionals belong to diverse professional groups, hence, to achieve interactions between these professional groups, forming a structure that will influence the level of sharing that takes place will likely aid effective dementia practice. Indeed, forming a structure that aids interaction helps create collective knowledge sharing platforms, useful because of the transient and diverse care teams involved in the care of dementia clients.

The structural dimension to social capital is therefore important due to the network of relationships between individuals that forms connectivity among and within people and units (Nahapiet & Ghoshal 1998). The network ties and interactions of the various care professionals involved in dementia care are important to the effective knowledge sharing process because these relationships form a platform for interaction and therefore can facilitate the sharing of unique and valuable knowledge. Network ties refers to relationships that exist between individuals in an organisation (Krackhardt & Hanson 1993).

In the context of this research, professionals involved in the care of dementia clients require a platform to form rapport that can ultimately enhance the knowledge sharing process and alleviate likely power issues. Building a rapport through network ties can strengthen respect for each

others' knowledge and ultimately facilitate knowledge sharing among teams of care professionals separated by distance or difference in knowledge perspectives. Indeed, a person's geographical location and position in an organisation or network can affect the interactions that occur over time.

The social structure of an aged care facility, therefore, determines the opportunities that exist for care teams to interact and share knowledge. But it is the culture in place in an organisation that determines the level of interaction along the functional and hierarchical level, both within and outside an organisation. Organisational structure refers to how the roles and reporting lines are aligned in an organisation (Argote & Ingram 2000). This is important to the process of knowledge sharing in care teams because different professionals have diverse knowledge perspectives and knowledge sharing can only be achieved through regular interaction and the existence of an avenue to share knowledge irrespective of an individual's position or placement in an organisation.

The structural aspect of social capital is therefore important in knowledge sharing as it refers to the inter-personal connections and interactions that exist among members of a network and how the network is configured to encourage knowledge exchange (Nahapiet & Ghoshal 1998). It is worth noting that knowledge exchange occurs through the development of effective relationships, which are formed through interaction among members of a network (Lin 1999). This demonstrates the importance of organisational structure and network ties in enhancing interactions between individuals in order to provide an avenue for knowledge exchange.

Building on Nahapiet and Ghoshal's (1998) argument about the connections and interactions that exist among members of an organisation and the effect of context on the level of interaction that occurs, the formal nature of interactions between individuals has been argued to have both negative and positive effects on the knowledge sharing process. According to Zaheer and Bell (2005), network ties are important to the transfer of information in an organisation. Network ties strengthen avenues for exchange of knowledge and information among team members.

However, such network ties hinge on formal relationships based on hierarchy and power, and they have both positive and negative effects on knowledge sharing (Poghosyan 2016). Network ties create inter-unit and inter-organisational linkages between individuals, which form bridges between units and professions within the organisation and outside the organisation (Edelman et al. 2004). This is what is termed *boundary spanning*, where knowledge from different network ties becomes a whole through interaction (Anand et al. 2002). Boundary spanning facilitates knowledge sharing among disparate and dispersed care professionals and can result in a rich collection of knowledge that will help achieve quality holistic dementia care.

In addition, the formal interactions guided by organisational procedures encourage knowledge sharing and interactions by ensuring that mechanisms are in place to facilitate interaction between functional and hierarchical structure. It can be argued that having a formal structure that has a platform where knowledge sharing is encouraged may create an avenue for managers to use legitimate power to ensure explicit knowledge is disseminated through online interaction or create a platform or event where knowledge is shared.

It has also been argued, however, that formal network ties may have a negative effect on knowledge sharing. According to Edelman et al. (2004), the use of formal power instituted by organisational structure has been known to influence the decision to either share knowledge or withhold knowledge from members of a given network. This can result in a powerful individual who possesses legitimate power in a network to manipulate or influence other individuals to withhold knowledge during interaction. Indeed, according to Chang et al. (2012), power is located neither within the individual leader, nor within the social structure of the organisation, but is expressed in the dialectic of human action and interactions. It can be argued that a formal structure can have both a negative and a positive effect on relationships that exist in network ties, and thus affect the flow of knowledge and information at various levels.

Arguments about the effect of informal structure on interaction between individuals with network ties suggest that informal structure is likely to encourage free flow of knowledge and information

among individuals who seek to develop collective knowledge (Chang et al. 2012). Informal interaction through social structures such as CoPs involves constant opportunities for professionals from different social networks to interact. This is important because herein lies the avenue to sharing valuable and unique knowledge, and experiences through casual storytelling and in a relaxed atmosphere.

The socialisation process in situations such as CoPs involves knowledge creation activities where there is constant interaction and the sharing of tacit knowledge from one individual to another. This constant interaction between individuals helps in building relationships and trust among network groups (Duguid 2005). Consequently, the issue of trust is paramount in the knowledge sharing process, given that the literature suggests that individuals will only share knowledge with those with whom they have developed a rapport. More so, close interaction and rapport have also been reported to help foster relationships between individuals with legitimate power and those without power conferred on them by the organisation (Jayasingam et al. 2010). It can therefore be argued that rapport can help eliminate the negative influence of power on the knowledge sharing process and encourage positive influences on knowledge sharing across the board.

To sum up, the literature illustrates the importance of social interactions between individuals in networks to the knowledge sharing process. This review indicates that formal approaches to social structure produced both negative and positive results. There was an emphasis on ensuring that all the parties in the organisation own social capital jointly, encouraging positive attitudes to knowledge sharing among individuals with position power. Informal interaction proved to be a positive influence on the knowledge sharing process among individuals in organisations. This suggests that interactions involving structural social capital influence knowledge sharing either positively or negatively, and that there is a need to encourage positive influence to enhance knowledge sharing among team members.

2.4.2 Relationships through relational social capital

The relational dimension of social capital is about relationships that are based on trust and shared norms (Nahapiet & Ghoshal 1998). These attributes are significant because they form the basis of

strong relationships between members of a team that encourages knowledge sharing. Trust has been defined as the belief that the results of somebody's intended action will be appropriate from another person's point of view (Misztal 1996, cited in Nahapiet & Ghoshal 1998). In addition, trust also involves the belief that the exchange of knowledge will benefit and add more knowledge to teams and individuals.

The issue of trust in relational social capital is closely tied to the nature of relationships that bind individuals together. This is more evident in the sharing of tacit knowledge due to the personal nature of this type of knowledge (Nahapiet & Ghoshal 1998). This suggests that relational capital within care teams is highly dependent on trust relationships that can be developed through frequent interaction. This brings to light the interdependency of structural capital based on interactions and relational capital based on relationships. It can be argued that structural and relational capital perspectives are integral to the success of the knowledge sharing process.

The second feature of relational capital is shared norms. Shared norms refer to the existence of consensus, openness and teamwork among team members. This form of social capital is significant to the knowledge sharing process among care teams in aged care facilities because the emphasis of working in a collaborative environment is important to the achievement of quality care. Further to this, Starbuck (1992) notes the importance of working in a collaborative atmosphere rather than a competitive atmosphere where information and knowledge are likely to be withheld.

Lin (1999), reiterating the significance of collaborative norms involving knowledge exchange, suggests that openness and collaboration are key attributes that motivate individuals to share knowledge. This resonates with the earlier review of reward power, where the importance of intrinsic motivators in the knowledge sharing process was explored. The belief that sharing knowledge with another person produces collective knowledge owned and beneficial to everyone serves as an example of a norm that aids collaboration.

Sharing different knowledge perspectives among groups of care professionals can result in collective knowledge which is accessible to everyone involved in the care of dementia clients through knowledge repositories and frequent conversations. This was important in informing this research about the benefits of collaboration and openness in achieving relational capital that can ultimately help in facilitating successful knowledge sharing among team members.

To summarise, the literature on relational social capital informs us that strong relationships are useful in facilitating effective knowledge sharing, especially among teams with disparate members who require a platform to build rapport, and share different knowledge perspectives that can enhance the provision of quality holistic dementia care to clients. The features of relational social capital – trust and shared norms – are therefore important for developing rapport among different professionals, bridging the barriers of professional dominance and encouraging respect, and trust for each person's expertise. Based on the review of literature, it can be argued that relational social capital within teams is likely to influence not only the knowledge sharing process, but also the possible power dynamics that can hinder the flow of knowledge and information.

2.4.3 Shared languages and narratives, basis of cognitive social capital

The combination of structural and relational social capital that manifest through interactions and relationships is important as it can help groups of professionals develop a shared agenda. Shared agendas are achieved due to regular interaction and the build-up of trust that contributes to common jargon, shared objectives and interests. The development of elements of common understanding and expression is evident in the cognitive dimension of social capital.

Cognitive capital refers to resources embedded in shared representation, interpretations and systems of meaning among parties (Nahapiet & Ghoshal 1998). Another definition describing cognitive social capital in a more distinctive way is that of Anand et al. (2002), which defines cognitive capital as the kind of personal relationships people develop with each other through a history of interactions (Anand et al. 2002). According to Díez-Vial and Montoro-Sánchez (2014), the cognitive dimension of social capital is embodied in attributes such as a shared interest or a

shared agenda that facilitates a common understanding of collective goals (Díez-Vial & Montoro-Sánchez 2014).

From these definitions, it can be argued that cognitive capital is likely to foster shared agendas among professionals, which will serve as points of common ground for collective knowledge. This is important for knowledge sharing among team members because developing common languages or jargons and shared interests helps motivate continued interaction and a platform for a common focus. This section reviews literature on cognitive social capital and its influence on the knowledge sharing process to further investigate its importance to knowledge sharing among expert teams in aged care facilities. Cognitive social capital from the perspectives of shared languages and codes, shared narratives and shared agendas are examined.

Shared language and codes serve as means of communication between individuals. This is especially important in the context of the disparate professionals involved in the care of dementia clients. Each profession expresses itself in a particular professional jargon. Indeed, through common jargon and codes formed through stories, experiences, routines and symbols, individual professionals can freely share information and a rapport that reduces misinterpretation among their colleagues (Nahapiet & Ghoshal 1998; Duguid 2005).

Shared language is cognitive capital, and shared narratives in the form of stories and myths have been known to provide powerful means of sharing valuable knowledge about past events in a particular context that can help solve current issues (Chang et al. 2012) and facilitate the flow of tacit knowledge (Díez-Vial & Montoro-Sánchez 2014). It can be argued that in the dementia care context bringing together shared narratives from diverse and transient care professionals with experience that span across practice areas, aged care facilities, narratives about different patients and past generations will serve as a wealth of knowledge to help tackle each dementia case and provide quality care.

Shared agenda refers to interests and objectives that form a platform for consensus. The presence of common ground motivates individuals to share knowledge (Nahapiet & Ghoshal 1998). In addition, shared interest and objectives serve as a means of collaboration and not competition

(Jayasingam et al. 2010: Nugus et al. 2010), in the sense that each individual perceives themselves as contributing to the team's shared purpose and not working against others' individual agendas. This is driven by a sense of obligation and commitment to achieve the holistic goals of the team. It has also been argued that a shared agenda strengthens the process of interaction and the relationship between individuals (Díez-Vial & Montoro-Sánchez 2014).

This demonstrates the importance of combining structural capital, relational capital and cognitive capital in achieving a good flow of information and knowledge among team members. These findings therefore suggest that there needs to be an integrated understanding of these three social capital features to achieve optimal knowledge sharing.

In conclusion, the literature on shared languages and codes, shared narratives and shared agendas suggests that cognitive social capital is likely to have a direct influence on the knowledge sharing process among care teams in aged care facilities if individuals are able to operate from common ground and a shared perspective. In addition, cognitive social capital helps facilitate and improve interactions and relationships that foster respect for each individual's expertise.

2.4.4 Social capital as a facilitator to the knowledge sharing process

The literature on structural, relational and cognitive social capital revealed the important role played by social processes in facilitating interpersonal connections that can contribute to the successful advancement of expert understanding, and thus the revision and enhancement of collective knowledge. Based on the above analysis, it is apparent that the quality of social interactions and relationships between members is likely to have direct impact on mutual learning and knowledge sharing opportunities within a team. Consequently, it can be argued that the quality of social interactions and relationships is likely to determine the level of knowledge sharing among care teams. Therefore, the literature examined in the preceding section of the review supports the development of the third proposition for testing with the case evidence:

Proposition 3: *Integrating structural, relational and cognitive capital is likely to facilitate knowledge sharing among members of care teams despite possible power issues.*

Table 2.7 Framework illustrating the influence of power and the role of social capital on the knowledge sharing process

Types	Dimension	Locus/Origin	Social structure/Knowledge sharing approach	Professional Attribute	Power Type	Power influence on knowledge sharing
Rationalised Knowledge	Explicit	Collective	Knowledge Brokerage	Care Collectives	Informational Power	Positive
Book Knowledge	Explicit	Collective	Knowledge Brokerage	Care Collectives	Information Power	Positive
Embedded Knowledge	Explicit	Collective	Knowledge Brokerage	Care Collectives	Information Power	Positive
Embrained Knowledge	Explicit and Tacit	Individual	Interdisciplinary Collaboration	E.g General Practitioners/Nurses	Expert Power	Positive Negative
Encoded Knowledge	Explicit	Collective	Knowledge Brokerage	Care Collectives	Information Power	Positive
Practical Knowledge	Tacit and Explicit	Individual	Communities of Practice Informal Networks Interdisciplinary Collaboration	E.g General Practitioners/Nurses	Expert Power	Positive Negative
Professional knowledge	Tacit	Individual	Communities of Practice Informal Network Interdisciplinary Collaboration	Care Collectives	Expert Power	Positive Negative
Cultural Knowledge	Tacit	Individual	Communities of Practice Informal Network Interdisciplinary Collaboration	Care Collectives – Context Based	Expert Power	Positive Negative
Embodied Knowledge	*Tacit minor initial explicit knowledge in display	Individual	Communities of Practice Informal Network Interdisciplinary Collaboration	Context Based, repetitive use makes it embodied	Expert Power	Positive Negative
Encultured Knowledge	Tacit	Collective	Communities of practice Informal Network Interdisciplinary Collaboration	Care Collectives	Expert Power	Positive Negative

2.5 Proposition and theoretical framework

The critical review of literature discussed in preceding sections has highlighted the issues that influence knowledge sharing in teams. Firstly, the literature suggests that social power may have a major influence on the knowledge sharing process. These influences manifest in negative and positive dimensions and therefore could either impede or facilitate knowledge sharing. Secondly, the review of literature on the role of social capital in the knowledge sharing process suggests that social capital is likely to help improve knowledge sharing among care teams through relationships. It was revealed that norms that emerge as a result of frequent interaction help build rapport that alleviates possible power issues.

The review of the literature suggests that both the organisational and social structures and/or organisational policies in place in organisations have a far reaching impact on the knowledge sharing process as they determine the social structure in place for knowledge sharing, and the control mechanisms that facilitate social power and serve as a foundation to the whole knowledge sharing process.

Facilitators of knowledge sharing were important to this research because without avenues by which to share diverse knowledge perspectives among disparate experts, the provision of quality holistic dementia care can be challenging since without knowledge sharing, care might be guided by poorly prepared organisational structures, procedures and policies. A theoretical framework is presented below in Figure 2.2; this reveals a theoretical representation of the findings.

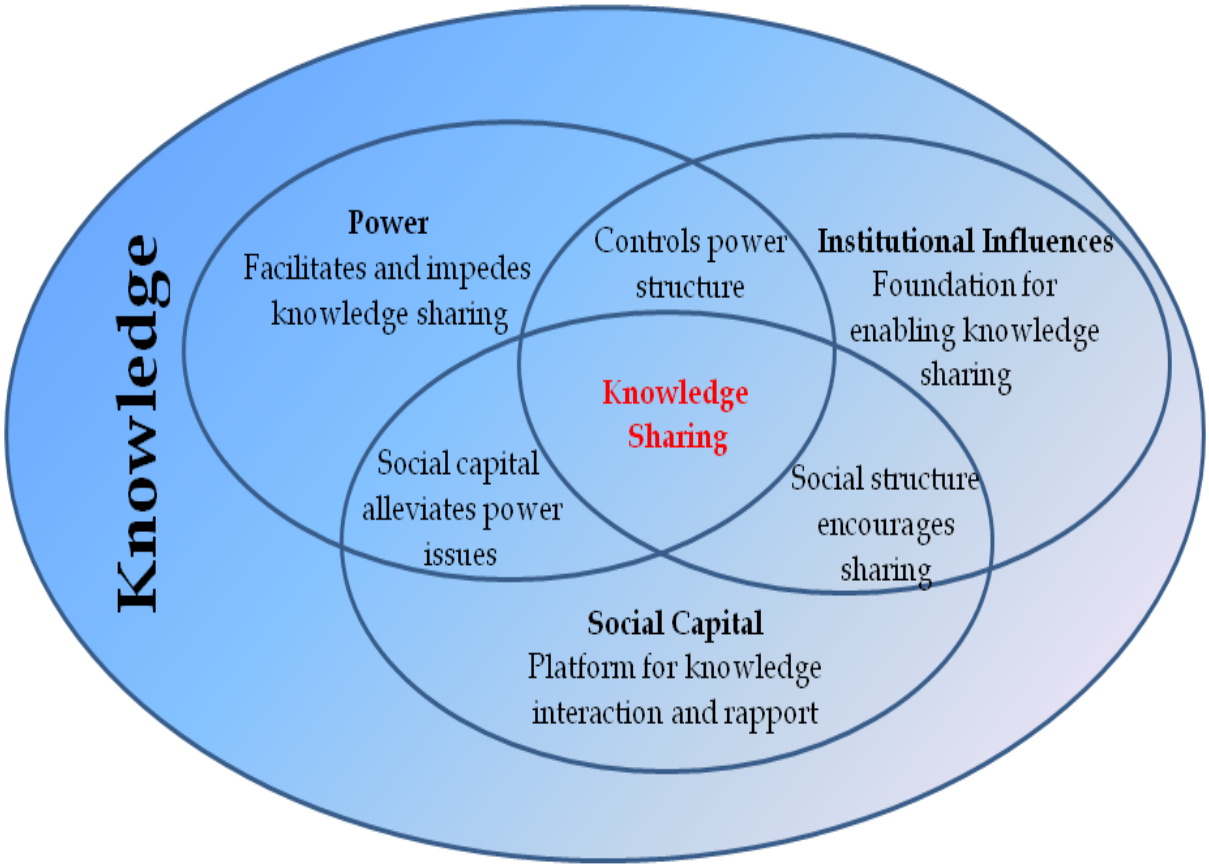

Figure 2.2 Theoretical framework

This study used this theoretical foundation to explore if, where and how these theoretical propositions are supported and informed by the knowledge sharing interactions that occur among the diverse professionals who provide care to dementia clients in aged care facilities. This exploration, involving empirical investigations, was supported by the research problem, question and three propositions. A summary of the research design path is presented in Figure 2.3.

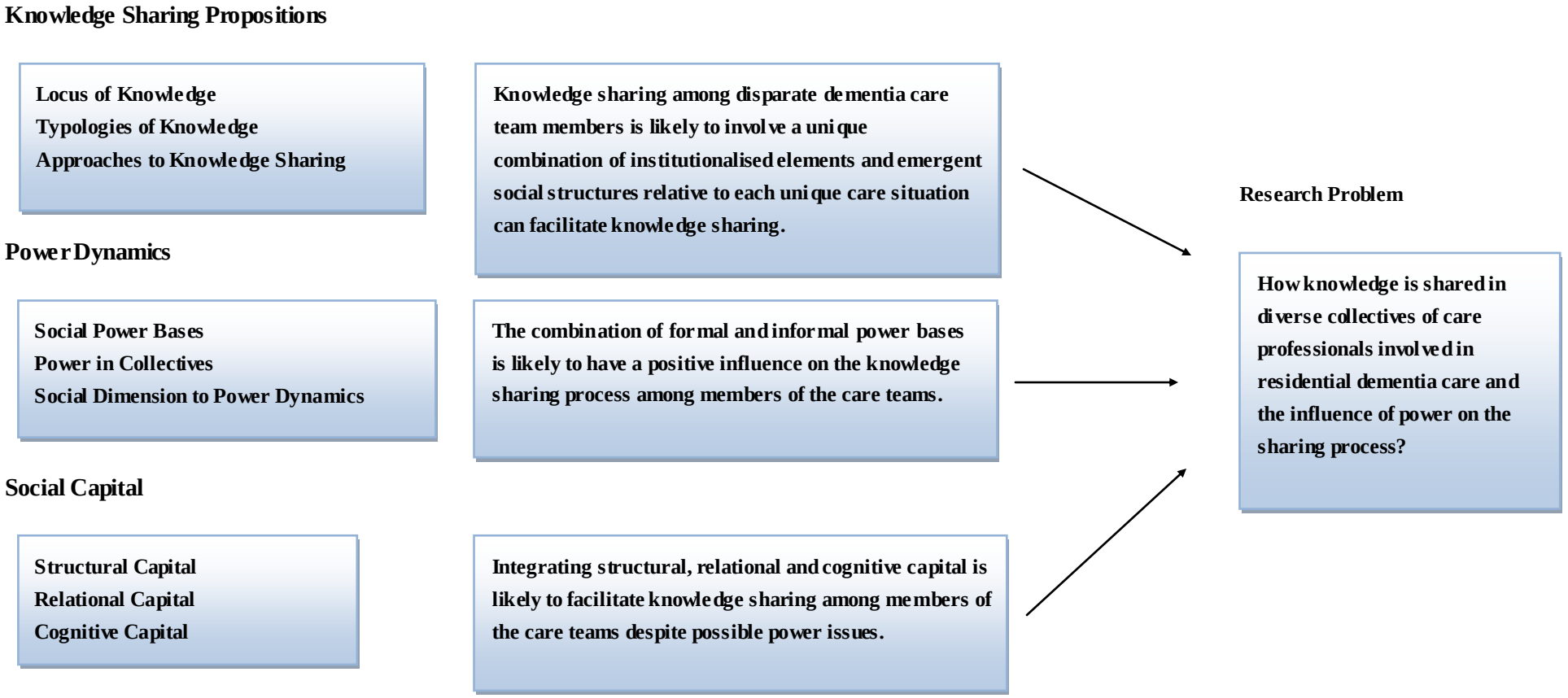

Figure 2.3 Research key issues, area of literature and propositions

(3) CHOOSING AN APPROPRIATE METHODOLOGICAL FRAMEWORK

3.1 Introduction

This chapter describes the methodological framework and justifies the philosophical perspective that guided the collection and analysis of empirical evidence during this research investigation. The reasons for the selection of the methodology are outlined, along with the epistemological concerns that affect research about the influence of power dynamics on the knowledge sharing process. It is important that the technique used to collect data provides adequate information to accomplish the research objective and answer the research questions. Crotty (2004) provides a useful insight into choosing the appropriate methodology. He explained that the choice of research strategy, methods and methodology is guided by the research question(s), research objectives and the philosophical stance of the researcher.

The involvement of human behavioural influences on the knowledge sharing process informed the use of the qualitative research method in this research. Qualitative research studies things and people in their natural settings, attempting to make sense of or interpret phenomena in terms of the meaning people bring to them (Denzin & Lincoln 2011, p. 3). Qualitative research entails working closely with the participants to embrace the multiple realities and perspectives presented by the research participants and the researcher.

The concept of multiple realities formed the philosophical perspective of this study, which is the ontology of critical realism. Critical realism provides a useful approach to examine the knowledge sharing process among care teams given the implicit power dynamics that influence the sharing process. Critical realism, as a philosophical foundation provided an appropriate approach to examine the role of social processes in the interaction between knowledge sharing and power dynamics.

Understanding the influence of formal and informal power on the knowledge sharing process among care team members and the involvement of human actions and the researcher's interaction with the participants leans toward an interpretive epistemology. The positive or negative influence of power on the knowledge sharing process encouraged the researcher view the source of knowledge from a phronesis perspective.

In line with the use of the qualitative method, semi-structured interviews and participant observation were used as data collection strategies. Interviews are appropriate as an evidence collection method when the research is concerned with the exploration of the attitude and influence of people in a particular context (Crotty 2004). Participant observation involves the researcher observing participants' behaviour, interaction and activities. For the purposes of this research, the method provided insight into the subtle influence of power on the knowledge sharing process. The interaction between knowledge and power dynamics involves individual behaviours and cultural orientation. Combining semi-structured interviews with participant observation provided a comprehensive picture of the study, and the different perspectives of individual power influence on the knowledge sharing process.

Given that this research is concerned with social behaviour, perception and cultural norms in relation to knowledge sharing among groups of experts, ethnography was used as the methodology in this research. This allowed the researcher to participate in the dementia care industry, working alongside care teams. It also allowed the researcher to be immersed in the influence and culture on display between the knowledge sharing processes and the influence of power dynamics on these processes. The opportunity to participate and be immersed in the context resulted in field notes that detailed reflections informing the research questions.

The chapter explains the rationale for the methodology used in this research while highlighting the philosophical perspectives. The use of ethnography as a methodology is discussed in line with the evidence collection method involving the use of semi-structured interviews and participant observation. Finally, the evidence analysis and documentation process are explained in detail.

The chapter concludes with a discussion about the credibility, reliability and validity of the chosen methodology to address the research problem: *To understand knowledge sharing and power dynamics in among teams of care professionals involved in residential dementia care.*

3.2 Philosophical assumptions

3.2.1 Ontology

There are a number of philosophical assumptions that guide a research project; choosing the appropriate ontology, epistemology and methodology is based on the researcher's perspective, belief and the context of the study.

The ontological assumption that guided this study was critical realism. Critical realism is concerned with the nature of causation, agency, structure, and relations, and the implicit or explicit ontology we are operating with. The use of critical realism as an ontology in this research allowed the researcher to ask such questions as; are there social kinds among individuals? Does power, status or class stratification exist as social entities? What constitutes a social entity? Are there consistent traits of fascism in the relationship that exist between care collectives that provide care to dementia clients? Critical realism, hence, allowed the researcher to adopt an ontological realist position that distinguishes between reality and empirical stance; and emphasises their relational nature.

Ontology relates to the nature of reality, the study of beings and their characteristics. There are various aspects of ontology; only two will be discussed in this thesis, namely, objective and subjective perspectives. Objectivism argues that social entities exist in reality external to the social actors. On the other hand, subjectivism perceives that social phenomena are created from perceptions and consequent actions of those social actors concerned with their existence (Creswell 2017).

Objectivism and subjectivism were useful to this research due to their belief in the nature, reality and social phenomena which contribute to the study of being. For the purpose of this research, subjectivism was adopted as the ontological perspective. Subjectivism was an appropriate perspective for this study about the influence of power dynamics on knowledge sharing, as emerged from the manifestations and influence of power dynamics on the knowledge sharing process. Subjectivism helped the researcher highlight social phenomena and how their meanings

were accompanied by social actors, whereas an objective perspective would exclude the involvement of social actors (Creswell 2017).

The level of knowledge sharing that occurs is facilitated by the influence of actors, which in the context of this research were teams of professionals who determined the level of knowledge sharing that occurred, based on their willingness to share or not to share. Behaviours in diverse care teams are dynamic due to the spontaneous actions among diverse people belonging to different professional groups with diverse knowledge perspectives. It is also worth noting that the involvement of different teams of care professionals in this research investigation necessitated sourcing for diverse perspectives regarding the research problem, including the researcher's perspective. Thus, subjectivism allowed for the involvement of different care teams in investigating the subtle influence of power on the knowledge sharing process.

3.2.2 Epistemology

Epistemology provides a philosophical background for deciding what kinds of knowledge are legitimate and adequate. Succinctly, epistemology deals with the sources of knowledge. There are various epistemological research philosophies, namely: positivist research, critical realist research, action research and interpretive research. In defining the sources of knowledge in this research, it was useful to examine different epistemologies and decide which perspective best suited this research.

A review of the positivist approach to searching for data suggested that a positivist approach posits and explains principles with the hope of gathering casual, empirical and testable data (Bernard 2012). This approach is concerned with generating objective data. Methods associated with this paradigm include experiments where quantitative data is the norm. Conversely, the interpretive approach posits that research starts from the position that our knowledge of reality, including the domain of human action, is a social construction by human actors and that this applies equally to researchers. The interpretive approach is also based on interpreting and understanding relationships through observations and interviews (Schwandt 1994).

Based on the review of different epistemological approaches, the interpretive approach aligned with this research, given the fact that this research is based on understanding the influence of formal and informal power on the knowledge sharing process among care team members. The actions in this research involved human actions and the researcher's interaction with the participants.

Moreover, the issue of power dynamics brought an important perspective to this research in terms of how power influences knowledge sharing. The issue of sharing ideas, wisdom and opinion and the involvement of inequality and power in the discovery of knowledge align with interpreting this research from a phronesis perspective. Phronesis has been described as practical wisdom, practical judgement, common sense or prudence (Flyvbjerg 2004; Nonaka & Toyama 2007). The concept of phronesis was particularly important to this research, given the potential positive or negative influences power has on the knowledge sharing process.

The involvement of interdisciplinary professionals in the care of dementia patients brings together individual values and judgements that in the absence of consensus can become conflicting and result in power dynamics about the best approach to achieve quality care.

Aristotle was a key proponent of phronesis who posed pertinent questions that related to the attributes of power during interactions between individuals in any given context. These questions about power and outcomes were: *Who gains, and who loses? Through what kind of power relations, what possibilities are available to change existing power relations? And is it desirable to do so? What are the power relations among those who ask these questions?* (Eikeland 2008).

Therefore, due to the peculiarity of this study's research problem, and the questions posed for the project, the epistemology of this research was based on the interpretive approach viewed from a phronesis perspective. This was best suited to appreciate the practical interactions of the independent members of the care teams.

3.2.3 Theoretical perspective

A theoretical perspective is a way of looking at the world and making sense of it. It involves knowledge about how we know what we know (Kwan & Tsang 2001). A combination of interpretive and constructivist theoretical frameworks were used in the evidence collection for this research. The interpretivist and constructivist researcher tends to rely upon the participants' views of the situation being studied (Creswell 2003, p. 8). According to Crotty (1998), the combination of interpretivism and constructivism results in a theoretical perspective of symbolic interactionism.

The use of symbolic interactionism in this doctoral research gave the researcher the opportunity to explore participants' perspectives in addressing the research questions. It is useful to note that through the use of symbolic interactionism, the researcher's perspective also contributes to the data through the use of participant observation as a data collection technique.

Symbolic interactionism is a frame of reference to better understand how individuals interact with one another to create symbolic worlds, and in return, how these worlds shape individual behaviours (Hall 2007). Symbolic interactionism helps in a researcher's exploration of the meaning that arises out of the social interaction that each care team has with other care professionals in the dementia care context. Symbolic interactionism helps individuals to see others as active in shaping their world, rather than as entities who are acted upon by society (Herman & Reynolds 1994).

In the context of this research, symbolic interactionism allowed the researcher to experience the knowledge sharing process among the professionals. The interpretation of the knowledge exchange by participants can only be understood by observing and discussing with those involved in the knowledge sharing process and who experienced the influence of power dynamics on the sharing processes. Therefore, considering the complex phenomenon of social interaction among diverse members of dementia care teams being examined in this research, a symbolic

interactionism approach was chosen as the most appropriate theoretical perspective to investigate the research issues.

3.3 Research methodology and methods

A methodology is recognised as the strategy, plan of action, process and design that guides the choice and use of particular methods in a research project, and links that choice and use of methods to achieving the desired outcomes (Yin 2013). There are different methodologies that can be used to answer the research questions posed in this doctoral study, such as action research which places emphasis on collaboration between researchers and participants in gathering data about peoples' attitudes and perspectives.

However, in line with the assumptions about the reality of the influence that power has on knowledge sharing amongst care teams, a participative approach that fit an ethnographic methodology was used. Ethnographic methodology also enabled the recording of a thick description of the influence of power on the knowledge sharing process among the professionals.

Ethnography is one of the methodological approaches that align with symbolic interactionism (Crotty 1998). This methodology involves the use of a qualitative method in the data gathering process. Furthermore, ethnography seeks to uncover culture, meanings and perceptions on the part of the actors participating in the research, viewing these understandings against the backdrop of other people's overall world view (LeCompte 2013). Indeed, various researchers investigating quality care in the health sector have used ethnography as a means of collecting and analysing data relating to human health and well being (Marquis, Freegard & Hoogland 2004; Robertson 1996) due to the intricacies involved in providing quality care to clients.

The provision of quality care involves different professionals providing one-on-one care to clients; this brings a level of dynamics to the relationship between professionals on one hand and between professionals and clients on the other. This research, however, investigated a context that has received little attention in relation to the effect of power dynamics on the knowledge sharing process. Indeed, ethnography helped the researcher to observe and study how different culture

and behaviours affect social processes that occur during interactions related to the provision of quality care. Ethnography therefore enhanced the researcher's understanding of the interactions between knowledge sharing and power dynamics among care professionals and what influenced these processes.

3.3.1 Data collection techniques

The involvement and perspectives of teams of care professionals and the researcher's own perspective made it necessary to adopt a mixed method approach to validate evidence gathered from observation. A mixed method technique helps validate evidence collected during the research process devoid of as much bias as possible. The use of two data collection methods helped the researcher confirm observations by comparing them with statements made by participants during the interview sessions. The combination of semi-structured interviews and participant observation was thus used in the data collection process.

3.3.1.1 Semi-structured interviews

Semi-structured interviews were one of the methods selected as the means of data collection in this study. Semi-structured interviews were chosen because they would allow the researcher to probe the participants for more information to clarify issues through the use of open-ended questions. In addition, dealing with complex research problems requires a means of gathering data that provides adequate information. Combining semi-structured interviews with participant observation provided the researcher the opportunity to hear statements about the effect of power on the knowledge sharing process whilst experiencing firsthand the subtle effect of power on the knowledge sharing process among care teams through participant observation.

This was important to the data collection process because interviewees were reluctant to talk about power issues and some stated that they had never observed the effect of power on the knowledge sharing process. The researcher as an unbiased observer was able to discern the subtle effects of power dynamics on the knowledge sharing process through participant observation. Moreover, combining participant observation with semi-structured interviews helped the researcher to confirm interviewees' statements through observation and what the researcher had observed was also confirmed through interviewees' statements.

Consequently, the semi-structured interview questions were open-ended and addressed a number of areas, being re-phrased depending on individual responses (Louise 1994). It should be noted that in accordance with Whiting's (2008) observation about questions and words meaning different things to different individuals, the interviews conducted in this research ascertained that not every word had the same meaning to every respondent and not every respondent used the same approach to answering questions. Clearly, using a semi-structured type of interview does not necessarily guarantee validity and reliability, and is not dependent on repeated use of the same words in each question, but upon conveying equivalence of meaning (Louise 1994). It is the similarity of meaning in the questions which helps to standardise the semi-structured interview and facilitate comparability.

3.3.1.2 Participant observation

The second data collection method used was participant observation. The use of participant observation had the advantage of enabling the researcher to experience interactions among teams of care professionals firsthand and to visually observe the processes of knowledge sharing and subtle power issues. This is important because, according to Porter (1991), the account given by participants can be different from the actual behaviour displayed in practice. In addition, information can be gathered from mundane and perceived insignificant events, which may not be known to the care teams but visible to an unbiased observer.

The use of participant observation allowed the researcher to be immersed in the interactions between knowledge sharing and power dynamics. Indeed, the researcher had direct experiences of interactions, reactions and the resultant effects of power on knowledge sharing. As noted by Chao (2008), participant observation involves the researcher getting to know the people being studied by entering their world and participating in that world. The dynamic nature of care teams allowed the researcher to observe the behaviours of care professionals and their group interactions, as well as be a party to their conversations, exchanges and behavioural nuances. Observations and the researcher's reflection were documented in written field notes on a daily basis. The researcher also made use of a tape recorder to record thoughts by speaking spontaneous thoughts and reflections into a tape. These recordings were later transcribed and combined with the field notes to develop the data gathered.

3.3.1.3 Case studies

Forty-seven (47) individuals were interviewed across four independently managed aged care facilities. The participants were members of care teams with diverse areas of expertise who offered various types of care to dementia clients. The type of knowledge and care contribution from these care teams resulted in classifying them into different categories:

- formal carers and administration
  - formal carers (personal care assistants, support worker, maintenance man, chef, kitchen hand, cleaner, activities coordinators)

  - administration (administrative and therapy assistant, work, health and safety coordinator, quality coordinator). These teams of care professionals represented care teams that were based in each facility.

- medical, nursing and allied health workers
  - medical (general practitioners, psycho-geriatrician, psychologist, pharmacist, geriatricians, dieticians, physiotherapists)
  - nursing (enrolled, registered mental health and clinical nurses
  - allied health (occupational therapists, creative therapist, holistic therapist, occupational therapists, psychologists) alternate between the four care facilities.

The medical, nursing and allied health professionals provided shared services to the aged care facilities examined in this study. The third category involves informal carers who make up clients' family members and community visitors and friends. The care professionals classified under these different categories were observed and interviewed in this research. Table 3.1 highlights the participants' details.

Table 3.1 Case teams participants' details

Sites	Positions	Code	Number of Interviews
City Care 1	1xRoster Coordinator	RosterCord(CC1)	19
	1xAdministrative Officer	AdminOff(CC1)	
	1xTrainee Personal Care Assistant	TPCA(CC1)	
	3xPersonal Care Assistants	PCA(CC1)	
	2xLifestyle Coordinators	LifeCord(CC1)	
	1xDementia Client Family Member	FamilyMem(CC1)	
	1xMaintenance Officer	MainteOff(CC1)	
	1xCleaner/Laundry Assistant	AuxAssit(CC1)	
	1xChef	Chef(CC1)	
	2xKitchen Hands	KitHand(CC1)	
	1xSystems Administrator	SysAdmin(CC1)	
	1xMental Health Nurse	MentalNurse(CC1)	
	1xSocial Worker	SocialWkr(CC1)	
	1xPsychologist	Psych(CC1)	
	1xAdministrative Assistant	AdminAssit(CC1)	
City Care 2	1xLifestyle Coordinator	LifeCord(CC2)	9
	1xService Manager	ServMan(CC2)	
	3xPersonal Care Assistants	PCA(CC2)	
	1xMental Health Nurses	MentalNurse(CC2)	
	1xTeam Leader	TL(CC2)	
	1xOccupational Therapist	OccpTherapist(CC2)	
	1xCreative Therapist	CreatTherpist(CC2)	
Remote Care 1	1xService Manager	ServMan(RC1)	9
	1xTeam Leader	TL(RC1)	
	1xLifestyle Coordinator	LifeCord(RC1)	
	2xPersonal Care Assistants	PCA(RC1)	
	1xTherapy Assistant	TherapyAssit(RC1)	
	1xMental Health Nurses	MentHeaNurse(RC1)	
	1xOccupational Therapist	OccupTherpist(RC1)	
	1xHolistic Therapist	HolTherpist(RC1)	
Remote Care 2	1xAdministrative Officer	AdminOfficer(RC2)	10
	2xPersonal Care Assistants	PCA(RC2)	
	1xLifestyle Coordinator	LifeCord(RC2)	
	1xChef	Chef(RC2)	
	1xMental Health Nurse	MentHeaNurse(RC2)	
	1xMaintenance Officer	MainteOff(RC2)	
	1xDementia Care Software Trainer	Trainer(RC2)	
	1xPharmacist	Phar(RC2)	
	1xChaplian	Chaplain(RC2)	
Total Number of Interviewees			47

3.3.2 Research design

The research design used in this thesis was iterative case study and the methodology was qualitative, which is well suited in the processes of examining individual behaviours and how this affects the knowledge sharing process. A combination of participant observation and semi-structured interviews were conducted in multiple independently managed residential care facilities. The data collection process occurred between March 2015 and February 2016. This research analysed evidence through the use of case studies gathered from four residential care facilities. The members of the care teams in these cases included: rostered workers, transient allied health professionals and medical specialists. These four residential care facilities are owned by a parent body along with 18 other independently managed aged care facilities across Australia. While these four facilities are under a parent body, they are independently managed by different managers, located in different parts of Australia and are not operated as a single corporate entity. .

In undertaking the empirical process, case evidence was gathered using semi-structured interviews and participant observation with the researcher keeping field notes and recording interviews. The field notes and interviews were then analysed using a thematic coding process. The analysis process involved the following steps:

- First the evidence collected from each case study was examined independently. Transcripts from interviews conducted were examined in line with the researcher's reflective field notes. This was done to identify common themes and arrange the evidence in a logical manner.
- Common themes were identified, such themes were ; knowledge sharing, power, relationships, care professionals, knowledge sharing, hoarding knowledge, dynamics involved in dementia care, effective interaction and team of experts. These themes contributed to the overall analysis of the results and how this informed the research problem;

> *to understand knowledge sharing and power dynamics in among teams of care professionals involved in residential dementia care.*

- Once coding was completed for each case based on the identified themes, a comparative cross case analysis was undertaken to help inform the research problem and existing theory and research propositions.
- The results from the coding tentatively supported the three propositions generated in the literature review;

> ***Proposition 1:*** *Knowledge sharing among diverse and disparate dementia care professionals is likely to involve a unique combination of institutionalised elements and emergent social structures relative to each unique care situation and to the various experts involved.*
>
> ***Proposition 2:*** *The combination of formal and informal power bases is likely to have a positive influence on the knowledge sharing process among members of the care teams.*
>
> ***Proposition 3:*** *Integrating structural, relational and cognitive capital is likely to facilitate knowledge sharing among members of care teams despite possible power issues.*

- The data was analysed through the inductive theory building process, which allowed the researcher to interrogate the results in line with the research problem, theory and propositions generated.
- Each theme was analysed while trying to inform theory and research problem presented in this thesis. Analysis took the form of going back and forth to observe and interview participants to either confirm themes and theory and to attempt to eliminate any possible bias.
- Once this process was concluded the researcher commenced writing up the results, while analysing themes in line with theoretical assumptions and research problem; and questions.
- The research design and how the researcher informed the research problem through an inductive theory building approach is illustrated in Figure 3.1.

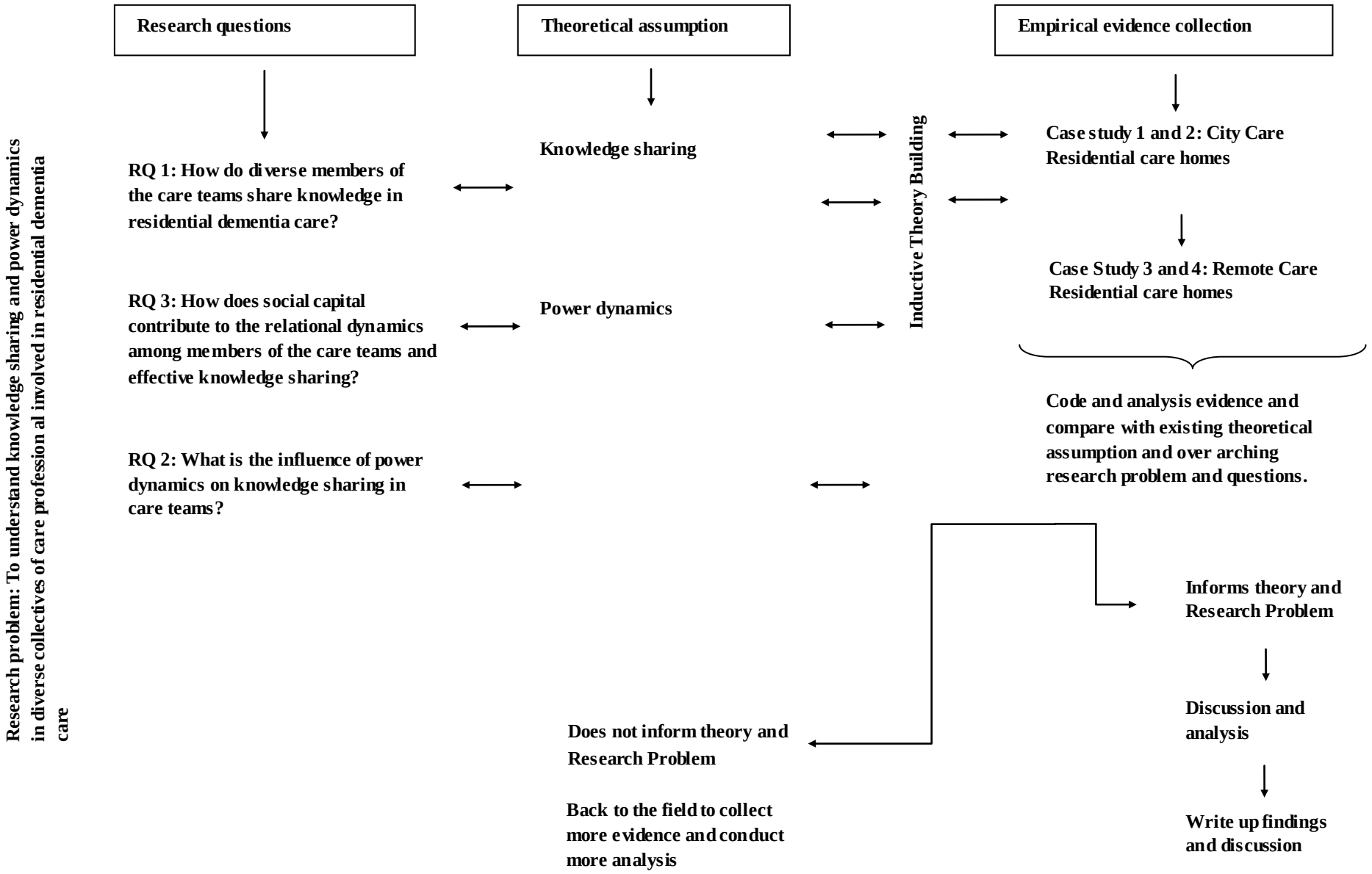

Figure 3.1 Research design and theory building process

3.3.3 Participant selection

The choice of participants was based on ensuring each professional group involved in the care of dementia clients was represented. There was at least one member of the medical team, allied health workers, auxiliary workers and the management team from each of the four aged care facilities represented in the participant list. Secondly, the researcher interviewed teams of care professionals that were present during the ethnography process of observing experts' interaction. This was to align the researcher's observation to the participants' observation and interview responses to ensure clarity (Flick 2002). Key issues observed by the researcher during the participant observation process were confirmed and clarified by participants during the interviews.

The four aged care facilities were guided by organisational procedures and processes and had clear reporting lines. The researcher approached the director in charge of the group of aged care facilities and a presentation was made to the management team. The opportunity to have face-to-face conversations with the management team facilitated the approval process. Thereafter, permission was granted to the researcher to approach four sites to conduct interviews and observe participants in the work place. A short synopsis of the research outline was sent to each service manager in charge of the four sites involved in the evidence collection process, introducing the researcher and inviting employees to participate in the research. Management encouraged the members of their teams to participate in the research study, and also gave free access to the researcher to visit the sites.

Ethnography involves the researcher participating and interacting overtly with participants in a given context over an extended period of time (Hammersley & Atkinson 2007). The researcher worked with various members of the care teams in the four facilities, according to the nature of the client and care context. This made the process of interviewing care professionals in the care facilities easier to organise.

The researcher's initial observation revealed that all the care teams involved in the care of dementia clients had an area of expertise. From the formal carers to the informal carers and the

allied workers to the medical specialists, everyone's skills and knowledge contributed to the provision of quality care. Participants were therefore considered to be experts in their own field and members of the group of experts at their various facilities. All participants were interviewed using a semi-structured approach with the use of open ended questions; this was achieved by working and discussing issues around knowledge sharing and the influence of power on the sharing process. This approach helped the researcher view interactions both from an ethnographic researcher's perspective and an employee perspective, while balancing this with the perspective of other participants. Indeed, the combination of semi-structured interviews with participant observation gave the researcher the opportunity to experience the attitude and subtle power issues that influenced knowledge sharing among the teams from a third party perspective.

3.3.4 Data collection process

The evidence collection process involved two stages. A source approach was employed; the first approach involved the researcher going into the aged care facilities to attend team meetings, client consultation meetings and to help personal care assistants attend to clients. These meetings and the opportunity to assist in caring for clients gave the researcher an insight into the dynamics of knowledge sharing among diverse and dispersed teams of experts. It also revealed some subtle and useful effects of power on the sharing process.

Semi-structured interviews were also conducted in between the participant observations to validate what the researcher observed and the reality of the situation. The use of participant observation had the advantage of experiencing the interactions among participants firsthand. The researcher personally observed the process of knowledge sharing and the subtle power issues on display. According to Porter (1991), the account given by participants during interviews can be different from the actual behaviour displayed in practice. In addition, more information can be gathered from mundane and insignificant events which may not be known to the care teams but are visible to an unbiased observer.

Having worked closely with the participants over a period of six months, they were willing to participate in the interviews. In addition, the relationship built over time with the participants and the organisation's management team as a whole provided the researcher the opportunity to review

the aged care facilities' organisational policies and procedures. This was done to identify and evaluate the structure and processes that had been put in place by the organisation to ensure knowledge was shared and what influenced the process. While policies and procedures around knowledge sharing were still being developed, the researcher had access to manuals used as a guide to storing knowledge in a software repository that was accessible to all the groups of experts involved in providing care for the clients.

To ensure confidentiality, the aged care facilities were assigned pseudonyms: City Care 1, City Care 2, Remote Care 1 and Remote Care 2. The four aged care facilities were under the umbrella of one large not-for-profit organisation, but each was managed independently as a separate entity. While some similarities existed between them, for example, the information technology for storing clients' information and the overarching aged care regulations and procedures, there were some differences between these facilities that added to the dynamics of knowledge sharing. There were, for example, differences in the methods of knowledge sharing. The size of the facility affected the knowledge sharing processes. At each facility, the power dynamics associated with knowledge sharing was unique. These similarities and differences will be discussed in Chapter 4.

3.3.5 Analysis of interviews

The interviews were transcribed and analysed using a thematic coding process provided by *NVivo* qualitative software. Thematic analysis is a process of encoding qualitative information and the encoding requires identifying themes (Boyatzis 1998). The process involved in the thematic coding was as follows:

- The researcher transcribed the recorded interviews and combined the data with the documented field notes.
- The data were coded and categorised into themes.
- An analysis of the themes and interpretation of meaning to inform the propositions were conducted. A detail account of the outlined process is discussed below.

3.3.5.1 Transcription

The researcher transcribed the recorded interviews and reviewed the field notes, identifying common themes and issues while typing reflections, observations and interview records against

each aged care facility. A sample of an interview transcript is attached as Appendix 1. A unique name was assigned to each site and group interviewed. During transcription common themes emerged, which were highlighted on a separate worksheet. Recurring themes included knowledge sharing, power dynamics, social capital and dementia. These themes had sub-themes that were identified as useful to understanding the research problem.

3.3.5.2 Coding

Coding is a form of qualitative analysis. It involves recording or identifying passages of text or images that are linked by a common theme or idea, allowing the researcher to index the text into categories and therefore establish a framework of thematic ideas (Gibbs 2007). The process of coding in this research involved dragging quotes made by interviewees and extracts from the researcher's field notes into different nodes representing the identified themes in the empirical investigation. The final themes and nodes were:

1) knowledge sharing
2) power dynamics
3) social capital.

It is worth noting that universal nodes were created initially, but that, during the coding exercise sub-nodes were created because there were emerging observations which informed more than one theme.

3.3.5.3 Analysis

In analysing the evidence, a data set was created through *Nvivo*, where the frequency of themes and how they overlap with other themes were identified. To have a general overview of themes after coding, models, a visual mind map and queries were generated using *Nvivo*. The report was tested against each theme to check the frequency of words and the relationships of such words to the three core research areas in this study – knowledge sharing, power dynamics and social capital – and how they cut across each age care facility and profession.

This process further expanded the researcher's thought pattern and a summary of relationships between themes was developed and coded. This streamlined the findings and led the researcher to

ask some pertinent questions, such as: *Why are some words recurring in the mind map report? Why are the words and recurring patterns relevant to the research questions? How would the findings contribute to knowledge in the dementia care industry?*

Samples of *NVivo* code classification for this research are attached as Appendix 2 and Appendix 3. The themes were identified and issues that were significant to the proposition highlighted in Chapter 2 were coded. The findings from this analysis were presented in Chapter 5 of this thesis, with an emphasis on the research propositions. Some useful findings which were beyond the scope of this research were also mentioned briefly. A comparison was conducted to determine similarities and differences, and a summary of findings presented.

3.3.5.4 Interpretation

Interpreting the themes involved taking a holistic view of each theme from the perspective of the interviewees and the researcher. Each theme was reviewed by placing statements made by the interviewees side by side with reflective statements from the researcher's field notes. This revealed what participants were saying and what their actions were about knowledge sharing, the influence of power dynamics on the sharing process and the role of social capital in these interactions, as well as how participants' perceptions aligned with the researcher's observation.

In discussing and analysing this evidence, the meaning of statements made was considered. The interpretation of what the interviewees were trying to convey in their statements required reflection on not just the statements, but on the themes that emerged from the field notes. It was therefore an exercise that involved reflecting on the interview transcript, field notes and researcher's memory of actions and statements made. In addition, it was important to relate the meaning of statements and actions to why they were important to the research issues and propositions.

The analysis evolved in the course of writing out the interpretation, discussion and constantly referring to the thematic coding until the full analysis was completed. This process contributed to generating meaning from the empirical findings informing the research problem.

3.4 Methodological Trustworthiness

Evidence was collected in this research through semi-structured interviews and participant observation. These qualitative research methods align with the critical realism paradigm to ensure credibility of the empirical investigation. These methods were employed conscious of the need to demonstrate a high level of credibility and present trustworthy results. The issue of credibility is important to ethnographic research given that data was gathered and analysed through the observation and interrogative process. This method was achieved by interviewing participants, observating and working closely with participants as an employee.

This process is especially important in ethnographic research because it involves the perception of both the participants and that of the researcher. It is important to ensure that results that are reported are unbiased. The issue of credibility was addressed in this research by using multiple collection methods, for example, semi-structure interviews and participant observation. In line with the issues of credibility and trustworthiness, the empirical investigation also involved a within case and cross-case analysis to determine the consistency of the findings between the verbal evidence provided by the interviews and the behavioural evidence provided by participant observation.

A comprehensive data collection and analysis process was followed. Multiple case studies were used with multiple participants. In addition, participant observation was employed to ensure the interviewees' responses aligned with the questions asked. To ensure an unbiased view from the researcher's perspective, the content of the field notes were verified during the interview sessions. This was significant, as they demonstrated the credibility and the quality of the results presented in this doctoral thesis.

Four different aged care facilities participated in this research. The use of four different aged care facilities in a period of one year, with the use of two different data collection methods adds to this research's transferability. The combination of participant observation and semi-structured

interviews provided a platform for rich data to be gathered. An example is seen in interviewees across the four facilities confirming what the researcher had observed in each facility. An example is demonstrated below:

> *Some personal care assistants do not share knowledge; they hoard what they use as a trigger to get the patient to adhere to instructions mainly because they want to have that knowledge as a competitive advantage. PCA (CC1), August 5,2011*

Observation from the field notes.

> *The client had a fall and all the personal care assistants were clueless about how to get him to get on the full body lift. They looked around for a particular personal care assistant who came in and stylishly spoke to the client and he obeyed her. Her colleagues approached her about what she said and how she got him to obey and she declined providing information to them. It looked like she was trying to hoard knowledge to give herself an edge above her colleagues.*

This brings transferability to this research; the researcher was able to confirm that similar issues occurred in all four facilities. The result of this research can therefore be applicable to similar context given the similarities in occurrences I the case study organisations used.

Confirmability is the degree of attempting to achieve neutrality in the research study's findings. The results presented in the thesis were based on participants' responses. Transcripts were recorded using a tape recorder which was later transcribed verbatim. Participants' responses were used as were recorded, while the researcher also used field notes from observations, the researcher's observations portrayed interviewees' responses to the questions posed.

The use of two different data collection methods, participant observation and semi-structured interviews, gave the researcher the opportunity to capture different perspectives about the knowledge sharing process among members of care groups and the influence of power on this process. The perspectives of the research participants and the researcher's perspective brought more understanding about the research questions. The use of two methods also served to curtail bias and bring credibility to the research findings, taking into account different perspectives.

3.5 Challenges

The researcher experienced some drawbacks during the data collection process. It should be noted that due to the sensitive and subtle nature of power as a means of withholding knowledge, some participants were reluctant to discuss the influence of power on the knowledge sharing process, while some did not admit that power affected the knowledge sharing process. It was therefore useful to have the researcher observing interaction among members of the care teams since participant observation helped provide an unbiased perspective.

Participants were also somewhat reluctant to discuss the issue of reward power and what would be considered to be a proper incentive to encourage them to share knowledge. Participants' reluctance might in part be due to a culture in the organisation of not discussing 'money matters' or because of individual preferences not to discuss what motivates them.

3.6 Conclusion

The aim of this chapter was to provide a synopsis of the philosophical and methodological framework that guided the collection and analysis of evidence examined during this research study. Four case study aged care facilities were examined in this research consisting of diverse and dispersed participants who provide care services to dementia clients. The knowledge sharing activities and the influence of power dynamics on these sharing activities were the focus of this investigation. The involvement of human interactions necessitated the use of a qualitative method in the evidence collection process. The use of a qualitative research method gave the researcher the opportunity to interact with participants and acquire different perspectives in order to answer the question of *How knowledge is shared among diverse care professionals involved in residential dementia care and the influence of power on the sharing process.*

The critical realism subjective ontology paradigm guided this investigation. This ontological stand addressed the diverse perspectives, actors and their actions in relation to the knowledge sharing process and the influence of power dynamics on the sharing process. In line with the ontology of critical realism, the use of interpretative approach as an epistemology viewed from a phronesis perspective was used in this research study. This allowed the researcher to consider the perspectives and knowledge of diverse participants, with the use of an interpretative approach viewed from a phronesis viewpoint, which allowed the researcher to ask pertinent questions about what kind of power relations were displayed among members of the care teams, how they affected the knowledge process and the losses and gains of these human actions.

The theoretical perspective that guided this research was symbolic interactionism. Symbolic interactionism allows the researcher to have firsthand experience of the impact of individual action on the knowledge sharing process, and not a general view of how the organisational processes, procedures and culture affect the knowledge sharing process.

Ethnography was used as a methodology in this study. Ethnography is the systematic study of people and cultures through observing and interacting with participants over a period of time. This methodology allowed the researcher to observe and explore the issue of knowledge sharing and the influence of power dynamics on the sharing process from the perspectives of various expert teams.

Participant observation and semi-structured interviews were therefore used to gather evidence. Notes from the researcher's field notes and recorded interviews were coded using a thematic coding process. The coding results were used to inform a within case comparison and cross-case analysis. Thereafter, the consolidated results were interpreted and discussed to support the propositions and also for theory building.

(4) RESULTS OF THE STUDY

4.1 Introduction

This chapter describes the data analysis conducted for this doctoral research. This chapter presents the analysis of the evidence from four case studies involving care professionals who work in residential aged care facilities to provide specialist quality and holistic care to dementia clients. The empirical investigation revealed that the care teams were formed from diverse groups, including:

- medical (general practitioners, psycho-geriatrician, psychologist, pharmacist, geriatricians, dieticians, physiotherapists)
- nursing (enrolled, registered, mental health and clinical nurses)
- allied health (occupational therapists, creative therapist, holistic therapist, occupational therapists, psychologists)
- formal carers (personal care assistants, support worker, maintenance man, chef, kitchen hand, cleaner, activities coordinators)
- informal carers (family members, community visitors and friends)
- administration (administrative and therapy assistant, work, health and safety coordinator, quality coordinator).

Investigation of the operations in four health care facilities discovered patterns and themes that informed the research problem and research questions outlined below.

Research problem: *To understand knowledge sharing and power dynamics in among teams of care professionals involved in residential dementia care.*

RQ1: *How do teams of care professionals* ***share knowledge*** *among team members when working in residential dementia care?*

RQ2: *What is the influence of* ***power dynamics*** *on knowledge sharing among care professionals?*

RQ3: *How does* ***social capital*** *contribute to the relational dynamics in care teams and effective knowledge sharing?*

The four aged care facilities that participated in this study belonged to an organisation with 18 facilities across Australia. These facilities were governed under the same policies and procedures. It should be noted, however, that the various facilities were located in different parts of Australia, some in remote areas and some in the inner cities. In addition, all the facilities were managed by different service managers who were registered nurses. The dynamics of location and the different managers involved in these facilities contributed to the differences and/or similarities in the knowledge sharing processes in these facilities.

This chapter is organised into four main sections. The first section presents evidence and themes from four aged care facilities, which represent four cases of professional interaction. In each case evidence is presented based on the emerging themes of:

- knowledge sharing
- power
- social capital.

These three themes best represented the evidence from the researcher's field notes recorded during participant observation and the content of the transcripts from the semi-structured interviews conducted among care teams. After describing the themes for each sub-case, a summary outlining key findings for each case is presented. The chapter concludes with a synopsis of the results.

4.2 Identifying the care teams

The involvement and attendance of care teams in the four aged care facilities varied, depending on their areas of expertise. The care teams that provided daily care to dementia clients consisted of professionals who were based in the care facilities. Examples were: personal care assistants, nurses and auxiliary employees.

There were also professionals who provided shared services to the four aged care facilities and were not permanent employees at any single facility. Examples were medical professionals, mental health nurses and allied health workers. The care professionals classified under these different categories made up the care teams involved in the care of dementia clients.

The teams of experts all had the same objective of providing quality care to dementia clients; the only thing that differentiated them were the methods of care delivery, areas of expertise and their attendance at the care facilities. The differences in tasks and work schedules between the care groups in the four aged care facilities added an extra dynamic to the knowledge sharing process.

The shift pattern in the aged care industry, coupled with the care professionals who provided shared services, presented a challenge that resulted in some individuals hoarding knowledge from care professionals they hardly knew or had never worked with. A service manager described a situation where knowledge and information about a client was not shared by a mental health nurse who worked across the four facilities because she was new in the role and had not met or worked with the service manager:

> *I called the mental health nurse about a client and she asked me to introduce myself and even after introducing myself she still refused to share any information about the client. She stated that she does not know who I am. The nurse that worked there before her would have easily released the information because we have met several times and have developed a relationship. SerMan (RC1), August 4, 2015*

This highlights the influence of power dynamics on the knowledge sharing process and the role of building rapport in alleviating possible hindrances to sharing knowledge. The issue of relationships was important to this research because relationships facilitate knowledge sharing. In addition, the statement made by the service manager indicated that relationships assisted in building trust that made people less protective of the knowledge or information they possessed. Evidence gathered about the effect of relationships on the knowledge sharing process is discussed in this chapter.

The professionals who were interviewed specialised in different areas of care, and might only be working in a facility or even a group of facilities for a short period of time. A systems trainer mentioned the fact that:

> *The set of professionals I trained a couple of months ago have moved interstate or to another aged care facility. So the industry is really dynamic and I have to*

repeat the training all over again to new set of professionals. Trainer (RC2), November 5, 2015

The complex nature of these care teams therefore made it challenging for the professionals to share knowledge that would contribute to holistic client management. It was therefore fundamentally important to compare the knowledge sharing processes and possible power dynamics that existed among these teams of experts in order to determine how knowledge sharing might be facilitated under these circumstances. The analysis of evidence from the four case studies revealed how knowledge was shared within and between complex expert groups and how power dynamics in such groups could influence the knowledge sharing processes.

Membership of the care teams cut across various professional and auxiliary occupations with the shared goal of providing what most of the service managers referred to as 'better practice care or quality care'. It was evident from the interviews and the researcher's observation that excluding any member of the care teams would prevent holistic quality care to dementia clients.

A psychologist highlighted the significance of considering the professional perspective of every professional involved, commenting that:

The importance of all information provided by everybody working and interacting with the clients is valuable, no one can be exempted. All the knowledge and information from everyone is useful to make a clinical judgments and advice on strategies to help clients. Psych (CC1), June 3, 2015

It was therefore important to include all the categories of professionals who were involved in providing quality care to dementia clients and discover the ways each expert's contribution enhanced or affected the knowledge sharing process.

It should be noted that, apart from the care teams, the interviews and the researcher's observations revealed the value of knowledge contributed by the family members of dementia clients, community visitors, neighbours, friends and previous colleagues of the dementia clients. The significance of contributions made by informal carers was questioned by the researcher in a field note entry based on statements made by a social worker training other care teams:

Observation from the field notes. The trainers kept talking about people saying professionals are the experts, but are they really the experts?

Considering the fact that she mentioned that they start with a clear sheet and interview, yarn and chat with families, friends, community and other professionals to have a good understanding of what triggers behaviour of concern and that informs the treatment plan.

During an interview with the social worker to affirm her statement about informal carers' contribution to knowledge during the training session, she reiterated the fact that the informal carers make valuable contributions to the care model for each client stating that:

As a social worker, I critically reflect on quality care and from my experience the experts are actually the clients, the family members and community. Because I ask myself, do I know everything about behavioural tendencies, psychological imbalance of a human body if I don't actually experience it myself? We start by working on a blank sheet and then fill this blank sheet with information we gather from the clients, family members, friends , previous colleagues, the bar man where the clients goes to every morning for a drink and then we reflect on that pattern to form our opinions SocialWrk (CC1), July 24,2015

The above quote shows the dynamics involved in sharing knowledge among diverse experts, with different professional perspectives, jargons and life histories from the clients. It also shows the possible wealth of collective knowledge that can be gathered from care professionals who possess explicit knowledge gained from their training and tacit, personal knowledge from care professionals who have firsthand experience of the type of care that will help to achieve quality outcomes.

While this group of care professionals had a clear agenda, definitive policies and standard operating procedure on how collective knowledge can be harnessed and the possible power issues that affect the process have not been fully explored. Moreover, the intricacies involved in sharing knowledge among disparate experts, given the professional jargon and possible professional power plays require attention. In addressing these gaps, the evidence presented here reveals the

knowledge sharing structure in place among the care teams and the influence of power plays on the sharing processes.

Care teams' case evidence collection. Evidence collected from care professionals based at four residential care homes with dementia units informed the study of teams of experts who provided specialised care to dementia clients. Participant observation was one of the main data collection techniques utilised in the study. This data collection method allowed the researcher the opportunity to have firsthand experience about the knowledge sharing processes and the subtle power issues that occurred during interactions between members in the care teams.

There were different periods of participant observation carried out in four different locations. The whole period of participant observation lasted for six months and went through distinct stages. At the outset of the participant observation process, the researcher spent some time to build rapport with the participants, new colleagues, learn new systems, policies and procedures. Observations began within the first few weeks; these observations were recorded in writing in field notes following periods of reflection. This was followed by informal interviews conducted in between observations. Illustrative extracts from the researcher's field notes and coded interview transcript are highlighted throughout the rest of this thesis.

The analysis of the evidence gathered was guided by three thematic categories: knowledge sharing, power dynamics and social capital, with some subdivisions that were developed in line with the issue of knowledge sharing and the influence of power dynamics on the sharing processes (see Table 4.1).

Table 4.1: Thematic code categories for the care teams

Sub-Cases	Thematic Coded Categories
Care Teams	Knowledge Sharing Power Dynamics Social Capital

The three thematic code categories are discussed below, outlining findings in each of the four aged care residential care homes.

4.3 Case 1: City Care 1

City Care 1 was a large aged care facility located in the inner city. There were diverse professional groups in City Care 1, from personal care assistants to mental health nurses and dieticians who attend City Care 1 regularly due to the high number of clients in this facility.

Regular meetings were organised in City Care 1 due to the involvement of different professionals in the provision of dementia care to clients. From the researcher's observation, these meetings were organised to prevent gaps in information about clients' progress. Every professional involved in the care of clients was strongly encouraged to attend to get current information about each client's care requirements.

It was also evident that the high number of professionals involved in the care of clients in City Care 1 required a platform to interact and build rapport. This was particularly important due to the fact that these professionals shared their time and expertise across the facilities. A statement made by a personal care assistant suggested that these meetings served *as opportunities to interact and share knowledge* [PCA (CC1), July 5, 2015].

4.3.1 Case 1: Knowledge sharing in City Care 1

From the interviews, it was evident that the care of dementia clients requires the expertise of diverse care professionals with unique knowledge, skills and experiences. In the everyday interactions between these teams with knowledge, information and skills peculiar to their experience and training, holistic care required the contribution from all the experts. This was apparent in the statement made by a social worker who suggested that:

> *All staff are experts irrespective of the job title as far as they have constant interaction with the clients. SocialWrk (CC1), August 24, 2015*

Hence, knowledge shared by all involved in the care of dementia clients was considered by this social worker to be important. Apart from the social worker who commented about the importance of collaborative knowledge among all the care professionals involved in providing care to dementia clients, a chef who worked closely with the dietician to prepare special diets for

dementia clients in palliative care acknowledged the importance of adopting and documenting strategies used by all the care professionals irrespective of the impact on clients' care:

> *While the strategies used by a personal care assistant or anybody while working with clients may be a guess or spontaneous reaction that comes to mind because of their level of experience. It needs to be documented. No strategy is right or wrong, if one strategy was used for client A and it didn't work the same strategy can be applied to client B and it can work beautifully well. So it's important to document the wins and the losses so that others can try them and it might just work for them. Chef (CC1), July 25, 2015*

The chef elaborated on the value of trial and error in deciding care approaches.

The benefits of documenting the practical processes and outcomes was that the documents provided other care teams with information and strategies that could be used to achieve quality dementia care. An example of using documented strategies was observed by the researcher when a nurse referred to the history of a client whose medications were administered while familiar sounds were played that encouraged her to relax. The chef's statement was exemplified in the observed action, thus showing the importance placed on collective knowledge in the aged care facilities and how collective knowledge ultimately assisted all stakeholders to make decisions about clients' personal care and clinical treatment. Collaborative knowledge also evolved as a result of shared knowledge and experiences which took place through continuous sharing and the documenting of strategies.

From the researcher's observation and interviews conducted, it was obvious that collaborative sharing through consultation with all care teams was paramount. This was evident in the statement made by a psychologist who stated that:

> *Sometimes I get a call from the team down here saying, look I want to do a sensory profile on this client what do I do. So we all have our specialty areas. I might talk to them more about drugs and the psychologist will talk from the psychology perspective. Psych (CC1), June 3, 2015.*

This suggests that collective knowledge from the professionals involved in the care of dementia clients helped in the refinement and generation of quality care strategies to manage dementia.

> *Observation from the field notes.* Walking along the corridor, the researcher observed that a small group was standing outside a client's room; the client had had a fall while in the toilet. Three different individuals who belonged to three different professions were working together to provide first aid to the patient. The personal care assistant cleaned up the area, making the client comfortable while the nurse checked his vital signs while communicating with the general practitioner on what further action was required.

The evidence collected from the interview and the researcher's observation highlighted the existence of collaborative knowledge sharing among care teams in City Care 1. This consultative method of sharing knowledge made it evident that these teams of experts were reliant on each other's expertise to make holistic clinical judgements and assessments.

An extract from the researcher's reflection written in the field notes stated that the care teams get:

> *Observation from the field notes.* Different types of knowledge from the personal care assistants, nurses, allied health professional, medical, nursing, administration and family members. Some knowledge and information has no direct link to dementia but they help solve the puzzle and contribute to prescribing treatment plans and strategies to help alleviate clients' behaviours of concern and develop programs that will ensure clients' independent living.

This reflective statement suggests that there are different types of knowledge that get transferred, depending on the professional. From this, it can be argued that care teams in residential aged care consist of diverse professionals with varying expertise, skills and knowledge which, if shared among the members of the teams, would result in a wealth of techniques and strategies that promoted quality holistic dementia care.

To further support the importance of creating opportunities to foster collaborative knowledge, a social worker revealed that 'having everyone in a room together makes it easy to share knowledge'. The personal care assistants knew a lot about the clients, and having them in a room together facilitated the flow of spontaneous tacit knowledge and technical explicit knowledge. This created a platform for technical and experiential knowledge to evolve into collective knowledge.

The above extract from the field notes highlights the relevance of using a range of sources to acquire knowledge. Combining formal and informal methods of sharing knowledge in tacit and explicit forms provided a good overview of how to tackle the medical and personal conditions the clients presented. In addition, different care professionals had different types of knowledge, and the care of dementia clients involved the use of tacit experiential knowledge, which the auxiliary employees gained from regular interaction with the clients and consistent practice.

On the other hand, the nurses, general practitioners and allied health professionals passed on technical clinical knowledge. The difference illustrates the importance of utilising different types of knowledge gained through different methods to inform the provision of quality care for dementia clients through collaborative knowledge.

Information required by more than one individual to complete a task needed to be shared for it to be useful and also shared with all care teams that provided care to dementia clients, irrespective of their contribution to the care model. The personal and historic information and knowledge about the clients were shared by the personal care assistants and the lifestyle coordinator assisted by the psychologist and the doctors to make assessments and generate a care approach to managing behaviours of concern to provide quality care to the clients. The transmission of individual knowledge to collective knowledge can therefore be achieved through collaboration and consultation among all care professionals involved in the care of dementia clients.

4.3.1.1 Informal and formal knowledge

Results also emphasised the importance of harnessing tacit spontaneous knowledge from personal care assistants who gained their expertise from frequent interaction with the clients and

explicit knowledge from experts, such as qualified nurses and doctors. These two types of knowledge were paramount in the care delivery process. One of the personal care assistants confirmed the importance of tacit and explicit knowledge in delivering quality holistic care. She revealed that while the personal care assistants had insights into the clients' personal life and what triggers their behaviour of concern, the process of articulating and developing a treatment plan required the expertise of trained medical professionals.

In addition, one of the service managers indicated that 'spontaneous strategies that have worked in the past' were documented by all the care professionals in a software system accessible to all stakeholders to ensure everyone was privy to this knowledge as it helped to enhance the care being delivered.

The researcher observed that during the data collection process care teams were being trained in the use of the software systems to ensure proper documentation was achieved. Given the different paradigms of knowledge from diverse care teams involved in dementia care, and the challenges presented due to the temporal and geographical separation of the professionals involved, the method of disseminating knowledge could vary depending on an individual expert's understanding of the issues affecting the clients' wellbeing. This was particularly evident in the statement made by the lifestyle coordinator about the level of understanding the personal carers had of their role in caring for the clients:

> *If the personal care assistants had time to sit and work with us we could have all that information. I find that personal care assistants do not want to have that time, they seem to care about just caring, they don't understand that it takes 24 hours caring. LifeCord (CC1), July 7, 2015*

Evidently, some of the teams of care professionals in City Care 1 recognised that informal avenues to share knowledge were significant for care teams' ability to develop their knowledge base and ultimately provide quality care. However, the lifestyle coordinator's statement suggests that the avenue to facilitate the knowledge sharing process among personal care assistants had not been explored.

The above extract from the interviews reveals the different ways and barriers experienced during the knowledge sharing process amongst team members in City Care 1; this was informed partly by the level of understanding of the care professionals contributing to the care of dementia clients. The researcher observed that the personal care assistants' perception of their skills and knowledge appeared to be narrow-minded. An observation recorded by the researcher in the field notes suggests that the personal care assistants did not regard their contributions as relevant:

> *Observation from the field notes.* The personal care assistant serving the clients their lunch seem to know what everybody liked. Speaking with him and getting him to comment on his contribution to providing care to the clients and knowledge sharing was met with some resistance. He quickly dismissed me by saying - I only follow the instruction of the nurses; I am just a personal carer. It appears the personal care assistants require a boost of some sort or education about the knowledge they possess and how it contributes to the overall care model.

This participant clearly felt that the knowledge owned by carers was insignificant and failed to appreciate how much they did contribute. This presented an issue, as every member of a care team played a valuable role in providing quality care to the clients, and each participant in the care of a dementia client needed to recognise their importance in the process. Otherwise, their knowledge and skills would go untapped. This was especially important because the clients' needs often seemed unpredictable due to the change in clients' behaviour and personality; this added to the complexities involved in caring for dementia clients.

Another personal care assistant made the point that 'routines, techniques and strategies are generated per time' from interacting and providing personal care to clients over a long period due to the peculiarity of dementia. These strategies became individual experts' *ways of dealing* with clients. An extract from the researcher's field notes contained an example of individual experts' ways of dealing with clients.

> *Observation from the field notes.* A detailed scene was recorded of where a personal care assistant approached a client to feed her and she refused to open her

mouth. I sat there watching the client get upset about being told to open her mouth. Minutes later, another care assistant walked in and immediately the client saw her, her face beamed. The personal care assistant sang a song for the client and the client immediately opened up to eat.

The importance of these strategies is lost when the expert resigns or retires from the organisation without sharing the knowledge or documenting it in an explicit format. This embodied knowledge that is hard to articulate needs to go through the transition process of sharing and documenting for ease of access to other experts.

This was evident in the statement of a mental health nurse who suggested that when caring:

Dementia patients you share all the knowledge you have or have acquired, you might find out that there is a good way of dealing with the dementia patients that only you know about, what you do is go back to the care plan and write it there so everyone can have access to the strategy. MentalNurse (CC1), July 12, 2015

4.3.1.1 Informal knowledge sharing

Observation from the field notes. Evidence gathered from an interview with a social worker suggested that using 'narrative therapy' as a knowledge sharing tool is especially useful in providing quality care to dementia clients because of the nature of dementia. Dementia affects the individual's cognitive ability. The social worker suggested, however, that residual knowledge helps dementia clients communicate their feelings, and that taking clues from the stories or narratives of the clients assists the team of experts to understand information being passed across to them. This is illustrated in the statement below:

I had a client who kept telling the same story about her father going to the farm to get a kangaroo for dinner. This client told this story every morning, afternoon and night at almost the same time. I sat with my client, listened and observed her. I noticed her stand up while telling the story and went straight for a rotten fruit and then it clicked, her residual knowledge was kicking in and it was her way of saying I am hungry. This helped us map out a diet for her and we got more funding to increase her supply of food. Most importantly it helped us look out for the clues the clients try to pass across through narratives and this

applies to all the clients. They love telling stories and through that means they are actually trying to tell you how you can make them feel comfortable or what their needs are. SocialWkr (CC1), August 24, 2015

The above statement illustrates the importance of face-to-face communication, as communicating face-to-face gives the listener an opportunity to observe clues, body language and ask questions to ensure the right message is being communicated. It is important that the residual knowledge of their past life is available to the care professionals in order that they might arrive at a clinical decision about the possible causes of dementia and how to provide quality, holistic dementia care.

While the initial stage of gathering knowledge about clients' past lives involved client participation and the cooperation of their informal carers; family members, community workers and colleagues, the continuous provision of quality holistic dementia care involved the combined knowledge and information from teams of care professionals who provided care to dementia clients.

City Care 1 interviewees revealed some useful evidence. The structure in City Care 1 encouraged informal chats, as all teams had a common staff room where informal chats occurred. The care teams in City Care 1 chatted informally on a regular basis, especially when they required specialist advice from other experts. Informal conversations were especially important, given the normally dispersed locations of these experts, since formal platforms for sharing knowledge among them were difficult to achieve. Moments taken to share knowledge informally helped build rapport among these multidisciplinary experts, presenting opportunities to share spontaneous knowledge that would otherwise be lost.

To illustrate the relevance of informal chats, the researcher observed a personal care assistant approach a nurse during their lunch break about the appropriate way to feed a client. An extract from the field notes illustrates the importance of informal chats taking place between experts:

Observation from the field notes. Members of the care teams were walking along the corridor after a training session and the nurse referred to a client and the strategies she used, she related it to what the trainer mentioned about being

observant to changes that occur in clients and the importance of documenting such information in the care plan. She mentioned an incident to buttress her point and the personal care assistants seemed to take the strategy as an added knowledge or skill.

It was therefore evident that informal knowledge sharing took place in City Care 1 and helped in the knowledge transfer and creation process. The roster manager summarised her morning routine and reiterated the importance of informal chats in the interview extract provided below:

> *We sit informally to share knowledge, I sit with the lifestyle officer and the cook and we have a cup of coffee and the service manager comes in as well and we share knowledge and strategies about the clients, the service manager come along and sit with us as well. Roster Manager (CC1), July 9, 2015.*

The statement made by the roster manager reinforces the importance of the water cooler conversations as valuable opportunities for knowledge sharing. This is especially important in the aged care industry where 'having conversations on the go' is common due to time constraints and spur-of-the-moment ideas that come to an individual's memory during conversations related to previous strategies that worked in the past.

These observations and comments suggested that there were avenues in place to share tacit knowledge between multidisciplinary professionals. This brought richness to the knowledge shared about quality care from a multidisciplinary perspective. While the informal sharing of knowledge occurred and added to the experts' knowledge base, the shift pattern affected the knowledge sharing process and limited opportunities to have fulsome conversations. This presented a challenge to the flow of knowledge and information between the members of the care teams.

The researcher observed that each shift in City Care 1 was attended by at least one professional in each of the professions represented in City Care 1. Each of these experts, however, only had about 15 minutes to handover to the next person. Unexpected activities sometimes disrupted the schedule, such as replacing one of the care professional midway into a shift to attend to emergencies. This hindered proper handover and disrupted the flow of knowledge and

information. In addition, some care professionals consistently worked on a different shift and had no avenue by which to have the types of social interactions that aid informal knowledge sharing.

According to a lifestyle coordinator, the shift pattern was a challenge that affected capturing and documenting information. Therefore, while 'most information is passed on verbally, the software system is the primary form of communication because people can have access to this information from anywhere' [LifeCord (CC1), July 7, 2015]. Hence, while informal face-to-face methods of sharing knowledge were beneficial to the members of the care teams at City Care 1, to ensure the accessibility of information by all care professionals in a team, knowledge and information were documented and also shared in formal settings. This method of sharing knowledge was confirmed by a mental health nurse who identified other means of articulating tacit knowledge by 'writing in the clients care plans, at handover meetings and face-to-face' [MentalNurse (CC1), July 12, 2015].

The issue of time constraint was also mentioned by a personal care assistant, who stressed how busy the aged care facility could be:

> *The floor is always busy with clients requiring one on one attention; it therefore becomes difficult to maintain face-to-face communication or documenting information or knowledge in the care plans.*

It appeared that the complexity of the care provided to dementia clients impinged on the experts' ability to share knowledge or document strategies and observations.

This challenge appeared prominent in the aged care facility due to the shift patterns that characterised the work routine and affected the time available to share and document knowledge gained during the various shifts. Similarly, a field note excerpt mentioned the effect of the shift pattern and how it limited the knowledge sharing interaction between employees who worked different shifts and rarely met one another.

It was evident from the observations and participants' comments that knowledge sharing was a social process that required social interaction and systems that ensured knowledge was documented. The work pattern and the transience of the care professionals in City Care 1 were a

source of challenge that necessitated the creation of structures to support knowledge sharing through informal and formal avenues to ensure all stakeholders had access to information. It was evident that the generation of knowledge was dependent on a combination of informal and formal information sharing processes in place in the organisation.

4.3.1.2 Formal knowledge sharing

Formal methods, such as training, handover, staff and case conference meetings, served as major knowledge sharing avenues for the members of the care teams in City Care 1. These methods were used as opportunities to gather all the individuals from different professions in one room to brainstorm and learn from each other's experiences. The methods were significant to the knowledge sharing process among the members of care teams because, apart from lending a platform to share knowledge, collaborative knowledge can be achieved through these means.

Only repeated interaction between the disparate groups could ultimately result in collective knowledge. A psychologist reinforced the contribution of formal meetings to the knowledge sharing process, describing the structure of a case conference meeting:

> *The first thing we do in case conference meetings is to have an idea of what the client's life was like and the current behaviours of concern and this can be achieved through contributions from all those involved in providing care to the clients. Psych (CC1), June 3, 2015*

This illustrates the importance of sharing information and knowledge and the need to interact and communicate among members of care teams. Indeed, the combination of historical and personal knowledge from personal care assistants who were constantly with the clients and technical knowledge from the allied and medical experts provided a holistic view of the care required by the clients.

According to the psychologist, this information assisted the allied health professionals and doctors to arrive at a diagnosis and a treatment plan for clients' ailments and behaviours. Moreover, an excerpt from the researcher's field notes provided an insight into the interaction that occurred between the members of the care teams and how information and knowledge from diverse experts informed and influenced personal and clinical dementia care:

> *Observation from the field notes.* The personal care assistant seemed to be struggling with feeding the client because she was sitting in a lopsided manner. There must be a solution to this awkward feeding style. Just as I was ruminating on

> these thoughts a mental health nurse and a social worker walked in and provided some advice on exercises that can improve the client's sitting posture and how to support the client to an upright position during feeds.

In essence, all the care professionals had their areas of expertise and the interaction between these areas of expertise resulted in techniques, skills and strategies used to provide quality holistic care to dementia clients. It was therefore paramount to have avenues to share knowledge informally and formally.

The importance of having a formal setting to share experiences and techniques about how to provide quality care to dementia clients was further emphasised by a lifestyle coordinator. She suggested that:

> *Once everyone gets busy on the floor there is either no time to share or alternatively people decide not to share knowledge but a formal institutionalised meeting helps to get 'busy people' to share. LifeCord (CC1), July 7, 2015*

Sharing knowledge during these meetings was, however, influenced by some barriers, such as diverse language and structural segregation. These barriers will be discussed at a later stage in this chapter.

The researcher observed that the organised case conference meetings where the clients, family members and the healthcare professionals had an avenue to exchange new ideas and information about the clients and how quality care could be provided offered a significant forum for knowledge sharing. According to the service manager, case conference meetings were an expansion of handover meetings, and involved all the stakeholders – multidisciplinary health care professionals, family members and the clients. This avenue seemed to provide a wealth of information from all stakeholders as care plans and progress notes were discussed during these meetings, knowledge was created and new strategies were developed by the care teams, families and clients. Interviewees, however, revealed that participation at case conference meetings was restricted to just some of the professionals attending. This is evident in the statement made by a chef:

> *I don't attend the case conference meetings but yes attending these meetings could help. It will be nice to sit with a family member to know what the client's likes and dislike are to help me do my job better. Chef (CC1), July 25, 2015*

This statement suggests that placing a restriction on who attends these case conference meetings prevented knowledge sharing that could have been valuable in achieving holistic care. The influence of such barriers will be discussed in subsequent sections.

The evidence from the interviews conducted with care s in City Care 1 clearly demonstrates that some professionals are willing to share knowledge, but are excluded from some meetings where opportunities to share are presented. The case conference meetings were therefore avenues for getting all the members of the care teams' perspectives and knowledge contribution. Excluding any professional from the case conference meetings prevented the whole picture of the patient and their needs from being understood.

Walking around the City Care 1 aged care facility, the researcher noticed pictures of clients on their doors dressed up as professionals or tradesmen and women. The researcher also observed that clients' rooms had more pictures displayed in front of their wardrobe with their life history, their likes and dislikes, routine, medications and general information that immediately gave a visual indication of the type of care the client required.

The importance of this visual display of knowledge and information about the clients was emphasised by a trainer, who commented about 'the importance of using pictures as a knowledge sharing method'. The trainer explained that the care plans were located in the main office area for confidentiality reasons, while the professionals provided personal care to the clients in their rooms. The images in the rooms served 'as a quick guide' to providing appropriate care to the client, who could not always articulate their needs. The information gleaned from the pictures was also internalised by the carer, becoming tacit. Each expert's knowledge base was thereby expanded.

Interpreting visual information can be a challenge, of course, and it was useful for the clients' care team to have access to the 'story' behind the picture in order to ensure that everyone had a

consistent understanding of the information being communicated. This pointed to the importance of using a hybrid knowledge sharing method, given the fact that face-to-face channels offer the prospect of richer communication and the ability to transmit multiple clues, body language, spontaneous intuition, hunches, and voice inflection.

Such direct links were particularly important given the different professional jargons that existed among these care professionals and the need to shed more light on meanings. This was illustrated in an interview with an occupational therapist who reported that a psychiatrist suggested a strategy for a client, but that the therapist felt he required clarity about the basis and usefulness of the strategy. He therefore arranged a face-to-face meeting to discuss the rationale behind the strategy. The process of enquiry between internalising the pictorial representation and investigating the story behind it contributed to the overall knowledge sharing process. During these interactions, the occupational therapist suggested new ideas and techniques. This pro-active behaviour on the therapist's part benefitted the professionals, who developed a rapport, and the patient whose care was enhanced.

> *Observation from the field notes.* Documenting information, new knowledge and strategies are ways of ensuring valuable knowledge and information are available to all the experts, irrespective of their location and frequency of attendance in the aged care facility. The aged care facilities examined in this research indicated that the experts were transient. To avoid losing knowledge when the experts have to leave the organisation, it is essential that knowledge and information be documented. A reflection from the field note noted the fact that:
>
> *It seemed mandatory for everyone from the personal care assistants to the service managers, allied health workers and doctors to documents daily activities, new information and knowledge in each client's care plan and also in the software used by the organisation.*

Care plans were paper based folders where the members of care teams recorded information about clients to ensure every expert involved in the care of the clients had access to information and knowledge about them. The use of an information management system was also one of the primary means of recording information about the clients as it was accessible by members of the

care teams irrespective of their location, either in the field, interstate or within the state. This was illustrated in the statement made by one of the personal care assistants, who commented:

> *We keep records in the systems and care plans ranging from difficulties in swallowing to the change in behaviour; we also complete behavioural charts to inform the specialists allied health workers when they need information about clients' behaviour. PCA (CC1), August 20, 2015*

Maintaining up-to-date care plans for all the dementia clients was a priority for City Care 1. Documenting the information in care plans served two purposes: 1) guiding the care teams on clients' progress and 2) for accreditation purposes. A statement made by a mental health nurse illustrates the importance of knowledge sharing for accident prevention planning and to develop better care practices:

> *We use the care plans to record cases of residents' falls during shifts, these numbers and incidence reports are used by the physiotherapist to determine how to prevent such incidences and protect clients' hips and bones. MentalNurse (CC1), July 12, 2015*

In addition, proper documentation of clients' personal and medical histories in care plans was a requirement of the Australian Aged Care Quality Agency. This helped to ensure that all care professionals involved in the care of dementia clients in City Care 1 diligently documented their ideas and information in the care plans. Apart from fulfilling the legislative requirements, the care plans also served as a reference guide to all care teams and a very important knowledge sharing tool. It is however worth noting that documenting knowledge and information in the electronic system and in care plans comes with some challenges which will be analysed under what influences the knowledge sharing process.

4.3.1.3 Combining informal and formal knowledge sharing methods

Analysis of the data from interviews in City Care 1 indicated that there was a recognition of the importance of initiating informal and formal avenues to share strategies. This was evident in the roster manager's statement about the best way to understand what the clients required. Understanding client needs involved 'understanding and getting to know the clients; share the ideas with the nurses; and then write everything in the care plan'. Having recognised this, City Care 1's teams of care professionals continually shared experiential knowledge through informal chats. The observations and knowledge were ultimately documented in explicit format to ensure accessibility by all involved.

Participants' statements revealed that the combination of informal and formal avenues of sharing knowledge had been implemented in City Care1. Documenting observations and strategies in care plans seemed to be only one of many formal methods of documenting knowledge in City Care 1. Formal avenues, such as handover meetings, case conference meetings, pictorial representation, and documenting information in electronic devices, were other ways City Care 1 shared knowledge.

However, it is worth noting that there was a general consensus among the personal care assistants and other auxiliary staff in City Care 1 that 'most of the information is passed verbally'. From this statement, and from the researcher's observation, it appeared that tacit knowledge was being articulated into explicit form by 'telling the stories' of their experience with clients and how issues were resolved. This narrative means of sharing knowledge provided a bridge between tacit and explicit knowledge, allowing tacit knowledge to be articulated through interactions fostered by opportunities to share stories (Linde 2001). The process involved a mandatory formal handover meeting to give the various care professionals an avenue to 'share their stories'. It was therefore evident that knowledge was being shared through the use of informal and formal means in City Care 1.

According to evidence from the interviews and the researcher's observation, knowledge sharing occurred among groups of care professionals in City Care 1. In addition, it was evident that knowledge was being articulated through social processes, leading to further insights and

knowledge creation which was ultimately documented. It was evident from the interviews that articulating knowledge through social methods was made possible through the hybrid method of sharing knowledge formally and informally. The use of various methods of sharing knowledge was essential. Evidence revealed the effectiveness of combining informal and formal knowledge sharing methods to enhance the delivery of quality holistic dementia care.

4.3.2 Case1: Power dynamics in City Care 1

Power was seen as a subtle attitudinal issue in City Care 1, and interview questions relating to power were answered with a bit of reservation. This made the researcher ponder on clues to look out for during the participant observation process that could inform the responses from the interviewees.

Observation from the field notes. An extract from the field reflective notes suggests that:

> *The members of the care teams seem to work together seamlessly sharing knowledge without any major issue. Is it possible that power has no influence on the knowledge sharing process here? Not long after that thought three different experts came in to attend to a dementia client and their areas of expertise became apparent as they all had an input into the client's care plan depending on their area of specialisation.*

Expertise based on expert power was apparent in the interaction mentioned above. It occurred to the researcher that power did not just manifest by unconsciously or consciously hoarding knowledge or using one's position to influence the knowledge sharing process, but was also manifested through *expert power*. Exploring the reflective statement above, it was apparent that power manifesting as valuable expertise displayed by different care professionals contributed to achieving holistic quality dementia care. This signifies that power can manifest formally or informally, either within a formal structure with defined position power or informally as expert power.

4.3.2.1 Expert power

Expertise or expert power is a form of power which is based on an individual's personal competencies, experience, techniques, know-how and strategies. This power base is personal in nature and not based on organisational structure or position. In City Care 1, different experts had unique knowledge and skills that made them subject matter experts. Given the diversity of these experts, they all had valuable knowledge peculiar to their field of practice that made their contribution vital to the quality of holistic dementia care.

This observation was buttressed by the maintenance officer's statement about personal care assistants and the nurses in Care City 1 being referred to as the 'eyes and ears of the other experts, because they relate with the clients more often. They know their trigger points, likes and dislikes'. It was also observed that during training sessions conducted by an allied health professional for the nurses, personal care assistants and auxiliary employees in City Care 1, the trainer mentioned the fact that the personal carers were the 'dementia detectives', stating that they were the ones who helped inform research and provided scenarios that assisted clinicians and doctors make diagnoses.

These statements illustrated the fact that in City Care 1 each expert possessed expertise, knowledge and skills that were useful and important to all the other care professionals to achieve quality dementia care. It is important to note that while every expert might not have position power in the scheme of professional relations in the aged care facilities, they had highly valued knowledge, which is under-stated power. It can therefore be argued that excluding knowledge and expertise from any profession prevents care professionals in that profession from making as much of a contribution to the care and well-being of dementia clients as they should.

Expert power is, however, mostly based on social tacit knowledge gained through interacting with clients and being familiar with clients' triggers and routines. Social tacit knowledge in this context refers to knowledge gained through social interaction and experiential knowledge and not through academic or technical qualification. From the researcher's observation and comments from interviewees, personal care assistants appeared to have historical knowledge about the clients mainly due to their interactions with them. This historical and personal knowledge

informed the allied health workers and doctors' clinical decisions and recommended strategies in the clients' care plan.

It is important to note that the contribution of every expert's knowledge was imperative to the delivery of quality dementia care, irrespective of their position in the aged care facility. According to the maintenance officer

> *Some personal care assistants have lots of experience and a good personality. Some of them are just carers, but they have more experience than the position they occupy, but they are happy to be carers, not nurses or the service manager. MainteOff (CC1), August 27, 2015*

This statement illustrates the fact that in the dementia care context, expert knowledge could be classified under a wide range of knowledge, including, but not limited to, technical, experiential and social tacit knowledge. Indeed, every skill, knowledge, technique and information has far reaching effects on the provision of care to the clients. The above statement makes a valuable contribution to a more comprehensive understanding of the clients' situation and the effect of expert power on the care model.

The knowledge and skills of every expert involved in the care of dementia clients needs to be recognised as valuable. An example can be seen in the skill and knowledge personal care assistants have in relation to their clients. Although personal care assistants do not have positions in the aged care hierarchical structure, their knowledge of clients' history and personal needs is required. This knowledge is gained through interaction with clients and their families on a daily basis.

The knowledge, skills and expertise that form the basis of care teams' expert power are based on interpersonal relations that involve mutual exchange of knowledge and are not inhibited by formal structure or rules. Indeed, the care teams as a community of practice (CoP) cultivate knowledge through relationships. It is therefore evident that building rapport among teams of experts can result in expert power having a positive influence on the knowledge sharing processes. This was further illustrated in the statement by a personal care assistant: 'Yes, we work

with the doctors and other medical you know when they need information about the clients they come to us; you know, we know more about the clients than they do'.

A dementia client's daughter also stated that:

> *I think the nurses; apart from the carers give more information about my mother to me. I guess it's because they relate more with her than other employees. Its only the nurses and personal care assistants that take out time to have a chat with us that we get information from but those who don't even bother to talk with us at all we don't get an opportunity to contribute or have an update about her care. FamilyMem (CC1), July 25, 2015*

This statement illustrates the importance of avenues to transfer knowledge, given that the care professionals who are recognised to have expert power due to their knowledge and skills can only transfer this knowledge and skill if there are avenues to share knowledge with others. This suggests that expert power can only have a positive effect on the knowledge sharing processes if the experts relate with other stakeholders.

Observation from the field notes. Observing the care teams as they worked together to arrive at care plans and strategies to provide quality care to the clients suggested that collaboration was paramount to achieving quality dementia care. An extract from the field notes mirrors the thought of the researcher about how everybody's expertise should be valued and considered in arriving at a decision:

They all seem to emerge from different parts of the facility to contribute their expert opinion about the clients' behaviour of concern and how this can be alleviated. Some have natural leadership qualities, taking note of suggestions and the implementation process. The name tag worn by those identified as leaders shows their job title as , personal care assistants and nurses who everyone respect both for their personality and knowledge and not because they have positions in the organisation. This point to the fact that having a position does not necessarily result in respect for the profession, rather the combination of position, expert and charisma power facilitates knowledge sharing. It appears combing personal and impersonal attributes facilitates knowledge sharing.

Although, the result of combining these attributes is subtle but it is noticeable by others over a period of time.

The researcher's observation about the influence of different power bases on the knowledge sharing process was further reinforced by a statement made by a program manager: 'There are no barriers to sharing knowledge in my team because they are all good in their different area of specialisation'. Hence, the convergence of knowledge and techniques from diverse experts is systematic in the creation of knowledge and the provision of client care. This is especially important given the richness of knowledge that care professionals who work in different facilities bring to the knowledge sharing relationship.

Indeed, some of the participants worked between the four aged care facilities that participated in the case study, and their involvement in the different facilities gave them a wealth of knowledge gathered not only from technical know-how acquired from training and education, but also from experience that could be transferred from one facility to another. The convergence of knowledge from different facilities and scenarios added to individual expertise and ultimately became collective knowledge through collaborative knowledge sharing.

It was observed that information about clients' past life and current attributes was gleaned through social interaction between personal care assistants and the clients. This gave the personal care assistants access to valuable information and leverage to providing quality care to the clients, and resulted in some personal care assistants becoming experts through the combination of experiential knowledge and access to historical information. Conversely, nurses had clinical expertise; they had the experience and training required to fill in the gaps about clients' clinical issues.

It can therefore be inferred that expert power in the dementia care industry involves a combination of tacit personal knowledge gained through experiential knowledge and through working closely with the clients, and technical knowledge gained from academic achievements. Furthermore, it appeared from this research that because care teams in City Care 1 realised that providing care to clients required collaborative knowledge sharing, there appeared to be no detectable resistance to sharing.

The data revealed, however, that expert power could have a negative influence on the knowledge sharing process. Some care professionals with specialist knowledge gained through academic study who worked in highly regarded areas of expertise in the aged care industry were sometimes not willing to share their knowledge. This was the case with a psychiatrist who mapped out a care plan for some clients and was reluctant to share the 'peculiar jargons' of her trade with professionals from other disciplines.

The implication of not sharing expert knowledge with others in the care teams was illustrated in a statement by the chef

> *People play childish games; holding back information is dangerous. The lives of clients depend on information being shared; it is dangerous not to share information or knowledge in the aged care industry. Chef (CC1), July 25, 2015*

This statement illustrates the fact that the effect of not sharing knowledge is problematic and detrimental to the ability of care teams to offer quality holistic care to dementia clients. The implication of not sharing expert knowledge is that the lack of cooperation hinders knowledge transfer. This is an undesirable outcome, as evidence suggests that building collective and collaborative knowledge from the diverse care teams involved in the care of dementia patients in residential care facilities is a catalyst to achieving quality holistic dementia care.

4.3.2.2 Charisma power

City Care 1 had a number of care professionals who had expert knowledge and had combined this power with informal power bases, such as, charisma and referent power. Some of these experts, however, combined expert power with good charisma and character.

> *Observation from the field notes.* The researcher observed that the chef in City Care 1 was an experienced chef who was respected by all because of her friendly disposition.
>
> *The kitchen was my favourite place in City Care 1, not because I love food but because of the atmosphere in the kitchen. The chef and the kitchen hands had a relaxed disposition around them, chatting all the way as they prepared clients' meals. The kitchen hands seemed to respect the chef a great deal. It appears not*

only because she was an expert but she treated everyone with respect and was willing to share. They all gathered around a small table laughing and sharing recipes. Linking this back to the kitchen hand's statement during an interview with her, commenting about how this chef was nicer than the other one they had before and she has taught her a lot since she commenced suggest that the chef had charisma and referent power.

The effect of having a good disposition is that people consult such individuals not only because of their specialty knowledge, but because they are approachable and people hold them in high esteem. From the researcher's observation, it was clear that there were some particular professionals that everybody consulted and shared their concerns with not just because they were subject matter experts in their profession, but mainly because they combined expertise with charisma.

Statements such as 'go to her; she is so lovely to talk to and will help; she knows all about the clients' illustrate the positive effect of charisma power on the knowledge sharing process. To further buttress the effect of charisma power on knowledge sharing in City Care 1, an administrative employee mentioned during her interview that:

People go to the team leader not only because she is a good leader but also because she likes to share her knowledge. She is definitely the go to person because she has knowledge and experience. Apart from this she has got good rapport with everybody so we all like to go to her. AdminAssit (CC1), August 3, 2015

This statement illustrates that charisma power makes a constructive contribution on the knowledge sharing process and helps to develop relationships and collective knowledge. From the above statement and the researcher's observation, charismatic power appeared to contribute to the knowledge sharing process. Indeed, professionals with expert knowledge, coupled with a friendly disposition, were seen as mentors by other professionals. The relationship that developed from this interaction contributed to the knowledge sharing process. These relationships also alleviated the effect of power dynamics, given the fact that rapport developed during the interactions which broke down structural holes and the effect of professional diversity among care teams.

4.3.2.3 Referent power

City Care 1 had a number of members in their care teams who the new employees and even those who had been there for a while looked up to and respected. This was evident in a statement made by a personal care assistant, who said, 'go to her; she will sort things out for you; you know she has lots of experience; she has innate leadership qualities and everyone respects her'. This statement is indicative of the positive effect referent power has on the knowledge sharing process as it attracts people to certain people who are not only respected for their expertise but also for their leadership skills.

It is worth noting that some of the professionals that had referent power had no organisational position attached to them to make them leaders formally. The identified leadership qualities just came naturally and were personal. It could therefore be argued that referent power contributes to the knowledge sharing process and helps build respect and relationships among teams of experts.

4.3.2.4 Professional power

Decision making and direction about the type of care provided to clients were mostly made by clinicians and the service manager. These professionals occupied positions of authority in City Care 1; ultimately, their position in the organisation's hierarchy gave them position power. It was evident that some of the professionals with position power shared knowledge with others and used their position in the organisation to mentor other professionals. Conversely, some of the professionals with position power deliberately hoarded knowledge and information. This arrangement was evident in the statement made by a kitchen assistant, who commented that:

> *I was taught the basics by the former head chef, nothing beyond what I should know, the chef was not ready to share knowledge but things are different now as the current chef loves passing knowledge even above my normal core duties. She gives me the opportunity to make the main meal at times and just guides me.*
> *KitHand (CC1), August 3, 2015*

This shows that position power can have a constructive contribution to the knowledge sharing process, depending on the disposition of the expert with authority to mentor and share. On the other hand; experts in positions of power can decide to withhold procedural and experiential knowledge from other experts.

The statement made by the kitchen assistant about the mentoring opportunity she received from the new chef revealed the effect of position power in either facilitating the knowledge sharing process and having opportunities to develop new skills, techniques and knowledge, or position power serving as a deterrent to sharing knowledge because of individuals who hoard knowledge due to their position in the organisation. An example of care professionals hoarding knowledge was related to the researcher by a personal care assistant who seemed to be upset with a nurse whom she had consulted about a client, only to have the nurse refuse to give her information, stating that the personal care assistant's role did not require her to have the knowledge she was making enquiries about. This statement suggests that some professionals are reluctant about sharing knowledge.

> *Observation from the field notes.* Blending into the background in the common area at City Care 1, observing interactions between different levels of professionals, gave the researcher a good perspective of the influence of position power on the knowledge sharing process. An extract from the researcher's reflection from the field note suggests that:
>
> *They all contribute and have a say but it appears the opinion of experienced professionals who hold hierarchical positions seem to hold more in making decisions.*

A similar display of power was observed in the form of professional power. For the purpose of this research, professional power was defined as the ability of a trained expert who belonged to a perceived superior profession to control the knowledge sharing process or decision making regarding a client's treatment plan without respecting other experts' input, or the display of superiority based on one's profession. While position power is based on an individual's position in the organisation's hierarchical structure, professional power is based on the value placed on each profession represented in the teams of experts.

In City Care 1, this type of power was illustrated by a personal care assistant stating, 'We don't share knowledge with the doctors. We are just meant to do what they instruct'. This statement gives an indication that professional boundaries are created when the ideas, opinions and skills of

other professionals are not integrated into the decision making process in the care of dementia clients. It can therefore be argued that professional boundaries create barriers to knowledge sharing, and the creation of collaborative knowledge.

In addition, a personal care assistant mentioned that:

> *The nurses can pitch in more here as there has been some struggling about people not doing what they are meant to do because they don't see it as part of their duty. They feel their job is just to give medications and give instructions and they hardly have time to mentor us. PCA (CC1), June 9, 2015*

This statement illustrates segregation among professional groups, as some professionals perceive themselves to be superior, while others regard themselves as inferior. This affects the level of rapport and opportunities to transfer knowledge and skills. Segregating one professional from the others due to perceived superior knowledge, skill, academic achievement and power from position held in the organisation can be detrimental to clients' care. There should be opportunities for diverse knowledge inputs, which would enrich the understanding and insight of each client's situation and thus inform quality holistic care.

4.3.2.5 Information power

Information is paramount in providing quality care to dementia clients. An individual who has access to important information in a dementia care unit possesses information power that is required by other professionals wishing to provide necessary care to clients. In City Care 1, a lot of information was passed on to the nurses due to their position in the organisation. Nurses served as service managers and team leaders in City Care 1, coordinating clinical and personal activities in the facilities. Nurses also served as a conduit to documenting and distributing information about the clients to other experts.

While observations and notes about the clients were written in care plans, it was the norm to also give a verbal handover to the nurse on duty. Nurses were responsible for disseminating information across City Care 1 by organising meetings and putting up notices on the notice boards. The nurses have therefore been recognised in this research as possessing information

power. The implication of this to the knowledge sharing process was that considerable information power was in the possession of nurses and they could decide to share or not share information that would help create new knowledge.

Dementia care clients and their families have also been recognised to possess valuable information which results in information power. Care plans are generated from information provided by them or their families when they are admitted into an aged care facility. The social worker mentioned that:

> *The care plans and activities are developed from information we get from the clients, their families and the community they come from. The clients give me bits and pieces of information and the personal care assistants who take time to build a relationship with the clients will actually have a lot of information about the clients. SocialWkr (CC1), July 7, 2015*

Information power adds a lot to the care of dementia clients, developing a treatment plan for a dementia client involves a lot of fact finding and research about their past life, their personality and medical history. The holistic therapist confirmed that without these details, developing a treatment plan for clients would be slow and laborious. Building a rapport with the clients would help facilitate the process of sharing this information, as clients generally only share information with people they trust. This shows that information power can be formal, documented in care plans, organisational processes and procedures, and informal, shared by people during informal chats. This evidence indicates that information power can be categorised under formal power bases as organisational information and also under informal power bases, because it can be gathered through relationships.

4.3.3 Case 1: Social capital in City Care 1

There are challenges in the process of sharing knowledge between experts, given the disparity in knowledge perspectives and transiency in attendance at the aged care facilities. Indeed, the dynamics and complexity involved in the knowledge sharing process and the influence of power dynamics in City Care 1 require a platform where the diverse and dispersed experts interact long term to provide quality care to dementia clients.

The structure and avenues to build wholesome rapport appeared to be an important factor in achieving a sharing culture. In addition, the contribution of power dynamics to the knowledge sharing process through the convergence of informal power bases and formal bases indicated that exploring social capital theories would further contribute to the sharing process amongst the experts. This was evident in the statement made by a program manager about building a rapport before approaching individuals for information and knowledge about a client. Evidence about the role of social capital theories in identifying the interaction between knowledge sharing processes and power dynamics in City Care 1 is discussed below.

4.3.3.1 Relational capital

Wholesome relationships help to propel knowledge sharing, as it appeared employees in City Care 1 only go to clinical experts with whom they have a rapport when they have questions or need expert advice about a particular case. This was evident in the statement made by a nurse who was the shift coordinator:

> *I know some of the employees who will not go to some nurses because they don't have a good relationship with them and they go to others to share and learn from them. MentalNurse (CC1), July 13, 2015*

It was therefore evident that good relationships helped to break power barriers and foster a knowledge sharing culture. It was observed that sharing knowledge in a relaxed atmosphere and sharing knowledge serendipitously appeared were common at tea time and lunch time. In addition, a statement made by the team leader revealed the importance of casual conversations about work issues and how they facilitated knowledge sharing. Sharing knowledge in a relaxed atmosphere helped people let down their guard and share knowledge with other professionals. The data indicated that relational capital could contribute to the sharing process and alleviate barriers to knowledge sharing as it helped to foster rapport and opportunities for informal chats.

4.3.3.2 Structural capital

Organisational policy, procedure and structure supported and provided avenues for members to share knowledge in various ways. City Care 1 had in place staff meetings, daily handover meetings and care plans where information could be documented. This indicated that social

relationships in organisations are shaped by administrative structures and that structures could support active knowledge sharing.

A personal care assistant described a typical day on the floor in City Care 1 as being:

> *So busy at times we don't have enough time to document progress notes, although the manager gives us 30 minutes to do that. PCA (CC1), July 15, 2015*

Comments like this made it evident that while the structure at City Care 1 encouraged knowledge sharing, the work load and busy schedule of the professionals prevented them from sharing knowledge.

Observation from field notes. Reflecting on the daily routine at City Care 1, an extract from the researcher's field notes suggested that:

> *Handover meetings, case conference meetings and staff meetings are organised to encourage sharing information and knowledge, some of the professions get called for an urgent situation during the meetings and they miss out on the information being shared. Do the professionals that miss out get an update of information missed or is it assumed that they already know what the clients require?*

It appeared that restricting knowledge sharing opportunities to formal meetings might result in missed information. On the other hand, encouraging informal chats appeared to encourage knowledge sharing. There were clearly network ties and various opportunities to interact outside of organised meetings. 'Passing information and knowledge in an informal way and in a relaxed atmosphere can facilitate knowledge sharing' (*Field note*).

Among influences on knowledge sharing among the care professionals in City Care 1, the ethos and ethics of their individual area of specialisation guided the experts' activities. They were also guided by their professional network and CoPs.

From the interviews conducted and observations, there appeared to be disagreements about treatment plans among some of the professionals. This was mainly due to subtle professional power issues. On further investigation and interaction with the experts, it was discovered that

when level of professional seniority was disregarded and informal brainstorming occurred, quality results were achieved and the care professionals usually came to a consensus about treatment plans.

This was evident in the statement made by a social worker stating that:

> *If the professionals are to come together informally disregarding their status or credit given to their particular profession, it definitely helps us to respect each other's views because it creates opportunities to share each other's perspective. SocialWrk (CC1), July 7, 2015*

In essence, the statement made by the social worker suggested that delineating professional and structural boundaries and establishing network avenues had helped to facilitate knowledge sharing among care teams in the past. It was therefore evident that these network avenues would also enhance collective knowledge sharing among these diverse and transient specialist professional groups and also tackle possible power issues.

Having recognised the importance of informal chats in the knowledge sharing process, some of the team leaders indicated that organisational processes and procedures should be used as a guide but that the clients' duty of care supersedes 'power structure'. Therefore, informal avenues were also used to share knowledge as they generated more results. While there was an onus on the care professionals to document activities, both for government regulatory purposes and organisations' processes and procedures, according to the team leaders, practice indicated that informal chats conveyed more knowledge.

Opportunities to have a quick chat about client issues were therefore widely encouraged in City Care 1 to foster knowledge transfer and rapport building. The use of these informal avenues to share knowledge indicated that the use of combined social capital elements contributed to knowledge sharing and ultimately quality dementia care.

4.3.3.3 Cognitive capital

It was apparent from observation and the interviews that the professionals working at City Care 1 had shared norms, values, and agendas. This congruence formed the basis of cognitive capital

that helped in the delivery of optimal care for the clients. To accomplish this there appeared to be a common repertoire of signs, triggers and a *lingua franca* that was shared amongst care professionals in City Care 1, clients and family members.

The care professionals at City Care 1 worked closely with and had developed a rapport with the clients, community members and clients' family members over a period of time. This had given them access to languages and gestures that encourage the clients to respond to bath times, medication and other activities in which they are required to participate. A personal care assistant commented about 'strategies being used to encourage clients to take their medication and get them to do what they need to do'. According to her, these strategies have gone through the trial and error stages to become 'shared clues and trigger' among the teams of experts.

Stories and clues are crucial in the provision of quality care because each client will have peculiarities that when understood and integrated into the care practice will contribute to the provision of quality care. These languages, clues and trigger points were documented to ensure that everyone had access to the information.

An example was seen in a client who was not keen on having a bath. A personal care assistant who had related with her family members and heard narratives about the client's past life sings for the client and says a couple of soothing words and the client easily goes with that personal care assistant to the bathroom, dancing all the way to the music. According to the personal care assistant, this technique was used for the client as a child and the client used it for her grandchildren before she came into care. The personal care assistant was privy to this technique due to constant interaction with the client and her family.

To further buttress the influence of cognitive capital on the knowledge sharing process, a statement was made by the lifestyle coordinator who affirmed that 'we take our time to get the important clues that we need to get the clients to partake in activities and other things'.

It was therefore apparent that employing three social phenomena – relational capital, structural and cognitive capital – contributed to the knowledge sharing process and alleviated possible power issues.

4.3.4 Case 1: Key findings in City Care 1

The results presented above suggest a convergence of factors that affect the knowledge sharing processes in City Care 1, the influence of power on the sharing process and how social capital facilitates the relationship between knowledge sharing and power dynamics. Common factors that impact on the issues of knowledge sharing, power dynamics and social capital in City Care 1 are highlighted below. Some of these factors affected the three main thematic categories, while some of these factors affected only one or two. The factors discussed below affect each main thematic category.

- collective collaboration and inclusion
- platform for knowledge sharing
- power as a knowledge facilitator or a deterrent
- the role of rapport.

4.3.4.1 Collective collaboration and inclusion

Results revealed the involvement of diverse care teams, with different knowledge perspectives involved in the care of dementia clients. These care teams were separated by shift routine and, in some cases, sporadic attendance at the aged care facility. The disparity in the professions and the transiency of attendance at City Care 1 contributed to the challenge and dynamics of sharing knowledge essential to the provision of quality holistic dementia care.

Interactions between these care teams revealed the need for collaboration. Team collaboration was seen as the convergence of different knowledge perspectives among the diverse professionals involved in the care of dementia clients. Responses from the research participants in City Care 1 revealed that individuals realised that knowledge from a single professional could not produce quality care because of the complex nature of dementia. Notably, a psychologist mentioned the:

> *Importance of getting information and knowledge from all the care teams because every professional's knowledge contributes to the provision of quality care. Excluding any information from a professional can be detrimental to the treatment plan. Psych (CC1), June 3, 2015*

Similarly, a team leader noted that 'dementia care cannot be managed by one or two individuals; it involves all the stakeholders working together as a team to provide care'. These statements reveal the importance of collaboration among the teams of experts involved in providing care to clients. Evidence therefore revealed the existence of collective knowledge sharing among members of the care teams in City Care 1.

Closely related to collective collaboration is the issue of inclusion. Inclusion in relation to this study referred to respecting the contribution of every professional in the care team. Results revealed a subtle segregation among members of the care teams in City Care 1. This was evident in the statement made by a personal care assistant, who said, 'We (referring to personal care assistants), only do what we are told to do by the doctors; we don't really contribute in anyway'.

This statement made it evident that some professionals' knowledge was sometimes excluded from the collective knowledge. This point was reinforced by the chef, who mentioned that it was unwise to exclude anybody's knowledge when it came to the care of dementia clients. It was important to harness the collective knowledge that resulted from the contribution of every care team because the act of excluding hindered optimum knowledge sharing.

> *Observation from the field notes.* An extract from the field notes detailed the researcher's observation about a pertinent question, which was,
>
> *How to educate or make experts know they are actually experts if they don't see the worth of their contribution? Is there a need to educate professionals about the impact of their contribution on achieving holistic quality care so they can feel included and more confident about the knowledge they have?*

The issue of inclusion was therefore essential in articulating knowledge and sharing such knowledge with other professionals. This was important because if an individual's knowledge is not acknowledged or recognised, then there is no way such an expert will share knowledge he/she does not realise exists. It is worth noting that avenues to share knowledge provide opportunities to articulate knowledge which translates to knowledge that can be shared and ultimately becomes collective knowledge.

4.3.4.2 Platform for knowledge sharing

Results revealed the various knowledge types that existed in practice among care professionals. These knowledge types manifested in the tacit and explicit form. Evidence gathered showed that the platform used to share knowledge was dependent on the knowledge type. Tacit knowledge was difficult to share or transfer through documentation. Tacit knowledge can only be shared by working closely with the expert because it is spontaneous. Sharing tacit knowledge involves a platform to articulate knowledge that develops through continuous practice. On the other hand, explicit knowledge can be documented and therefore shared through documented processes and procedures.

While both knowledge types are paramount to the provision of quality holistic dementia care, tacit knowledge appeared to be considered more valuable by the interviewees. A psychologist commented:

> *Knowledge of the clients' life and what triggers their behaviour is important to making clinical decisions. This knowledge can only be derived from working closely with the clients and over a period of time you just have a feel for their routine, past life and what triggers behaviours of concern. Psych (CC1), June 3, 2015*

It is apparent from this statement that the foundation of providing quality care begins with knowledge that is tacit in nature. A social worker also suggested that:

> *Treatment commences with having a blank sheet and sourcing information through interacting with the clients, families, personal care assistants and all those that through interaction know the clients deeply. SocialWrk (CC1), July 7, 2015*

Indeed, these statements not only suggest the importance of tacit knowledge but also the informal nature involved in sharing such knowledge.

Knowledge was shared in various ways in City Care 1. There were informal methods, such as: face-to-face during lunch breaks, over coffee and while filling up water bottles at the water cooler. Other methods that stood out were narrative therapy or what was simply referred to as

having a 'yarn' and pictorial therapy. These informal and relaxed methods were found to be major ways of sharing knowledge and building rapport amongst professionals whose schedules were busy and attendance at the facility transient.

The holistic therapist commented on the information and knowledge gathered during pictorial therapy or narrative therapy:

> *All the stakeholders sit in a relaxed atmosphere. Sometimes we just tell stories and share pictures that trigger memories. This gets everyone talking in a relaxed atmosphere; these sessions are mostly not planned, so we don't have agendas. During these sessions knowledge and information gathered solves the puzzles about clients and informs the treatment plan. HolTherpist (CC1 and RC1), August 10, 2015*

These sessions were also considered as avenues to form relationships which helped the knowledge sharing process. A trainee personal care assistant stated that:

> *Initially I didn't know anyone and they all seemed very busy and didn't have time to train me, but attending these sessions opened up their softer side. It broke the ice for me. They now share with me and I get trained because I have built a rapport through these sessions. TPCA (CC1), June 20, 2015*

These statements emphasise the effect of informal methods of sharing knowledge on the provision of quality care.

Informal avenues of sharing knowledge were important to the teams of experts, given the involvement of professionals who worked out of other facilities. While these professionals, such as the psychologist, social worker and holistic therapist provided expert care to dementia clients in City Care 1, they also worked in the other three facilities that participated in this study. This limited their attendance at City Care 1 and their regular attendance at formal meetings. Hence, having informal opportunities to mingle and share with other professionals in City Care 1 was valuable. This was especially important as knowledge and experience gained from the other aged care facilities contributed to the knowledge base in City Care 1 and was also transferred across the facilities by these experts.

While informal avenues to share knowledge appeared to be the preferred method to articulate tacit knowledge, formal knowledge sharing methods also contributed to the knowledge sharing process and ensured knowledge and information were documented for future reference. Hand over meetings, training sessions, writing in care plans and case conference meetings were some of the formal methods used to share knowledge in City Care 1.

The data highlighted the importance of combining formal and informal methods in achieving quality holistic dementia care. Pictures placed in clients' rooms and written information in care plans could be taken out of context, especially due to different professional jargons. Therefore, meeting informally to discuss issues face-to-face provided a platform to raise questions and develop new ideas that could lead to knowledge creation from different perspectives.

4.3.4.3 Power: A knowledge facilitator or a deterrent

Results revealed that power had a subtle influence on the knowledge sharing process in City Care 1. The involvement of diverse professionals who occupied various management and leadership positions impacted on the level of interaction and relationships between the members of the care team in City Care 1. The analysis of the data suggested that relationships usually developed between professionals who either belonged to the same profession or the same hierarchical level in the organisation.

> *Observation from the field notes.* Knowledge sharing involved interaction which had been proved to facilitate sharing; this was evident in an observation documented in the researcher's field notes stating that:
>
> *The professionals came in one after the other and exchanged pleasantries, some group of people seem to stick together throughout the meeting exchanging glances and nods to acknowledge information and knowledge being disseminated and sharing what they know about the client or issues raised.*

Similarly, a statement made by a personal care assistant revealed a subtle segregation between professionals depending on their profession and level in management, *I don't think my contribution makes any difference; I only follow the direction of my seniors. PCA (CC1), August 15, 2015*

This quote shows a division between professionals and a division between those in management positions and those in the lower levels. Reinforcing the issue of segregation, attendance at case conference meetings was restricted to professionals in management positions.

Excluding some professionals from meetings or not respecting the knowledge offered by some professionals provided a disincentive to some individuals, preventing them from sharing knowledge. Indeed, the issue of excluding some professionals resonated with the influence of position and legitimate power which created a demarcation between professionals and influenced the flow of knowledge and information.

Recognising the effects of position and legitimate power on the knowledge sharing process prompted the service manager to organise and encourage informal networking opportunities that facilitated the process of building rapport and encouraged knowledge sharing.

While results revealed that the influence of power on the knowledge sharing process created some restrictions on the sharing process, the data also revealed that power served as a facilitator to the knowledge sharing process. This was evident in the influence of some professionals' personal character and disposition on the sharing process.

A statement made by a personal care assistant about the disposition of some nurses, stating that 'some of the nurses are so nice and share what they know with everyone; we respect the nurses in this category and approach them for guidance' reveals the fact that power bases such as charisma and referent power facilitate knowledge sharing. Professionals with expertise who had charisma and were respected by other professionals provided a conducive atmosphere to generate relationships and therefore share knowledge. It can therefore be argued that the existence of informal power bases such as charisma and referent power facilitated the knowledge sharing process.

4.3.4.4 The role of rapport

The evidence revealed a strong connection between rapport and building expertise in City Care 1. This was evident in a statement made by the psychologist:

It is important to build rapport with individuals before approaching them for information and knowledge about clients. You need to win their trust before stating your mission. Psych (CC1), June 3, 2015

Observation from the field notes. The statement is an illustration of the fact that trust and relationships are paramount in the knowledge sharing process. An extract from the researcher's field notes described an incident where the service manager sat with different levels of employees, from the cleaners to the lifestyle coordinator to the nurses to have tea and in the process garnered information from them.

From observation, most of the knowledge shared during this informal and unplanned meeting was information that would enhance care provided to dementia clients. It is important to note that creating avenues to build rapport among care teams would enhance the level of trust and foster knowledge sharing that would ultimately result in quality holistic dementia care.

Similarly, the lifestyle coordinator mentioned the importance of collective sharing to develop shared understanding. Her comment about sourcing information from care teams and passing on information to other teams of experts, which develops shared understanding, resonated with building cognitive capital. She also mentioned developing norms, shared language and signs through constant interaction, noting that the more one shares, the more one knows because the other professionals let down their guard or perceived power and share without reservation.

These statements and observations suggested that building rapport among disparate professionals advanced the knowledge sharing process.

The result also revealed that the emerging knowledge sharing methods used in City Care 1 were achieved through building relationships. An example was seen in narrative therapy and lunch time informal chats. According to the interviewees, these knowledge sharing methods contributed to filling the gaps concerning clients and provided a good platform to develop treatment plans.

The social worker stated that the information and knowledge transferred using these methods were the result of building trust through spending time with the clients and other care teams to have a 'yarn', as they would only share knowledge with those they have come to trust.

The importance of rapport in the knowledge sharing process was reinforced by the fact that some professionals struggled to fill information and knowledge gaps about the clients, and this affected their ability to prescribe a holistic treatment plan. Further investigations revealed that allied health workers, doctors and therapists' attendance at City Care 1 was transient, and this restricted opportunities to build relationships with other teams of experts and the clients. Their sporadic attendance at the facilities limited the level of rapport between the professionals at all levels, and their knowledge of the clients.

> *Observation from the field notes.* The willingness to share, irrespective of one's professional group or hierarchical level, was facilitated by social capital. An extract from the researcher's field note revealed the effect of rapport on the sharing process:
>
> *Initial meeting between some care teams of experts seemed a bit awkward with everyone keeping to themselves and not making any contribution. The activities coordinator made an opening statement stating the agenda and then invited other teams of experts to take the lead prompting them with light barter, this broke the ice and immediately everyone started contributing.*

This observation reveals the effect of informal chat on subtle power structure. The ability to form a bond or opportunities for informal discussions alleviated possible power issues and promoted knowledge sharing. In addition, opportunities for informal chats provided avenues to identify subject matter experts and experts who had innate leadership skills.

4.4 Case 2: City Care 2

City Care 2 was a small aged care facility with a close knit group of care professionals. While the professional groups in City Care 2 were not as diverse as in City Care 1, the membership of this group of experts seemed to account for ease in communicating tried and tested strategies relating to clients' needs. This was mainly because of the small number of professionals involved in the care of clients in City Care 2.

The structure in place in City Care 2 encouraged clients' independence and good rapport between the care professionals and the clients' family members. From the researcher's observation, it was evident that the structure in place facilitated knowledge sharing and the exchange of ideas and information. This was further illustrated in the statement by a personal care assistant about 'having a close relationship with the client and knowing clients' families and getting adequate information from them on clients' preferences'. Moreover, from the personal care assistants, nurse, activities coordinator to the service manager in City Care 2, they all mentioned that 'they all share knowledge due to the closeness that existed among them'. This structure fostered communication, knowledge sharing and the exchange of ideas.

Informal knowledge sharing. Conversations were a popular way of sharing knowledge among the care professionals in City Care 2. Knowledge about strategies or important information was shared 'on the go and as it happens'. This was significant to the knowledge sharing process as this ensured a consistent flow of knowledge and information among the care professionals involved in the care of dementia clients. The approach to sharing knowledge was important for making swift clinical decisions, mapping out care plans and ultimately providing quality dementia care to clients.

A lifestyle coordinator suggested that her relationship with clients' family members helped in making decisions quickly. She gave an example of an observed pattern of a client who required medical and psychological attention. Her observation was communicated to all the professionals in attendance by a personal care assistant immediately it happened and was passed on to the client's relative by the lifestyle coordinator who had a rapport with the family. A quick decision was made that facilitated the client's treatment plan. This suggests that sharing knowledge immediately something occurs can facilitate the provision of quality holistic dementia care.

> *Observation from the field notes.* An extract from the researcher's reflective notes suggests that 'the structure at City Care 2 facilitates informal knowledge sharing processes; there was a relaxed atmosphere in the common area where the clients have their meals. The flow of communication and knowledge between the teams of experts in City Care 2 was mainly informal. Different experts

were going into the service manager's office freely to advise her of any changes observed and strategies that worked while attending to clients.

This observation was confirmed by the service manager during an interview with her. She mentioned the ease with which she related with the team of experts

The staff will usually come and have a chat with me in the office or over a cup of coffee if they notice something abnormal about the clients, they also have conversations with the families to keep them in the loop. ServMan (CC2), October 15, 2015

According to the lifestyle coordinator, the care professionals in City Care 2 had found face-to-face sharing beneficial, as this method of sharing knowledge helped to ensure clients' triggers and behavioural challenges were reported early and made known to all those involved in providing care to the clients. The continuous sharing of knowledge and ideas helped the teams of experts to expand their thinking about ways to improve the care given to dementia clients. This also helped in articulating tacit knowledge, converting it into explicit format, which ultimately helped create new knowledge. The free and rapid sharing of knowledge helped the care teams discover new methods of handling peculiar challenges that were displayed by clients on a daily basis.

The activities coordinator reaffirmed the usefulness of collective sharing in her statement about the 'use of methods that have not worked in the past' after having an informal conversation with the group of personal carers. This statement reinforces the importance of conversations in sharing knowledge among multidisciplinary professionals. Informal conversations generate new knowledge, serving as a platform for different professionals to discuss ideas and knowledge that have been used in the past. Conversations provided the opportunity to fine tune strategies, with reference to what had been used before that worked or didn't work. In addition, it was clear that sharing knowledge through conversations encouraged consultation, helped to clarify ambiguity and provided an avenue to demystify professional jargon. Hence, collective sharing of informal knowledge is significant in renewing and refining experts' knowledge and skills. It is also worth noting that knowledge is socially constructed and collectively held. Therefore, sharing knowledge

in a closely knit organisation, according to the evidence gathered in City Care 2, encourages collective sharing and learning.

Formal knowledge sharing. Knowledge sharing among the care professionals at City Care 2 was more informal than formal in many cases. However, while many of the care professionals working at City Care 2 had been there for years, the fact that every organisation experience natural attrition and the varied roster system necessitated proper documentation of valuable knowledge to ensure all professionals at City Care 2 had access to information. In addition, it is a requirement of all aged care facilities to have proper documentation about clients' information. Compliance issues and the value of documenting information have informed the decision to have a communication book in City Care 2, organise formal case conference meetings, staff meetings and implement a software system to document information. Analysis of the formal knowledge sharing processes is discussed below.

Structured planning days were one of the methods used by care teams in City Care 2. These were brainstorming sessions, where all the personal care assistants, nurse, service manager, lifestyle coordinator and medical experts set some time apart to discuss various cases being handled. These sessions provided each professional an opportunity to make contributions to cases handled by their colleagues.

According to the service manager, the sessions were held once a month:

> *Peer reviews occur in these sessions and people walk away with new ideas and techniques. After these sessions people get excited and don't wait for the next formal meeting to share their wins. Generally when people are excited informal sharing takes place. ServMan (CC2) October 15, 2015*

The combination of this formal and informal way of sharing signified the natural flow of explicit knowledge to tacit knowledge, given the fact that ideas were shared in a formal setting based on technical and experiential expertise, and then used in practice to create new knowledge and techniques.

Another structured meeting mentioned by the interviewees was the case conference meeting. According to the team leader, this meeting takes place when City Care 2 has a new client and periodically to update clients' care plans. The service manager and family members attended these conference meetings. According to the team leader, case conference meetings provided all health professionals opportunities to share knowledge and ideas with clients' family members. The case conference meetings were therefore important because they are meant to serve as a convergent point for all stakeholders irrespective of their shift pattern and frequency of attendance at the aged care facility.

It should be noted that attendance at case conference meetings in City Care 2 is however restricted to the service manager and family members. This presents a barrier to knowledge contribution and the creation of wealth of knowledge because of the absence of key professionals, from personal care assistants who provide care to clients round the clock, to nurses who are privy to clients' clinical history.

The challenge of care professionals being geographically dispersed presented another hurdle that was addressed by implementing an information system to ensure all the professionals involved in the care of clients could access information from anywhere. At the time of data collection at City Care 2, training sessions were being conducted in preparation to launch the software to be used for record keeping. The researcher was given the opportunity to review the software manual; this revealed a segmentation of the system into parts to document such information as the personal care required by clients, medications, progress notes and administrative issues. The implementation of this software as an avenue to share knowledge shows City Care 2's continuous initiative to codify valuable knowledge to ensure dissemination of ideas and information. These efforts contributed to knowledge sharing and information exchange, overcoming much of the geographical dispersion of the experts. This issue will be discussed in detail in subsequent sections.

The researcher observed that a communication book was placed in a central place in City Care 2 in order that up-to-date information about the clients could be recorded. It was readily accessible

and experts were encouraged to document their observations, ideas and information about the clients. The communication book was an informal and useful way of sharing knowledge about dementia clients.

Two of the personal care assistants and the service manager mentioned that:

> *The size of City Care 2's workforce and the size of the facility enhance informal communication which in turn supports the use of a communication book because it is easier [for staff] to coordinate. PCA x2 (CC2) and ServMan(CC2), October 16, 2015*

The use of the communication book simplified the knowledge sharing process among the care professionals in City Care 2 and also made it easy for them to refer to information. Furthermore, having the communication book close to where clients were being attended to made it difficult to forget to record information. The book served as a quick reference point for professional teams, from the personal care assistants, nurses and auxiliary employees to the psychologists, doctors and occupational therapists. One of the personal care assistants, however, pointed out the obvious weakness of the book – that its success as a quick reference guide depended 'on the employees' willingness to share new ideas and care strategies'. Achieving collective knowledge sharing cannot succeed if some of the care professionals refuse to share knowledge and techniques, even when provided the opportunity.

A combination of knowledge sharing processes was being used, according to the service manager, to ensure information and knowledge was shared by one method or another. According to the service manager and the personal care assistants, a monthly employee meeting took place to accommodate that shift pattern in place in City Care 2. This meeting was seen as the 'best time to communicate'; as this was where a good representation of all professional headings are and everyone can listen to new ideas and how the clients are progressing with various strategies in place. It appeared that all of the care professionals fully participated in this meeting. One of the personal care assistants and the activities coordinator mentioned that 'the only downside to this meeting is that it takes place only once a month; otherwise everyone makes it a point to attend'.

The comment indicates that a monthly meeting did not provide sufficient time to share knowledge and that increasing the frequency of the meeting would be beneficial. Combining written methods of knowledge sharing, such as the communication book, with face-to-face knowledge sharing processes, is essential in building rapport among the experts. The two methods used in conjunction with one another ultimately result in people who would otherwise not share letting their guard down and sharing valuable knowledge.

It was therefore clear that information and knowledge were shared through the combination of various knowledge sharing methods. This was further exemplified in the statement made by the team leader stating that:

> *Experts ensure they document ideas and knowledge every day in the communication book and then in the clients' care plan as well; however we still ensure attendance at employee monthly meetings are compulsory. TL (CC2), October 10, 2015*

Consequently, while spontaneous ideas and information are shared informally through face-to-face interaction, this is followed up with documenting information in the communication book and with care plans. Combining the two methods of sharing knowledge is important in achieving quality dementia care; particularly given the involvement of diverse and disparate teams of experts with few opportunities to have time to share knowledge.

4.4.1 Case 2: Power dynamics in City Care 2

City Care 2 is a relatively small aged care facility with a small number of professional staff. This makes every expert in City Care 2 take on more responsibility and ultimately become experts in different areas. As a result, the care professionals in City Care 2 possess different expert power bases, meaning they are specialists in many areas in comparison to other facilities that were studied in this research. This is illustrated in the statements made by the service manager:

> *I think they all have knowledge of the age care industry because they have worked here for so long. Also because they know the clients so well and can take on any role. But it's not just that that makes them experts also because they are*

natural leaders as well as the fact that they have that confidence and readily take on other people's problems. ServMan(CC2), October 15, 2015

The statement made by City Care 2's service manager signifies that some of her employees combine various social power attributes. The personal care assistants consistently interact with the clients and are privy to client routines, the aged care policies and procedures, and techniques which have made them experts in different techniques. On the other hand, by building rapport with the clients, sourcing for information about clients' background history and building a relationship with clients' family members, they have information power about the clients that they share with other professionals that ultimately contributes to clinical judgement. The various power bases observed during the data collection process are discussed below.

4.4.1.1 Charisma power

Before the researcher was introduced to the team at City Care 2, an extract from the researcher's field notes mentioned an individual who stood out in City Care 2. She was interacting so well with the clients and other professionals, she had casual banter and informal chats about techniques that would help provide required care to clients.

An interviewee revealed that the team leader was an experienced personal care assistant with natural leadership tendencies and charisma power. This impression was reinforced by the lifestyle coordinator referring to the team leader, saying:

She is just a natural leader; she brings us all together and makes us feel like a family; she is fantastic at mentoring and getting information around. LifeCord (CC2), October 25, 2015

The team leader to whom the interviewee referred turned out to be the same woman to whom the researcher had been earlier introduced, and who had made such a positive impression. From the foregoing, it can be argued that the team leader obviously had a pleasant disposition and shared knowledge easily. There was evidence that charisma power could facilitate the knowledge sharing process, and that City Care 2 had experts who could use their power bases to enhance the knowledge sharing process, which ultimately contributed to the knowledge sharing process in place at City Care 2.

4.4.1.2 Referent power

Referent power in City Care 2 helped the experienced professionals to mentor new employees. The team leader was identified as having a 'wealth of knowledge and experience'. This and the fact that she had an open, warm personality and assured manner made other professional staff members go to her whenever they had questions. The statements from the other employees showed that she was well 'respected and they all look up to her for guidance'. In this context, having referent power contributed immensely to the knowledge sharing process. It was one of those situations that show how individuals seek out those they respect in order to learn, which brings about an exchange of ideas, knowledge transfer and knowledge creation.

4.4.1.3 Information power

Dementia clients require care from diverse and disparate professionals, for example, doctors, psychiatrists, psychologists and allied health specialists, personal care assistants, nurses and auxiliary employees. All these professional groups were not represented in City Care 2, which had to share some specialists with other facilities in the aged care group.

As mentioned earlier, the professionals at City Care 2 were closely knit. The data indicated that the closeness that existed among this group of experts made the culture of hoarding information by specialists working across different aged care facilities a bit abnormal. The care professionals in City Care 2 shared knowledge readily, but specialists who were transient found it difficult to share with such level of openness or due to time constraint. Once again, the transiency of the attendance of some care professionals affected the level of knowledge sharing.

According to the service manager, there were some transient experts:

> *Who like to be the experts and keep some knowledge and information about clients to themselves and this is certainly a hurdle. ServMan (CC2), October 15,2015*

It is evident from this statement that while information power contributes to the knowledge sharing process, the inaccessibility of information can impede the ability to provide required care to clients. Indeed, the 'ownership' of information by an individual or a group can prevent others

from having access to important information, again emphasising the importance of codifying information in repositories that are accessible to all stakeholders.

Conversely, from the interviews and researcher's observations, it appeared that information 'owned' by the experts who were stationed at City Care 2 was shared without restriction due to the nature of their close knit relationships. Each employee had information needed by other employees, and collaborative sharing occurred freely. Collaboration renewed and expanded everybody's knowledge base and thinking.

It was evident that building rapport influenced the level of knowledge shared amongst the members of care teams. It appeared that the periodic attendance of some of the experts made building rapport challenging, which in turn affected the experts' willingness to divulge information. It can therefore be argued that consistent interaction affects the level of information hoarding and ultimately the knowledge sharing process.

4.4.1.4 Professional and generational power

The researcher observed that while the size of the care teams in City Care 2 allowed for specialisation, the number of professionals resident at City Care 2 was limited, so the care team required more support from professionals with specialist skills who worked across different aged care facilities.

The contrast in the level of rapport that existed between professionals who were permanently placed in City Care 2 and those who provided specialist shared services to City Care 2 and other aged care facilities revealed subtle professional power issues. Statements made by the lifestyle coordinator illustrated that transiency hindered the building of relationships. She reported being told:

> *What do you know; you are just a personal carer. You don't need to know all the information. Such reaction makes me think we are not valued but they forget that we spend more time with the clients than they do. LifeCord(CC2), October 30, 2015*

This segregation of the professionals disrupted the flow of knowledge and information. The boundaries also created the perception that some professionals' contribution to the care of dementia clients was not valued.

Apart from professional power, it appeared that generational power existed in this residential facility. This was exemplified by a remark made by a personal care assistant, who commented that:

> *Some of these professionals say I have worked so hard to get this knowledge so why should I share my knowledge with you because you are just starting off. What they don't realise is that someday they will be the ones that will need care from the younger generation and if they have not taught the young ones the right ways then they won't be getting the right care. PCA (CC2), November 12,2015*

This indicates the existence of subtle age or level of experience disparity among the experts. This would clearly hinder any mentoring system put in place for the younger generation to learn from the older and more experienced employees. Australia has a high percentage of baby boomers in the aged care industry and there needs to be a system in place to share knowledge, organisational norms, stories, processes and information with the younger generation. This was reiterated by the software administrator, when she stated that the aged care industry was a 'transient industry' where employees that you trained today might not be in the organisation the next month.

4.4.2 Case 2: Social capital in City Care 2

Building relationships with other professionals is important in the dementia care industry due to the need to call on different knowledge bases to provide quality care to dementia clients. In the same vein, building relationships with the clients and their families is also important as the information they provide according to the service manager at City Care 2 serves as a 'foundation to work from' to build care plans for them.

4.4.2.1 Relational capital

The importance of relational capital was reinforced in a statement made by the service manager:

> *Clients' families initially put up a resistance to sharing information but after a while when we have established a relationship with them they often just call me*

to have an informal chat about their parents and ways to improve care provided. ServMan (CC2), October 15, 2015

The implication of this statement is that taking time to build relationships with all teams of experts helps to establish trust and rapport which facilitates the sharing process. In addition, it provides an avenue by which to arrive at a general consensus on the type of care that is needed, mainly because in the course of interacting, new ideas develop and a care framework is developed by all the stakeholders involved in the care of dementia clients.

The effect of building rapport with all stakeholders involved in the care of clients in City Care 2 was that sharing knowledge among rostered employees and the professionals who worked between facilities was made easier due to the relationships that had been formed among them. Despite boundary spanning and the periodic attendance of some specialists, analysis of the data indicated that building rapport could help to ensure knowledge was shared without barriers.

4.4.2.2 Structural capital

City Care 2 had put in place opportunities for the professionals to network which complemented the structure in place in the care facility. While there were established rules, regulations and an organisational structure in place in City Care 2, there were networking opportunities that facilitated rapport building among the groups of experts. This was evident in the relationship that existed between the nurse, personal care assistants and the service manager in City Care 2. It was obvious that network ties existed because of the opportunities for all care professionals to meet and discuss client care challenges in informal forums. This was evident in the statement made by a personal care assistant, stating that:

We all eat lunch together, service manager, nurse, team leader and we also attend trainings together. These opportunities provide us with platforms to share knowledge and it creates a bond, you know. PCA (CC2), October 30, 2015

It was therefore evident that the structure in place in City Care 2 encouraged team work and limited segregation.

Interactions with the expert teams revealed that most of the employees had worked in City Care 2 for years and had formed strong bonds of friendship. It appeared that team longevity contributed to the level of rapport, as time is what it takes to break down the structural barriers that might exist and develop shared agendas and shared languages. This rapport appeared to have been transferred to the relationship between the care professionals and the clients they cared for. This contributed to the overall closely knit culture that existed in the facility, which translated to the development of collective knowledge and agendas. This was evident in the statement by a personal care assistant who revealed that:

> *I know all the clients' family members. At times they invite me for dinner in their house and we talk about different things. It helps to provide needed care to their mums and dads.PCA (CC2), November 6, 2015*

On the other hand, the attendance at case conference meetings at City Care 2 was restricted to the service manager, the clients and their family members without involving the personal care assistants and auxiliary employees who provided round the clock care to the clients. Despite the various avenues organised by the facility to encourage knowledge sharing, it appeared that some barriers remained in the constitution, membership and attendance at some of the meetings which might ultimately break the conduit of knowledge that flowed horizontally and vertically.

4.4.2.3 Cognitive capital

The communication book at City Care 2 contained shared meanings and had information known to the group. The content was written in such a way that anyone working in City Care 2 immediately understood what is being communicated. The researcher observed that during conversations between the expert staff in City Care 2, there was an exchange of language and words that seemed to be common and peculiar to the care team, with the meaning hidden to an outsider. The existence of shared norms was also exemplified by the chef who stated that 'everyone who works here know the routine at lunch time and the routine helps us manage the clients' It was therefore apparent that there was shared understanding among this group, which facilitated knowledge sharing and the provision of quality care to the clients.

4.4.3 Case 2: Key findings in City Care 2

Results from City Care 2 revealed some useful facts about the impact of the different professions involved in the care of dementia clients, the knowledge sharing process and the influence of power dynamics on this process. Indeed, the size of City Care 2 accounted for some of the successes and challenges they had encountered during the process of sharing knowledge. Evidence also revealed the impact of generational and professional segregation in the knowledge sharing process and how these factors could potentially affect the knowledge sharing process and the role of social capital in these relationships. Key findings in City Care 2 can be highlighted as:

- size, conversations and specialisations
- faster diagnosis and cost cutting
- rapport and collaborative sharing
- professional and generational power

4.4.3.1 Size, conversations and specialisations

Observation from the field notes. The number of care teams in City Care 2 was small in comparison to the other aged care facilities examined in this project. Stepping into City Care 2 revealed a homely and friendly atmosphere. The interior was a small cottage-like aged care facility with a hand full of care teams having chats around the lunch table. An extract from the researcher's field notes detailed the observed ease involved in sharing knowledge in City Care 2.

It was more like a house with many rooms but with one big family living in the facility. Informal banter while attending to the clients occurred between the teams of experts in City Care 2 and the clients. Care teams were constantly chatting and having conversations about clients on how to provide care to them. The more time spent there the more it was obvious that they (care teams) worked as a team and were all specialists in their areas and could also step into other specialist area because they have opportunities to work and think outside the box because the care teams in City Care 2 were only a small number of professionals who had to learn different techniques and expertise.

Similarly, the lifestyle coordinator mentioned the ease involved in sharing knowledge due to the informal culture that existed in City Care 2. These statements revealed that a lot of informal conversations occurred in small sized organisations, such as City Care 2. According to the researcher's observation and the interviews, informal conversations occurred due to the close knit culture that existed among the few professionals that worked in City Care 2. It was evident that opportunities to have conversations in a relaxed atmosphere resulted in knowledge sharing, knowledge development and knowledge creation.

The small number of professionals in City Care 2 resulted in each professional being an expert not only in their field but to have gained expertise in other areas of specialisation. This was evident in the way each professional filled in for others during the researcher's observation period. The statement made by the service manager also attested to the fact that each professional in City Care 2 had been working there for years and over time had become good in their area of expertise and also taken on other specialisations.

The evidence presented above reveals the impact and effect of size on the knowledge sharing process in City Care 2. Indeed, the convergence of size, conversation and specialisation resulted in knowledge sharing, knowledge development and knowledge creation. In addition, opportunities to have conversations solidified relationships and facilitated respect for other professions' expertise and knowledge. This ultimately alleviated possible power impediments to sharing knowledge.

4.4.3.2 Faster diagnosis and cost cutting

The proximity and geographical location of the members of the care teams in City Care 2 made decision making faster. Unlike other aged care facilities examined in this project, City Care 2 usually made decisions about clients' treatment plans faster, without engaging in a series of meetings. The service manager pointed out that when the care professionals in City Care 2 discovered some concerns or had new techniques to suggest, they simply walked into her office and had a quick discussion and made a decision about the way forward. This form of knowledge sharing facilitated quick action that ultimately resulted in quality dementia care. It was therefore evident that City Care 2's size eased the process of consultation, knowledge sharing and reduced

time spent in making decisions about clients' care plans. Invariably, the ability to expedite the decision making process saved time, money and reduced laxity in following up on clients' treatment plans.

4.4.3.3 Rapport and collaborative sharing

The culture in City Care 2 supported an atmosphere conducive to building relationships. This was evident in the statements made by the personal care assistants and the service manager. These interviewees confirmed that employees who work at City Care 2 had a closely knit relationship which facilitated relationship building. Furthermore, the interviewees reinforced the importance of rapport in facilitating collective knowledge sharing. A personal care assistant described how building rapport with clients' family members had enhanced the knowledge sharing process and facilitated getting to know how to deal with difficult situations that pertain to the clients. This was due to the information shared by the clients' family members about their mum or dad's preference and past history. Similarly, the service manager stated that building relationships strengthened people's trust and encouraged the flow of knowledge and information. It was therefore evident that consistent interaction and rapport had a mutual correlation to the level of collaborative sharing that occurred among teams of experts in City Care 2.

4.4.3.4 Professional and generational power

It is important to note that while some power bases facilitate knowledge sharing, some power manifestations were found to impede the flow of knowledge among teams of experts in City Care 2. The size of City Care 2 facilitated knowledge sharing, specialisation and conversation; however, the small representation of professions in City Care 2 brought another challenge to the issue of knowledge sharing. The number of professionals in City Care 2 was restricted to core professions, such as nurses, personal care assistants and manager, who relied on shared services from the other aged care facilities studied in this project. The professionals that provided shared services to the clients in City Care 2 tended to be isolated from the rostered professionals in City Care 2. Because their attendance in the facilities was sporadic, they had limited time to form relationships with other experts. This ultimately resulted in segregation between professionals which caused professional power. This was evident in the service manager's statement about

some professionals hoarding knowledge because they felt superior. It could be argued that professional power impedes the process of knowledge sharing, despite the positive effect of size on the knowledge sharing process.

It is worth noting that professional power was not the only factor that impeded knowledge sharing in City Care. According to the lifestyle coordinator, there was a subtle generational power issue as well. This was evident in older teams of experts' reluctance to share their wealth of experience with younger experts. The benefit of mentorship was therefore defeated due to this generational segregation. This was especially important in the aged care industry because of the transient nature of experts who changed jobs and took up new positions with competitors which could create a knowledge gap in City Care 2's knowledge bank.

4.5 Case 3: Remote Care 1

Remote Care 1 is located in an isolated area in Australia, where the aged care facility has to compete with other organisations to attract skilled and experienced professionals. It was therefore imperative for care professionals to share knowledge and have consistent avenues to transfer knowledge across all employees, given the high attrition rate at this location. The small community of experts in Remote Care 1 therefore valued opportunities to share knowledge. Collaborative care and avenues for collective sharing seemed to be important to the care teams in Remote Care 1.

Informal knowledge sharing. From the researcher's examination of Remote Care 1's structure it appeared that their operation was mostly informal. While there were clear reporting lines put in place, the structural lines did not appear to serve as a barrier to forming wholesome relationships that facilitate knowledge sharing. Therefore, there was a close rapport that existed among the professionals in Remote Care 1; the knowledge sharing process appeared to be relaxed and informal. The service manager confirmed that 'the communication is just there among the employees, in an informal way we all chat and share with one another'.

This enhances the knowledge sharing process and the exchange of valuable insights and techniques. Such was the atmosphere during lunch breaks at Remote Care 1; activities involved a

mixture of informal banter and opportunities for the senior professionals, such as the team leader, service manager and nurses to take junior professionals, such as the personal care assistants, cleaner and administrative employee through routines and how to deal with difficult client issues. Opportunities to interact and share knowledge provided an avenue to transfer valuable knowledge among diverse care teams and within professionals with different levels of experience. This ultimately results in new and unique ways of providing care to clients.

Informal discussions and exchange of ideas also occurred between the care professionals and family members, and experts and community volunteers. The remoteness of this facility and the close knit community environment appeared to add a sense of belonging and trust to the knowledge sharing processes as everyone seemed to know everyone's intention to share knowledge for the benefit of providing quality care.

This was confirmed by the lifestyle coordinator who stated that:

> *Many people, including clients' guardian, volunteers and family members pass information and confidential matters as it will get to the right people. I know some residents that have families in city who I help to pass information to and from them. LIfeCord (RC1), December 5, 2015*

The involvement of all stakeholders who contributed to the care of dementia clients facilitated better knowledge sharing and the knowledge transfer process was shortened through direct communication and collaboration. To further buttress the importance of informal communication in providing care to dementia clients, the team leader stated that, based on direct conversations with stakeholders and her interaction with the clients, it was easier to make 'on the spot' recommendations with which everyone felt comfortable, and this ensured that issues were solved quickly. It can therefore be argued that informal means of communication provide avenues to create common knowledge and clarify any ambiguity.

Finally, clients' observation as a means of determining the type of care needed by the clients was another unique method of gathering information in Remote Care 1. This was immersed in the ability to pick the subtle routine and triggers from the clients through constant observation and

sharing such information with other experts. During one of the training days conducted, the maintenance man mentioned that the cleaner was the 'best pair of eyes in Remote Care 1 and she just knows when something is not right with any of the clients'. She observes and reports abnormal behaviours displayed by clients to the clinical staff. Furthermore, during a brainstorming session among the care teams in Remote Care 1, a client buzzed and all the personal care assistants checked the time and knew exactly what the client's need was. Indeed, consistent interaction with the clients helped the care professionals develop a level of understanding that could only be gained by observing and spending time with the clients over a period of time. This developed into a form of knowledge that became valuable to the care model and clinical assessment. Having insights into clients' routines and behavioural changes served as a guide for clinical experts on the type of treatment plan required and contributed to the delivery of quality dementia care.

Formal knowledge sharing. From the researcher's interaction with the personal care assistants to the service manager, it was evident that a number of avenues were used to disseminate information, from the use of employee notice boards with the schedule of employees' in-house training and formal education organised to expand the knowledge of employees to strategic informal activities to bring employees together to mingle and share.

The researcher attended some of the structured trainings organised for employees in Remote Care 1. The training sessions were structured to involve teams of experts working in the morning, afternoon and mid-night shifts. The sessions were structured to ensure every expert, irrespective of their shift pattern, benefitted from the transfer of knowledge. The delivery of these sessions in batches spread throughout the day was important to the knowledge sharing processes and facilitation of knowledge creation. This occurred through discussions of techniques, strategies and scenarios among care professionals during the training sessions. From the brainstorming that occurred during the training sessions, it was evident that each professional relied on the other professionals' skills and expertise to provide care to the clients.

This was evident in a statement made by the service manager, stating that:

Information and knowledge are gathered from all staff to determine clients' progress and conduct client assessments. ServMan (RC1), December 6, 2015

This signifies the importance of collective knowledge in the knowledge sharing and creation process which helps in the provision of quality care to dementia clients. The act of dementia care through collective sharing and collaborative care in Remote Care 1 was further reiterated by the lifestyle coordinator who confirmed the importance of collaborative knowledge sharing from all experts' contribution:

Lifestyle activities are developed from me reading life stories from clients' family members, personal care assistants' observations documented in the care plans, initial assessments and diagnosis from the GP or clinical staff. I use that to prepare lifestyle activities. LifeCord (RC1), December 5, 2015

The above interview extract suggests that the care provided by diverse care professionals was generated from the skills, knowledge and experience of all care teams involved in providing care to dementia clients. In addition, assessment notes developed from discussions at training sessions and meetings, were an example of the interaction between explicit documented knowledge and tacit knowledge. The information in the care plans and assessment notes was transferred to knowledge and ideas that assisted each professional to provide adequate care to clients.

This is evident in the service manager's statement about having a:

Collaborative care process, with nurses evaluating the residents; and if they have any concerns they refer them to the allied health team, GP and gero-psychologist who can help diagnose the issue and strategies to use to deal with the behaviours. ServMan (RC1), December 6, 2015

It was apparent that constant knowledge interactions occurred among the teams of experts in Remote Care 1, which was important in achieving quality dementia care.

Remote Care 1's service manager appeared to believe in the use of training and formal education to equip care teams with knowledge and skills needed to provide care for dementia clients. Providing training and formal education was important to the delivery of quality dementia care,

especially when the level of education and training among the care professionals varied, depending on the type of job being performed in the facility. The care teams in Remote Care 1 consisted of employees who did not require formal training to provide care to the clients; such as cleaners, maintenance officer, kitchen hand and personal care assistants. Every personal care assistant was required, however, to work towards a certificate in aged care in the first few years as carers to dementia clients.

To ensure this requirement was met and to provide knowledge and skills to these employees, Remote Care 1 organised in-house training sessions through registered training organisations which they partnered. The trainers provided formal training to those who required it and refresher courses for those already trained.

Training and formal education as a means of acquiring technical knowledge enhanced the tacit experiential knowledge these care professionals already had. This form of knowledge sharing also facilitated group learning and collective sharing. This was illustrated in a statement made by the service manager, who commented:

> *My strategy here is, first, education for the staff; we have done a lot of research on those who can offer training to staff about improving the care for clients. During these trainings the trainer can mention something that can be used to improve care for a particular resident and then they discuss the strategies informally during training or lunch breaks. Then the information gets filtered to the nurse who in turn makes notes in the care plans .ServMan (RC1), December 6, 2015*

The quote makes it clear that there was constant formal and informal interaction and sharing knowledge of many diverse types. Indeed, the combination of explicit knowledge and tacit knowledge evident when the professionals used the interpretations they got from the formal training experience as a reference to their everyday experiential knowledge helped expand their knowledge and develop new ideas and strategies.

While formal training and education were beneficial to knowledge sharing, the opportunity to meet regularly to exchange new ideas and techniques through formal training added richness to

the knowledge sharing process in Remote Care 1. This avenue to share ideas, experiences and skills provided the platform for these experts to articulate the tacit knowledge gained from everyday interaction with the clients and their colleagues.

The personal care assistants and the nurses mentioned the importance of attending handover meetings, which took place three times a day, and employee meetings, which occurred once a month. Case conference meetings were held every three months. The attendance at each meeting differed. The case conference meetings were usually for the families, the clients and staff to exchange ideas and receive feedback about the care being provided.

The care professionals in Remote Care 1 used these meetings as an opportunity for different multidisciplinary teams to share ideas and strategies. It was therefore evident that collective knowledge continuously was developed through interaction between the experts who took care of clients in Remote Care 1. In addition, the knowledge sharing process involved the use of formal avenues to get care professionals to articulate and share tacit knowledge. This knowledge and ideas are then documented in repositories for easy access by all stakeholders.

During the researcher's fieldwork in Remote Care 1, the fact that a group of key professionals had to share their time between facilities, and that this posed problems, was obvious. As one employee was there one day and the next day they had migrated to another part of Australia, outside the country or found another job. This could cause a gap in face-to-face knowledge sharing, given the tendency of care professionals to walk out with untapped knowledge in their heads.

The service manager, therefore, acknowledged the importance of codifying knowledge to ensure professionals could make reference to documented strategies or information in the future. The lifestyle coordinator and a nurse commented about how a client's past was related to the behavioural challenges being displayed, and how this information was gleaned from reading the care plans, observing and interacting with the client. Remote Care 1, therefore had care plans in place where all the professionals were required to document new information, observations and ideas about clients in writing.

For record management purposes and to ensure client information could be accessed virtually, a computerised information management system had been put in place in Remote Care 1. The information system was programmed in such a way that different aspect of client care could be input. According to the personal care assistants, the information in the software system was used for 'clients' assessments, evaluation and to inform the care plans'. This suggests that the use of information technology to share and distribute knowledge was important.

The information stored in the software represented encoded knowledge which provided an accessible collective resource for shared understanding. It is however worth noting that the software is an enabler and by itself does not have knowledge unless knowledge is input into it by people. The availability and genuineness of the information in the software was dependent on care team's willingness to share knowledge and actually put information into the system.

4.5.1 Case 3: Power dynamics in Remote Care 1

Power is manifested in different ways and ultimately influences the knowledge sharing process. The manifestation of power and the influence on the knowledge sharing process in Remote Care 1 will be discussed below.

4.5.1.1 Expert power

Remote Care 1 engaged in a lot of in-house training for care teams that provide care to dementia clients.

> *Observation from field notes.* While attending one of the training sessions, there were opportunities to brainstorm on how different experts apply their knowledge to solve unique client issues. After the brainstorming session the trainer made a concluding statement about different professional groups having their areas of expertise which contributed to quality dementia care.

The researcher further observed that when the trainer asked about trigger points, how to get a client to take their medication and clients' routines, only the personal care assistants and auxiliary employees could answer. This showed their area of expertise, being personal care and historical information about the clients. On the other hand, when questions

around clinical issues came up the nurses and the service manager responded to the questions.

The researcher observed the display of different expertise by individuals who were regarded as 'subject matter experts' and consulted for various issues. The group at Remote Care 1 therefore had a variety of skills, expertise and techniques with each individual being identified for their area of speciality.

This indicates that each care team had expert power which gave them leverage and added to the dynamics of the involvement of diverse care professionals with power at their disposal.

4.5.1.2 Charisma power

Remote Care 1 was located in an isolated place where relationships contributed to the level of interaction that occurred among all the stakeholders involved in the care of dementia clients. Some of the employees that worked at Remote Care 1 had personalities that made everyone want to have a conversation with them. Such conversations were avenues for informal knowledge sharing, information gathering and knowledge creation.

A good example can be seen in the statement made about the activities coordinator, who 'has a good relationship with the clients' families and the whole community'. Everyone therefore feels giving her information which she transfers to her colleagues to help provide the right care for the clients. This was a good example of the impact of charisma power in facilitating the knowledge sharing process and building rapport among diverse experts.

4.5.1.3 Referent power

The interviews revealed that the team leader was respected by her colleagues and superiors. The researcher also noticed different employees going to her for guidance on issues or approval about a technique. It is useful to note that a clinical employee mentioned that she also was inspired by the team leader and 'going to her to ask questions makes things easier'.

The team leader seemed to combine three power bases: position power, referent power, and expert power. She served as a team leader with position power to influence and make decisions. She also had engageing qualities that made her a mentor to her colleagues and superiors. In line

with this evidence was referent power manifesting as informal personal attributes, which, combined with a formal position resulted in optimal knowledge sharing.

4.5.1.4 Legitimate power

The aged industry is guided by a government regulatory body; as such the aged care facilities have some mandatory guidelines. As part of these guidelines, the facilities are required to keep proper documentation of clients' information and share such knowledge with the government. This is part of the aged care channel funding requirement. This process is characterised by a high level of processes and procedures that need to be adhered to.

From the foregoing, it can be seen that the government has legitimate power to control the aged care model due to funding and regulatory requirements. The requirement to prepare reports for regulatory bodies also prompted the aged care facility to document and share valuable knowledge. According to the service manager, this process served as:

> *Part of sharing knowledge because everyone is involved in the process, we gather information and knowledge from all stakeholders and document it before the inspection; it's not just about ticking the boxes. ServMan (RC1), December 5, 2015*

This suggests that legitimate power, organisational agendas, procedure and processes also contribute to the knowledge sharing process and are not just embedded in rules and regulations, given that the process brings all the care professionals together to share knowledge under government directives.

4.5.1.5 Information power

Information power in Remote Care 1 was decentralised among all care teams. This presented a challenge given the disparate and transient nature of the group. The transiency of some care professionals and the high employee turnover rate affected the knowledge and information sharing process. When care professionals resign, the process of building relationships with different bodies that provide services to the age care facility slows down the process of sharing knowledge and information. This was evident in the statement made by the service manager that:

> *Information was not released because she didn't know us, so we had to reintroduce ourselves and build a rapport with her before we could get the information we needed. ServMan (RC1), December 6, 2015*

Transient workers who only visited the facility periodically and the transiency of age care workers due to the high turnover of employees affected the transfer of information as information 'controlled' by a select few cannot be evenly distributed among all the care teams involved in the care of dementia clients. This situation emphasises the importance of decentralising information power to avoid delay in care decisions and provision of quality care to clients with dementia.

4.5.1.6 Position power

Handover meetings were coordinated by the nurse in charge of each shift. During these meetings, all the teams of experts on the previous shift and the new shift shared knowledge and information about each client and everyone had an opportunity to speak.

> *Observation from the field notes.* While Remote Care 1 was a close knit facility, it was observed that some of the clinical employees used their position power to discourage others from sharing. This was observed during a handover meeting. A personal care assistant who appeared to have considerable knowledge about a client was trying to provide information and the nurse who was coordinating the hand over session kept shutting him up.

It was, however, obvious that she was only able to give clinical information about the client and not information about clients' routines, trigger points and history. Historical and personal information about the clients were provided by the personal care assistants. This situation illustrated the impact position power has on the free flow of knowledge and how it inhibits the alignment of clinical and personal information required to provide a better understanding of care requirements.

Thus, various care professionals had their areas of specialisation. An alignment of technical knowledge and experiential knowledge is paramount to achieving quality care. Experts, irrespective of their position in the hierarchical ladder, should be given a platform to share their knowledge and opinions.

As discussed earlier, case conference meetings served as an avenue for all stakeholders to converge and share knowledge and information that can add to the care of clients. Attendance at these meetings was, however, limited to mainly clinical professionals. Knowledge from other professionals was 'presented from explicit documented knowledge' by the clinical employees. The exclusion of personal care assistants and other ancillary employees prevented practical experiences from being shared during the case conference meeting. In addition, exclusion of some of the care professionals gave the impression that more value was placed on academic and clinical knowledge than on experiential and practical knowledge. This could be detrimental to continuous knowledge creation and knowledge sharing.

4.5.2 Case 3: Social capital in Remote Care 1

The importance of establishing rapport among the members of a care team whose expertise is required to provide quality care to clients cannot be overemphasised. Rapport can help to overcome power issues. The service manager in charge of Remote Care 1 emphasised the effect of relational capital on the knowledge sharing process through her statement about:

> *The need to create avenues to initiate a relationship with transient and diverse teams of experts to avoid reluctance in sharing knowledge and information.*
> *ServMan (RC1), December 6, 2015*

She confirmed that regular social interaction occurred between employees in Remote Care 1, with employees sharing banter and jokes, while relating it to work issues, thus using that opportunity to share knowledge. From the service manager, the team leader to the personal care assistants, sharing knowledge informally appeared to be the preferred mode of transferring knowledge among these experts.

Data from the interviews indicated that some experts would rather share face-to-face than document knowledge or information. This was due to the amount of time it took to record knowledge, techniques and ideas. The approach was often to chat over lunch or have chats as they walked from one client's room to the other. It was clear that informal chats and rapport building were very important in the knowledge sharing process. The avenues to build a trust

relationship, according to the team leader, helped to alleviate any 'individual agenda to withhold information and knowledge'.

It was evident that adopting the concept of relational capital contributed to the knowledge sharing process, built relationships and ultimately alleviated possible power barriers to knowledge sharing among teams of experts. One-on-one interaction was clearly critical because it improved the willingness to share.

4.5.2.1 Relational capital

According to the therapist, the role of taking time to 'develop rapport and build that trust while developing life stories' was of utmost importance. This method, according to the therapist, encourages the clients and care teams to share. Similarly, the therapist stated that:

> *Working as a transient worker can be advantageous because they don't see me there often so they tend to want to talk to me, not only that but they will share because while I am there I have taken time to build that trust working with them. OccupTherapist (RC1), November 24, 2015*

This statement reveals a particular relationship between transient care professionals and care professionals on the regular roster which can be developed with the appropriate behaviours and attitudes. People tend to share knowledge with people who they do not see often but with whom they have built a rapport. In the research, this was termed juxtaposed relationships. Periodic attendance at the facility became something to look forward to as an opportunity to learn and share.

A manager made a statement about the approach to getting people to share knowledge without the influence of power dynamics. She stated that:

> *The way you approach people for information is very important, you have to build a rapport before launching into a conversation about what you need from them. There needs to be continuous relationship between you and whoever you want to get information from to be able to gain their trust enough for the information to be shared. ServMan, (RC1), October 6, 2015*

It can therefore be inferred that the approach used when searching for knowledge and information from individuals influences how these individuals respond to questions asked and their willingness to share knowledge.

4.5.2.2 Structural capital

Building network connections helps to bridge possible gaps between team members. Remote Care 1's service manager mentioned systems that were in place to give the experts opportunities to share knowledge. Examples of such avenues were training sessions where multidisciplinary professionals who made up the care teams converged to brainstorm and connect. There were informal planning days where everyone had chats about their clients, shared techniques and gave a status report.

Avenues to share knowledge informally and formally were built into the processes and procedures at Remote Care 1. Interactions take place during handover meetings, lunch time chats, and monthly staff meetings and training sessions. According to the team leader 'good knowledge sharing and mentoring occur during these sessions'. Ultimately this enhanced the transfer of techniques and skills among the experts. Remote Care 1 ensured the meetings were organised to suit everybody's timing and encourage everyone's attendance.

4.5.2.3 Cognitive capital

Consistent daily interaction between experts, experts and clients, experts and clients' family members had resulted in shared stories, narratives and codes that defined the needs and character of each client. An example was seen where, during a training session, a client's alarm went off and, at the same time, the personal care assistants checked their wristwatches and said 'it is time for his tea; he usually gets a cup of tea at this time'.

The researcher's interaction with these care professionals revealed that all the clients have trigger points and stories that are known by every personal care assistant and passed on to new employees that help them discern what a client requires at a particular time, or the interpretation of actions linked to their past stories that help staff manage clients' behavioural tendencies. This means cognitive capital contributes to the process of interpreting clients' needs and understanding their tendencies. Having shared codes and narratives fostered knowledge sharing among these specialists and also improved power over some information. The codes were not only known by individuals but documented in repositories and had become part of Remote Care 1's knowledge base and not owned by a particular individual.

This situation emphasised the importance of combining expert technical knowledge with the ability to build relationships to get required information and knowledge to enhance clinical decisions. In addition, these relationships and relational capital ensued from shared norms, meanings and stories that became common knowledge among the specialists and all stakeholders.

4.5.3 Case 3: Key findings in Remote Care 1

Results gathered from Remote Care 1 revealed the importance of combining different methods across the three major areas investigated: knowledge sharing, power dynamics and social capital. Indeed, evidence revealed that utilising a combined approach in these three areas facilitated the relationship between knowledge sharing and power dynamics. It was discovered that the three thematic categories – knowledge sharing, power dynamics and social capital – interact at every stage of the knowledge sharing process. Thus, each area promoted the contribution of the other areas in order to achieve holistic quality dementia care. Key findings in this section were:

- minimised complexity in communication and observation
- mingling and bookworm approach
- entwined power bases
- juxtaposed relationships

4.5.3.1 Minimised complexity in communication and observation

A summary of the findings from Remote Care 1 suggests that while the small community feel facilitated knowledge sharing, the high attrition rate in this location presented a complexity in retaining shared knowledge and information. This aged care facility had, however, developed avenues to share knowledge due to the peculiarities that existed in their facility. Evidence revealed that creating an organisational structure that supported collaborative sharing by ensuring an open system between members of care teams in Remote Care 1 irrespective of their position in the organisation's hierarchy had been established. This was evident in the way each team of experts related with one another irrespective of their position or profession.

To minimise the complexity involved in sharing knowledge between transient employees who relocate from remote areas to the suburbs, Remote Care 1 had an open door policy and informal

chats occurred regularly. This approach to sharing knowledge ensured new observations and developments about clients were communicated among the care teams on a regular basis.

The service manager noted that, despite the involvement of specialists who were only periodically in attendance, and the complexity involved in sharing knowledge between these particular teams of experts, combining various methods of communicating knowledge and information facilitated the development of collective care processes that resulted in the provision of holistic quality dementia care. She noted that this was achieved through constant platforms for knowledge interaction, both informally and formally. She was however, more in favour of informal methods, mainly because they 'facilitates building relationships which in turn results in quick decision making and ease in sharing knowledge'. This statement signifies the effect of informal avenues in the knowledge sharing process and how rapport can be created despite the complexity involved in sharing knowledge among specialists and professionals who were not geographically or temporally co-located.

From the researcher's observation, the auxiliary employees seemed to be the 'detectives' in Remote Care 1. At various times during the data collection process, the researcher noticed the cleaner had a good rapport with the clients and while cleaning their rooms would notice Mrs A or Mr B's behaviour had changed and immediately report it to the clinical experts. Her role as a cleaner allowed her to relate with the dementia clients closely, having chats with them and serving as a listening ear. During these conversations the ability to pick subtle changes of routine and triggers from the clients through constant observation proved a useful tool to help inform clinical decisions and manage behavioural concerns. Similarly, the researcher's observation was confirmed by one of the experts, who stated that the cleaner was the 'best pair of eyes in Remote Care 1 and she just knows when something is not right with any of the clients'. Indeed the combination of different knowledge sharing methods not only enhanced sharing among care professionals but also helped build relationships between the care teams.

4.5.3.2 Mingling and bookworm approach

Results from evidence gathered from Remote Care 1 suggested that a combined approach was used to share knowledge among care team members. Avenues to have informal chats during

lunch breaks and casual meetings in the corridor or at the coffee machine facilitated knowledge sharing. These informal methods of sharing knowledge has been referred to as the mingling approach, this approach involves providing avenues to ensure consistent interactions between specialists and professionals who were not geographically or temporally co-located, which results in relationship building and opportunities to share knowledge.

On the other hand, Remote Care 1 also had a formal approach to sharing knowledge, which was referred to as the *bookworm approach* in this project. Remote Care 1 organised various forms of formal training and education. They partnered with different registered training organisations (RTOs) and the care teams were encouraged to enrol in short courses and training to enhance their knowledge about dementia care. According to the service manager, the training sessions were structured to ensure that every expert, irrespective of their level of education or experience, got an opportunity to improve their skills and knowledge of dementia.

From the researcher's observation, though the trainings were formally organised, the atmosphere during training was nothing like a strict classroom environment. The training was structured in an informal way which allowed each care team to provide different scenarios of clients' behavioural issues and techniques and skills used to address the clients' needs. The training's theoretical and life stories elements brought an informal and interactive feel to the training sessions.

The two approaches described above, mingling and bookworm, were methods used in Remote Care 1 to share knowledge. It can be argued that these two approaches facilitated knowledge sharing and helped to alleviate possible power issues that might hinder knowledge sharing. This is given the fact that care teams have various avenues to interact and build relationships while sharing knowledge. It is therefore apparent that using a combination of methods at various stages of the knowledge sharing process facilitates knowledge sharing and contributed to building rapport.

4.5.3.3 Entwined power bases

The aged care industry is guided by various rules and regulations outlined by the aged care channel and other agencies. There are also power bases that manifest among all professionals and

organisations. The teams of experts that provided care to dementia clients in Remote Care 1 exhibited these power bases, which could either facilitate or impede the knowledge sharing process. The combination of these power elements added an interesting twist to the interaction between knowledge sharing and power dynamics.

Evidence gathered in Remote Care 1, however, suggested that combining formal power bases in the form of legitimate and position power with informal power bases, such as charisma and expert power, resulted in a win-win situation, where all the care professionals benefitted from the combined wealth of knowledge. This was evident in the statement made by the lifestyle coordinator, who noted that:

> *The best approach to overcome the hurdle of some individuals hoarding knowledge is building a relationship with all stakeholders and this will bring the realisation that everyone needs the other person's expertise to provide quality care to the clients. LifeCord (RC1), October 15, 2015*

Similarly, statements made by one of the personal care assistants supported the fact that 'at the end of the day, it's all about the clients and their well being, not individual agendas'. The researcher observed that a number of the members of the care team in Remote Care 1 had formal and informal power bases which they used to enhance knowledge sharing. An example was the team leader, who had position power, and all her colleagues agreed that she combined her position power with expert power and charisma power. The combination of these power bases encouraged knowledge sharing and alleviated hierarchical power issues. This evidence suggested that combining formal and informal power bases facilitates knowledge sharing.

4.5.3.4 Juxtaposed relationships

Remote Care 1's care team consisted of care professionals who work between facilities and experts who were based on site. The remote nature of the aged care facility, however, created an issue of high employee turnover. This created the challenge of losing experts with knowledge and experience that required sharing across all the care teams involved in the care of dementia clients. The complexity involved in sharing knowledge among specialists and professionals who were not geographically or temporally co-located, however, created the valuable effect of a juxtaposed

relationship. This was the willingness of visiting professionals to share knowledge and information, while the experts who worked together on a daily basis were not as forthcoming.

This was evidenced by the statement made by the occupation therapist that:

> *I find that when I have worked in Remote Care 1 for long time and return there after a couple of weeks or months the personal care assistants are always excited to see me and share all the information and knowledge I seem to have missed. They sometimes share information and knowledge that they have not shared with their colleagues and I find that a bit strange. OccupTherapist (RC1), October 30, 2015*

On the other hand, another set of experts who work permanently in Remote Care 1 shared knowledge with those whom they worked closely and found it difficult to share knowledge with the transient experts.

Further investigation revealed that those who shared knowledge with the transient care professionals did so because the transient experts had built a rapport with them, and gained their trust and respect. Interviewing some of the experts suggested that the transient experts showed that their knowledge was valuable and useful, and permanent staff look forward to sharing their ideas with someone who they know values their knowledge and the information they can provide.

This finding is important to this study because it reveals the importance of social capital in the knowledge sharing process and the influence of trust and rapport on possible power issues. This is given the fact that individuals tend to share and not hoard knowledge from those who they perceive to value their knowledge and are not likely to compete with them. Their periodic attendance in the facility became something to look forward to as an opportunity to learn and share.

4.6 Case 4: Remote Care 2

Diverse teams of professionals had worked in Remote Care 2 facility for years; this has resulted in them gaining experiential knowledge through interacting with the clients. On the other hand,

due to the ageing aged care workforce, new employees were taking the place of the older ones and knowledge sharing was paramount to the continued success of the facility.

Informal knowledge sharing. Knowledge among these care professionals were shared in various ways. New employees were mentored by pairing up new employees with employees that had been in Remote Care 2 for years and had experience. According to the service manager, new employees got to 'work closely with' the incumbent expert to gain experience. This shows that the care professionals in the Remote Care 2 facility had opportunities to transfer knowledge and improve the quality of their knowledge base. There was a constant exchange of ideas and interactions between experienced and non-experienced employees, showing that knowledge sharing was a recurring activity among care professionals in Remote Care 2.

In addition, knowledge was being passed from experienced employees, who may potentially exit the organisation, to new employees. This encourages continuity of strategies, techniques and clinical plans. Apart from sharing knowledge among different levels of experts, knowledge is also shared from one shift to another. This is achieved through informal and formal interaction between team members in Remote Care 2.

A statement made by one of the personal care assistants suggested that 'knowledge sharing is a continuous process, as knowledge sharing is not only from staff to staff but from shift to shift'. It is also worth noting that different experts have different knowledge about the clients depending on their area of expertise and the level of experience and rapport they have with the clients. Hence, it is important to have continuous interaction between care professionals to have a holistic view of the care required.

The researcher observed that the lifestyle coordinator wrote the care plan by sitting down with the clients and their families to write the initial life stories. Other care professionals might record the plan in a different way. Care professionals such as the personal care assistants, nurses or allied health worker will also view the information differently. This fact highlights the importance of collaborative care through collective knowledge, and its importance in interpreting the contribution of each expert to quality dementia care.

It appeared that story telling also served as an important means of sharing knowledge. Clients and family members shared valuable knowledge about their history that helped the different team members align the care plan to the clients' individual care needs, and also to arrive at clinical diagnoses. For clients with dementia and no family to support them, getting a complete picture of the clients' history was often a challenge or impossible. Access to information that could help make a diagnosis sometimes involved contacting different communities where the client had lived, putting together the different information from different sources to provide appropriate care to the dementia clients. Interaction between care teams and the communities where clients lived in the past was therefore important in gathering information about the best type of care required by each client.

Remote Care 2 was a relatively small aged care facility where sharing knowledge involved a lot of face-to-face communication. This was confirmed in the statement made by the lifestyle coordinator, 'I have to sit down and have a chat with the clients about their past life, what they used to do and what they like so I can plan some activities for them and also document it'. The opportunities to share knowledge face-to-face in Remote Care 2 created an avenue for rich communication and opportunities to develop a rapport with the story teller.

Knowledge was also verbally communicated over the telephone and face-to-face during lunch breaks. In fact, the nurses affirmed that 'most knowledge about the clients is mainly shared face-to-face'. Thus, knowledge sharing through informal methods was common in Remote Care 2. This appeared to be one of the convenient methods of sharing knowledge in a busy aged care environment.

The use of face-to-face communication, however, did present some challenges, as the holistic therapist noted, 'people easily forget information'. This suggests that there is a need to document and store information for future access by everyone in the team. Documenting knowledge shared verbally involves externalising knowledge in order to discuss and share experiences, and ultimately documenting it for ease of access.

Formal knowledge sharing. Articulating knowledge that is gained through experience and interaction requires a platform for care professionals to meet regularly to share and also a system of recording observations and strategies that have worked in the past. Recognising the importance of documenting knowledge, Remote Care 2 had put in place formal systems to aid the sharing of knowledge among personal care assistants, nurses and the service manager. Remote Care 2 held staff meetings, handover meetings between shifts, aged care channel meetings, and documented observations and information in clients' care plans and the information technology system.

Knowledge sharing during staff meetings appeared to be a useful. According to one of the personal care assistants, knowledge was shared during the staff meeting every month, which, according to her, 'makes knowledge sharing easy'. Opportunities to share knowledge and observations during a formal meeting ensured knowledge transfer across all the experts, irrespective of what shift they worked, as the meeting was compulsory for all staff. In addition, informal chat also occurred during and after the meeting as information missed during the normal routine work was discussed on the corridors around 'triggers and scenarios' and strategies were suggested as a group. It was therefore evident that knowledge creation occurred during these meetings through the formulation of new techniques, ideas and strategies during discussions among the experts.

Unlike the monthly staff meetings, handover meetings occurred three times a day, depending on the shift an employee works. The frequency of this meeting facilitates knowledge sharing in smaller groups. In addition, it was observed by the researcher that the success or challenges of knowledge created through discussions on strategies and techniques during the monthly staff meeting were reported during the handover meeting. This process added to the knowledge creation process and helped fine-tune techniques being applied to care for the clients.

This collective sharing process also allowed for care professionals who otherwise would not have shared knowledge due to the shift pattern in the aged care industry to share knowledge across disciplines. Social interactions also occurred during these meetings, which helped staff identify who the subject matter experts were in particular fields. Therefore, while there was currently no

repository to refer to for experts in certain fields, these meetings helped care teams to identify experts in bespoke fields and form a relationship for when they needed to consult them.

This is evident in a statement made by one of the nurses, who said, 'We also talk about strategies a lot during different training sessions and meetings that we go for'. This suggests that exposure to training and meetings could potentially improve experts' attitudes to sharing knowledge. The researcher observed that during a training session, staff were able to identify where their expertise overlapped and how knowledge from each professional could help inform quality holistic dementia care, emphasising the importance of formal meetings and training sessions to the knowledge sharing process.

Continuous informal and formal communication between care professionals in Remote Care 2 occurred through care plans and a repository system used to document knowledge and information. According to the lifestyle coordinator, the care plan was a very useful tool to document rich knowledge and information about the clients:

> *The care plan is a living document. From day one, you add information but it continues to build up even after years of the clients being here. One of the clients has been here for 10 years and we thought we knew everything about him until someone was able to connect with him and that brought valuable knowledge that has helped improve the care offered to him. No matter how inconsequential information seems to be, it will help complete the jigsaw puzzle regarding the clients. LifeCord (RC2), October 30, 2015*

This statement suggests that knowledge was not only shared informally but was made explicit through documentation. This meant that there was access to updated documents about the clients, even when the subject matter experts were not available for a face-to-face discussion. This knowledge was then available for use to solve similar kinds of problems, or consult for ideas about methods and techniques to solve behavioural issues in other clients.

The use of newsletters, notice boards and pictorial representation serve as other methods of communicating information and knowledge about clients' needs and progress to teams of experts

involved in the care of dementia clients in Remote Care 2. This is evident in a statement by the lifestyle coordinator:

> *I write the newsletter and use photos to match the stories and this get noticed by those who are visual and add to their understanding of how clients' care can be improved through different activities. LifeCord (RC2), October 30, 2015*

This level of knowledge sharing shows that the care professionals in Remote Care 2 had different avenues by which to share knowledge that can appeal to different audiences. Visual representation helps to overcome the language barrier, given that one of the barriers to knowledge sharing discovered during this research was differences in language. English is the second language spoken by a number of professionals in Remote Care 2.

Visual representation and the use of newsletters were combined with verbal face-to-face sharing to aid understanding. This was confirmed by the lifestyle coordinator who stated that:

> *When you put things on the notice board or newsletter, you will still rely on informal face-to-face communication to pass on the message to ensure staff read it and understand it.LifeCord (RC2), October 30, 2015*

The fact that the specialists and professionals were not geographically or temporally co-located necessitated different methods of knowledge sharing within the multidisciplinary group and with clients. From the researcher's observation and data from the interviews, it was obvious that collaborative sharing through consultation with all stakeholders, combined with structured 'planning days', case management meetings, training, narratives, small talk/informal chats, pictorial representation and one-on-one mentoring were some of the ways used to share knowledge.

4.6.1 Case 4: Power dynamics in Remote Care 2

The involvement of diverse professionals and individuals in the care of dementia clients brings complexity to the knowledge sharing process. This is due to individual desire to control and hoard knowledge believed to be personal. This introduced the display of power in the relationship between care team members in Remote Care 2.

4.6.1.1 Expert power

In Remote Care 2, key mentoring opportunities occurred between nurses and personal care assistants. Some nurses with clinical and personal care experience were willing and available to share their expertise with the new employees. Informal knowledge sharing chats occurred, with some nurses explaining techniques to the younger employees. The contribution of senior staff members on imparting knowledge to new employees allowed professionals high in the organisation's hierarchy to add to the knowledge sharing process.

On the other hand, some nurses and senior staff did not 'communicate with' the younger employees in a respectful way and were not ready to mentor them. This meant that expert power did not necessarily bring about reference power, as the younger employees did not 'hold nurses who were not ready to share in high esteem'. Clearly, it was the combination of expertise and a good demeanour that facilitated knowledge sharing. This combination was not always available, however.

There are diverse ways of acquiring expert power. It can be gained through academic achievements and experience. It is useful to note that expert power can also be developed by building key relationships. According to a senior personal care assistant, expertise could also be acquired through 'techniques and skills developed while managing the behaviours of dementia clients...through interaction and working with clients for a long time'. Consequently, experience can help an individual develop key expertise that ultimately becomes one's area of specialty. Acquiring expert power is aligned to the process of gaining experiential knowledge. This in turn contributes to the diverse knowledge perspective.

4.6.1.2 Charisma and referent power

It was particularly evident when the issue of charismatic power was raised that charisma power helps facilitate the knowledge sharing process. This was evident in the statement made by a personal care assistant about experts who were not just 'experts in their field but also have a nice personality and this draws people to them when questions arise'. Consequently, a good character, combined with being an expert in a particular field, made people respect individuals, not only for their knowledge, but for their personality. It was therefore evident that in Remote Care 2, the

combination of power bases, such as expert, charisma and referent power, contributed to knowledge sharing and mentoring opportunities.

A comment made by one of the personal care assistants exemplifies the influence of charisma power and referent power on the knowledge sharing process. She stated that:

> *The doctors that come here are part of the family. They value our input and they are always ready to share. The two of them have been the regular doctor for this facility for 30 years, so they know everybody. They always stay for lunch and have a chat with the clients and employees. We all relate like one big family. They are always approachable. PCA (RC2), November 19, 2015*

It can be inferred from this statement and other evidence gathered in Remote Care 2 that irrespective of an individual's position or profession, the exchange of ideas and knowledge was not limited to some professionals. The doctors were willing to learn from other care professionals and also share knowledge. In addition, they were approachable and respected by everyone. They believed that they could learn from everyone, irrespective of their profession and position in the organisation. These behaviours and attitudes define a mindset that enables communication. The doctors in Remote Care 2 were receptive to sharing and learning from others, which presented opportunities for greater insight and care outcomes.

4.6.1.3 Position power

The organisational structure in place in Remote Care 2 had a hierarchy of power, with the service manager in charge of both clinical and auxiliary staff. The nurses were next in the hierarchy, as they were the first reporting line before matters went to the service manger and team leaders who were next in the hierarchy and were directly in charge of the auxiliary staff and personal carers. This structure reflects the membership of key meetings, such as case conference meetings, which were usually attended by the service manager, doctors and nurses, while other employees' contributions were communicated in writing. This implies a structure that supports employees with positions to take the lead.

The use of face-to-face communication as a source of sharing knowledge and as an opportunity for knowledge creation would not be possible if the contribution of other professionals were not

adequately captured in such discussions. Case conference meetings were opportunities to re-strategise and deliberate about clients' care. Representation and the contribution of all the professionals at the meeting enhanced knowledge creation and promoted holistic client care. The exclusion of some care team members defeated the purpose of organising these meetings, as face-to-face communication helped trigger thoughts that would otherwise be forgotten if only documented in care plans or repositories.

4.6.1.4 Information power

The general misconception that information power only resides in those in position of authority was refuted by the lifestyle coordinator in Remote Care 2, who observed that:

> *The office administrative officer is actually a wealth of information about everything to do with the clients. If anyone needs information that will help them do their jobs better in relation to the clients, she is the go to person. The clients love her and sit with her for hours chatting and just enjoying her company and that way she gets to know them. A lot of people here know if they need any information about the clients she can help. LifeCord (RC2), October 30, 2015*

The researcher observed personal care assistants and the chef in the kitchen updating clinical employees about clients' preference and behavioural issues. Extract from the field notes detailed an incident where a client required urgent attention and clinical employees had to seek information from the auxiliary employees to guide their decision.

This illustrates that valuable information can reside in diverse individuals and repositories, and that all avenues should be explored when sourcing for client information. Taking this approach provided diverse perspectives to problem solving and providing holistic care. Clearly, valuable information existed at every level and in every professional that had constant interaction with the clients, irrespective of their position and professional orientation. The provision of holistic dementia care is therefore reliant on information from all stakeholders and not some select few.

It is also useful to note that 'dementia clients actually give more information about how to provide quality care to them more than any of the professionals'. It is easy to overlook the importance of information that clients can provide to aid the care process. The method of

communication can, however, differ, depending on the effect of dementia on their cognitive abilities. Consequently, it can be inferred that every professional, client and informal carer has information that can add to the care process and therefore have information power.

4.6.2 Case 4: Social capital in Remote Care 2

Building relationships that facilitate knowledge sharing is key to achieving shared agendas and alleviate possible power issues. Remote Care 2 recognised the importance of rapport in facilitating knowledge sharing and had in place avenues to interact and share.

4.6.2.1 Relational capital

The social structure and avenues to share knowledge in Remote Care 2 created a platform to build relationships and encourage knowledge creation. The chaplain in Remote Care 2 reinforced the importance and effect of building relationships on the knowledge sharing process in Remote Care 2. He stated that:

> *I have never experienced any of the clients or their families not sharing knowledge, as I told you I have become part of the clients' family and know them and their families very well. I have been a chaplain to them even before they were admitted into this aged care facility. Chaplain (RC2), November 10, 2015*

It was therefore evident that the existence of 'relationships' fostered knowledge sharing and ameliorated incidences of hoarding knowledge and possible power issues.

Such was the effect of relational capital on the knowledge sharing process, that incidences of power dynamics through segregation between the medical professionals and auxiliary professionals were minimal. This was evident in the statement made by one of the auxiliary staff, who remarked:

> *The doctors that come here are different, different in the sense that they are part of the family they value our input and they are always ready to share. The two of them have been the regular doctors for this facility for 30 years so they know everybody. They always stay for lunch and a chat with the clients and employees. PCA (RC2), November 21, 2015*

The community feel in Remote Care 2 fostered communication and transfer of knowledge among care team members, clients and their families. This translated to social interactions that facilitated casual chats where important information was shared that facilitated the provision of quality care to clients. The lifestyle coordinator reiterated this in her statement about the importance of 'building a relationship with the clients from day one, which enhances the provision of comprehensive care for them'.

This highlights the contribution of having constant face-to-face interaction and communication to enhance the process of knowledge transfer and creation. Building trust involves consistent interaction. According to the lifestyle coordinator 'transient workers will probably not have that opportunity because they are here today and gone tomorrow.' It was evident that although the clients had dementia, they still knew those who attended them regularly and those who were not frequent. They were therefore cautious about giving such people much information about themselves. It appeared that developing a 'long time or consistent relationship' facilitated knowledge sharing and curtailed the incidence of hoarding knowledge and the effects of power issues on the knowledge sharing process.

4.6.2.2 Structural capital

Individual culture and organisational culture play a part in the process of knowledge sharing and breaking power barriers. The membership of Remote Care 2 consisted of professionals who, due to long term experience and service to the facility, had inculcated their culture into the formal culture and structure of the organisation. Due to long years of service, almost all the professionals saw themselves as members of the same family; this culture had filtered into the organisational culture, and everyone shared freely.

The only downside to this was that new employees and transient workers had to fit into the culture. Acceptance into this culture had never been an issue, however. According to one of the nurses, 'the closely knitted environment encourages mentoring opportunities for the new ones'. One of the personal care assistants, however, mentioned that some 'individuals' personal culture of superiority' still affected some aspects of behaviour. This, however, represented a minority of

those clinical staff, not a majority. In essence, the role of structural capital in terms of cultural orientation had a role to play to promote knowledge sharing among the employees.

4.6.2.3 Cognitive capital

The connection between communities where the clients lived before moving to the residential facility and the care professionals who worked in Remote Care 2 helped to build shared meaning, symbols and stories about the clients. These meanings, symbols and stories formed a major part of the knowledge required to provide care to the clients.

The clients in Remote Care 2 consisted of indigenous clients with dementia. According to the lifestyle coordinator, these clients' backgrounds were typified by 'storytelling and pictorial representation'. This had therefore translated into the way they shared knowledge and information about themselves.

The care professionals who provided care to these clients recognised this and keyed into this method of sharing and retaining knowledge about clients. Narratives, clues, norms and symbols had become a means of sharing knowledge among the experts. The management and employees therefore encouraged avenues for sharing knowledge through narratives, and also told stories through clients' pictures and the use of pictures to communicate their needs. These methods had enhanced knowledge sharing and continued to be a means of sharing knowledge among experts in Remote Care 2.

4.6.3 Case 4: Key finding in Remote Care 2

The peculiarity of Remote Care 2's location affects the level of knowledge shared among members of the care teams who work on a permanent basis in Remote Care 2 and also the transient experts who attend Remote Care 2 on a needs basis. Results revealed that all three research issues influenced one another to enhance the knowledge sharing process. Two major findings that summarise how knowledge was shared in Remote Care 2 and how power influenced this process are discussed below, as they affect each main thematic category.

- coalescence of diverse, past and present knowledge
- rapport: a conduit between knowledge and power

4.6.3.1 Coalescence of diverse, past and present knowledge

The combination of knowledge from disparate team members in Remote Care 2 accounted for collective knowledge. The remoteness of this facility created a closely knit feel that facilitated knowledge sharing. The care teams in Remote Care 2 were made up of care professionals who had worked in the industry for a considerable number of years and experts who were relatively new to the industry. In addition, Remote Care 2 operated a rotating shift pattern. Hence, the members of the care teams were not only different due to their level of experience and expertise, but also in the shifts they work. This presented a challenge, given the diversity that existed among the members of the care teams. This challenge was, however, mitigated by the methods used to share knowledge at Remote Care 2.

According to the lifestyle coordinator, care professionals who had been in Remote Care 2 for years mentor new employees, and thus experiential knowledge was shared with new employees. This method of sharing knowledge was undertaken among diverse experts, from the nurses to the personal care assistant to the doctors. Experience, skills and techniques were shared across professions and shifts.

> *Observation from field note.* The method of sharing was observed when the researcher watched different experts working together. The personal care assistants, nurse and allied health experts worked closely together to arrive at strategies to alleviate clients' behavioural issues. These individuals were professionals with diverse and different levels of experience. The opportunities provided to work closely together became a platform for them to share different knowledge perspectives. These knowledge perspectives enhanced the provision of quality holistic care to dementia clients as they produced collective knowledge.

Narratives, storytelling and pictorial representation were also some of the ways knowledge was shared in Remote Care 2. The peculiarity of these knowledge sharing methods brought a rich array of knowledge from diverse members of the care teams, and historical and current knowledge about the clients that enhanced the quality of care provided to the clients.

An extract from the researcher's field notes reveals the level of information and knowledge shared during narratives and pictorial therapy sessions:

> *Observation from field note.* In attendance during one of the therapy session, it was like a jigsaw puzzle being completed through stories of the past and the show of pictures that trigger thoughts about the past gets linked to the current behavioural issues. Like a detective who just got a breakthrough about a crime, the members of the care teams suddenly give knowing nods, smiles and exchange of understanding to one another. Vigorously writing in their note pads, capturing all the knowledge being shared thorough this method to inform their treatment plan.

From the interviewees' statements and the researcher's observation, it was apparent that the convergence of various experts' knowledge made up collective knowledge in Remote Care 2. The involvement of diverse care professionals in the care of dementia clients created collective knowledge from diverse knowledge perspectives. Furthermore, the platforms used to share knowledge, such as narratives and pictorial therapy resulted in a mix of past and present knowledge about the clients that informed the provision of quality care.

4.6.3.2 Rapport: A conduit between knowledge and power

Opportunities to share narratives and develop norms and clues from these interactions were made possible by the level of rapport that had developed among members of the care teams over sometime. Evidence suggested that each expert possessed knowledge that was important to achieving quality care. Each expert's knowledge needed to interact with other knowledge perspectives to become collective knowledge, which will ultimately result in holistic quality dementia care. A challenge was, however, presented by the fact that care professionals protect information and knowledge they own jealously. This was evident in a statement made by a personal care assistant who stated that 'some of the nurses tend to act in a superior way and are not ready to mentor or share information'. This statement highlights the intricacies involved in sharing knowledge, which emanate from power dynamics.

> *Observation from field note.* The researcher's field notes documented an incident where a client needed assistance but the person working with him at the

time the incident occurred required some information from another expert. The expert who had the information came to the rescue, but diplomatically refused to share the information with others.

This illustrates how power is displayed in relation to information or knowledge. It provides a picture of the effect hoarding knowledge can have on the provision of quality care to clients as the absence of an expert with important information can delay the provision of care.

On the other hand, during the data collection process, the role of power as a facilitator in the knowledge sharing process was evident. This was evident in the comments made by some of the personal care assistants and the lifestyle coordinator, which suggested that building rapport with other members of the care teams enhanced the knowledge sharing process. Examples were given of chats over a barbeque or a social function in the aged care facility, where everyone interacted and let down their guard about sharing knowledge. This illustrates the role of rapport as a conduit between knowledge sharing and power dynamics. Indeed, opportunities to build relationships alleviate the display of power based on position, information or professional power.

4.7 Key similarities and differences: Cross-case analysis

The aged care facilities examined in this research were independently managed facilities owned by the same corporation. The members of the care teams who worked in the four aged care facilities examined in this study consisted of care professionals who were mostly based in the facilities and care professionals who provided shared services to the four facilities and were therefore transient.

These aged care facilities were governed by the same processes and procedures, although the management of each site was different and the sites were located in four different locations. A comparative assessment of these cases is provided in this section, highlighting the similarities and differences between these facilities. This comparative analysis was guided by the thematic headings that had been identified – knowledge sharing, power dynamics and social capital. In doing so, a synthesis of the body of evidence collected from the sub-cases was examined to determine how these thematic categories influenced the research problem, which was *to*

understand knowledge sharing and power dynamics in among teams of care professionals involved in residential dementia care.

4.7.1 Similarities

Common themes emerged across the four aged care facilities examined in this study. Prominent in the four facilities was the issue of diverse knowledge perspectives from different members of the care teams developing into collective knowledge through collaboration. The four aged care facilities studied had established routines and methods of sharing knowledge that facilitated knowledge interaction between members of the care teams.

The methods were broadly categorised into formal and informal. These knowledge sharing methods were: face-to-face sharing through narratives, storytelling, and pictorial therapy, staff and case management meetings, training sessions and water cooler conversations. Other methods involved documenting information and knowledge about the clients in care plans and software repositories.

These four aged care facilities had similar methods, as mentioned above. It should be noted that transient members of the care teams added a level of complexity to the knowledge sharing methods. This was because they not only shared knowledge within a particular aged care facility but shared experiences and scenarios across all four facilities, and this resulted in inter-facility knowledge sharing. The evidence suggested that through the use of different knowledge sharing methods knowledge was not only shared among different members of the care teams, but also across facilities. It can therefore be argued that this results in inter-facility and inter-profession collective knowledge.

4.7.1.1 Knowledge sharing

This research explored three main thematic categories – knowledge sharing, power dynamics and social capital – with sub-categories examining members of the care teams who provided care to dementia clients in four different aged care facilities. This section highlights the interactions between members of the care teams in each aged care facility as they relate to the knowledge sharing process.

Evidence gathered revealed that each aged care facility had avenues by which to share knowledge, both within the facility and with professionals outside the facility. The transient nature of some of the experts that provided shared services to the four aged care facilities brought an interesting perspective to the issue of knowledge sharing among the members of the care teams. The care professionals who only attended the facilities sporadically contributed a different kind of knowledge base to the dementia treatment plan. All these factors added to the dynamics of the relationships and ultimately the knowledge sharing process in each aged care facility.

4.7.1.2 Power dynamics

It was evident across the four cases that the combination of formal and informal power dynamics contributed to the knowledge sharing process among the members of the care teams. The structure and culture of each facility influenced the level of rapport that occurred. Analysis of the data indicated that the size of each facility also affected the power issues that existed and structures put in place to alleviate these issues. Across the board, informal power bases contributed to the knowledge sharing process and also generated social capital amidst the members of the care teams. Indeed, the downside of formal power bases was alleviated by informal power bases across the case study sites. It was evident that using a hybrid of formal and informal power contributed to the knowledge sharing process among members of the care teams.

The manifestations of formal and informal power in the four aged care facilities were similar. The relationship between knowledge and power in the four facilities was such that power facilitated knowledge sharing when applied correctly through the combination of informal and formal power bases. Evidence however suggested that power could deter knowledge sharing when not applied correctly. The impact of power on the knowledge sharing process in each facility appeared to be determined by the level of rapport that existed among the members of the care teams in each facility. In addition, the size and membership of the care teams affected how power influenced knowledge sharing. Examples of how similar the manifestations of power were in the four facilities are provided by the similarity of the statements made by different care professionals in each facility.

At City Care 1, a chef mentioned how:

> *Some people play games about the knowledge they have about clients and not share. Not sharing can be very detrimental to clients' wellbeing. Chef (CC1), July 15, 2015*

At City Care 2, a personal care assistant mentioned the fact that:

> *Some people hoard knowledge because it makes them important and indispensable. PCA (CC2), September 15, 2015*

The researcher observed that despite the closely knit feel in Remote Care 1, a nurse displayed position power during one of the staff meetings. A personal care assistant was trying to contribute to information about a client he had provided care for during the week, and the nurse kept interrupting the carer. It appeared that the nurse was trying to take over the meeting because of her position in the organisation. Similarly, in Remote Care 2, there was a display of power with a personal care assistant carefully avoiding questions asked about a client by her colleagues. Apparently, she was one of the few professional who knew how to get the client settled and she was reluctant to share that information with others.

The display of informal power and the combination of informal and formal power bases facilitated the knowledge sharing process in the four aged care facilities. Indeed, the display of charisma and referent power combined with expert and position power appeared to enhance the knowledge sharing process across all the facilities examined in this study. From the foregoing, it can be argued that there were some similarities in the influence power had on the knowledge sharing process in the four facilities examined in this study.

4.7.1.3 Social capital

The influence of power dynamics on the knowledge sharing process and the role of social capital in this interaction was examined in this research. The four care facilities examined in this research were guided by organisational structure, processes and procedures that facilitated knowledge sharing. The implementation and success of these processes were dependent on how the experts applied them to achieve the desired results. Evidence revealed that each site utilized these policies

and procedures as a guide; the interpretations were dependent on the level of interaction that occurred at each site.

Avenues for care professionals to converge and share knowledge were influenced by informal relationships built over time. Such avenues consisted of informal chats over lunch, spontaneous brainstorming sessions and training. These avenues helped to facilitate knowledge sharing among members of the care teams and attenuate possible power issues. This occurred due to constant interaction that generated rapport among members of the care teams; as such, people let down their guard and shared knowledge.

Opportunities to interact occurred in each of the aged care facilities, which revealed that constant interaction between members of the care teams produced knowledge and ideas on how to better provide care to clients. This emphasised the important role social capital played in the knowledge sharing process. Network opportunities aligned to relational capital also produced shared meanings and agendas.

Peculiar to the four facilities was the use of narratives to share knowledge. This method of knowledge sharing produced norms and stories that were passed on to new employees and used as clues to know what the clients needed at a particular time and how to provide care to them. Across the four facilities examined there was a consistent consensus that social capital served as a conduit between knowledge and power dynamics. This was evident in statements made by different interviewees across the four facilities, examples of which are recorded below:

A personal care assistant explained that:

> *We have a very good relationship with the doctors and allied health workers, when they come for consultations. We have barbeques together and while eating together we get to chat about the clients and interestingly techniques, strategies and treatment plans are developed through these interactions. PCA (RC1), October 10, 2015*

Similarly, a lifestyle coordinator suggested that:

> *Having a face-to-face conversation with people help in sharing knowledge because they can put a face to the writing in the care plans or the bulletin on the notice board. The opportunities to have conversations also help in building relationships and hear new ideas. LifeCord(RC1), September 10,2015*

During a team training session, the researcher observed that the relationship between each participant was close. After close interaction, it was discovered that this was formed through relationships built over the years. The experts had shared cues, language and agenda.

From the foregoing, it can be argued that social capital enhances the knowledge sharing process among members of the care teams. Creating opportunities to interact and building rapport alleviated the effect of power as a deterrence to the knowledge sharing process. Building rapport with other professionals created an opportunity to get to know their area of expertise and how the care professionals could work together to provide holistic quality care to the clients.

4.7.2 Dissimilarities

There were some differences in the knowledge sharing methods used in some of the facilities. These differences were a result of the peculiarity of either the size, the location of the facility or the management style. Size plays a decisive role in the methods used in two of the aged care facilities studied in this research, namely Remote Care 1 and Remote Care 2.

Aged care facilities that had a small number of clients and employees employed more informal methods of sharing, mainly because conversations occurred constantly between the members of the care teams. Sharing knowledge through this method was relatively easy. In addition, these facilities made use of communication books, which were placed in strategic and accessible places. The book was used in conjunction with the care plans. According to some of the interviewees, the communication books served as easy reference books which were accessible to all the experts to document or get updated information about clients' treatment plans.

4.7.2.1 Knowledge sharing

The remoteness of two of the facilities studied in this project accounted for the type of knowledge sharing method used. Two of the aged care facilities were located in remote areas. The remoteness of their location resulted in a high turnover rate, with the potential that professionals who had knowledge and information about the clients would leave without sharing with others. The aged care facilities had therefore devised means of ensuring knowledge was shared.

Mentoring and shadowing were methods used to combat the loss of knowledge due to transient experts. According to the service managers, spontaneous tacit knowledge is shared in the process. The aged care facilities also made use of formal knowledge sharing methods, which highlighted the use of different methods, depending on the size of the facility.

Another knowledge sharing method used in the smaller aged care facilities was communication books. This method, according to the personal care assistants, was effective in documenting information on the spot before they had the opportunity to document knowledge and information in the care plans. It appeared that the span of time between the occurrence of a situation and when the professionals would have the opportunity to document the information in care plans could often be long and result in individuals forgetting what they observed. Hence, the use of communication books alleviated the incidence of individuals forgetting to document important information, as it was placed near where they attended to clients and accessible to everyone.

Management style accounts for another difference in the knowledge sharing method in the four aged care facilities examined. Remote Care 1's service manager's management style supported educating all her employees. This approach was referred to in this research as mingling and bookworm. This approach also encapsulated platforms to build relationships and empower employees. According to the service manager, this avenue not only provided an opportunity to get educated in the field of dementia care, but also a platform for all the members of the care teams to mingle and form relationships. The result of these methods was evident in the close knit family feel that existed in the facility, as observed by the researcher.

City Care 1 and 2 were large aged care facilities with some differing knowledge sharing methods. It appeared that the most common methods used in these two facilities were ensuring compliance

in documenting the clients' details in care plans and staff and case conference meetings. Evidence revealed that relying solely on these methods might not allow for adequate knowledge sharing. This was because the care plans were usually locked up in a secure area and access to the documents were limited. The restriction in accessing clients' care plans was more pronounced when an expert was attending to a client in their room or the common area and required urgent information to provide care. In addition, while staff meetings were attended by most of the experts, evidence revealed that some professionals were usually absent from some of the meetings due to the very busy schedule in the aged care industry. The case management meetings were also attended by only the service managers and some selected experts, which restricted the level of knowledge interaction to particular experts and could ultimately defeat the knowledge sharing process.

The researcher observed that what care professionals shared with others was limited to what they decided to share and not the entire knowledge or information they possessed. The researcher observed that what was shared in informal chats and during formal meetings was different from the strategies and techniques used in practice, which was evident when observing an experienced expert mentoring a new employee. The experienced employees' spontaneous reactions to clients' behavioural issues were different from instructions given when conversations take place.

It was therefore evident that learning and sharing by working closely with care professionals facilitated the knowledge sharing process in comparison to other methods. This was because spontaneous actions were captured by the mentees and knowledge that the mentor could not articulate or refused to share was transferred during this process. The question was, therefore, not so much whether the professionals shared knowledge and information, but did they share all they knew and did they feel that what they knew was significant enough to make a difference in the lives of the clients.

4.7.2.2 Power dynamics

Informal power bases are intrinsic and based on individual disposition and the environment. People influence the manifestation of these power bases, which emerge as charisma power,

expert power and referent power. The expression of these power bases influenced knowledge sharing methods used in each of the facilities examined in this study.

Remote Care 1 and 2's small size accounted for the family atmosphere in these facilities, and affected the expression of power and the knowledge sharing process. The lifestyle coordinators in these facilities noted the prominence of informal power bases, which they credited to the small number of staff working in the facility. Relationships were formed easily between the small number of employees, which had a significant impact on knowledge sharing. Irrespective of the shift one worked, everyone worked with everyone else at one time or another other.

The display of informal power bases was observed by the researcher in Remote Care 1 and 2. It was observed that the staff in these two facilities behaved with respect toward one another, valuing each others opinions and expertise. The interaction among the members of the small staff revealed those who had charisma power, and those who were subject matter experts and demonstrated information power. Knowledge sharing and ultimately enhances the provision of quality holistic dementia care.

The different types of power enhanced the knowledge sharing process in Remote Care 1 and 2. Evidence suggested that the size of a facility or a group affected the level of power displayed, which would either facilitate or deter the knowledge sharing process among the members of the care teams.

4.7.2.3 Social capital

The effect of social capital in a group or organisation is dependent on opportunities to interact and build rapport. It was evident from the data that staffs in the smaller hospitals interacted and built relationships and rapport fairly easily. There were many opportunities for informal conversations among the small number of members of the care teams in comparison to large facilities with minimal avenues for conversation and informal meetings. The complexities associated with time and movement of staff when staff numbers were high in the aged care facilities restricted the formation of relationships that could result in optimal knowledge sharing.

4.8 Conclusion

This chapter presented a summary of findings from interviews and participant observation conducted in four aged care facilities. The findings addressed the issues of knowledge sharing, power dynamics and social capital, which interacted constantly in the organisations

The knowledge sharing process was facilitated or deterred by power dynamics. Formal power dynamics can either serve as a deterrence or a facilitator of knowledge sharing. The data demonstrated, however, that combining informal and formal power bases facilitated knowledge sharing, a process further enhanced by social capital. It was evident that social capital played a prominent role in the knowledge sharing process and in alleviating the effect of power on the sharing process through building relationships.

(5) INTERPRETATION AND DISCUSSION

5.1 Introduction

This chapter presents an interpretation of how the empirical research work conducted in this project aligns to theoretical investigations and research propositions outlined in Chapter 2 of this doctoral thesis. The central premise of this research was that there exists a need to inform contemporary understanding of the influence of power on the knowledge sharing processes among members of the care teams in dementia care facilities, who are scheduled to attend each facility only periodically. The researcher anticipated that the consolidation of empirical findings, together with the theoretical premises, would help to identify the role of social capital in the relationship between knowledge sharing processes and the influence of power dynamics among groups of experts who provide care to dementia clients.

Chapter 2 described how propositions to guide the empirical investigation were developed in this doctoral research. Three overarching propositions were developed relating to the influence of power dynamics on the knowledge sharing process and the role of social capital in the relationship. This chapter interprets and discusses evidence from teams of dementia care professionals and allied health care experts. This evidence was used to inform the three propositions presented in Chapter 2.

This chapter is organised into four sections, which discuss and interpret the results in relation to the review of the key literature themes of knowledge, power, and social capital. The first section considers and interprets results related to how knowledge is shared amongst experts involved in the care of dementia clients. This discussion informs and supports the first proposition.

> ***Proposition 1:*** *Knowledge sharing among members of the care teams is likely to involve a unique combination of institutionalised elements and emergent social structures relative to each unique care situation, and can facilitate knowledge sharing.*

The second section examines the interpretation of results in relation to the literature presented in Chapter 2 on the influence of formal and informal power bases on the knowledge sharing processes among diverse and dispersed experts involved in the care of dementia clients. This discussion was guided by existing literature and empirical evidence gathered from the case study conducted to inform the second proposition:

> ***Proposition 2****: The combination of formal and informal power bases is likely to have a positive influence on the knowledge sharing process among members of the care teams.*

In the third section, the themes identified from the case study about the role of social capital in facilitating the knowledge sharing process, given the power issues that arise during interactions between professionals in the dementia care industry, is discussed. This discussion was informed by case evidence gathered about the role of social capital in the dementia context among varied and dispersed experts. The results gathered related to the third proposition presented in the literature review in Chapter 2.

> ***Proposition 3:*** *Integrating structural, relational and cognitive capital is likely to facilitate knowledge sharing among members of the care teams despite possible power issues.*

The following discussion is centred on each of the three thesis propositions. This discussion examined how the empirical findings addressed the research problem and questions.

5.2 Knowledge sharing among members of the care teams

The literature explored the process of knowledge sharing among intra-organisational professionals who belonged to diverse professional groups (Nonaka & Konno 2005). There was, however, a paucity of empirical research that had considered knowledge sharing among inter-organisational dementia care experts whose ability to share knowledge was not only challenged by diverse knowledge perspectives, but by geographical and spatial issues. Evidence gathered in this research addressed the research gap that exists with regards to the process of sharing

knowledge among dispersed and disparate teams of experts, given the influence of power dynamics.

5.2.1 Knowledge types

Dementia care in this study required expertise from an array of professionals whose attendance at the aged care facilities was periodic. This was due to the shift system in operation where different professionals were rostered to work at different times of the day. The involvement of specialist medical and allied professionals who offered shared services to the four aged care facilities presented another challenge to the knowledge sharing process. Indeed, the dynamics of different knowledge perspectives and periodic attendance revealed a need to implement various knowledge sharing methods that could facilitate knowledge sharing through the development of shared agendas, language and norms.

The review of the literature suggested the existence of different types of knowledge, which are broadly classified as tacit and explicit. These knowledge types manifest at different times during the interactions that occur between diverse professionals, depending on context. This is evident in such knowledge types as embrained knowledge, where knowledge is acquired through formal education, but requires specific professional activities to be applied and interpreted, and for explicit knowledge to become tacit while providing care to dementia clients (Blackler 1995).

The process of combining different stages of knowledge to novel situations aligns with Nonaka and Konno's (2005) SECI spiral model, involving the processes of socialisation, externalisation, combination and internalisation (SECI). This model was, however, limited to teams of experts who worked in the same organisation and were guided by the same social structure. The implication of this is that diverse professionals guided by different knowledge perspectives and structures might not be able to share knowledge effectively, develop shared agendas, norms and language that will promote quality holistic dementia care because of the involvement of diverse social structures.

In addition, Nicolini et al. (2003) argued that knowledge sharing needs to be considered from diverse geographical and organisational contexts, ensuring that participation is mediated by a

plurality of institutions and structures. The combination of these two perspectives formed the basis for this research's first proposition, highlighted in Table 5.1.

Table 5.1 Proposition 1

Proposition 1	**Knowledge sharing among diverse and disparate dementia care professionals is likely to involve a unique combination of institutionalised elements and emergent social structures relative to each unique care situation and to the various experts involved.**
Proposition 2	The combination of formal and informal power bases is likely to have a positive influence on the knowledge sharing process among members of the care teams.
Proposition 3	Integrating structural, relational and cognitive capital is likely to facilitate knowledge sharing among members of the care teams despite possible power issues.

Evidence gathered from the four aged care facilities studied in this research supported the first proposition developed from the review of the literature. It was evident that the involvement of diverse care professionals necessitated the use of various knowledge sharing methods, taking into consideration the different knowledge perspectives and dispersed nature of the experts. Indeed, diverse professionals require updated information about the clients to ensure continuity in the clients' treatment plan and quality dementia care.

Effective and efficient knowledge sharing was even more important to the specialist medical and allied experts involved in the current study, given the periodicity of their attendance at the aged care facilities. More specifically, evidence from the data revealed that the combination of formal and informal methods was used to facilitate knowledge sharing and knowledge development among groups of experts who operated under different social structures. This was evident in the statement made by one of the service managers, who stated that:

> *We have informal chats that are at times spontaneous and formal meetings where we brainstorm and then document techniques and new knowledge about the clients. Sharing information requires both informal and formal avenues, because you can't predict when an idea might come to your mind or when an action is replicated in an emergency. ServMan(CC2), October 16,2015*

Furthermore, a holistic therapist mentioned that:

> *All the stakeholders sit in a relaxed atmosphere sometimes we just tell stories and share pictures that trigger memories. This gets everyone talking in a relaxed*

atmosphere, these sessions are mostly not planned so we don't have agendas. During these sessions knowledge and information gathered solves the puzzles about clients and informs the treatment plan. These information and knowledge is what results in the care plan notes that facilitate treatment plans. HolTherpist(RC1), November 5,2015

From the statements made by the service manager and holistic therapist, it was evident that the combination of formal and informal knowledge sharing methods facilitated the knowledge sharing process. In addition, it appeared that the groups of experts devised strategies to share knowledge, depending on the different knowledge perspectives involved and the particular situation at the time.

Observation from the field notes: Extract from the researcher's field note detailed the emergence of peculiar social structures as it applies to unique care situations.

Exhausted, I sat alone in the staff room; in comes the first lot of employees coming in for their lunch break. Mugs of coffee in hand and cutleries clinking on plates in the background were discussions about a particularly difficult client situation and strategies used. The team leader stepped in and offered some expert advice. In came a set of personal care assistants who offered experiences. The combination of ideas and knowledge shared were strategies used in different scenarios but could apply to the scenario being discussed.

Tagging along after lunch I, noticed the nurses writing rigorously in the care plans. On closer observation, I discovered they were documenting the knowledge, ideas and strategies shared over lunch in the care plans.

The above observation suggested the need to apply different social structures during the knowledge sharing process, depending on the type of knowledge being shared. Informal knowledge sharing eventually culminated in documenting knowledge in care plans and repositories. This was essential to disseminating and sharing knowledge among experts whose attendance at a facility was periodic, as knowledge is fluid and requires consistent sharing to be useful in providing quality care to clients.

From the foregoing, it can be argued that formal structured meetings and documentation were organised to facilitate knowledge sharing at the organisational or group level, while spontaneous and informal avenues of sharing knowledge during lunch times and other unplanned interactions encouraged individual knowledge sharing. This finding supports Lawson et al.'s (2009) premise on the importance of a combination of formal and informal knowledge sharing in achieving improved performance in an organisation.

Indeed, the convergence of informal and formal methods of knowledge sharing created opportunities to share spontaneous tacit knowledge and explicit technical knowledge. The involvement of multidisciplinary professionals in the care model necessitated avenues for sharing knowledge while working with the clients and during organised meetings to ensure distribution of information to both rostered staff and care professionals who attended periodically, and to ensure different types of knowledge were shared.

5.2.2 Social structures that facilitate knowledge sharing

The review of the literature revealed various social structures suggested by such authors as Wang and Noe (2010), Noanaka (1994) and Wenger and Snyder (2000). While these social structures on their own contribute to knowledge, their combined effect on care professionals in the dementia care industry has not been explored in the literature.

Diverse social structures were explored earlier in this thesis. Each structure operating on its own presented challenges to sharing knowledge among the groups of visiting and permanent experts who expressed divergent knowledge perspectives (Contu & Willmott 2003). Nonaka (1994) suggested that the knowledge sharing method used in a particular context would either enhance or impede the level of knowledge interaction that occurred. Indeed, evidence gathered from the four age care facilities that participated in this research supported these arguments. Each social structure is discussed below.

5.2.2.1 Collaborative sharing through software

Knowledge brokerage is a means of facilitating knowledge sharing through the use of an information management system, customised by each facility, to store information and knowledge about the clients and customers (Waring et al. 2013). The case study suggested knowledge brokerage was an avenue used to share knowledge between diverse teams of carers.

This information management system is managed by super users who are regarded as knowledge brokers. The knowledge brokers are tasked with the job of serving as a conduit between all teams of experts to store clients' information, and the knowledge and skills from all the experts contributing care in the four aged care facilities, either permanently or periodically. The information stored in using the software program is made accessible to all of the care professionals involved in the care of clients.

Observation from the field notes. From observation:

> *There were different groups of experts engaged in documenting their ideas in the software system strategically placed in the handover room. I observed a nurse interacting with an allied health professional on the portal. This is given the fact that the system can be accessed from anywhere.*

This empirical finding aligns with Wang and Noe's (2010) study on bridging structural holes between disconnected professionals by aligning the exchange of knowledge with information technology. This approach to knowledge sharing codified knowledge in explicit form and stored such knowledge in repositories. The use of knowledge brokerage serves as a means of connecting disparate experts virtually. This was apparent in the statement made by the lifestyle coordinator stating that:

> *Most information is passed on verbally, but the software system is the primary form of communication because people can have access to this information from anywhere. LifeCord(CC1), July 7, 2015*

It was apparent from the case study that the use of knowledge brokerage as a means of sharing knowledge about dementia clients' care is fast gaining ground in the aged care industry and supports collective collaboration, and attempts to include all care experts' contributions.

Interacting with the knowledge broker assigned to one of the facilities revealed that the downside to recording information was that individuals' memories could be fallible, especially as there wasn't always time to record information immediately. Having fragmented and incomplete knowledge and information about clients' history distorted the continuity in clients' treatment plans. This ultimately prevents the teams of experts from having access to comprehensive and accurate information that can contribute to the provision of quality holistic dementia care.

5.2.2.2 Interdisciplinary collaboration

One of the avenues used by interdisciplinary professionals to share knowledge is through case conferencing. Care conferencing, according to Nugus et al. (2010) is a formal meeting that provides opportunities for interdisciplinary professionals to communicate, share knowledge about patients and document specific care plans for patients. Case conference meetings are beneficial to the knowledge sharing process among disparate care teams with periodic members because they serve as a platform for all those involved in providing care to dementia clients to share knowledge, information and ideas.

The case study revealed that the concept of sharing knowledge through formal mechanisms had some success and in some cases limitations. The instances of successes and limitations were observed during some of the meetings attended by the researcher.

> *Observations from the field notes:* During a case conference meeting, it was observed that different professionals involved in the care of dementia clients came together to have extensive discussion and brainstorming sessions about how to improve the care provided to clients. An extract from the researcher's field notes summarised the knowledge sharing process that took place during one of the case conference meetings:
>
> *I got the opportunity to attend one of the case conference meetings along different experts organised for a client. In attendance were nurses, client's family members, a general practitioner, a social worker, a service manager and some allied health workers. It was evident that case conference is a unique way of sharing knowledge that saves costs, time and produces wealth of knowledge. The researcher noticed a downside, which was the absence of some members of*

the care teams, examples are personal care assistants who spend a lot of time with the clients and are privy to a lot of things about the clients.

Some professionals who possessed valuable experiential knowledge appeared to be excluded from the case conference meetings, therefore, such as personal care assistants and some auxiliary employees. This seemed unfortunate as the data from this research revealed the important contribution personal care assistants and auxiliary employees could make to the care model and plan. Their exclusion could ultimately affect the provision of quality holistic dementia care. This was apparent in a statement made by a mental health nurse, who commented:

During a case conference meeting doctors, nurses, the client and the client's family members and other workers were present but no personal care assistant was present. I had to insist that we needed personal care assistants in attendance, because they take care of the needs of the clients round the clock and I noticed that some of the medical professionals felt insulted.
MentalNurse(CC1), July 12, 2015

Personal care assistants provided personal care to the dementia clients and spent more time with them than any other member of the care team, and were likely to make useful contributions to the care model. Analysis of the data demonstrated that when formal knowledge sharing was limited by a lack of participation on the part of carers, informal avenues in some of the aged care facilities contributed to deeper knowledge sharing. Examples of informal knowledge sharing methods used to alleviate the impact of the exclusion of some experts from formal meetings were informal chats during lunch, pictorial representation and narratives. These informal avenues helped to break down the segregation between professionals and helped professionals respect other experts' contributions and skills.

5.2.2.3 Collaborative sharing through informal avenues

Informal networks are presumed to evolve from collective thought processes (Krackhardt & Hanson 1993). They involve the distribution of information through an organisation's grapevine, the information shared among employees. Informal knowledge sharing was a prominent method for sharing knowledge across the aged care facilities studied.

The contrast between formal structured forums and the informal and sometimes spontaneous sharing opportunities observed in this study can be seen in the fluidity of the exchange of ideas, skills and knowledge during informal sharing. Ultimately, informal avenues used to share knowledge create a platform for collective knowledge sharing, learning and opportunities to form rapport among diverse professionals.

Unstructured activities, such as 'yarning' (informal story telling) are a way of sharing narratives that integrate information and knowledge. Informal conversations during lunch breaks and social events organised for the clients create a relaxed and conducive atmosphere in which to share knowledge. In addition, the 'water cooler' opportunities to share knowledge where employees converge for lunch, coffee and a snack formed an important platform for sharing knowledge and building relationships. Indeed, the sharing opportunities observed in this study resonated with Weeks and Fayard (2007) photocopier and water cooler theory, where the importance of informal interaction and the effect of the physical environment where conversations took place influenced the level of knowledge sharing that occurred. These avenues alleviated any unconstructive power effect on the knowledge sharing processes and supported social capital theories.

Shadowing opportunities where new employees observed experienced employees dealing with clients also provided a good platform for sharing knowledge, as this method mostly rules out the issue of hoarding knowledge or not being able to articulate tacit knowledge. This is because that we do not know what we know (Noanaka 1994). Employing the mentoring method will therefore create a platform for knowledge to be transferred by observing techniques and replicating actions and methodology. Hence, the case evidence revealed the contribution of mentoring opportunities to the knowledge sharing process and how the hoarding of knowledge can be overcome, as techniques, skills and methods are displayed on a spontaneous basis.

5.2.2.4 Communities of practice

Storytelling, which has been referred to in this research as 'yarning', which is an informal method of sharing knowledge, involves informal conversations among teams of experts, clients and family members. Small talk and conversations were observed as an important knowledge sharing tool. The empirical evidence reinforced Lave and Wenger's (1998) communities of practice, that

is, the premise on learning and sharing as an ongoing activity among professionals with shared agendas and interests. This was apparent in the statement made by a lifestyle coordinator, who said:

> *The doctors, nurses, personal care assistants, allied health workers that come here are part of the family. We sit over barbeque and discuss clients' progress over lunch and drinks. A lot of sharing takes place during these informal chats. LifeCord (CC2), October 25, 2015*

Observation from the field notes. An observation by the researcher as detailed in the field notes also revealed:

> *Group of five or six members of the care teams sitting together over lunch and coffee discussing scenarios and solutions that helped unique client issues. New employees asking questions and explanations from others helping them understand how to deal with difficult clients. They had shared understanding and similar experiences that promoted knowledge and learning.*

The lifestyle coordinator's statement and the field note extract resonates with Lave and Wenger's (1991) concept of CoPs that evolve naturally due to common interest in a particular field and becomes an avenue for sharing knowledge and learning.

Opportunities to interact informally presented an avenue for care professionals to interact and form meaningful relationships as a community. Empirical evidence suggested that regular interaction among these teams of experts enhanced techniques, skills and strategies for providing care for dementia clients. Sharing in a relaxed atmosphere overcomes structural holes and professional dominance.

It is worth noting the influence of sharing in an informal setting precipitated by unplanned informal sharing in line with the organisation of CoPs. While each aged care facility had a formal structure in place to facilitate knowledge sharing, unconscious and unstructured informal avenues had evolved in some facilities that had enhanced relationships among professionals. These relationships helped generate a level of respect for other professionals' input, knowledge and

skills to the care delivery model. Knowledge perspectives from different experts were shared in a relaxed atmosphere which generated rapport.

5.2.3 Knowledge sharing: Hybridised social structures

Empirical evidence revealed the importance of combining formal and informal social structures to facilitate knowledge sharing among experts. Using a hybrid of different knowledge sharing mechanisms to facilitate tacit and explicit knowledge sharing among diverse experts was important, as adopting different methods of sharing knowledge could ensure that every member of the team shared and received important knowledge and information, irrespective of their shift, professional group or periodicity of attendance at the aged care facilities.

In addition, the combination of different social structures and methods facilitated the transfer of tacit and explicit knowledge, which required informal and formal platforms to share knowledge. According to Hara and Foon Hew (2007) and Holdt Christensen (2007), the combination of professional training and experiential knowledge contributes to collective knowledge; it is therefore important to harness the two types of knowledge to ensure knowledge transfer . Thus, the consolidated case evidence revealed that, in spite of the diversity in the professions, the movement of some of the professionals between facilities and the power issues that influenced the knowledge sharing process, a hybrid of informal and formal mechanisms of sharing knowledge could facilitate collective knowledge.

This premise is dependent on the following evidence, which suggests that there are factors that facilitate or impede the achievement of shared knowledge and information using the combination of different sharing methods.

5.2.3.1 Inclusive collaboration

The involvement of diverse teams of caring professionals and family in the delivery of quality holistic dementia care necessitated collaboration. The data suggested that knowledge, ideas and experiences from all those involved in the care of dementia clients were needed to facilitate the provision of quality dementia care. Indeed, excluding a professional could create a gap in the information required to develop care plans for clients.

The four aged care facilities introduced strategies to encourage inclusion. Such strategies have been referred to in the thesis as mingling and bookworm and informal network. These knowledge sharing strategies created platforms for care teams to mingle and share ideas and experiences in a relaxed, unplanned atmosphere. This was achieved by organising lunch hour events with the intent to get the care professionals to form a rapport, which can ultimately lead to sharing knowledge. The informal platforms to share knowledge reduced the complexity of communication and provided an avenue to define jargon and build shared language and understanding.

Observation from the field notes: This was evident in the researcher's observation:

> *Lunch hour events and training sessions are so informal, noticed a lot of members of the care teams who were reluctant to participate in the research relax after a while. Everyone chatted informally about various things and eventually started talking about scenarios and experiences and how they provided care to clients. Complex issues were discussed and after everyone's contribution there appeared to be solutions provided as a group, this was achieved by pulling from different knowledge perspectives.*

This observation suggests that collaboration through inclusion breaks down possible power barriers, and makes communication and conversations among experts simpler.

5.2.3.2 Group size and conversations

The effectiveness and efficiency of combining informal and formal knowledge sharing methods appeared to be influenced by the size of a group or an organisation. Irrespective of the social structure used, knowledge brokerage, interdisciplinary collaboration, informal networks and CoPs, the membership and size of a group or organisation determined the level of knowledge sharing that occurred.

The size of an organisation or group of professionals affects the ability and ease of forming social networks and rapport that facilitates knowledge sharing compared to large organisations or groups.

Observation from the field notes. The importance of the size of an organisation appeared in the data from the researcher's field notes, where it was written:

> *Different meetings, trainings and informal chats were held to share knowledge, a recollection of the impact and effectiveness of these meetings seem to be in how large or small the group are. Meetings or facilities with large membership are seen to struggle to pass on information and knowledge. On the other hand, small sized facilities and large facilities who break their members into smaller groups recorded more success in sharing knowledge and engageing professionals to talk about their experiences and converse.*

Indeed, conversations were easier in small groups. Large organisations require various methods to break the learning and sharing process into manageable experiences to ensure proper dissemination of knowledge, skills and techniques. Analysis of the data showed the importance of combining formal and informal knowledge sharing methods in large organisations and also in small organisations.

The findings suggested that knowledge shared and documented by care teams depended on the knowledge each individual was willing to share. The issue of knowledge as power was reflected in the statement made by the chef in one of the facilities:

> *Some people hoard knowledge because they want to hold on to what they know as an advantage, it's dangerous not to share knowledge with the care of dementia clients. Chef (CC1), July 12, 2015*

This statement illustrates the importance of sharing knowledge and the effect of power dynamics on the knowledge sharing process. Hoarding knowledge to retain power or to maintain a competitive advantage over other teams of experts presents a challenge to providing quality holistic care to dementia clients. There is actually no way to ascertain how much knowledge or information each person possesses or is willing to divulge.

The review of the literature revealed that the evidence relating to how much knowledge is shared versus how much knowledge is owned by an expert has received little or no attention in the study

of knowledge sharing in the dementia care industry. This emphasises the power issues involved in an individual's ownership of knowledge, both experiential and academic. There are issues of intellectual property and questions of ownership related to experience, discoveries and models developed by the expert employed by an organisation. Furthermore, there is the issue that 'we don't know how much we know'. Therefore, it is difficult to determine how much an expert is actually sharing of their experiential knowledge.

On the other hand, knowledge gained through academic training is often equally elusive, unless the expert decides to share in a manner that can be understood by others in the team not expert in the same field. Making expert knowledge available is beneficial to achieving quality dementia care.

Identifying this gap in the knowledge sharing process through the evidence gathered for this doctoral thesis therefore contributes to existing literature about how much articulated or unarticulated knowledge is actually shared using an informal and formal knowledge sharing process. The summary of evidence outlined above therefore supports the first proposition that

> *Knowledge sharing among diverse and disparate dementia members of the care teams is likely to involve a unique combination of institutionalised elements and emergent social structures relative to each unique care situation and to the various experts involved.*

5.3 Influence of power dynamics on the knowledge sharing process

The evidence from this research illustrates the complexities that power dynamics bring to the knowledge sharing processes. In line with the review of the literature, the manifestation of formal power bases in the knowledge sharing process hinders the free flow of knowledge in most instances (Peiró & Meliá 2003). Conversely, the manifestation of informal power bases or a combination of informal and formal power bases contributes to knowledge sharing and encourages transfer of knowledge among experts.

Analysis of the data generated during this study revealed a connection between the social structure or culture in place in an organisation or group and the type of influence power has on

the knowledge sharing process. It became clear that the influence of power on the knowledge sharing process was dependent on how power was applied, given the relational process in place in a given context. This section therefore discusses the second proposition highlighted in Table 5.2.

Table 5.2 Proposition 2

Proposition 1	Knowledge sharing among diverse and disparate dementia care professionals is likely to involve a unique combination of institutionalised elements and emergent social structures relative to each unique care situation and to the various experts involved.
Proposition 2	**The combination of formal and informal power bases is likely to have a positive influence on the knowledge sharing process among members of the care teams.**
Proposition 3	Integrating structural, relational and cognitive capital is likely to facilitate knowledge sharing among members of the care teams despite possible power issues.

5.3.1 Effect of entwined power bases on knowledge sharing

The case study highlighted the difference between the influences of formal power on knowledge sharing among professionals who provide shared services to the four aged care facilities and the professionals who were assigned to particular facilities on a permanent basis. The difference between these two groups of professionals was mainly attributed to the differences in the structures of the aged care facilities.

Care teams of both permanent and shared professionals were guided by organisational structures and agendas, regulated by a hierarchical structure where there were recognised reporting lines. The hierarchy affected the participation of the care professionals in knowledge sharing. This is apparent in the statement made by a chef about the restrictions on who attends case conference meetings

> *Case conference meetings are restricted to some professionals. It will however be nice to attend these meetings as these meetings could help my diet plan for the clients. It will be nice to sit with a family member to know what the client's likes and dislikes to help me do my job better. Chef (CC1), July 15, 2015*

Given the fact that case conference meetings were intended to be a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet clients' health needs, they would benefit from having all stakeholders in attendance. The data, however, indicated that there were restrictions on attendance. Furthermore, it was evident that some professionals who attended case conference meetings used their position power to dominate discussions, which discouraged other professionals from sharing knowledge.

The effect of power on the knowledge sharing process, as highlighted above, is consistent with existing literature that suggests that a disparity exists in the knowledge sharing process among collectives due to position power and the negative effect this can have on the knowledge sharing process and on the achievement of quality holistic dementia care (Nugus 2010).

Conversely, some professionals with position power take advantage of the opportunity to mentor other professionals and pass on valuable techniques, skills and knowledge during these meetings. Interestingly, the data suggested that professionals at the top of the hierarchy who were positive and down-to-earth also possessed informal power bases, such as referent power and charisma power. This suggests that the combination of informal power, such as, charisma or referent power, and formal power, such as, position and legitimate power, can contribute to the knowledge sharing process.

5.3.2 Power does not equate to knowledge

Another finding of this study was that professionals holding high positions in the organisational hierarchy were not necessarily those who had the most expert knowledge or information that was needed to provide care to the clients. This was apparent in the statement made by a psychologist, who commented that:

> *Those with the important information and knowledge about the clients are sometimes not those who have the positions in the organisation. It is those that relate closely with the clients who are just part of the employee group. Psych (CC1), June 3, 2015*

Mechanic (1962) suggests that power does not always connote expert knowledge. It is evident that dementia care involves collaboration between different professionals, but that technical and/or academic knowledge may not suffice on its own in providing care to the clients. The importance of combining power bases was observed during medication rounds where administering medication to clients involved the combination of technical knowledge of to prescribe the correct medication and the skill to manage behaviours of concern in clients, as well as the experiential knowledge to decipher what triggered such behaviour.

These behaviours and triggers were described to the medical teams by the auxiliary employee who provides round the clock personal care to clients and therefore possess tacit experiential knowledge about them. Although the auxiliary employees did not exert position power, the knowledge they possessed contributed to decisions made by professionals with technical knowledge backed with position power. Evidence from the study supported the premise that position power did not have a direct correlation to expert knowledge or *vice versa*.

It was observed that power influences the knowledge sharing process among medical and allied health workers shared among the facilities in different ways, because the shared professionals were not dominated by organisational hierarchy at a facility, but were more independent as specialists. The manifestation of formal power in this group was based on professional power.

Despite the clamour for a platform for multidisciplinary input regarding dementia patients' care, it appeared during the study that some professionals still regarded treatment plans and meetings as a platform for competition and not collaboration. This was evident in a complaint from one of the nurses who noted that some professionals hoarded knowledge and failed to acknowledge other professionals' contribution to client care.

Case evidence revealed a misrepresentation in the importance accorded to some professions over other professions. The act of ignoring diagnoses given by some professionals, exclusion of some professionals in developing clients' treatment plans and subtle innuendos of disregard for other professionals was evidence of this misrepresentation.

5.3.3 Individualism: Influence of power on knowledge sharing

Evidence revealed that the perception of power among the professionals who were shared across the facilities was not a general consensus. The display of professional power did not include professionals who were generally respected by other professionals or those who had a good disposition towards others. The exhibition of professional power, therefore, appeared dependent on the individual's personality and attitude.

The review of the literature revealed a lack of empirical studies that had examined the effect of individual attitude on the issue of professional power (Nugus et al. 2010). Indeed, empirical evidence suggested that the manifestation of power among groups of experts was dependent on individual personalities. This finding contributes to the body of literature that addresses the impact of individual characteristics on professional power display. It was evident that the display of power occurred on a case by case basis, as there were some professionals who, irrespective of their profession, always respected the contribution of other professionals, which others did not.

In this case study, the shared medical and allied health workers were respected for their specialist skills and knowledge. Some of these professionals (namely, allied health professionals, doctors, and dieticians) took advantage of their expertise to exclude the knowledge of some permanently rostered professionals (namely, personal care assistants, nurses and auxiliary employees). The effect of this was that professionals like personal care assistants underestimated the value of the knowledge they possessed and this inhibited the development of collaborative knowledge that could assist in the provision of holistic quality dementia care.

On the other hand, medical and allied health professionals shared between the facilities who, by nature valued and respected others, willingly shared knowledge with everybody and sought to learn from them. Their attitude ultimately resulted in collaborative care and collective knowledge. This result is consistent with existing literature, which suggests that there is a correlation between personality types and the display of power (Lasswell, 2009). This finding is important to the delivery of quality dementia care, given the need to develop collaborative collective knowledge in the dementia industry to ensure a convergence of care perspectives from all the professional team.

The evidence demonstrated that informal power bases had a positive effect on knowledge sharing among diverse experts. Informal power bases, such as referent and charisma power displayed by some professionals with expert and position power facilitated the knowledge sharing process. Professionals who had charisma were respected by their superiors, peers and juniors as their personality endeared them to everyone.

The effect of this was that those with charisma power in high hierarchical positions, combined with expert power were identified as subject matter experts and were willing to share knowledge. They also exercised important informal power bases that enhanced rapport among diverse experts. The opportunity to share knowledge created through interactions with experts that displayed informal power bases resulted in avenues to mentor other professionals and form collaborative and collective care plans for dementia clients. Relationships that developed through shared agendas, shared values, a common language and experiences ensured a free flow of knowledge and the provision of quality dementia care.

5.3.4 Conclusion

The literature suggests that instead of homogeneity and stability among professions, there is segmentation that creates rules and a divide among experts, resulting in knowledge being sought (and provided) by some professionals and a disregard for knowledge on the part of other professionals (Riege 2005; Nugus 2010). Informal power, however, can alleviate this situation because it can be used to build rapport and trust among for each others' skills and knowledge. This is achieved through constant interaction and avenues to share knowledge.

The case evidence presented in this thesis suggests that informal power bases affect the knowledge sharing process positively among groups of experts. In addition, combining formal power bases and informal power bases produces positive knowledge sharing opportunities and rapport irrespective of the periodic nature of the attendance of some of the professionals in the dementia care industry, whose skills are shared between facilities. Power used tactically and strategically, combined with individual disposition contributed to the knowledge sharing relationship among the members of the expert teams. Hence, the evidence presented here supports Proposition 2, which suggests that 'how power bases are applied is likely to determine

the type of influence power dynamics will have on the knowledge sharing process among diverse and disparate professionals'and adds to literature on the influence of power bases on knowledge sharing and building rapport.

5.4 Social capital: Conduit between knowledge sharing and power dynamics

The evidence gathered from the research case study demonstrates the important role social capital plays in the interaction that occurs between knowledge sharing and power dynamics among members of the care teams in the dementia care industry. The results (presented below) signify the importance of constant interaction between multidisciplinary groups in fostering collective knowledge sharing and collaborative care for dementia clients.

This empirical evidence is consistent with literature that suggests that individuals gain valuable insights, skills and knowledge through social interactions and connections (Tsai 1998). It is, however, useful to note that case evidence also revealed that there is a difference between the effect of social capital on the knowledge sharing process between small sized organisations or groups and large organisations or groups. Indeed, the empirical evidence from this research confirms that the size of the organisation or membership of a group affects the knowledge sharing process by determining the ease with which social networks and rapport can be formed. Compared to large organisations where professionals are disparate and geographically dispersed, smaller, more coherent organisations find it easier to share knowledge and provide holistic care.

This research adds to literature about how the size of a group and the social capital in place in an organisation affect the knowledge sharing process as there is a paucity of evidence on the effect of social capital on the influence of power dynamics on the knowledge sharing process in the dementia care context. This was deduced from the review of literature which formed the basis of the third proposition highlighted in Table 5.3.

Table 5.3 Proposition 3

Proposition 1	Knowledge sharing among diverse and disparate dementia care professionals is likely to involve a unique combination of institutionalised elements and emergent social structures relative to each unique care situation and to the various experts involved.
Proposition 2	The combination of formal and informal power bases is likely to have a positive influence on the knowledge sharing process among members of the care teams.
Proposition 3	**Integrating structural, relational and cognitive capital is likely to facilitate knowledge sharing among members of the care teams despite possible power issues.**

5.4.1 Rapport building in small groups

Evidence revealed that one drawback of small sized groups was the limited range of expertise that existed in small organisations, which suggest that these facilities still required the input and contribution of other care professionals to achieve quality dementia care. The involvement of different experts and small group linkage are achieved by integrating professionals into the culture of rapport building and consistent interaction that exist in the facility or group.

Observation from the field notes. The professionals who worked across the four facilities who approached the task that their profession was superior quickly acclimatised to the sharing culture due to the frequent interactions that occurred between groups and the rapport that developed through these interactions. An extract from the researcher's field note detailed interactions between rostered and transient experts:

There was barbeque cooking and drinks were shared small group of experts, everyone naturally formed their pocket of friends not necessarily belonging to the same profession. Experts who are resident in the aged care facility mingled with the transient medical and allied group. Everyone seemed to have let down their guard and blended into the culture in place in the facility. Light banter gradually turned into discussion about the day's work, challenges and how these challenges were solved. This platform seemed a good place to share and learn from experiences.

This evidence contributed to the body of knowledge regarding how the size of an organisation affects the interaction between power and knowledge and the role of social capital in these interactions in the dementia care industry.

5.4.2 Structural capital

Case evidence also demonstrated the role of structural capital in the knowledge sharing process. Empirical evidence gathered for this research suggests that network ties and connections between internal and external care teams are important in ensuring positive power influence on the knowledge sharing process.

Given the organisational hierarchies, power dynamics and the busy shift patterns that existed in the aged facilities, each facility had developed platforms to share knowledge to bridge the hierarchical and professional divide. Avenues organised to share knowledge included:

- handover meetings
- staff meetings
- planning days
- case conference meetings
- training sessions
- conferences.

These meetings offered opportunities for internal and external groups of professionals to connect, share and develop knowledge. As a result of these structured meetings, opportunities for professionals to interact across boundaries occurred on a weekly, monthly and sometimes daily basis. These meetings ultimately provided avenues to share knowledge, learn and develop collective techniques and shared understanding among otherwise disconnected multidisciplinary professionals.

The existence of structured platforms for meeting regularly created linkages between functional and professional boundaries of the expert teams. These avenues closed the gap created by hierarchical and professional boundaries and encouraged knowledge sharing. This evidence was consistent with existing literature that noted the importance of network ties in creating inter-unit and inter-organisational links between individuals (Zhao 2013).

Empirical evidence in this case revealed links between permanent local staff professionals and those professionals who attended the facilities periodically. One of the nurses observed that 'we also talk about strategies a lot during different training sessions and meetings between all stakeholders'. It was therefore evident that processes, procedures and organisational agendas influenced the level of collective knowledge sharing and development of new ideas.

In addition, these knowledge sharing platforms provided opportunities to refine and renew collective knowledge. Regular interaction between the teams of experts revealed how each professional contributed to the overall care agenda and encouraged informal interactions, which builds rapport and respect among the multidisciplinary group.

5.4.3 Relational capital

It was apparent from investigations conducted during the research that building rapport between diverse experts created opportunities for collaborative knowledge sharing. This was substantiated by a service manager who stated that:

> *Collaborative care process occurs with nurses evaluating the residents and if they have any concerns they refer them to the allied health team, general practitioner, and geropsychologist who can help diagnose the issue and strategies to use to deal with the behaviours. ServMan (RC1) December 5, 2015*

Indeed, knowledge interaction between the professionals revealed the importance of relational capital in achieving a sense of collective ownership of norms, narratives and knowledge among the various members of the care teams. This was apparent in the use of narratives that were important when determining care strategies for the clients. These narratives were shared across the board during various unplanned and unstructured meetings. They were shared at informal opportunities to chat over lunch or in the corridor, and have a yarn with the clients. These interactions were found to provide valuable knowledge about a wide range of issues. This was apparent in the statement made by a social worker:

> *I look at the reports from other professionals and they mention language as a barrier to getting information from the client. They can actually use narratives*

to help to build rapport and then identify ways of communicating that will help in the transfer of knowledge. SocialWrk (CC1), July 24, 2015

The atmosphere created during these informal discussions helped professionals who normally would consider themselves superior to let down their guard and share knowledge more readily. Relational capital also assisted in building rapport which contributed to the development of strategies for communicating with care professionals for whom English was a second language.

Narratives successfully provided an understanding of clients' behavioural patterns and what triggers the behaviours. Narratives gave care teams the knowledge to predict clients' needs when they displayed a particular behaviour or signed with their hands to communicate their needs. These signs and triggers were shared by all the members of the care teams, both old and new, in form of narratives, stories and pictorial representation. It is however important to note that these narratives, stories and yarns only occurred in a relaxed, unplanned atmosphere when an individual felt comfortable sharing the seemingly mundane but valuable information.

The significance of this will be discussed below when elaborating on cognitive capital. It was evident that relational capital provided opportunities for collective learning and also provided a positive influence on the interaction between knowledge sharing and power dynamics.

Evidence gathered about relational capital illustrates the influence of social processes within and between teams of experts. The quality of social interaction, social processes, norms and narratives influences power manifestations between teams of experts and ultimately facilitates collaborative knowledge sharing and the development of new ideas and techniques. It is therefore worth noting that regular interaction between multidisciplinary professionals ultimately helps educate all professionals about the importance of collaborative sharing. This study contributes to the body of knowledge about the use of narratives to encourage knowledge sharing, a technique which is in the formative research stage.

5.4.4. Cognitive capital

The existence of narratives and stories developed through regular interaction and relationships helps in generating shared language, shared agendas and codes. This is consistent with Nahapiet (1998), who has written on the significance of social capital to organisational performance. Evidence revealed the effect of cognitive capital on knowledge sharing. Frequent interactions between professionals involved in the care of dementia clients resulted in collective knowledge, learning and social activities. This in turn generated a shared language, codes and signs, which bridged the gap that naturally exists between professionals due to different professional jargon peculiar to each profession.

Cognitive capital not only helps professionals to build rapport, but also reduces the segregation caused by the organisational hierarchy and position power on the free flow of knowledge among professionals in a structured setting. An example of this was seen among the research participants who commented on the relationship that had developed over a number of years with allied health workers and doctors due to informal activities, such as barbeques, among employees and clients.

> *Observation from the field notes.* An extract from the researcher's field notes detailed an observed informal gathering among the teams of experts:
>
> *On a Friday evening after putting the clients to bed for an afternoon nap, the group of experts sat around a sizzling barbeque. The doctors, chaplain, allied health workers, personal care assistants and auxiliary employees gathered round for lunch and chats. It turned out to be an unstructured meeting where ideas, knowledge and strategies to provide care to clients were discussed.*

Thus, according to activities observed during participant observation, and from information gathered during interviews, frequent interactions give rise to knowledge refinement, generation of common agendas, development of codes and shared language. Cognitive capital therefore helps in the development of care agendas, which will ultimately result in everyone focusing on how to achieve quality holistic care.

The significant role of social capital as a conduit between identified barriers to knowledge sharing among care professionals was identified from the data. More specifically, social capital through

social activities, social interactions and key relationships generates positive power influences on the knowledge sharing process. Ultimately, collective knowledge sharing occurs, new knowledge is developed and rapport is created despite the diverse and dispersed nature of individuals that make up the teams of experts who provide specialist care to dementia clients. This confirms the third proposition about social capital, stating that *integrating the three social capital dimensions can likely facilitate knowledge sharing among the various members of the care teams*.

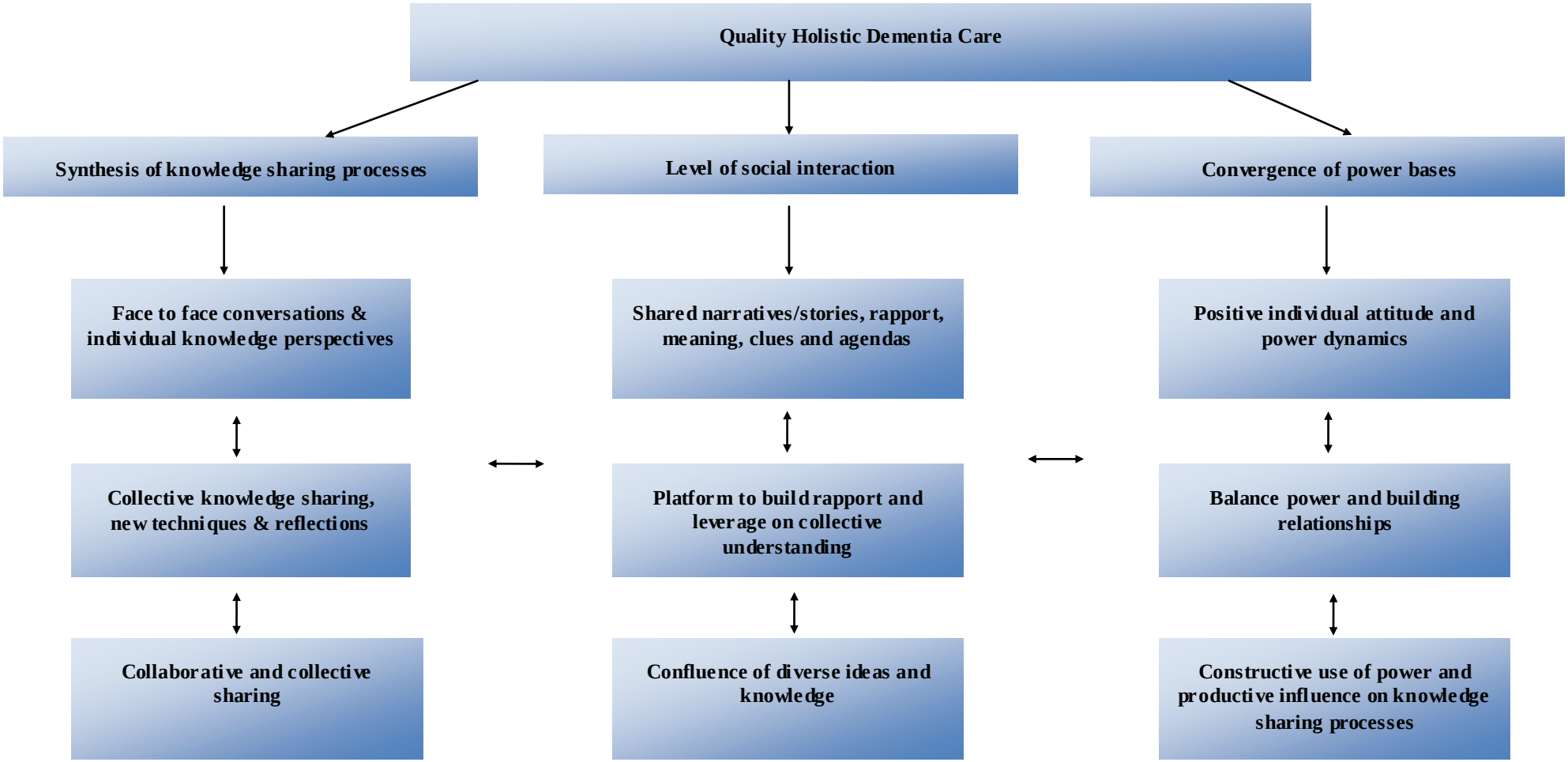

Figure 5.1 Synthesis of findings

5.5 Synthesis of theory and findings

This section presents a synthesis of theory and evidence to illustrate how these findings align with the research problem and objectives of this doctoral research. One of the main research objectives was to examine the knowledge sharing processes among teams of experts that provide specialised care to dementia clients and the influence of power dynamics on this process. The influence of power on the knowledge sharing process has significant implications for achieving quality holistic dementia care.

There is, however, a paucity of research directly addressing the interaction between knowledge sharing and power dynamics and the role of social capital in this process. The empirical evidence gathered in this doctoral investigation revealed the importance of social activities and interactions in alleviating possible negative effects of power dynamics on the knowledge sharing process among multidisciplinary professionals and professionals separated by boundaries. Indeed, empirical evidence suggested that social capital results in positive attitudes and contribute to the knowledge sharing process.

The results of this study also revealed the impact and effectiveness of using a hybrid of social structure, informal and formal, in the knowledge sharing process. Evidence revealed that combining social structures results in a connection between knowledge sharing processes and power dynamics. The involvement of dispersed and diverse care professionals in the care of dementia clients presents a challenge that requires social capital to encourage knowledge sharing in the dementia care industry. The results presented in this thesis contribute to the body of knowledge on achieving quality holistic dementia care through efficient and effective knowledge sharing processes.

The empirical evidence gathered during this study also informs research on the effective use of narratives and pictorial representation in sharing knowledge among teams of professionals. These knowledge sharing avenues contribute to the process of transferring and articulating tacit knowledge in a way that every individual, irrespective of their cultural background or level of understanding, will be able to interpret clients' needs according to their history and care plans. These knowledge sharing methods is especially important in the aged care industry given the

different perspective and level of understanding that exist among professionals in the dementia care facilities studied.

The issue of what level of articulated and unarticulated knowledge can be shared formally was also a key issue identified during the evidence gathering exercise. It was assumed that the professionals would document or share all the articulated knowledge they had, either through documentation in care plans, recording in a computer management system or sharing knowledge face-to-face. It is, however, worth noting that professionals only share knowledge they are willing to share, and there is no way of measuring how much each individual knows or how much they will choose to hold back, because of their busy schedules, the frailty of human memory and/or experts being unwilling to share knowledge.

Data revealed the importance of shadowing, mentoring and on the job training, where new employees' worked alongside experienced employees to ensure knowledge was transferred. Knowledge that was difficult to articulate because a professional did not know they possessed it until they displayed it on the job should ideally be learnt by the other employees being mentored. It can be argued that those professionals who have the intention of hoarding knowledge will find it difficult to hoard knowledge they either do not know they have or want to hoard but reveal when responding to clients' needs spontaneously.

Evidence revealed two important views about the issue of professionals hoarding knowledge or avoiding avenues to share knowledge. Firstly, the perspective of knowledge as a source of power accounted for some of the knowledge not shared. This was apparent in the statement made by a chef stating that 'some people can be funny with knowledge they feel they possess'.

There was also the general idea of some professionals that they had a right to the knowledge and, essentially owned it. Secondly, some professionals displayed mannerisms and attitudes which gave other care professional the impression that their knowledge or contribution was not relevant or important in the care process. This behaviour tended to make their colleagues reluctant to express what they knew. The investigation suggests that, despite the reluctance shown by some

experts, constant interaction through such methods as structured meetings, narratives, planning days and small talk in small groups helps alleviate the two issues identified above.

This was apparent in a statement made by a personal care assistant, who stated that:

> *Initially there was reluctance to share knowledge by some experts, but over the years we have become like family. We all chat about ways to improve the clients' care over lunch and barbeque. PCA, (RC2), November 3, 2015*

This conveys the significant contribution social capital has on the interaction between knowledge sharing and power dynamics among diverse and dispersed experts. From the foregoing, it can be argued that rapport is built during these interactions and trust is generated between professionals, which makes it easy to share knowledge with others. Professionals who shy away from sharing knowledge get more confident about discussing what they know due to constant interaction and opportunities to share.

It is apparent from the evidence presented above that the confluence of power bases, such as, position power, charismatic and referent power, contributes to knowledge sharing among experts. This is further buttressed by a statement made by a therapist assistant about a team leader who had position power augmented by the fact that he was also approachable and friendly. People approached him for information and he went out of his way to share knowledge. He was an example of how power contributes to the knowledge sharing process if applied correctly.

It was evident from the case study that individual experts' attitudes affected the level of influence power had on the knowledge sharing process. Particularly noteworthy was the significant effect of social capital in the power relationships. This was exemplified by the attributes of charisma and referent power, which included building relationships, conversations that, produced new ideas and knowledge and equal contribution to the case model because of respect for other experts' views. The findings of this research about the influence of power on the knowledge sharing process contribute to existing research and pave a way for future research on how to identify the level of knowledge being hoarded due to power issues.

Finally, social capital theories serve as a bridge between knowledge sharing processes and the influence of power on the sharing process. It is worth noting that the size and structure of an organisation have a significant effect on the knowledge sharing process and the influence of power on this process in the dementia care industry. This was reflected in the group of medical and allied specialists who worked across the four study facilities. The specialists found it easy to share knowledge and discuss client issues in small groups, and to form interpersonal rapport that facilitated the free flow of knowledge and information.

In addition, the travelling specialists did not group themselves into a strict hierarchical formation, which encouraged innovation and knowledge sharing. This was an example of how the structural, relational and cognitive capital in place in organisations influenced knowledge sharing. This finding supports previous research on social capital theories, and can pave the way for new research directions.

(6) CONCLUSION

6.1 Summary of findings

The aim of this doctoral research was to explore the knowledge sharing process among teams of experts and the influence of power dynamics on the sharing process. In doing this, the role of social capital in the interaction among the care professionals and how power influences this process was examined.

The findings from this research revealed that an organisation's social structure, social processes and structural size have a positive influence on knowledge sharing processes, despite the effect of power dynamics. It was therefore paramount to investigate the role of social capital on the knowledge sharing process of care teams working with dementia clients.

This research is therefore important to organisations, given the significance of collaborative knowledge sharing among disparate and dispersed groups of experts seeking to achieve quality care delivery.

In today's world, knowledge serves as a strategic resource. This resource is, however, controlled by individuals, groups and organisations. Disseminating knowledge, skills and techniques is a challenge due to the power dynamics involved in the control of a knowledge base. Power dynamics can affect the sharing of knowledge because individuals perceive their knowledge about processes, procedures and techniques as their own and as giving them an edge above others. Knowledge can, however, provide a competitive advantage for an organisation as a whole and needs to be shared. Understanding how to utilise the social processes that occur among groups of experts can facilitate sharing, despite potential individual and group bias.

This chapter is structured into four parts. The first part outlines the key findings of this doctoral research. This section is followed by a discussion of theoretical contributions and implications. The penultimate section of this chapter outlines the limitations encountered during this research and suggestions for future research. Finally, a synopsis of the major conclusions of the research is presented.

6.1.1 Key findings

The key findings of this study reveal the value and role of social capital in aligning informal and formal power bases to achieve collective and collaborative knowledge sharing among teams or groups of experts. This doctoral research also ascertained from the empirical investigation that the process of knowledge development involves the combination of informal and formal knowledge sharing methods.

The distribution and development of knowledge among multidisciplinary experts, some of whom work across multiple facilities, revealed a need to engage in various methods of knowledge sharing in order to achieve good dementia care. In particular, this research revealed the importance of using narratives, and pictorial representations to promote knowledge sharing. These methods were found to encourage knowledge exchange and opportunities to have genuine conversations that facilitated shared agendas.

Groups of experts participated in various narrative activities, incorporating pictorial memoirs and graphical representations of clients' life history in the activities. Knowledge sharing using these methods were sometimes unstructured and unplanned, spontaneous avenues by which to share knowledge. Evidence also revealed that the unstructured nature of narratives and stories created an environment that resulted in professionals being relaxed and willing to share without inhibitions. The result of this informal method of sharing is the transfer and development of knowledge, techniques and skills.

6.1.2 Spontaneous knowledge is elucidated through observation

The research revealed that knowledge is shared with new employees, as well as among more experienced professionals, during the process of observing and mentoring while caring for patients. This process reduces the problem of hoarding knowledge because experts, who may otherwise be reluctant to share, usually respond spontaneously to the clients' needs and unconsciously pass on knowledge, skills and techniques while resolving patient problems. In addition, employees being mentored get to learn new ideas and ways of doing things by simply observing.

Face-to-face communication and interaction, therefore, offer avenues for richer knowledge sharing experiences than ideas and techniques written in repositories without context. Putting context to particular techniques and/or activities ensures that individuals understand situations that occur with clients that necessitate reacting to the situation in a given way. Having an understanding of why and when various techniques were used helps in the knowledge development process and fosters the ability to use the same method in other novel situations.

These interactions alleviate ambiguity in meanings and techniques used to provide care to dementia clients by those collectively working in dementia care facilities and help develop cognitive capital where shared norms and languages are formed. Constant interaction and mentoring opportunities also provide opportunities to build and develop wholesome rapport.

From these findings it can be concluded that observations and face-to-face communication; and interactions is likely to reduce the issue of hoarding knowledge among collectives of experts in any context. Organisations and groups need to encourage and advocate for experts to work together on client cases through mentoring and observation. An example is pairing up experts to work on client case management together to ensure that each expert is familiar with the client's trigger points and routine. In addition, the method of pairing up experts to work on individual cases may eliminate the issue of monopoly of knowledge as each expert will react to client's needs spontaneously based on their tacit knowledge which can in turn be 'learnt' by others in the group. This method can encourage everyone involved in client care in developing shared norms and languages. Also, combining various methods of knowledge sharing, such as the communication book, with face-to-face knowledge sharing processes, is likely to help in the process of building rapport among the experts.

6.1.3 Size and social structure: Panacea of knowledge sharing

A distinction in the influence of power on knowledge sharing between medical and allied health professionals attending multiple facilities and professionals who were permanent employees of a single care facility was evident. Professionals assigned permanently to a residential aged care facility were guided by the organisational policies, procedures and structure of the particular

facility. The structure in place could sometimes restrict the flow of knowledge through informal avenues.

Furthermore, the organisational policies and hierarchical structure through formal power bases gave some of the medical professionals the impression that they had more power than others, depending on the position they occupied in the hierarchical structure. This ultimately affected the sharing process, as those in high positions exerted power over organisational or group knowledge or belittled the knowledge of individuals with no position in the hierarchy.

The influence of power on the knowledge sharing process among the permanent staff was affected by this hierarchical structure, which did not encourage permanent employees to contribute to the knowledge sharing process. On the other hand, the medical and allied staff who worked across all of the facilities were mostly regarded as specialist consultants bound by their specialisation in assessing and treating dementia clients.

Most of the professionals in this cohort were conscious of the fact that they required the contribution and expertise of others to make clinical decisions since they were only periodically in the facility. It was therefore evident that the influence of power on the knowledge sharing process among groups of experts was determined by the structure in place in an organisation or a group.

This finding adds to good practice by care teams in dementia care facilities because it identifies the effect of organisational structure and group constitution on the knowledge sharing process and informs how dementia facilities can better manage the relationships that exists in this group to achieve good dementia care practice.

Organisations are likely to benefit from defining the importance and contribution of each profession's expertise in achieving the organisation's corporate goal or in this context achieving holistic dementia care. This can be achieved by encouraging collegially facilitated case conferences and meetings which involves responsibilities and discussions shared by every member of the collective with no control from a perceived dominating leader. Collegially facilitated meetings can be achieved through allocation of responsibilities among professionals

to ensure collaboration and contribution from all the professions represented at each meeting. This encourages collective decision making, knowledge sharing and is likely to curtail the influence of power on the knowledge sharing process. In the dementia care context, collegial facilitation involves equitable representation from medical, allied health workers, auxiliary employees, clients and family to personal care assistants. Attendance at case conference should not only involve some selected professions but each profession that contributes to dementia clients' care should be represented in each meeting. Furthermore, allocating responsibilities and at these meetings serves as a means of involving every care professional.

Identifying subject matter experts in each professional cohort will also encourage a balance of power among all professional groups. Organisations' organisational structure also needs to reflect the balance of power. The structure needs to be flat to accommodate experts in different professions to be represented in the leadership group as this will discourage perceived superiority from selected professions.

More importantly, professionals require some sort of education about how each profession's contributions assist other professions' success story. Periodic focus groups or consultations are required to map out how each individual fits into the provision of holistic dementia care or the corporate objective. This platform may generate some rapport and respect between professions, demystify misconceptions; and provide a graphical representation of how important every individual is.

6.1.4 Combined power bases facilitates knowledge sharing

Another finding of this research was the positive dimension and influence that power had on the knowledge sharing process when used correctly. The combination of informal and formal power bases, such as combining position power with charismatic power, contributed to and facilitated the knowledge transfer process.

This was mostly achieved through the use of social phenomena represented by informal power bases, such as charismatic and referent power among groups of experts. Informal power bases are based on social interaction and people's perceptions of qualities that appeal to others. The

manifestation of informal power bases in diverse care teams through social interaction and social attributes showed a direct correlation between social capital and power and how these can be used to curtail the negative influence of formal power bases on the knowledge sharing process.

There are individuals in every organisation who possess informal and formal power bases. Team building meetings are avenues that can be used to identify individuals who possess a combination of informal and formal power bases. In addition, investing in engaging a consultancy firm with specialty in personality profiling will help organisations to identify individuals with these traits. Engaging a neutral facilitator to conduct this exercise is likely to eliminate any issue of favouritism. The review of literature in chapter two of this thesis revealed that favouritism was one of the disadvantages of using knowledge brokerage in facilitating an in-house knowledge sharing platform. It is therefore recommended that engaging an outside consultancy firm to conduct a personality profile is likely to result in unbiased outcomes. After identifying these individuals giving them responsibilities as mentors or coaches is likely to assist every organisation in the process of harnessing the positive effect of combining informal and formal power bases in the knowledge sharing process. Promoting these qualities may create a positive culture of knowledge sharing.

6.1.5 Small group experience and social capital

Finally, the findings showed the significance of social interactions, shared agendas and language in the knowledge sharing process. Social capital was indeed important in harnessing knowledge among experts in dementia care. Furthermore, regular face-to-face interactions between experts involved in the care of dementia clients helped bridge the gaps created by formal power. This was achieved by building rapport among disparate and dispersed professionals. Such methods as handover meetings, training sessions and team building meetings were held and facilitated opportunities to build rapport.

Vital to this finding was the fact that an organisation's size affected the level of interaction, knowledge sharing and how power influenced the sharing process. Evidence revealed that there was a tendency for aged care facilities and small numbers of experts, often who only attended

periodically, to share more and have a wholesome rapport that contributed to the knowledge sharing process.

Indeed, the facilities studied that were small in size had better knowledge sharing mechanisms in place and fewer power issues compared to the large aged care facilities or professional groups. An example was seen in the membership of the small teams of professionals, who readily shared knowledge and rapport. The ability to meet more regularly in small groups and mingle with the specialists added to the uniqueness of the group and the sharing experience. The limited size of the group of experts, along with the nature of those involved, created a relaxed culture and encouraged knowledge sharing.

This trend was also observed in the small aged care facility as the size of the facility affected the level of interaction and rapport. This was evident in the level of rapport that existed among the experts in the smaller aged care facilities. The closeness among the diverse collectives in the smaller facilities was obvious in their knowledge sharing techniques and how knowledge was shared on the spot. In addition, the culture in these facilities reflected one of sharing among every professional, irrespective of their position in the organisation.

The positive effect of small group experience in the knowledge sharing process is likely to assist organisations to develop a culture of rapport among diverse collectives of experts. Creating an atmosphere to encourage interaction and sharing in small groups is likely to improve knowledge sharing and a culture of rapport. This can be achieved through designing the office space to be conducive for conversations. Adopting the water cooler approach by placing coffee machines and water fountains in strategic high traffic areas might help start conversations.

Organising social events such as morning tea events and project days are opportunities for professionals to mingle and share. Organising training and brainstorming sessions, assigning individuals to mentors; and job shadowing opportunities are likely to further enhance knowledge sharing.

6.2 Contribution to body of knowledge

This research contributes to the body of knowledge by revealing the significance of stories, narratives and pictorial representations to the knowledge sharing experience among experts and the role of these methods in influencing power dynamics among this group. While narratives and pictorial representation have been discussed in the literature, there is a paucity of empirical study on how these methods can be used to create and share knowledge among diverse experts, some of whom only visit a facility periodically, in relation to power dynamics.

Another contribution of this research is that it demonstrates the unique influence and contribution power dynamics has on the knowledge sharing process. The influence of power dynamics on knowledge sharing has been viewed from the professional and institutional perspective in the literature. However, the main focus of most of the research has been on power bases as a barrier to knowledge sharing. This research expands this focus to include how power can positively affect and influence the knowledge sharing process, an area that has not been recognised previously in the literature. Consequently, this research adds to knowledge, not only by highlighting the interactions that exist between knowledge sharing and power dynamics, but also the role of social capital in making this interaction positive.

This research reveals a need for future empirical research on the link between organisational size and knowledge sharing. This is especially important given the fact that a number of authors have stated that a curvilinear relation is assumed to exist between the size of an organisation and how knowledge is shared and have advocated for empirical evidence to prove this theoretical assertion (Bontis 2007; Riege 2005).

Indeed, this research provides empirical evidence to suggest that the size of an organisation and the social structure in place affect the level of knowledge sharing and the flow of information among professionals. Small groups and smaller organisations access knowledge and information more quickly and easily than large groups or large organisations. The concept of small group experience therefore presents a possible strategy for large organisations whose objective is to ensure knowledge is shared across boundaries and professions. The social structure of a group

and organisation also informs the level of rapport and therefore the level of knowledge sharing that occurs among professionals involved in the care of dementia clients.

6.3 Implication for organisations and practice

This research enumerates a number of practical applications to organisational issues in relation to sharing knowledge among disparate dementia care professionals. The empirical evidence of this doctoral research revealed that the social structure of a group or organisation helps to bridge the knowledge sharing gap between groups of experts with diverse knowledge perspectives, and ultimately results in power dynamics having a positive influence on the sharing process.

In fact, the size and social structure of an organisation play a vital role in harnessing and cultivating knowledge sharing and building a platform that encourages the free flow of ideas, information and knowledge devoid of negative power influences. This suggests that small group experience will facilitate expert and specialised knowledge sharing among the members of the care teams of care experts separated by boundaries, structural holes and professional barriers in dementia care facilities, and may lead to informing similar small expert groups in other care situations, such as mental health professionals.

Social interaction and processes created avenues for multidisciplinary teams to share and refine expert knowledge in the facilities investigated. The findings of the research can broadly inform managers and organisations about the importance of using social phenomena to generate positive power influence on the knowledge sharing process among groups of experts. Narratives and experiences shared among groups of professionals were significant knowledge sharing methods in the dementia care facilities. Representing this knowledge and the ideas in pictorial form, through the use of quick dashboards with clients' routine and vital information, would ensure that every care professional, irrespective of their educational background, could participate in the knowledge being shared.

Based on the results of this research, organisations, stakeholders and managers across industries can use the following practical evidence from this study to encourage the combination of

informal and formal power bases to achieve positive knowledge sharing results. Important results from this research demonstrated:

- how the size of an organisation can influence the knowledge sharing process and assuage possible power issues
- the contribution and influence of combining informal, charismatic, expert and referent power and formal, position power bases on the knowledge sharing process
- that narrative, stories and pictorial therapy facilitate knowledge sharing among groups of experts
- the contribution of social capital phenomena to the relationships that exist between knowledge sharing processes and power dynamics, and how this facilitates rapport among dementia care professionals.

Furthermore, this study deviates from conceptualising power as an influence dominating organisational knowledge or individual knowledge based on hierarchical or position power. Power is revealed in this research as having a positive influence where applied correctly. Indeed, adequately recognising that position power is not the ultimate achievement, but the combination of position power with such power bases as expert power and charisma power enhances social interaction. Individuals who combine position power with expertise and charisma were observed to contribute significantly to the knowledge sharing process among groups of professionals. Furthermore, individuals without positions in the organisation's hierarchy, but who exerted authority through the charismatic force of their personality, referent and/or expert power, were also observed to be important conduits of knowledge sharing.

Organisations need to identify and encourage these individuals as their input offers immense benefits to the delivery of quality service delivery. Negative power dynamics need to be discouraged and every professional's view should be taken on board, behaviour which charismatic leaders with the right personality, regardless of their position in the hierarchy, are able to achieve.

Finally, to enhance knowledge sharing among professionals separated by distance, professional jargons, time and hierarchical structure; managers and the organisation as a whole may find it

useful to create opportunities for collaborative and collective knowledge sharing. Collaborative and collective knowledge sharing results in cultivating and developing knowledge. In addition, a convergence of individual and organisational knowledge is achieved that may ultimately result in the provision of quality holistic dementia practice.

This can be achieved through shared resources, common lunch rooms, and open office space, weekly or monthly catch up meetings, training, and information technology repositories. Creating an interactive environment to share knowledge will improve trust, openness and knowledge creation. Having genuine conversations and interactions among diverse experts would allow individual knowledge to contribute to the whole care agenda.

It is therefore important to relate with other groups of professionals to find out how individual knowledge contributes to the other experts' specialist areas. This sense of collaboration and sharing may result in respect and trust for each expert's area of specialisation and therefore produce quality dementia care. Indeed, this can be achieved through CoPs that informally bind individuals together who share common agendas and passion for the same enterprise, which will ultimately enhance and encourage the recognition of different expertise and knowledge from diverse professionals.

6.4 Identified areas for future research

The evidence gathered during this research addressed a number of questions about the role social capital plays in the influence power has on the knowledge sharing process among teams of experts in dementia care. Nevertheless, future research could seek to validate the findings of this research in alternative situations involving teams of professionals. Finally, this study explored knowledge sharing and the influence of power dynamics among professionals working across facilities and those permanently located in facilities, and experts in the dementia care industry.

Face-to-face semi-structured interviews were the methods used in this research to provide participants with opportunities to discuss and reveal their thoughts about the influence of power dynamics on the knowledge sharing process. Participant observation was also used in the data collection process, as this method provided the opportunity to study the experts at their usual

work place. This was especially useful, given the fact that the manifestation of power is subtle. It was similarly useful to observe interactions between teams of experts to discern the influence power has on knowledge sharing. Future research could use alternative methods of data collection, such as focus groups or autoethnography to explore the issues from different perspectives and in depth.

This study examined the influence of various power bases, e.g., position, expert, referent, information and charismatic power on the knowledge sharing process. This study revealed how power from the various bases identified can be harnessed to result in positive and successful knowledge sharing exercise. Example of such is seen in the issue about reward power; due to the position held by the researcher in the organisation discussing the issue of reward power resulted in some resistance and suspicion from the participants. While this was beyond the scope of this project it could be an area for future research.

A useful insight made during interacting with the experts revealed the fact that there was no way of measuring or ascertaining if experts were sharing all the knowledge they possess or if they hoard some and share only what they are willing to share with other experts. Having an understanding of the level of knowledge shared is important in achieving quality holistic dementia care given the fact that all information and knowledge from teams of various experts caring for dementia clients adds to the delivery of good care to clients. The question of determining how much knowledge is shared is worth exploring in future research as it will contribute to the body of knowledge about where knowledge resides in teams of experts and further expand the typologies of knowledge that exist in the dementia care context. It would be useful for future research to conduct a longitudinal study assessing how what individuals know or information they possess can be measured, or if knowledge and information they share over time changes with context or collective membership.

This doctoral research explores the knowledge sharing process among collectives of dementia care experts who have periodic face-to-face interactions and how power influences this process. It would also be useful to have an understanding of the influence of power dynamics on teams of

experts whose interaction is largely through virtual means, for example, the internet, intranet and other communication software, as well as other more permanent diverse teams of experts to see if the power dynamic changes in different contexts.

Finally, this evidence was drawn an Australian care facility with multiple facilities, and while it is a representation, it may not reflect the situation in other aged care facilities across Australia or the world at large. Conducting similar research in other parts of the world would therefore add to the body of knowledge as it relates to knowledge sharing and the influence of power dynamics on the sharing process.

6.5 Limitations

The context of this study was limited to a single organisation (with multiple facilities) that employed all of the participants. Although the disparate and dispersed care teams involved in the care of dementia clients provided a representative case study, conducting similar research in a different context would add knowledge to the area of knowledge sharing and the influence of power dynamics on the knowledge sharing process.

In addition, it would be interesting to expand this study to explore and understand how power influences the knowledge sharing process among virtual teams of experts, given the fact that in virtual workplaces experts will hardly ever have opportunities to interact on a face-to-face basis.

6.6 Final observations

The main objective of this research was to explore the influence of power on the knowledge sharing process among diverse teams of professionals and the role of social capital in these interactions in dementia care facilities. Research on the importance of knowledge sharing has been explored by a number of authors. There is, however, a paucity of research that focuses on the influence of power on knowledge sharing among disparate and dispersed groups of professionals and the role of social capital in this process. In fact, where power has been linked to knowledge sharing, it has mainly explored the negative influence of legitimate and position formal bases on knowledge sharing. This research has shown the possibilities of using a hybrid of informal and formal power bases to achieve positive outcomes. Hence, this research set out to explore the influence of power on the knowledge sharing process. This overarching objective was achieved in this research.

The research informs the understanding of the behaviour of teams of experts in the dementia care industry and organisations, and how power bases can be leveraged to achieve positive outcomes in knowledge sharing. This research therefore contributes and informs stakeholders in the dementia care industry and managers in organisations which utilise diverse and dispersed experts to provide care, and demonstrates the unique role social capital plays in ensuring power has a positive impact on knowledge sharing in multidisciplinary and dispersed teams of professionals.

The empirical investigation of this research provides academic and organisational contributions by highlighting the significance of social processes and utilising hybrid methods of informal and formal knowledge sharing methods and power bases to articulate and transfer knowledge among individuals with specialist knowledge.

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APPENDICES

APPENDIX 1 SAMPLE OF INTERVIEW TRANSCRIPT

Researcher: What is your role in this site?

Manager: I am the program manager of the City Care 3

Researcher: How long have you worked as the program manager?

Just over 12 months. I took over the program manager's role of City Care 3 in August/September 2014.

Researcher: Before City Care 3 how long have you worked with dementia clients?

Manager: Before CITY CARE 3 I was working in the disability sector, so my focus has been working with clients with disabilities across a life span. However I had a number of clients who had been diagnosed with behaviours of concern. Usually an in mental health and dementia

Manager: Basically we are trying to find out how those working with dementia client share knowledge and the possible barriers to sharing knowledge. So you work in a lot of CITY CARE 3 sites delivering advisory services to them and all that. Because you team are transient they go into the sites and come out they are not based in a particular site. Do you find that they find it difficult to get information from people

Manager: I think the most difficult process is found around getting the accurate information that is being recorded. Generally if people have time ot be able to sit down with you they will share information. Also the way you approach them to get the information is also very important. For instance if I go in and I act as if I know everything and I make them feel they are doing the wrong thing. Their ability and desire to share information with me is quite limited. But fi I go in and consider them the professional, I consider them the person who knows more about the clients it helps us grow together in the journey of meeting the needs of the client

Researcher: Before you picked your call, we were talking about identifying a key person. So we were talking about a particular scenario where you identified the Don or the service manager as the key person and I asked if they were the key person with the right information or you assumed they were the key person because they are the service manager or Don or..

Manager: Yeah sorry, I suppose on my level as a manager I try to establish a relationship with the Don or service manager but they are not always the ones with the most amount of information. In a situation quite recently it was the Enrolled Nurse that had the most information and the most access to information about the client. So it's not always the person that is able to devote the most that has the information needed but when I come into a case management of a client it is always that higher, level of information sharing.

Researcher: Barriers to knowledge sharing. What are the identified barriers that you think you have had over the years with regards to knowledge sharing amongst care professionals?

Manager: I think generally I would say people want the best for the clients. There is a few logistical barriers to be able to record clients' data . Some of them are around having time to record clients data and having information shared between professionals that move on from services so the importance of recording that information in someone's care plan. But I time generally people want to share the information. It's just having the time and acknowledging people for the knowledge that they have. In regards to … iam just trying to think of a situation where someone had not want to share information about a client.

Researcher: I will trigger your thoughts, we were having an informal discussion a couple of months ago when I first approached you about my project and you talked about culture, an Indian guy not wanting to share knowledge with you because.

Manager: Yeah, yeah, I remember I think it's also what people from different culture perceive has important information to share I think the most difficult part for me is males from different culture feel that some information is not important to females. They take into consideration the fact that I am a woman and they don't really value our relationship and they don't feel I am someone that is in the power to do anything. And also the fact that if they were to share their information with me that is relinquishing some of their power to a woman as well. Which in some culture is difficult, so yes thank you for reminding me about that, a good example? I do think that sometimes the idea of honesty and the idea of transparency are different from one culture to another as well. I think for some culture it's important to be perceived to always doing the right thing and always doing what is correct and that might make what actually happened get lost in the journey a little bit.

Researcher: Does that mean that culture can also be a barrier to sharing knowledge in some instances.

Manager: Yes and I think that is more about continuing to have that relationship with someone to be able to get that information across. I think that in any culture if someone sees you as a threat even if it's their relaxed environment where they don't have to do much or any extra work. Or the fact that they are not as successful as they wish to, that can serve as a threat to anyone. And someone comes in to take that away from them that is considered a threat if anyone sees them in that situation.

Researcher: So how have you being able to break those barriers?

Manager: I think being humble. Being very humble, being understanding and empathetic. One of the things we have being trying to do is being able to share that empathetic practice in aged care with care professionals, care workers. We need to be very empathetic and humble. By being empathetic it means handing over the reins and the control to the other person and then just listens. Very many times I will hear people say things and in my mind I know they did that wrong but I will never criticise, I will just listen and gain as much information as possible even if I am concerned about the situation. The only time I intervene is if the client is at risk. It's about making the other individual feel comfortable with you without them feeling you are a threat to them. One of the things we try to communicate to service providers is to ensure they know with are with them throughout the client journey. We are here to walk through the journey with them and there to support them and that we have resources we want to share with them. So it's not about us

coming in a shaking our heads and finger that they are doing things wrong. Its about coming in and saying how can we help or support them in the journey. A perfect example is we were working with a family and they were in a house where they were using restraints on the older person with in the house because they were concerned that she will have a fall. Our job was to go in and reduce those restraints, now we could come in and say as the high and mighty and say they are doing everything wrong using restraints and all that but if we do that we are not going to get any support from the family. Our approach is to let them understand that we do know that they want the best for their mother and let them know that we are there to support them and let them know we are there to reduce restraints and how can we support you to reduce restraints and ask what are your concerns.

And once they let us know what their concerns are we say okay we will put in place some exercise routine so that she can walk around and get stronger so she is less likely to fall. So its about sharing the same goals together and not coming in waving a finger.

Researcher: You talked about families. Have you ever had any barrier to getting information or knowledge from family members?

Manager: I think it's definitely a yes. Probably from people who are embarrassed about what is happening. I have got vulnerable people, especially with regards to domestic violence or cognitive issues or even sexualised behaviours. This is because they believe what happens in the family stays in the family, so this can make them really embarrassed. Then you have a professional coming in saying I need to know all these things to be able to support you guys. So these are obviously barriers to sharing knowledge and it's really about taking that time to developing a relationship with the clients. And I think from a clinical point of view pairing up the family with the right carer and with the right clinician will help. There has been situations where I have noticed that the relationships are no working and that is when I swap people over because purely from peoples' background, gender and profession different clinicians will work better in different background and situation so it's not just about their clinical background but also their personality and gender.

Researcher: Your background is psychology. How long have you being psychologist?

Manager: 8 years

Researcher: So you have a strong team in City Care 3working with you. So in your team you have occupational therapists, nurses and creative therapists, social worker so how do you share knowledge amongst your team and have you noticed any barriers to sharing knowledge among your team.

Manager: One thing I am passionate about is having a multidisciplinary team. Basically we follow the same therapeutic journey with the client but we have different area of specialisation but I don't think my team have any barriers to sharing knowledge because they all have something they are good at. I think sometimes if people disagree about the best approach or outcome for clients that might limit someone who is less confident. In being able to get their point of view across. So if i have someone who is very confident within my team and they have a very strong point of view about something they might not be right or wrong and then I have another person with a strong professional point of view i think sometimes those with less confidence

might not be voicing their opinion and i think that is my job as a manager to determine what I take on board. I also try to empower my staff as much as possible and ensure I trust their judgement as far as they are able to back it up with research and best practice they I have every confidence in their suggestions and they are allowed to share their opinion through one on one meetings with me or through report writing but you know with the dynamics of team I sometimes find that people might be reluctant to express their opinion about things but generally the team is really good.

Researcher: Apart from the formal methods used to share knowledge do you have other informal methods used.

Manager: We sometimes joke in a humorous way about cases as a team. Definitely we get together for lunch and ideas flow. I had a clinician message me on the phone in the middle of the night saying O I thought of this about that case.. you know that informal decision making does happen especially when it comes to decision making because we do the brain storming together. We also have situations where we have a peer review session and people will walk away and come back with a totally different idea or generally if someone has had a win , a success in a particular case they don't want to wait for the formal meeting they just share their wins and idea in a more informal setting. So it's generally when people are excited about a win that informal sharing takes place.

Researcher: You have some senior doctors working with you as consultants do you find that as senior as they are do you find out that they relate well with the fresh graduate occupational therapist well

Manager: I remember when I first met our geriatrician he said to me well I employ a lot of psychologist in my practice and I said I am currently employing you as our geriatrician. So definitely there is that attitude working with doctors especially the older doctors and there is no doubt about it ,don't get me wrong the reason why I sought him out to do clinical review is because he is very good at what he does and passionate about sharing knowledge about what he is passionate about. But is he good at seeking out advice and information from other clinicians and my staff about how to better his practice? Probably not as much as they are gaining from him, if you talk to nurses or other clinicians they will probably say the same thing. I am not saying it happens all the time but the situation that we are in at the moment that is what is occurring. I have found out before with our geriatrician he is happy to take us through things, very happy to share information but I have never had a situation where I feel they have gained anything from us. Maybe it is to do with anything to support his diagnosis. What is really interesting is the relationship that exists between the two senior professional doctors, the geriatrician and the geriatrician do not see eye to eye about diagnosis or medication. It's very difficult to get those two to see eye to eye on anything. I was given a referral the other day to have a case reviewed y the geriatrician because he didn't think the diagnosis was appropriate, I am like I am not even touching this because the amount of conversation I have had with the doctor geriatrician around the fact that we shouldn't be involving this other person (the geriatrician) is not once or twice, its huge

Researcher: So that means there are power issues between those two?

Manager: Absolutely, it's really territorial

Researcher: Do you feel its professional power as well.

Manager: Yes definitely, they both have very different ideas. When you are looking at the main issues with regards to medications and approaches they both have very different ideas and don't agree.

Researcher: Do you feel that if they both come together and try and agree on approaches regarding clients' needs will it make things a lot better and produce far reaching care for the patients?

Manager: Definitely, it's just because of the conflict that exists and you know it's so predictable when one of the doctors suggest a pharmaceutical approach the other doctor is very quick to query the approach and suggest the direct opposite.

APPENDIX 2 SAMPLE OF *NVIVO* NODE CLASSIFICATION

	A: Charisma power	B: Expert Power	C: Institutional Power	D: Negative Influence of Power on Knowledge Sharing
1 : Knowledge sharing process	1	51	2	12
2 : Formal knowledge sharing process	0	9	1	1
3 : Hybrid method of knowledge sharing	0	3	0	1
4 : Informal knowledge sharing	2	17	0	1
5 : Institutional knowledge	0	4	0	1
6 : Types of knowledge	1	7	0	0

APPENDIX 3 SAMPLE OF *NVIVO* NODE CLASSIFICATION

Coding Summary By Node

Knowledge Sharing and Power Dynamics

28/05/16 12:37

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number	Coded By Initials	Modified On
Node						
Nodes\\Care Collectives						
Document						
Internals\\Field Notes from Observation\\field note transcript _ Site 3						
No		0.3522	9			
				1	OO	27/05/16 20:50

September 11.19am -

Sites 3 the quality coordinator was complaining to someone about the inability to get information from a colleague within the organisation. She stated that she had sent emails several times and them realised maybe building a relationship first will help. She did and it worked but it was a slow process and it delayed the job she had to deliver.

2	OO	23/04/16 11:25

Staff handover meeting

2.46 pm 7th of October 2015

In attendance: 2 nurses, the service manager and 5 carers.

3	OO	23/04/16 11:27

Asked about how often case conferencing was done for each client? Every three months. It only always involves Nurses, doctors and allied health workers, service managers, families and the client.

4	OO	23/04/16 11:32

Everyone on night duty turned up all supporting staff and nurse on duty and that care for staff came. Maintenance man, cleaner, laundry assistant, cook, kitchen hand.

5	OO	23/04/16 11:47

Trainer in describing a particular reaction from some clients asked a question about how to recognise what the client is trying to communicate with non verbal gestures since they can't communicate because of the effective of cognitive issues.

The maintenance man cuts in and said the cleaner, mentioning her name is actually the best pair of eyes in the residential home as she notices differences in behaviour early and reports it to the carers or nurse.

6	OO	23/04/16 11:52

She commented that the scenario the cleaner gave will actually help her and her team make a clinical judgement or assessment. The scenario mentioned by the cleaner according to the trainer signified that the client was dehydrated and encouraged kitchen staff and the cooks to ensure that liquid is always offered to the clients because they can't express themselves when they are thirsty.

	7	OO	23/04/16 11:56

Staff room during lunch time. Administrative officer and the team leader were having lunch and the team leader was sharing how to fill out the specimen chart for clients' laboratory test.

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number	Coded By Initials	Modified On
				8	OO	23/04/16 12:00

The trainer started with emphasising the importance of every information provided by everybody working and interacting with the clients and stating that no one is exempted, cleaners, kitchen hands, cooks, maintenance man, nurses, carers, family members, community and activities officer. All the knowledge and information from everyone is useful to make a clinical judgement and advice on strategies to help clients.

	9	OO	23/04/16 12:23

It was a teleconference meeting where a decision had to be made about retaining a client with dementia in a residential facility or returning her to her community and home. However because of her behavioural tendencies her husband and relative and herself needed to decide what the decision was going to be.