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THE TACIT KNOWLEDGE IN ACTIVITIES OF DAILY LIVING: KNOWING BY DOING CARE

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Abstract

This paper discusses how knowledge is generated and applied in care practice in residential aged care settings. This study focuses on how 'care' knowledge-base is established and applied taking into consideration the lived experiences of the residents. This paper is based on a literature review from an ethnographic project of residents' lived experiences in Residential Aged Care Facilities (RACFs). Using ethnographic descriptions of Activities of Daily Living (ADLs) in RACFs from previous studies, the author explores the explicit medical knowledge and the tacit experiential knowledge within a theoretical framework of phenomenology and Polanyi's epistemology. This paper aims to reveal that there exists a tacit dimension of shared knowing, doing and experiencing in ADLs for both the residents and staff in RACFs. To effectively integrate the explicit knowledge into the knowledge-base for care, the codified and generalized knowledge has to have practical application and in a form that can be acquired tacitly as embodied skills.

Rationale

Residential aged care provides accommodation, everyday living support (meals, laundry, cleaning), and personal care services. 'Personal care services' include varying levels of assistance with bathing, toileting, eating, dressing, mobility, managing incontinence, and nursing care, etc. (Productivity Commission, 2011, p. 25). 'Personal care services' are mostly delivered via Activities of Daily Living (ADLs) by Personal Care Workers (PCWs).

The provision and delivery of ADLs have a direct impact on the residents' quality of life as the ADLs are fundamental to the residents' preservation of life. Any tangible improvement in performance of ADLs can dramatically change the residents' experiences of care and enhance their sense of well-being.

The institutional care practice in RACFs has been criticised as constraining and incapable of catering to the residents' individual care needs (Bland, 2007; Harnett, 2010). Corresponding to the Knowledge Translation (KT) initiative in health care more generally (Straus, Tetroe & Graham, 2009), the implementation of knowledge-based care practice is also strongly recommended as a solution to the existing problems in RACFs.

The "Knowledge to Action" (KTA) framework (Graham et al., 2006) is a KT model outlining the relationship between knowledge generation and application. This model

proposes that KT starts from identifying both a problem and the knowledge relevant to the problem (p. 20). The presupposition of this proposal is the perceived lack of knowledge in existing practice (as the 'problem') and the assured efficacy of the 'remedy' - implementation of the "best available knowledge" (p. 22). Nevertheless, what is taken for granted and remains unquestioned in this model are the conception of knowledge (or knowledges) in the given practice and how the adapted constitution of knowledge (knowledge-base) is relevant to the outcomes that the practice aims to achieve.

According to Michael Polanyi (1966), there exists a tacit dimension of knowing in lived reality. All explicit human knowledge is generated by subsidiarily applying a wealth of tacit knowledge (p. 16). Drawing to phenomenology and Polanyi's epistemology, this paper explores the following questions: What constitutes the knowledge-base for care in RACFs? How is this knowledge-based care practice relevant to the residents' experiences of care?

Methods

A search of the literature published between 2004 and 2014 was undertaken to identify qualitative RACF studies using ethnographic methods. Ethnographic descriptions of the residents' experiences of care in RACFs were extracted for review. Quantitative and qualitative studies with no ethnographic descriptions are excluded. A 10-year limit is set to reflect the *status quo* of care practice in RACFs. The author's experience as a veteran PCW also contributes to the discussion.

Discussion

To answer the first question "What constitutes the knowledge-base for care in RACFs?" the nursing facility needs to be understood as "*a contested cultural space upheld by social processes"* (Stafford, 2003, p. 10, italics original). As a sector affiliated to the health system, aged care reinforces standardised practice primarily formed and shaped by medical knowledge.

Medical knowledge is commonly interpreted as the empirical facts verified in primary research by the scientific, biomedical method (Malterud, 1995, p. 183). The "best available knowledge" is developed through distillation and synthesis, and is regarded as well-justified and potentially more useful for the end-users (Straus, Tetroe & Graham, 2009, p. 167). Being explicit, it is easily formalized and codified in text forms such as databases and documents.

However, how does this explicit medical knowledge function in daily clinical work? To use Polanyi's phenomenological example of medical student learning to read chest radiographs, it is demonstrated how explicit knowledge in the language of pulmonary radiology is only *becoming* meaningful when the tacit understanding of pulmonary radiograms is bodily acquired through persistent *engagement* (Polanyi, 1958, p. 101). Polanyi's epistemology is based on the notion that all human achievements are built upon the awareness of our own bodies, which is the existential framework of tacit, pre-linguistic knowledge (Henry, 2006, p. 189-190).

In-depth ethnographic studies highlighting the context-rich descriptions demonstrate the ways that tacit knowledge is generated and utilised in ADLs. In a Canadian RACF, a caregiver is reported to undertake ADLs for nine residents with physical

disability and cognitive impairment on day shift while two staff members care for 27 residents at night. The caregivers describe the workload as “overwhelming” and “insane” (DeForge, Wyk, Hall & Salmoni, 2011, p. 419). We pose the question of how such a heavy workload is daily undertaken by the staff. The fieldwork observations illuminate the significance of routines, which serve as a justified stable structure for the ADLs to be carried out in a repetitive, labour-saving and straightforward manner (Sandvoll, Kristoffersen & Solveig, 2013, p. 368-369). The caregivers are auto-driven by the embodied routines through time and space. Drawing to my experience as a PCW, two skilful caregivers often act simultaneously and smoothly under the same schema with no hesitation and intermission. Verbal communication is only necessary when unexpected events turn up.

Research has revealed that “A marker of skilled performance is the ability to deal with vast amounts of information swiftly and efficiently” (Kahneman, 2011, p. 416). The “skills on hand” is the embodied “skilful knowing” (Polanyi, 1958, p. vii, 64-5) of care work. Together with personal experience and expertise, skills constitute the tacit knowledge for care. Some veteran caregivers have the reputation of being “know their work” to “get the work done” and “know their residents” to provide individualised care.

ADLs are characteristic of close-up interactive bodily movements and constant intimate human touch. The nature and character of ADLs make the activities central to the staff’s knowing about the needs, feelings and experiences of their residents. In her study of clinical decision-making in American RACFs, Kayser-Jones (2003) reports an example of shared knowing of pain given by an African-American Certified Nursing Assistant (CNA). The CNA demonstrated vividly in a focus group discussion:

> “Even if they cannot communicate, they understand what you are saying.” When asked [by the researcher] how she knew that they could understand her, she gave an example of a resident who she thought was not feeling well. … When she asked the resident whether something was wrong, the resident took the CNA’s hand and moved it in a circular motion around her [the resident’s] face. The CNA then asked, “Are you dizzy?” the resident nodded yes. Then the resident took the CNA’s hand and placed it on her forehead. The CNA asked, “Do you have a headache?” The resident nodded yes.” (p. 53)

It is well demonstrated in this case that if “perception [is] an instance of tacit knowing” and “body is the ultimate instrument of all our external knowledge” (Polanyi, 1966, p. 15), “it is in [embodied] action, not in contemplation, that knowledge is both gained and given expression” (Kensinger, 1991, p. 45).

These empirical materials help develop an insight into the explicit and largely tacit knowledge-base for care. Yet, the purpose of this paper is not to facilitate a discussion on the knowledges *per se*, but to explore the second question in this paper - “How is the knowledge-based care practice relevant to the residents’ experiences of care?” The implementation of a knowledge-based care practice fails its purpose if the residents’ experiences of care remain unchanged. The ultimate goal of any knowledge-related discussion in residential care should aim at the service outcomes, namely the everyday lived experiences of the residents.

From a phenomenological perspective, the lived experience lies in the tacit dimension. The instant engagement of the body with its world involves the flow of

time, shifting of bodily space, and the subtle but intense sensuous interchange between the two (Jackson, 1996; Polanyi, 1966). The lived experience is, for the most part, unspoken and perhaps unspeakable. The residents *know* their caregivers share no interest with them when the PCWs talk back and forth over the residents during ADLs. Greetings from staff on other occasions make the same residents feel acknowledged and respected. What is being tacitly performed is tacitly experienced.

Implications for policy and practice

To develop and implement a knowledge-based care practice, the multiple sources of knowledge generation have to be recognised and acknowledged. Medical professionals and care staff hold overlapping but practically diverse bodies of knowledge and expertise but neither can provide the residents with satisfactory lived experiences without the knowledge, expertise and labour of the other.

Summary

There exists a tacit dimension of shared knowing, doing and experiencing in ADLs for both the residents and staff in RACFs. The tacit knowledge is generated and utilised in the ADLs and largely constitutes the knowledge-base for care. To effectively integrate the explicit medical knowledge into the knowledge-base for care, the codified and generalized knowledge has to have context-specific practical application and in a form that can be acquired tacitly as embodied skills.

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