The Role of Cultural Consciousness and Knowledge Development in Managing Multicultural Staff in Norwegian Nursing Homes

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Dedication

Dedicated to my lovely mother Alice Kokushubira, for laying a foundation for my education. I know, this achievement will make you smile as you continue to Rest with the Angels!

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Abstract

This PhD thesis draws attention to multicultural staffing leadership of multicultural staff in Norwegian nursing homes. Studies on the implication of multicultural staffing on leadership practices in nursing homes is scarce. The study is set within the thematic areas of care work, migration, and the welfare state. The overall aim is to explore the ways forms of leadership and staff work-practices in nursing homes are negotiated in relation to diversities in the workforce, focusing on cultural background and migrancy.

The thesis is an ethnographic study of everyday work practices as they unfold at the intersection of immigrant inclusion in care work, leadership practices and the organizational context of nursing homes. The thesis focuses on two main questions: (1) What are the tensions that characterize organization and everyday work practices of multicultural staff in nursing homes, and how do these tensions influence leadership practices and immigrant inclusion in work? (2) How do leaders organize and strategize to manage a multicultural staff?

Data collection was qualitative based on ethnographic methods: participant observation (during daily work at the nursing homes), semi-structured individual interviews, focus group interviews, and informal discussions and conversations, from eight wards of three nursing homes for four months. Data analysis draws on theoretical perspectives of agency, intersectionality and implicit leadership, while employing specific concepts of habitus, social stock of knowledge, and identity, to enable an in-depth analysis of the relevance of context, culture and communication in work practices and in order to understand such processes within the broader spheres of immigration/integration policy of the Norwegian welfare state.

The analysis brings out three key aspects: (1) Structural and contextual factors shaping agency and work practices in nursing homes; in which factors that mediate, enable or constrain immigrant inclusion in work and influencing work processes are presented and analysed. (2) Language competency, communication and the social stock of knowledge among nursing home staff; whereby situated communication and interaction processes are explored to establish factors that facilitate or inhibit inclusionary practices in work beyond competency in Norwegian language; and (3) Norwegianness and the organization of a multicultural workforce in nursing homes; whereby aspects of Norwegian culture and the taken for grantedness in organizing and providing care are examined to establish identity formation and negotiation processes among the immigrant staff, as well as the way these identities intersect to influence and contribute to immigrants unfavourable experiences at work.

Sammendrag

Denne PhD- avhandlingen retter oppmerksomheten mot flerkulturell stab og ledelse av flerkulturelt personale på norske sykehjem. Studier om implikasjoner av flerkulturell bemanning for ledelsespraksis på sykehjem erfå. Avhandlingens tematiske områder er omsorgsarbeid, migrasjon og velferdsstat. Det overordnede målet er å utforske hvordan ledelses-former og personalets arbeidspraksiser på sykehjem forhandles i forhold til mangfold i arbeidsstyrken, med fokus på kulturell bakgrunn og innvandring (migrancy).

Avhandlingen er en etnografisk studie av arbeidshverdagene, og hvordan disse formes av og utfolder seg i krysspunkter mellom innvandreres inkludering i omsorgsarbeid, ledelsespraksiser og sykehjemmenes organisatoriske kontekst. Oppgaven fokuserer på to hovedspørsmål: (1) Hvilke spenninger kjennetegner organisering og arbeidshverdag for flerkulturelle stab ved sykehjem, og hvordan påvirker disse spenningene ledelsespraksis og inkludering av innvandrere i arbeid? (2) Hvordan forholder ledernes strategier og praksiser seg til det å administrere et flerkulturelt personale?

Datainnsamlingen var kvalitativ og basert på etnografiske metoder: deltakende observasjon (i daglig arbeid ved sykehjemmene), semi-strukturerte individuelle intervjuer, fokusgruppeintervjuer, og uformelle diskusjoner og samtaler, fra åtte avdelinger på tre sykehjem i fire måneder. Dataanalysen trekker på teoretiske perspektiver om agens (agency), interseksjonalitet og implisitt ledelse, for å muliggjøre en grundig analyse av arbeidspraksiser og prosesser. Analysen bringer frem tre sentrale aspekter: (1) Strukturelle og kontekstuelle faktorer som former agens og arbeidspraksiser på sykehjem; hvor faktorer som formidler, muliggjør eller begrenser innvandreres inkludering i arbeid og som påvirker arbeidsprosesser blir presentert og analysert; (2) Språkkompetanse, kommunikasjon og sosial kunnskapsbestand blant sykehjems personell former arbeidspraksiser; hvor situerte kommunikasjons- og samhandlingsprosesser utforskes for å fastslå faktorer som fremmer eller hemmer inkluderende praksiser i arbeid utover det å inneha kompetanse i norsk språk; og (3) Norskhet (Norwegianness) og organisering av en flerkulturell arbeidsstyrke på sykehjem; hvor aspekter av norsk kultur og det som er ´tatt for gitt i organisering ´ omsorg blir undersøkt for å analysere identitetsdannelse og forhandlingsprosesser blant innvandrerpersonalet samt måten disse identitetene krysser og bidrar til immigranters ugunstige arbeidsopplevelser.

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Chapter 1: Migration, Care Work and The Welfare State

Introduction

This thesis is set within the thematic areas of care work, migration, and the welfare state, and the overall aim is to explore how leadership and staff work-practices in nursing homes[1] are negotiated in relation to diversities in the workforce, focusing on cultural background and migrancy[2]. More specifically, this study intends to identify, describe and analyse how, in what ways, when, and where multicultural staffing informs cooperation, inclusion and communication among staff in service delivery in the nursing homes context, and the role the leaders play in negotiating diversity in the workforce. I explore the extent to which the Norwegianness[3] aspect of the nursing homes accommodates or challenges the multinational staffing and leadership practices. The study contributes with new knowledge on the ways diversity in the care workforce articulates, and to contribute to the broader academic and public debate on diversity, work life inclusion and integration.

In Norway, nursing homes are a municipal responsibility, although a very small percentage of nursing home places are private or run by private agents (2017; Vabø, Christensen, Jacobsen, & Trætteberg, 2013). The percentage of private for-profit nursing homes has been dwindling, from 6.6% in 2015 to 5.2% in 2018 (Statistics Norway). The non-profit nursing homes, a third category (run by voluntary organizations), constitute about almost as high a percentage, close to 5%. The rest, around 90%, are run by municipalities. Thus, nursing home services are generally public, and people pay for nursing home services through the pension system (Jacobsen, 2015a:78). Due to the increase in the number of older people living with dementia, severe frailty and multi-morbidity in Norway, as is the case in other parts of Europe, it is projected that there will be an increase in demand for nursing home care services in the future. The situation has already started to manifest, and currently, Norwegian municipalities are facing

[1] In this thesis, the term 'nursing homes' refers to the institutional settings in the long-term care services, where residents live together, and are taken care of by the employed staff throughout the day, by provision of social and health care. It is different from what is known in Norway as home-based care and sheltered housing.

[2] Migrancy refers to the socially constructed subjectivity of 'migrant', which is inscribed on certain bodies by the larger society in general and legislative practices in particular, in addition to the state or condition of being a migrant (Louise Seeberg & Goździak, 2016; Näre, 2013b:605)

[3] 'Norwegianness', as used in this thesis, aims to reflect aspects of nursing home practices as they would be defined by a "Norwegian Norwegian from Norway", reflecting on cultural practices such as Norwegian customs, traditions and the cultural codes (Vassenden, 2010). These form the organization and provision of care in the nursing homes.

challenges in recruiting and retaining sufficient and competent staff (Gautun & Hermansen, 2011; Tingvold & Fagertun, 2020). In this regard, there is an increase in recruiting immigrants to cover staffing levels, making such workplaces increasingly multicultural (Aalandslid & Tronstad, 2010; Debesay & Tschudi-Madsen, 2018; Tingvold & Fagertun, 2020). This thesis, therefore, seeks to understand the way work-life reality is constructed as leaders and multicultural staff negotiate to meet the needs of the residents on a daily basis.

Set within the social sciences and collecting data through qualitative methods such as fieldwork with participant observation and interviews in three different nursing homes in Norway, this thesis presents the way leadership practices and minority inclusion in work is negotiated through the multiple and overlapping structural and local contexts of the nursing homes; the role of language competency and the social stock of knowledge in shaping communication patterns and processes; and the way care processes embedded in the majority culture relate to processes of social identity formation creating 'us' and 'them' among the majority and minority[4] staff, and extended to the residents and their relatives. As such, the study presents an interplay between culture, context, and communication and leadership of multiculturally staffed nursing homes.

Background and Statement of The Problem

Norway is increasingly becoming a multi-cultural society in terms of a large number of immigrants[5] residing in the country, and immigrants increasingly contribute to the workforce in the municipal health care sector, particularly in elderly care (Fagertun & Tingvold, 2018). According to Statistics Norway (SSB 2020) at the start of 2020 there were 979,254 (18.2%) immigrants, consisting of 790,497 who were born abroad and 188,757 who were born in Norway with parents born abroad. These two groups have a background in 221 different countries and independent regions. Migration patterns in Norway are either made by choice or forced (or a mixture of the two) (Godzimirski, 2005), people migrate to Norway either seeking for better opportunities or personal interests, or due to political instabilities in their home

[4] In this thesis, the majority-minority relationship bases on cultural differences, being religious, linguistic, ethnic, or the combination (Haug, 2000).

[5] In some cases, 'minority' might refer to immigrants, based on the differences in number, that is, if the immigrants are fewer than the ethnic population. However, sometimes the number of immigrants may supersede that of the ethnic populations, thus making them a minority in that particular context. In this thesis that was not the case, thus, minority staff will always mean immigrant staff throughout this thesis, and the two concepts may be used interchangeably.

countries. The status of immigrants ranges from being students, skilled workers, migrants and their descendants (family reunion), refugee and asylum seekers (McIntosh, 2015:312).

Coming from different parts of the world, immigrants to Norway have different starting conditions in forms of language, social networks, and living conditions. Some have the asylum-seeking background, a status that may cause post-traumatic experiences (Tamrat 2010). Others have migrated as workers as part of the EEA agreement, mostly from Eastern Europe, to seek for better working conditions as compared to the situation in their home countries (Isaksen 2012). The largest share of immigrants to Norway are from EU28/EEA countries, with 7.2%, followed by Asia, including Turkey (6.1%), Africa (2.6%), European countries outside EEA (1.6%), South and Central America (0.5%), and North America (0.2) of the total number of immigrants. Some immigrants in this study had an upper- or middle-class background in their country of origin, potentially experiencing downward social mobility in their new country (Norway) by, for example, not getting credit for higher education and/or working on relatively lower professional levels, which is deskilling[6]. However, this downward social mobility is context- dependent as observed by Christensen and Guldvik (2014), for example, it is stronger in the UK than in Norway.

The inclusion of immigrants in labour is one of the key political measures for integration in society (Friberg & Midtbøen, 2019), although the forms and intentions of inclusion and integration are still questionable, and thus challenging the use of the concept as both a policy tool and analytical concept (Rytter, 2019). In Norway today we observe emerging 'immigrant niches' in the lower tiers of several 'services fields' such as the hotel, fish processing industry and also in municipal health care (Orupabo and Nadim 2019; Tingvold & Fagertun 2020). This is partially explained by the current demographic situation facing Norway, whereby there is (and expected to become) a significant increase in the older population which affects the demands on the health care systems, and also leads to an increasing demand for long term care services. With a relatively slower increase in population amongst the working generation, and lack of interest among the native Norwegians to work in the elderly care sector, recruiting immigrants for long term care services is inevitable (Chłoń-Domińczak, Kotowska, Kurkiewicz, Abramowska-Kmon, & Stonawski, 2014; K. Christensen, 2012). At a more

[6] Deskilling in this context is defined as the undervaluing of immigrants' skills, education and experience, which results in various workplace disadvantages (Creese & Wiebe, 2012:58).

specific level, the increasing recruitment problems in nursing homes make it easier for immigrants to access this kind of work. One reason behind this trend is that work in the elder care sector, specifically nursing homes, has historically been regarded as a low status area, characterised by very hard work routines, and regarded as women's work (Munkejord & Tingvold, 2019; Seeberg, 2012). As such, the municipal care sector, which is responsible for providing long term elder care services, increasingly employs a substantial number of immigrants. Even though the immigrant inclusion in care work may help to address the problem of labour deficiency in nursing homes, less attention has been paid to its implication for nursing home leaders[7] who are managing such culturally diverse staff. While implications for leadership are important, even more important is to understand the broader change involved here regarding the working environment with multicultural staffing.

The process of immigrant workers' inclusion in nursing home staff is relatively new in Norway compared to trends in other countries, partially due to the historical reality that Norway has never colonized any country and that it did not possess significant economic attractions for the immigrants in general, as compared to other European countries (K. Christensen & Wærness, 2017). Consequently, the implication which immigrant staff may have on leadership is insufficiently researched -a knowledge gap to which this thesis contributes to fill. Kristiansen et al. (2016:2) conceptualize leadership in nursing homes as a process through which those in managerial positions inspire and engage others to participate so as to accomplish goals. As such, to what extent does the form of leadership inspire and engage staff across cultural differences? In the same way, what are the factors that promote or hinder immigrants' participation at the workplace or in the workforce?

The main objective of this study is operationalized into exploring the interaction between leaders, staff with a minority and majority background as well as service recipients in nursing homes in order to identify and analyze the ways this interaction influences immigrant inclusion and thus integration at the workplace. A part of this overall objective is also to identify

[7] In this thesis, the term 'leaders' refers to 'first line leaders', who have direct responsibility on the wards. There were either three or four wards at each nursing home department in this study. In some of the nursing homes in this study there are different levels of leaders: at the level of the institution as well as those at the level of the wards (who are mostly referred to as front-line leaders). However, in this study, the leaders were responsible for the wards under study, either three or four in each home, and there was no official lower-level leader. These leaders had no one above them to report to at the level of the nursing home. They had direct responsibility for the staff. In this manner, this thesis will identify a leader or manager as the same one person throughout.

leadership practices and workplace arrangements for including workers in work, as well as the leaders and employees' agency[8] with regards to a number of structures guiding their actions within their local contexts of practice. The main objective is addressed in the following two interwoven research questions.

RQ1: What are the tensions that characterize organization and everyday work practices of multicultural care workers in nursing homes and how do these tensions influence leadership practices and immigrant inclusion in work?

RQ2: How do leaders' strategies and practices relate to managing a multicultural staff?

As such, the study has the following specific objectives:

- To analyze factors which may facilitate or constrain leaders and immigrants in the inclusion process by identifying facility specific and contextual factors of the nursing homes as workplaces, such as the characteristics and functional ability of the residents, recruitment procedures and processes, as well as shift allocations among the staff (see chapter 4 and 5).
- To identify and examine how the intersection of ethnicity, class and gender influences the working environment and working relationship among leaders, minority and majority employees, as well as the employees' positionalities within the municipal nursing home work force and the employment hierarchy (see chapter 6).
- To identify attitudes, values, and expectations, that shape identities at work, in order to analyze how these factors influence the working relationship between leaders, majority and minority staff (see chapter 6); and
- To explore the channels, patterns and ways of communication and information flow at the NHs in order to identify and analyze language difficulties and implicit knowledge, which is taken for granted by the majority staff and influence work processes (see chapter 5).

[8] Agency in this thesis refers to the socio-culturally mediated capacity to act (Ahearn, 2001)

Rationale and impact of the study

This study contributes to the ongoing political, public and scientific debates on immigrant integration[9] through inclusion[10] in work by shedding light on the reality it creates (both positive, negative and mixed orientation) in a particular place and space, Norwegian nursing homes, and for particular people.

The study will also scrutinize the way the municipal elderly care sector strategizes to include immigrants as a labour resource in nursing home care provision, by highlighting related structural challenges and the standards and regulations these impose on the organization of care.

For the nursing home leaders and staff, this study reveals some of the taken for grantedness(es) that exists in the organization of care, which facilitates the construction of 'us' vs 'them' relations in the working environment. This study will hence bring forward new knowledge for creating more inclusive and harmonious NH working places. The study highlights the Norwegianness of organizing nursing home care, which to some extent functions to exclude the minority staff with limited knowledge about Norwegian cultural practices (see chapter 6). Moreover, the study reveals cultural contributions of the minority staff, which is not officially acknowledged in the care planning processes, such as language management apart from the Norwegian language (see chapter 5), and extra emotional care drawn from their home country experiences which can be resourceful (see chapter 6). The study also describes, discrimination facing minority staff members by the ethnic majority staff, residents and relatives to the residents, and analyse such actions as accent discrimination and identities contributing to axes of differences (skin colour, gender and ethnic background) (see chapter 5&6).

In addition, the study contributes to the research literature on leadership of multicultural staff, particularly in nursing homes in Norway, where there is lack of such relevant studies. While other studies, like Lindheim (2020), contribute to implicit ideas on leaders who are engaged in

[9] Integration refers to the process which "directs us toward what has to be done in order to make normally existing differences between individuals accepted as normal" (Emanuelsson, 1998:98). It is both a political tool and an analytical concept in research (Rytter, 2019), and it entails allowing immigrants to participate in the host country at the same level as natives (Hellgren, 2015).

[10] Inclusion refers to the achievement of a work environment in which all individuals have a sense of being part of the formal and informal processes of the organization system (Mor Barak, 2015:85). In this study, inclusion is explained in the structures and contexts guiding recruitment, organization, and provision of daily care, as well as social activities in the multicultural nursing homes.

care together with the staff they are managing, this study adds value to such implicit leadership ideas by discussing leadership practices of distant leadership do not engage in body care of the residents in the wards, hence this research compliments the picture.

State of The Art

The complex realities of leadership and multicultural staffing in the elderly care sector are not unique to Norway. Several studies have shown that the presence of immigrants in health care in general, and elderly care in particular, is increasing in most of the western societies (Dahle & Seeberg, 2013; Grignon, Owusu, & Sweetman, 2013; Kline, 2003; Stilwell et al., 2004; Tingvold & Fagertun, 2020; Yeates, 2004). In order to explore the trends on this work life reality, and the way it has shaped the nursing home care sector in Norway, it is important to dig into existing relevant research. Further, to arrive at the existing realities on multicultural staffing and leadership of multicultural staff in Norway, this section will start by tracing the migration of care workers from a global context, in Europe, down to the situation in the Nordics and Norway, relating to the integration politics of the welfare state[11].

Migrant care labour: an international overview

Migrant care work is not a phenomenon unique to Norway; rather, it constitutes a global reality, thus it can hardly be traced in exclusion of the global trend of movement across borders and boundaries. The global migration of care workers is, amongst other factors, a result of care deficits in the global north and socio-economic inequalities in various parts of the globe. It involves the migration of care workers from the less wealthy to the wealthier regions of the world, from the global south to the global north but also from poorer countries within one region to more wealthy countries (Hussein & Christensen, 2017; Hussein, Ismail, & Manthorpe, 2016; Misra, Woodring, & Merz, 2006). This phenomenon is often explained by the popular concept of 'global care chains', referring to a series of personal links and networks between people across the world based on care work, both paid and unpaid, and in formal and informal economies (Giles, Preston, & Romero, 2014; Lise Widding Isaksen, 2012; Isaksen, 2019; Yeates, 2004). Global care chains are conceptualised as a phenomenon whereby people from the global south, especially women, travel to look for caring career or job opportunities in the global north, while leaving other fellow women to do the care work for their own families from their countries of origin (Giles et al., 2014). The popular conception by Hochshild (2000) as

[11] https://www.regjeringen.no/en/dokumenter/meld.-st.-30-20152016/id2499847/

quoted by Yeates (2004:372) explains the way global care chains operate, especially through women who simultaneously "supply their own care labour while consuming other women's care labour, both paid and unpaid". The typical example is that one may find "an older daughter from a poor family who cares for her siblings while her mother works as a nanny caring for the children of a migrating nanny who, in turn, cares for the child of a family in a rich country" (ibid. pg. 373).

However, this one-sided perspective on migration has been challenged for ignoring other aspects of migration and care situations. Christensen (2017), for example, claims that migration research needs also to present the women as agents, rather than victims of global care trajectories. Additionally, the global care chains perspective need a broader understanding, to capture the realities on "pressure on social care due to demographic challenge of an ageing population in Europe, into care work, here for older and disabled people"(K. Christensen, 2017:642). As for example Christensen and Guldvik (2014:1-2) maintain, recent migration around the globe is triggered by diverse factors such as

> "…wars, violent conflicts, political or racial persecution, uneven development of living conditions as well as migration policies regulating access to different nations, and possibilities of obtaining citizenship in other countries. Included in this may also be people's desire to maintain a lifestyle not possible in one's homeland".

One vivid factor in the above quotation is that there are more reasons than one for immigrants to be part of the care sector in the global North. Sometimes, they end up there through forced migration, because of wars and/or political instability in their areas of origin. However, due to limited opportunities and other conditions in the labour market, some may willingly or unwillingly end up in the care sector in the global north, as for example for some of the minority staff in this study (see chapter 4).

Migrant recruitment in the care sector in Europe follows a specific trend from these global realities. It is projected that, in the year 2060, one third of the population across most European countries will consist of people older than 65 (Fujisawa & Colombo, 2009). Such projections on population ageing paired with the ratios of working to non-working people with care needs have resulted in important policy debates in many countries in Europe. Population ageing is related to the future shrink on the population entering the labour market (Fujisawa & Colombo, 2009). To be specific, countries will face a significant problem of recruiting sufficient of their own labour force, despite the fact that very few of the elderly population will need care until the last years of their lives (Cangiano, 2014; K. Christensen & Guldvik, 2014; Erel, 2012;

Tingvold & Fagertun, 2020). It is estimated that there will be a global shortage of health care workers amounting to around 14.5 million by 2030[12]. Christensen and Guldvik (ibid.) have commented that such realities are already evident, especially in Norway and UK, where they have conducted their studies. The long-term care sector has been considered unattractive among the working age local majority populations, facilitated by the perceived unfavourable employment conditions (Fujisawa & Colombo, 2009). One of the reasons is the lower wages for people employed in the long-term care sector, as compared to the average wage in the economy, although this level may often be relatively higher than in other low skilled professional sectors. In addition, care work has traditionally been associated with 'women's work', and as a result it has always been difficult to recruit and retain men in this job category (Calasanti & King, 2007; Fujisawa & Colombo, 2009; Hussein & Christensen, 2017; Robinson, 2006; Russell, 2007).

Although care labour deficit is common across Europe, the provision of care varies in relation to the labour market and welfare state regimes of different countries (Bettio, Simonazzi, & Villa, 2006). In response to labour deficits, many European countries have resorted to migrant caregivers. Between the years 1999 and 2009, for example, Cangiano (2014) maintains that, the recruitment of migrant labour force in the care sector has been relatively larger than their recruitment in other sectors in some selected countries in Europe. Due to their variations in economic and welfare status, the majority of immigrant recruitment is characterised by migration from eastern to western European countries, and from the global south to the north (Erel, 2012).

Narrowing down to the Nordic countries, the realities of the market-oriented form of global care chains are also evident in this region. According to Isaksen (2010), the ambition to recruit immigrant care workers is a single solution to a two-sided problem, one being a looming labour shortage alongside a growing deficit for care, and second, a need for cheap labour. Due to emphasis on gender- equality politics among the countries in the Nordic region, care work is no longer defined as a traditional "natural job for women" (pg. 11). Instead, it is now the responsibility of the welfare state, whereby women are actively taking part in formal employment. Due to women participating fully in formal employment, it has been difficult for them to balance work and care, thus opening the care services and domestic duties to the global

[12] https://commonslibrary.parliament.uk/social-policy/health/the-health-and-social-care-workforce-gap/

market. Moreover, since within the Nordic states welfare policies emphasize quality care as a social right, elderly care has been central (Dahl & Rasmussen, 2012; Eriksen & Dahl, 2005; Henriksson & Wrede, 2008, 2012), with an interest in balancing divergence between family formation and care responsibilities on one hand and the welfare state on the other hand; and furthermore, to strike a balance between demographic changes and market outcomes (K. Christensen, 2012; Vabø, 2005). As such, the potential of immigrant care workers in relationship to the efforts of the welfare state policies to meet current and future long-term care needs is the evident focus of research in the Nordic region.

The Norwegian welfare state, diversity, and immigrant integration politics

It is important at this point to have a specific focus on Norway, being the country of interest in this study, having charted the care work of immigrants from the international trends. Historically, the immigration political agenda began in Norway in the 1970s, due to the arrival of labour immigrants from countries such as Pakistan, Turkey and Morocco (Bratsberg, Raaum, & Røed, 2014). Due to concerns, which emerged in regard to the experience of social problems and subsequent threat to existing workers of a cheap and vulnerable labour force impacting on work and wage conditions, the country introduced immigration restrictions in 1974/75. However, due to wars, particularly in the targeted third world countries, immigration from these areas continued in the form of refugees and family reunification.

Generally, the reasons for migrating to Norway varies. These range from individual factors such as family reunification (39%), employment (33%), being a refugee (22%), and studying (6%) (SSB 2018); see also (Debesay & Tschudi-Madsen, 2018; Hagelund, 2002). In addition, there has been a gradual increase of immigrants from other parts of the world than those mentioned above, making the country's population more heterogeneous. As such, in the course of the past four decades, Norway has changed from being a relatively homogeneous into a heterogeneous, multi-ethnic society, with citizens from 221 different countries (Debesay & Tschudi-Madsen, 2018). Until 2011, immigrants constituted 11 percent of the total workforce in Norway care sector, with larger numbers in big cities (Christensen, 2017; Ramm, 2013). As of the year 2017, immigrants in the long-term care services increased to 17 percent of the total 142,000 persons years (FTE's), and women accounts to 85% of the workforce (SSB, 2018[13]) (Fagertun &

[13] https://www.ssb.no/helse/artikler-og-publikasjoner/innvandrerne-sto-for-1-av-6-arsverk-innen-omsorg

Tingvold, 2018; Tingvold & Fagertun, 2020). Therefore, Norway is becoming an employer of global care workers (Erel, 2012), and immigrants are contributing to its cultural diversity (Brochmann & Hagelund, 2012).

The ambition to restrict immigrant entry into Norway led to significant challenges in relation to healthcare staffing, especially when the country faced labour crises like many other European countries. Due to this reason, the country slowly considered opening the doors again for the immigrants, although with a specific strategy. After 2004, Norway implemented migration policies, which opened the doors for immigrants from EU and EEU countries, while simultaneously restricting those from outside that region. Concurrent with this, the EU got new member states and, therefore, EU citizens could move to other EU countries without restrictions (Christensen, 2017). In a sense, immigration policy lies in two broad categories, namely external and internal. The external category is about access, that is, who is allowed into the country. The second category is about rights and duties, which concerns the conditions which are offered to those who get access (Brochmann and Hagelund 2012:13). Implicitly, this category highlights that integration starts first within the country, after access, through a number of planned activities. At present, most of the migrant population in Norway are from European countries, comprising about fifty percent. The rest come from Asia, Africa and the Middle East. The largest number of immigrants in Norway come from Poland, followed by Lithuania, Sweden, Somalia, Turkey, Iraq, and Eritrea, (SSB 2018). It is estimated that in the next forty years, the population of immigrants in Norway will increase from 13.4%, to somewhere between 19 and 21% (Krohne, Døble, Johannessen, & Thorsen, 2019).

Although this thesis does not intend to evaluate policy implementation in actual nursing home practice, it is important to have a reflection on politics through which immigrant integration[14] can be traced from the system level, down to the way it may inform immigrant inclusion strategies and realities in the daily working practice. I would therefore like to start this discussion by referring to a quote by the Norwegian minister of Trade, Industry and Fisheries, Torbjørn Røe Isaksen (at the time of an article) by Krohne et al., (2019:10), that, "There is a pressing need to do something about integration, which seems to function miserably in many places". Not explaining in detail, Krohne et al., (2019) highlight the fact that immigrant inclusion in work is a challenge. However, although such a '*myth'* might carry some degree of truth, I argue that instead of taking this myth for granted, several questions may help to open

[14] 'immigrant integration' relates to the process of including immigrants in several important domains of society (Tronstad, Nygaard, & Bask, 2018).

its relevance to various contexts of integration processes. For example, why is integration miserable? Where? In what ways? Under what circumstances? To whom?

As Rugkåsa (2012:19) maintains, integration is a complex concept, and Rytter (2019) emphasises further that the concept is both used as a policy tool and an analytical concept in research. According to Norwegian public policy (St. meld nr. 17 (1996-97); St. meld. nr. 49 (2003-2004); St. meld. nr. 6. (2012-2013); St. meld. 30 (2015-2016), integration is referred to as both a goal and a process, to be implemented by a number of authorities, through policy formulation. Differentiated from the concept of inclusion, integration has a main focus on system reforms, while inclusion focuses on the processes through which individual differences (i.e. diversity) may be accommodated in the integration processes (Vislie, 2003), see also Rytter (2019).

Ethnic minority groups are one of the focuses of the integration politics of the welfare state. One of the basic strategies for achieving integration is the 'Introductory scheme for newly arrived immigrants, and language and social education' (Vislie, 2003:43), and the law on introduction for new citizens in 2003 (Rugkåsa, 2012). However, the extent to which such strategies may cater for the diverse needs and backgrounds of all the immigrants still brings interest. However, Rytter (2019:680) cautions that integration is an "exceptionally unclear" concept, since it holds a myriad of meanings and is used differently by different people in different situations. As such, when writing about the concept, it is important to be specific with the exact meaning we refer to in relation to the people we are studying. In this study, integration is both understood as being a policy tool that describes political ideas of how new residents in the country should be included in society, and I use it as an analytical concept to describe the structural and contextual factors that are guiding immigrant inclusion in work.

As a political tool Integration and inclusion strategies, need to consider cultural differences (heterogeneity) among the intended groups of people, since immigrants have quite different starting points and trajectories before they land in Norway as their country of residence. As Rugkåsa (2012) points out, despite the fact that Norway for a long time has been a multicultural society, there is hardly any policy focusing on multiculturalism at hand, although political ideologies such as respect for cultural differences may acknowledge diversity. However, multiculturalism emphasizes acknowledgement and creating room for supporting the existence of various distinctive cultural or ethnic groups within a society. Multiculturalism responds to heterogeneity which seeks to communicate the social conditions under which differences can

be contained and order achieved from diversity (Hartmann & Gerteis, 2005). More attention is directed towards equality ideals than multiculturalism ideals in Norwegian policy, whereby ethnic minority people are using the same schemes in the welfare state as the ethnic majority populations. Integration policy and debates in Norway may be generalized as focusing more on containing diversity rather than cherishing it as seen from the assimilation politics of the 1973-74 to the more recent political ambitions of demanding immigrants to go through language training as an entry to integration in the Norwegian community and labour market (Hagelund 2002, Rugkåsa 2012, Borevi, Jensen et al. 2017). This strategy, furthermore, does not offer any room for special religious or cultural rights of those immigrants, as they may threaten to break what the welfare state protects as 'the ideal of equality and solidarity' (Rugkåsa, 2012).

Setting grounds for discussion in this section, I appreciate the work by Hagelund (2002) which describes the process of integration politics in Norway, with culture at the centre of discussion. Her point of departure is the poor definition and hence application of integration as a concept. Hagelund (2002) points out, for example, the dilemmas between rights and duties, posed by the tension between immigrants' freedom to preserve their culture, while provided with one option of learning about language and culture as a way of being able to settle in their new land, and participate in job opportunities and social life. Although immigrants are given the freedom to practice their religion and cultural traditions, they are at the same time also warned about the danger of abstaining completely from partaking in the Norwegian civilization and culture. They have the obligation to participate in the education system, working life and housing (Hagelund, 2002), see also (St. Meld. No. 39, 1987-1988, p. 49). Hagelund (2002) points out that ideas, models and practices of integration in Norway mostly have followed assimilation. Assimilation refers to an emphasis on "immigrants' unilateral responsibility to adapt to Norwegian ways and values", while integration refers to "the compromise between equality and diversity" (pg. 403), where "cultural diversity must be accommodated and celebrated" (pg.405), it is neither assimilation, nor segregation. A concept of 'nodal point' is applied as one way to understand integration, which combines together "a long string of ideas, problems, concerns, purposes, measures and so forth into the field of integration politics" (2002:406). Hagelund (ibid.) exemplifies assimilation tendencies in the immigrant integration in the western societies, by perceiving well integrated women as those who are outspoken women without veils and with good careers, some of the attributes of which are typically western-oriented. In this line of thinking, I further argue that today, language is the element most emphasised by the authorities in policy, by employers and by the civil society concerning successful integration of

immigrants. Moreover, this affects the care workers' reception and functioning at the workplaces in the municipal nursing homes. Looking at the points of views presented by Hagelund and Rugkåsa above, I find that they hold a resemblance in the way they challenge one-sided aspect of integration politics in Norway, whereby it is the immigrants who are compelled to adopt to the Norwegian ways of socialization than the other way round.

Political matters concerning immigration have undergone a significant change during the 1990s, from the former polarization of stance as being for or against immigration, to seeing both opportunities and challenges surrounding this reality. As such, immigrant integration paved its way in the political debates, acknowledging the heterogeneous Norwegian society and thus cultivating the ways diversity can be fruitfully enhanced. In a sense, the recent integration politics in Norway focus much on the ideal development and functioning of a multicultural society (Borevi, Jensen, & Mouritsen, 2017; Breidahl, 2017; Hagelund, 2002; Modood, 2017) see also (Meld. St. 30 (2015–2016)[15] . However, the extent to which such political strategies have been realistic in terms of the practice contexts, such as the nursing homes' working environment in this study is important to explore. Paying closer attention to the integration policies in Norway, one may argue that much focus has been directed towards social equality and harmony. As such, egalitarian, and inclusive, welfare-state thinking have been the overall aim, and hence have attracted a consensus for both the left and right political stances (Vike, 2017). In this manner, integration politics are directly linked to the politics of the Norwegian welfare state, rather than only being matters of cultural diversity. Consequently, such processes have neglected individual qualities, by treating all immigrants as a homogeneous group, with standardised integration measures (Borevi et al., 2017; Hagelund, 2002; Modood, 2017).

The municipalities as Long-Term-Care (LTC) providers

The concern for good and relevant services in the long-term care services has for long been public and political agenda in Norway. Policy has since the 1990s been fuelled by new public management ideologies (NPM), although such ideologies paved their way into the public sector in Norway in the 1980s (Dahle & Seeberg, 2013; Jacobsen & Mekki, 2012). Norway is a welfare state, and the primary responsibility for elderly care/ long-term care is decentralised under the municipalities (Christensen & Wærness, 2017). These provide services several ways, ranging from home help which covers domestic tasks and/or home nursing, institutional care in terms

[15] https://www.regjeringen.no/no/dokumenter/meld.-st.-30-20152016/id2499847/

of nursing homes, and sheltered housing. Recently included services are meals on wheels and safety alarms (Christensen & Wærness, 2017:15).

The overall ambition of the welfare state is that every citizen should have equal access to services of equal quality (Fagertun & Tingvold, 2018; Vike, 2017). In reforms of care services and welfare services in general over the past ten-fifteen years, the political ambition has been de-institutionalization (i.e. getting less nursing home services), active ageing, personal-centred and co-created services and user involvement (Askheim, 2016, 2017; Fagertun, 2017b; Jacobsen, 2017; Slagsvold et al., 2012). These ambitions have, amongst others, resulted in municipal development of home-based assistance and limited expansion of institutional care (Christensen & Wærness, 2017). Although home-based care for the elderly population is currently more emphasized, care at the institutions (nursing homes) remains important for the oldest sick throughout the country, being the last home for most of the population, whereby around 40 percent of the Norwegian population die there (Christensen & Wærness, 2017; Jacobsen & Mekki, 2012). With the emphasis of staying home as long as possible, nursing homes are therefore gradually turning into places for the very sick older adults, who cannot otherwise manage on their own at home. Moreover, time spent in hospitals is reduced, implying that more people are sent home earlier, while earlier they could stay longer in hospitals (Ågotnes, 2016). This puts pressure not only on home-based services, but also on nursing homes. In this regard, nursing homes function as part of the care system for the elderly in need of support in daily living. Such trends, I argue, could partially explain the tendency of medicalization in nursing homes functioning as mini hospital departments, hence also the professionalization of the services (see chapter 4). The general projection across Europe is that, although there will be an increase in healthy life expectancy, with a delay in ageing effects, there will also be an increase of elderly people with multi-morbidity, due to effects of diseases like cancer, fractured hips, strokes and dementia (Hervie, 2019; Rechel et al., 2013).

It is a right for all people to receive care in their home community, despite the country's low population and subsequently low population density, based on the geographic characteristics ((Jacobsen, 2015b; Jacobsen & Mekki, 2012), see also Norwegian Health Directorate 2012). However, this care is need-based, that is, care is provided according to individual health needs of the person, contrary to means-tested, as it is in many other countries, including the UK (Ågotnes, 2016; Christensen, 2012; Christensen & Pilling, 2014; Hervie, 2019). As such, for example, although nursing homes are mainly specifically for the elderly sick people (mostly above 67 years of age), this study has found some variations, whereby some residents were as

young as mid-forties, but still admitted due to illness. This may seem a small group of residents; however, it can clearly change the group of residents in a ward in terms of social needs and interactions, as well as the way daily care is organized (see Chapter 4).

By not being means-tested, it means that the care service is delivered independently of gender, resources, etc., That is to say, people are entitled to receive care services regardless of their ability to pay for them. However, due to the municipalities being responsible for the services, there can still be differences in care service provision between municipalities (Ågotnes, 2016). The municipalities in Norway vary greatly in size, with populations ranging from 214 to 500,000 inhabitants, although this picture is now slowly changing due to the municipal reform implying a clustering of small municipals into larger units. Nevertheless, depending on its size, at the very least each municipal has one nursing home, which may further be categorized as being relatively small, medium or large (Jacobsen 2015, Ågotnes 2016). The nursing home sector has specific characteristics, for example, 80% of residents have dementia, a female dominated workforce (85%), a low social regard for the work, high turnover, sick leave and much part time work (Christensen & Guldvik, 2014; Tingvold & Fagertun, 2020). Residents at nursing homes receive medical and rehabilitation care, as well as social care. This issue, of nursing home as being both a medical institution and a home for the residents, has created a lot of contradictions and various researchers have drawn attention to the asymmetrical relationship between being private homes and public places in terms of being a workplace. Being a public space, a nursing homes is bureaucratically organized, with policies and guidelines which frame their existence and functioning. The municipalities are responsible for paying for the running costs as well as staffing procedures. The funding of the nursing homes comes from the federal government which provides a block grant, part of which is calculated based on taxes paid within the respective municipalities. These municipalities have relative independence with regard to the amount they choose to spend on elderly care. As such, nursing homes receive a fixed amount of revenue from the municipalities, depending on number of beds at the institution. This amount remains the same, regardless of ownership, size and location of the nursing home (Ågotnes, 2016; Ramm, 2013).

On the other hand, being private spaces as resident homes, the residents, after being admitted can own and decorate their private rooms with their personal belongings. However, the field study of residents in nursing homes´ living rooms by Hauge and Kristin (2008) established that, despite the fact that residents have private single rooms and more home-like interior decoration, the living rooms are still characterised with ambiguous boundaries between the private and

public spheres. This is contrary to the clarity which is common in a home. In addition, apart from being old and having situations which force them to live under the same roof, residents do not necessarily share any personal relationships or friendship among each other. Other studies elsewhere have also argued against the issue of public versus private place and space in the nursing homes, such as in the Netherlands (De Veer & Kerkstra, 2001) and in the UK (Higgs, MacDonald, Macdonald, & Ward, 1998).

Recruitment of work migrants and immigrants to long term care work

Dahle and Seeberg (2013) study on the ethnic dimension of employment hierarchy in Norwegian health care work draw attention to the existence of '*Norwegianness'* as an informal competency in the healthcare (nursing homes and hospitals) workplaces, dictating the immigrants' journey to excel to a higher hierarchy in the professional ladder. As such, most immigrants face what they (ibid.) calls 'the concrete ceiling of race' due to their failure to align themselves to the 'Norwegianness', while few others manage to find jobs up to the professional ladder after being able to assimilate to the pre-existing 'Norwegianness' schemas. Dahle and Seeberg (ibid.) claim that recruiting immigrants into the health care sector, has been a public policy, whereby there has been national policies[16] aiming at recruiting and qualifying 'unskilled' immigrant workers, with the expectation that they will gradually qualify as auxiliary nurses. However, although this may have functioned previously, the challenging process of excelling in the professional ladder and qualify in the Norwegian system puts this ambition to be unrealistic for many of the employees with immigrant background, leaving most of them confined at the lowest level of the professional pyramid (see also Orupabo et al (2019; Friberg et al (2019; Tingvold & Fagertun (2020). It is important also to mention that the perception of staff with immigrant backgrounds as *'unskilled'* refers to those skills, which have not been able to convert relative to a broader labour market, because in a sense, most of the first-generation immigrants come with a certain professional background from their home countries, which are either been evaluated as irrelevant or lower level for professional practice (*c.f. the concept of deskilling*).

Complimenting to the above exploration of professional hierarchy in the long-term care sector, a study by Hervie (2019) offers an insight on the situation of unskilled immigrant healthcare

[16] SHD 2006, Rapport nr 3. Rekrutteringsplan for helse- og sosialpersonell 2003-2006: rekruttering for bedre kvalitet [Recruitment plan for health and social workers 2003-2006: recruitment for improved quality], Sosial- og helsedirektoratet [Directorate of Health and Social Affairs], Oslo.

assistants in the elderly care sector/LTC in Norway and skill evaluation. In her PhD thesis based on an ethnographic study in Oslo, she explored the experiences, roles and challenges of this cluster of workers in the context of institutional and home care settings. Her study was however not for comparing the group of workers in institutions and home settings. She analysed the practices of these workers in the intersection of two policy fields, namely, the field of healthcare focusing on needs for the elderly people, and the field of migration (integration) focussing on including immigrants into the labour market. Hervie argues that the two fields were not working in harmony to the best for immigrant workers. Hervie (2019) maintains that unskilled immigrant assistants are part of an established working environment which is bureaucratically regulated, and they must find their place in the hierarchy, a place that seems not to be recognized in the care workforce hierarchy. This aspect of being ´invisible´, according to Hervie, is a paradox because they constitute an increasing share of staffing at nursing homes and in home care. Moreover, being ´invisible´ creates an implication for their working conditions.

Nursing homes, multicultural staffing and the role of leadership

Leadership of multicultural staff in the era of globalization has been a research concern in different disciplines, such as health, business, management and education (Connerley & Pedersen, 2005; Rittle, 2015; Webb, Darling, & Alvey, 2014). Working with employees from a variety of cultural backgrounds creates a demand for leaders (and other staff) to understand differing cultural perspectives which originate from different factors, such as geographic origin, migratory status, language and dialect, religious faith, traditions, values, and symbols, and so forth (Rittle, 2015:532).

By law, it is a requirement for all nursing homes in Norway to have one unit manager. The unit manager must be a registered nurse who is responsible for ensuring/overseeing patient (residents) care. Unit managers supervise the staff - nurses, assistant nurses, healthcare workers and assistants (unskilled staff) working in the wards, while taking responsibility for medical and economic issues for the whole unit (Kristiansen, 2016). Being registered nurses, leaders of nursing homes hold a three-year bachelor's degree in nursing education. There are several structural changes in long term care for older adults, which simultaneously raise new challenges and demands for all kinds of health personnel, particularly a sharpened focus on competency management (Dahle & Seeberg, 2013). However, none of the current reforms, such as the

quality reform for elderly care "Leve Hele Livet"[17] (Live throughout Life, Meld.st. 2017 – 2018) and *Omsorg 2020*[18], have reflected on the issue of ethnic composition of staff, or management of such increasing diversities.

The present situation of recruiting immigrants and the implication it bears in the elder care sector, has only drawn attention to a few researchers in Norway (Boge, 2020; Christensen, 2017; Christensen & Guldvik, 2014; Debesay & Tschudi-Madsen, 2018; Fagertun & Tingvold, 2018; Hervie, 2019; Munkejord, 2019; Munkejord & Tingvold, 2019). Very few have adressed the issue of leadership of multicutltural staff in care (Kristiansen, 2016; Lindheim, 2020; Munkejord, 2019).

Munkejord (2019) has partially paid attention to the role of leadership in enhancing immigrant work inclusion in the nursing homes. She describes the way healthcare managers can challenge what she terms as '*the existing ethnic pyramid*' in multicultural staffed nursing homes, by paying attention to and implementing diversity-sensitive leadership which has proven to improve care services and working environments. Munkejord emphasizes that diversity management is an important leadership skill, which may lead to higher levels of satisfaction and trust among the staff, if the management encourage and arrange for dialogue and connection. She further maintains that "diversity management is an important tool for counteracting ethnically based workplace discrimination and deskilling…" (Munkejord 2019:2). Diversity management encompasses the main idea of perceiving and using 'multiculturality' among the staff as a resource in service delivery and in creating inclusive working environments. However, as other researchers, she argues that there are very few studies focusing on diversity management in the healthcare sector in Norway.

Munkejord (2019:4-5) identified and thus suggested the 'golden rules in diversity management' as; taking responsibility for the quality of care in the unit, engaging in all aspects of care work within the scope of practice and collaborating and helping each other in daily tasks. These rules were identified together with measures set by the nursing homes in order to meet them, although they were not written rules at the nursing home. Although these rules are well argued for as relevant working for this particular nursing home, I hold that Munkejord's study only focused on what would make things work to accomplish the daily tasks and routines among the staff,

[17] https://www.regjeringen.no/no/tema/helse-og-omsorg/innsikt/leve-hele-livet/id2547684/

[18] https://www.regjeringen.no/contentassets/af2a24858c8340edaf78a77e2fbe9cb7/omsorg_2020.pdf

while ignoring the structural, contextual and environmental factors that may also inform such arrangements. In addition, these rules were identified by the staff, but suggested to work for the leaders, who do not appear in the complete list of respondents in the study. How then can we be sure that such rules would work for the leaders and improve leadership practices, and what is their role in enhancing such rules? I also think that observational studies would supplement the arguments in Munkejord's findings, by paying attention to what was actually taking place in the course of the working day in order to have a more comprehensive understanding of the situation.

A study by Lindheim (2020) offers another important understanding on leadership of multicultural staff. In her study conducted in three nursing homes in Oslo, Norway, she was inquiring into the implicit ideas of good and bad leadership as part of the factors shaping relationships between managers and employees. She explored implicit ideas of good and bad leadership through "contextual factors at the institutional and organisational levels, along with experiences of leadership from the country of origin and Norway" (ibid. page 108-109). These implicit ideas of leadership were then used to analyse the way leadership is negotiated in everyday interaction across cultures. Such an approach to studying leadership is relevant to this study, although this study goes further in exploring other factors that shape leadership practices of multicultural staff in nursing homes. Implicit leadership ideas may inform this study by presenting a form of context within which leaders' agency may be understood (see chapter 2, 4 and 6).

Another recent contribution on migrant recruitment in the elderly care and the way it relates to leadership was explicitly made by Olakivi (2019). Although the study reflects the situation in Finland, it can be used comparatively to understand the trend in Norway, as it is part of the Nordic region, and hence shares some realities, particularly on migrant care workers. Olakivi highlights the fact that care work managers (whom I equate to nursing home leaders) play a big role in the process of immigrant recruitment in elderly care. The main contribution of Olakivi is that leaders, as representatives of employers, recruit immigrant staff depending on the way care recipients, migrant workers and their broader political environment are constructed and interpreted. In doing this, they may reproduce the trends of recruiting migrants to the precarious jobs on the lowest ladder of the organization hierarchy of old-age care institutions.

In describing situation of immigrant recruitment, among other examples, Olakivi highlights the following two analytical statements from interviews with leaders. First, recruiting immigrants is inevitable, because it is difficult to find people, meaning ethnic majority staff. Secondly, it is

a good thing to recruit immigrants because they serve older clients and their families, as they take good care of the residents. In the first example, Olakivi refers to globalization of care (global care chain) and the economic inequalities shaping immigrant recruitment in the care labour market (as discussed earlier in this chapter), as the political reality shaping care work in western communities. That is to say, immigrants are recruited as a second solution to solving recruitment problems. In the second example, the author highlights the stereotype the leader holds towards immigrant staff, which may influence the leaders' preferences in recruitment processes (Olakivi, 2019:8).

Olakivi (2019) and Munkejord (2019) research is useful to this thesis with regard to leadership of multicultural staff. Firstly, they both acknowledge the agency of leaders in the organization and provision of care for older people. While Munkejord does not explicitly discuss the role leaders may play in enhancing inclusive work arrangements (based on her methodological stance), Olakivi on the other hand, highlights some important structural factors contributing to shaping agency of leaders in recruiting and including migrant workers. As such, Munkejord's work is relevant to this study in analysing agency of the multicultural staff in organizing and providing care, but also to including other structural realities informing agency as well as focusing explicitly on leadership daily practices through employing ethnographic methods (see chapter 3). Olakivi's work highlights the importance of understanding facility specific and organizational factors shaping agency of leaders in recruiting migrant workers. Going further, this thesis analyses recruitment processes, but also the organization of daily work as a continuous process which plays a part in shaping and re-shaping ideals of leadership practices, including recruitment processes. This aspect is important with a reflection that agency of leaders can never be defined once and for all, especially in caring processes where people, things, policies and environment keep on changing.

The era of neoliberalism and New Public Management

Generally, the research on 'globalization of care work' has focused much on the international distribution and redistribution of care, with pushing factors forcing immigrants to seek care work in wealthier countries. However, neoliberal economic restructuring and migration policies of the global North have also contributed to a reshaping of the redistribution and internationalization of care work (Misra et al., 2006). Misra et al. (2006:318) refer to neoliberalism as "the predominant economic strategy employed worldwide and assumes that economic growth is strongest when the market is not constrained by state protections." In their

analysis on the role of neoliberal economic restructuring and migration policy on globalization of care work, they argue that lowering state costs for care and withdrawing from social care provision of the states has consequently intensified the care work requirements, particularly for women. This shifting of responsibility of care from the state to the family, has affected poorer women, who have to migrate and work as carers in order to support their families, while wealthier families hire these poor immigrant women to cater for their care needs. In this manner, neoliberal strategies have placed the burden of care on the migrant women workers, who are considered the least powerful, and are thus more disempowered. However, I argue, although migrant women dominate in the care labour force mostly in the global north, there are also a trend of migrant men from poorer countries working in the care sector, as observed in this study (see chapter 6). This trend is also observed for another female dominated service sector in Norway, the cleaning industry (Orupabo & Nadim, 2019).

Furthermore, welfare state restructuring and structural adjustment have shaped the pull and push for care (Misra et al., 2006). In restructuring the welfare state in Europe, neoliberal strategies have emphasized market-based solutions and ideals leading to a significant reduction of social and care expenditure by the states, while opting for privatization and marketization of care provision. This implies that the change of trend from government providing services and care has encouraged the development of private care service sectors with low wages, especially in, for example, Finland and the UK (K. Christensen & Pilling, 2014; Kröger, Puthenparambil, & Aerschot, 2019). Combined with states' withdrawal from worker protections through de-regulation, it is no longer possible for families of the middle and working classes to depend on a single income, whereby women from such families have to join the labour force, looking for jobs to subsidise for family income (Misra et al., 2006). This situation has created demand for immigrant women to work as carers in replacement of working women. The impacts of neoliberal strategies may be also related to austerity, the policies that were launched after the financial crisis in Europe in 2007/2008, as a result of which the public sector has decreased and the welfare services have almost disappeared in some countries, e.g. UK, although the impacts in the elder care sector in Norway are not as intense as in other countries in Europe (Edmiston, Patrick, & Garthwaite, 2017; Fagertun, 2017). In addition, the trends can also be linked with precarious labour, where people work but do not earn enough to make a decent living (Orupabo & Nadim, 2019; Tingvold & Fagertun, 2020).

On the other hand, neoliberal ideologies have created push-to-care in terms of structural adjustment policies, through the international lending agencies (e.g., IMF and World Bank).

These have imposed readjustment politics in developing countries, by reducing government expenditure, encouraging privatization of government enterprises, liberalization of markets, enhancing the rights of foreign investors, and so forth (Misra et al., 2006). Contrary to improving economy as preached by neoliberalism, such policies have resulted in higher levels of income inequalities among people, forcing many to migrate in search of better opportunities in other countries (ibid.). At national levels, these adjustments have resulted in high levels of unemployment and very heavy burdens of government debits, which have subsequently caused further reductions in health and social care services. In turn, these reductions have added to the burden of caregiving responsibility, forcing people to migrate and work in the care sector elsewhere, so that they are able to support their families through remittances (Misra et al., 2006).

Neoliberal reforms paved the way across Western countries as a mode to combat the financial crisis faced in those countries, which have then resulted in adoption of a new form of management, famous as New Public Management (NPM). NPM emerged as an extension of neoliberal politics/governance which were mainly aiming at reducing the costs related to public spending, while challenging what was traditionally known as 'Public Management' (Gottert et al., 2018). The assumption was that the public sector was inefficient and too large, hence NPM focused on reducing public sector size and budgets and use inspiration from private sector management (Alonso, Clifton, & Díaz-Fuentes, 2015; Christensen & Lægreid, 2001; Osborne, 2006; van Riemsdijk, 2010a). NPM reforms are greatly inspired by market principles of "competition, efficiency, and customer satisfaction" (Torfing & Triantafillou, 2013:10), with the attempt to impose those principles into the public services (Alonso et al., 2015). The main features of NPM, are "hands-on professional management that allows for active, visible, discretionary control of an organization by persons who are free to manage, explicit standards of performance, greater emphasis on output control, increased competition, contracts, devolution, disaggregation of units, and private sector management techniques" (Christensen and Lægreid 2001:78). The variety of reforms inspired by NPM have been employed in different countries, at a varied level; and hence have created a varied number of consequences to individual countries and institutions (ibid).

Within the care sector, in particular, Norway bears distinctive characteristics when compared with other European and OECD countries, for example, in the extent and ways private and for-profit care provision has been adopted. Christensen and Pilling (2014) found that although both Norway and England embraced the cash-for-care funding schemes allocated to long term care

recipients, Norway has maintained a lower diversity in the care provider market, while the opposite has been the case in England. Furthermore, Norway has adopted neoliberal and hence NPM strategies slowly and cautiously resulting in a slower implementation of market reforms and subsequently a distinct, modified form of marketisation techniques and deregulation. Until recent, the Norwegian government has maintained the key role in providing and distributing healthcare services through public funding (Christensen & Lægreid, 2001; van Riemsdijk, 2010a). In addition, New Public Governance (NPG) has also come into place, supplementing NPM reforms, but with a specific emphasis on public-private collaboration between different levels, sectors and actors. The ambition is to empower and engage stakeholders in solving public problems and service production (Osborne, Radnor, & Strokosch, 2016; Torfing & Triantafillou, 2013). As such, new trends of New Public Governance reforms has introduced more involvement of public service users in planning and delivering effective public services, through co-production and co-creation ideologies (Osborne et al., 2016). In Norway, such trends are evident in the Coordination reform (*samhandlingsreformen* – St. Meld. Nr. 47 (2008-2009)[19]) creating a closer relationship between services in hospitals and services in the municipalities (locally), while in the elder care the trends may be traced through increased involvement and cooperation through resources mobilization in interaction between public services and users, families, networks and communities (Askheim, 2016), for example the volunteering organizations participating in nursing home care sector.

The aim of NPM to professionalize management has led to a shift in management from a professional hierarchy to a position in a managerial hierarchy (Rasmussen, 2012). Specifically focusing on nursing home leaders, who Rasmussen (ibid.) terms as unit leaders, NPM reforms have been entrusted leaders to have freedom in making necessary decisions in order to achieve their objectives. However, these leaders have to work within the conditions of their job, which require them to operate within a predetermined budget, while delivering good and quality care services. Thus, NPM constitutes an important structural and local contextual dimension for understanding the leaders´ space for action, hence their agency. As for this study, NPM shapes the context in which leadership is articulated and will therefore be analysed in this framework with regard to immigrant inclusion at work (see chapter 4).

19 https://www.regjeringen.no/contentassets/d4f0e16ad32e4bbd8d8ab5c21445a5dc/no/pdfs/stm200820090047000dddpdfs.pdf

Thesis Chapter overview

This thesis is organized in seven chapters. Chapter one laid the foundation with a brief introduction, statement of the problem and the main and specific objectives guiding the study. This was then followed by a discussion of previous studies relevant to my topic.

In chapter two I discuss central theoretical perspectives that shape the study, both methodologically and analytically. These perspectives are important for the analysis of leadership practices and multicultural work organizations and processes.

In chapter three I present my methodological choices, backed up with my ontological and epistemological stances in approaching the field. Through this starting point, I trace the process through which I managed to choose relevant research methods and gained access to the field for data collection.

The next three chapters are analytical chapters of this thesis. In chapter four, I present and analyse contextual and structural factors guiding leadership practices and immigrant inclusion in work. The main argument of this chapter is that leadership practices and work processes simultaneously shape and are shaped by the structures and contextual factors within which nursing home care is organized and provided. Through the use of the concept of agency as a theoretical tool, I analyse leaders and immigrant actions, choices and attitudes as being shaped by the structures and the local context their work is embedded in. Thus, the relationship between agency and structure is analysed through a focus on situated practices in the nursing home context, and the perspectives of Bourdieu (1977), Emirbayer and Mische (1998) and Ahearn (2001) are employed.

In chapter five, I present and analyze communication and interaction processes in organizing and providing care at the nursing homes. The main argument of this chapter is that although the Norwegian language is emphasized as a means for communication in nursing homes, the form and content for dialogue also matters in informing communication between and among multicultural staff, residents and relatives to the residents. Through the use of the theoretical concept of habitus (Bourdieu, 1977) this chapter analyses the way linguistic and hybrid habitus formation (Bourdieu, 1991) improve the social stock of knowledge of the immigrant staff, hence enabling their agency for communication in the nursing home context.

In chapter six, I examine roles, identities and activities at the workplaces, and I analyse these as relational and co-constructed through routine and non-routine activities at the nursing homes.

I argue that the 'Norwegianness' (Vassenden, 2010) form of organizing and providing care promotes the creation of 'us' and 'them' among the majority and minority staff, which also function as the basis for stereotypes. Moreover, cultural differences and social identities are negotiated and renegotiated, to reveal simultaneously interlocking and interplaying of individual identities, thus challenging the homogeneous perception approach to minority staff by the leaders, residents and their relatives. Through an intersectional perspective based in Cho et al., (2013) and Crenshaw (1990), the chapter highlights several axes of difference which intersect and contribute to unfavourable and discriminatory experiences among the immigrant staff.

Lastly, in chapter seven, I present the conclusion of the thesis, by taking the readers back to the key findings in the empirical chapters and placing the study within the larger debate of migrant care work, inclusion in work life and integration, and reflect on the thesis relevance and contribution. Finally, I present the policy implications of this study and suggest new questions important for future studies.

Chapter 2: Theoretical Perspectives

Introduction

In research, theories are of importance in order to give the researchers a 'lens' through which complicated problems and social issues can be viewed. This chapter presents an overview of the theoretical perspectives that influenced the research process, particularly data collection and analysis. As such, specific concepts will be gradually uncovered and discussed relative to issues covered in each of the analytical chapters.

This thesis is based on an ethnographic study with the ambition of exploring the way daily (work) practice is negotiated through planning, organization and conducting of tasks among leaders and multicultural staff as they provide care services to residents in three nursing homes. I explore the forms of interaction among leaders, staff, and residents in establishing opportunities and challenges, which may be associated with multicultural staffing. In order to analyse what is going on in these working premises, the relation between structure and agency becomes an important overarching analytical dimension. To be specific, I study the relationship between agency and structure in terms of exploring actions and attitudes of leaders and staff in care practice in the workplace, which I refer to as *agency.* This agency is situated within an institutional landscape shaped by immigration, integration and long-term care politics impacting the nursing homes and their types of residents, the labour market and institutional organisation, which I refer to as *structures*.

The discussion of the relationship between agency and structure holds a central place in the social sciences, for example illustrated by methodological individualism versus methodological collectivism, represented by Weber and Durkheim**.** I take an analytical grip with Bourdieu (1977) on the relationship between agency and structure. The concept of habitus is the core in Bourdieu´s theory of practice, and in his understanding of the acting agent. Agents embody various attitudes towards the world, which assemble as sets of dispositions that shape their actions within the social space and social fields of the society (structures). The habitus is both ´structured´ and ´class-specific´, meaning that agents habitus is a product of positions in society. Yet, the agents also influence structures through their social practices. On this background, I use culture to explain the ways of acting and thinking, and tie this to habitus formation, which then informs communication in care work processes through social stock of knowledge (Berger & Luckmann, 1966), tacit knowledge (Börjesson, Bengtsson, & Cedersund, 2014), taken for

grantedness/Norwegianness (Bourdieu, 1977a; Vassenden, 2010). At the local contextual level, I include the theoretical understanding of Emirbayer and Mische (1998) on the temporal aspect of agency to explain situated work practices in which employees negotiate their actions with reflections on their past experiences. Finally, I identify the leadership practices at the nursing homes as agency shaped by implicit ideals of leadership (Lindheim, 2020). I analyse its implications through a focus on the way leadership is negotiated and experienced by the staff with different cultural backgrounds.

Agency and Structure

The concept of *agency* has increasingly gained popularity in disciplines of the social sciences, educational sciences, healthcare sciences, psychology, gender studies, and professional studies. Despite its popularity, the concept has been endlessly perceived as vague and lacking clarity (Ahearn, 2001; Eteläpelto, Vähäsantanen, Hökkä, & Paloniemi, 2013). The main source for its complexity lies in the idea that the subject and the structures may simultaneously co-exist as one and yet different (Fagertun, 2009; Parker, 2005), or as Ortner (1989) puts it, that actors are creating a society which created them. Agency emerged as a concept in the social sciences with a feminist orientation, to describe the actions or practice of oppressed or severely constrained people, through 'free will' against structures (Parker, 2005).

Agency is a relevant concept in this thesis because it enables the analysis of the number of ways through which leaders and staff with different cultural backgrounds negotiate through practice their daily activities in the working place. The working definition of agency by Ahearn (2001:112) is useful it refers to the socio-culturally mediated capacity to act and acknowledges the motivation and intentions of social actors who are embedded in social, cultural and political-economic systems (structures) (Ahearn, 2001; Rahman, 2005:184). I therefore argue that people or agents negotiate their lives based on the number of factors that set the ground for their choices of action (i.e., structures). In addition I also appreciate the conception of the temporality of agency, as a subject of time, put forward by Emirbayer and Mische (1998:963) that, agency is

> "… a temporary process of social engagement, informed by the past (in its habitual aspect), but also oriented towards the future (as a capacity to imagine alternative possibilities) and toward the present (as a capacity to contextualize the past habits and future projects within the contingencies of the moment)"

Emirbayer and Mische bring in the important aspect of the temporal context of action, being a simultaneous subject of the influence of the past, orientation towards the future, and engagement with the present. Such an approach to agency is applicable when set within micro contexts such as the nursing homes in this study. This conception of agency challenges concepts of the 'victimization' of agents, by viewing them in the dimensions of interpretation and strategization, hence capable of influencing structures (which influence them as well), within a specific context. In other words, this conception of agency stresses the importance of context in which agency is seen as the capacity to both maintain and transform social structures. Agency is situated in the flow of time, whereby actors continually reflect and reinterpret their orientations and actions in response to emergent events (Biesta & Tedder, 2006). I therefore argue that it is important to understand agency both in terms of the individual's life course as well as transformation of contexts for action over time. This is to say, the capability and choice to act or react is subject to time and place. For example, in regard to this thesis, minority staff may act differently as they get into contact with different cultures, something which may not be explained in the context of their initial socialization or to the culture in their current home country, that is Norway. As such, agency is understood by focusing on individuals as being capable of combining their efforts and available resources to act, rather than simply acting in an environment (Igira, 2008). Moreover, the temporal aspect of agency in this thesis is useful bearing in mind that care work is contextually situated in nursing homes with residents of different health and social characteristics (see chapter 3), and nursing homes organised under changing social and political ambitions (see chapter 1).

Agency understood in this temporal aspect means that the past entails subconscious past social experiences, which form a framework from which the actor has the ability to recall and apply selected actions which they had developed through past experiences (See also habitus concept by Bourdieu (1977)). Within the future spectrum, social actors, rather than repeating the structures and actions of past routines, they generate possible alternatives to problems, by imagining the future as different from the past. In the practical present aspect, actors respond to the current need of the situation at hand, considering the alternative possible trajectories of action. An action, at any given case, therefore, can be related to the past, directed towards the future, or responsive to the present, to a varied degree (Igira, 2008). Therefore, I argue that the temporal context of action is important in understanding what is going on in nursing homes because the agency of leaders and other staff may be understood within their life histories and professional biographies, which may direct them to replicate practices in certain situations.

Moreover, within the projection aspect, their agency may be located in choices made among several desired outcomes. As Emirbayer and Mische (1998:970) clearly put it, the projective aspect of agency encompasses "the imaginative generation by actors of possible future trajectories of action, in which received structures of thought and action may be creatively reconfigured in relation to actors' hopes, fears, and desires for future". My understanding of this temporal aspect of agency, in relation to this study is that human agency is complex, and it may be influenced by either past and/or present experiences, or the projection of the outcomes of the action. As such, human agentic actions are difficult to pre-determine, but rather to understand them within those three temporal spheres, which may either contribute individually or altogether. The temporality of agency, therefore, is reflected within situated work practices of the nursing home contexts in this study. This is contrary to the essentialised and deterministic conception of habitus in relation to agency and structure by Bourdieu (1977). However, Bourdieu (ibid.) offers an important contribution to agency, that habitus informs agents ´actions within a particular structure in which the habitus is formed (see the next section). In a nutshell, the focus on relation between agency and structure is useful throughout this thesis, when discussing structural and contextual factors shaping leaders' strategies to recruit and include immigrants in work (chapter 4), language as a form of action in care processes (chapter 5) and the implication of Norwegianness in the multiculturally staffed nursing home care processes (chapter 6).

The habitus

The concept of habitus is central in this thesis in understanding the tension between agency and structure. Practice theory refers to "the relationship between the structure of society and culture on the one hand, and the nature of human action on the other" and emphasises the social influences on agency in which human actions are 'central', but shaped by social structures (Ortner, 1989:11). At this level of theorizing, scholars like Giddens (with structuration theory), Bourdieu and others, have tried to move beyond treating agency as a synonym for free will, rational choice or resistance against structures. Bourdieu (1977) uses the term *habitus* to explain what characterises social agents´ practice through the dispositions and lived experiences. He explains how and why agents act as they do in concrete social situations, by taking into account the opportunities within the actor and the structure that characterizes the situations in which the actors practice (ibid). Although Bourdieu does not directly address or use the concept of agency, I find that the concept of habitus embraces agency in the way he conceives how agents´ actions are made possible. Bourdieu emphasizes that habitus is reproduced through practices and

representations, which are conditioned by structures. Through these structures, agents internalize principles in *praxis fields*, which shape their habitus, being limited to act in particular ways. Habitus is therefore constructed within a specific *field*, through which people continuously interact, which regulates and is itself regulated by the actions (Bourdieu, 1977). As such, this conception nullifies the possibility for 'pure agency' or ´absolute free will´. Bourdieu holds that agents are predisposed to think and act in a manner that reproduces the existing system (of inequalities), with a relative limited possibility of challenging or changing the structure. Thus, human agency (habitus) and routinized activities, in his perception, is habitual, repetitive and taken for granted (see also (Emirbayer & Mische, 1998)). However, like other critique of Bourdieu (R. Jenkins, 1982; King, 2000; McCall, 1992), this study rejects such a deterministic approach to agency. Although people may act within a number of structures, they are not necessarily confined into "conformity to a perceived state of affairs in which a similar or predictable future is implicated" (R. Jenkins, 1982:278). Instead, agents are capable of penetrating the cultural frameworks which place them to function in relation to their gender, race and work categories (ibid.). In this regard, habitus, although it is part of the tension between agency and structure, it is viewed as flexible and elastic.

Although Bourdieu´s perspective is macro-sociological and the concepts intended to refer to general societal levels, different authors have borrowed the concept of habitus to explain situations at the micro levels. The same is intended in this study, to use the concepts of habitus, and field in analysis of actual situations in multiculturally staffed nursing homes.

Looking at the way different researchers have used Bourdieu´s habitus conception, Lo and Stacey (2008) sets an example. The authors employed the concept of habitus together with axioms of multiple and intersecting structures (by Sewell Jr (1992)) to explain ´hybrid habitus´ formation of patients´ culture. They used this understanding to explain the way social actors reproduce culture in clinical encounter contexts. As such, they address issues of cultural competency when doctors have to manage complex cultural complexity of their patients. By paying particular attention to the relationship between culture, contexts and social structures, the authors developed a conceptual model to understand the role of culture in clinical encounters. They argue for the concept of a ´hybrid habitus´ which broadens the understanding of culture as found in Bourdieu´s conception. By this, they claim that habitus formation may be subjective to "axioms of multiple and intersecting structures". In this vein, hybrid habitus is understood in terms of, first, broad understanding of culture (that is, from values and beliefs of an individual to cultural orientations). Secondly, conceptualization of culture as both flexible

and systematic (i.e. as habitual, formulated over time through constant exposure to surrounding structures to inform sense-making schemas). Thirdly, recognizing the way enactment of cultural schema is contingent and contextual- bound (allowing social actors to mix-and-match schemas in relation to the present clinical encounter) (Lo & Stacey, 2008:753-754). Such an understanding of hybrid habitus is relevant to this study in order to understand the immigrant trajectories into the elder care sector and thus analyse the way they negotiate their position in the Norwegianness characterised nursing home working environment.

In another exemplifying study, Glasdam et al., (2019:143) employed the concept of habitus to explain the way "nurses habitus and capital, the logic of medicine and the structural, political and administrative frameworks constituted, framed, directed and enabled nurses to think and act in specialised palliative homecare". They argue that the difficulties facing nurses who work in palliative home care is due to the conflict between the logic of medical structures and palliative care philosophy (2018:148). This in turn has always played part in socializing nurses in the role as assistants to doctors, whereby the medical logic unconsciously rules their practical sense in the specialized palliative home care. As such, medical knowledge and skills are assumed to be high cultural and symbolic capital for nurses, whereby medical tasks appear to be more important than nursing and social tasks related to caring in palliative home care. This understanding of the logic of care is relevant to this study as it contributes to understanding of the habitus of registered nurses (as well as leaders and other staff) and the way it is reproduced at the nursing home workplace. In the same vein, it exemplifies how the tension between agency and culture is situated organizational frameworks.

Drawing from the two studies above, this study employs the concept of habitus from Bourdieu (1997) to analyse the way attitudes, practices and resources of leaders and other staff are shaped within the premises of the logic of elderly care. In particular, to analyse the way structural, political and administrative frameworks constituted, framed, directed and enabled leaders and other staff to think and act as agents in the context of nursing home care. Furthermore, this study also employs the concept of habitus to explore the opportunities and challenges facing organization and provision of care within the logic of organizational structures of the nursing homes under this study.

Culture

Culture plays a significant role in forming habitus from socially ingrained habits, skills and dispositions, which are acquired through socialization (Bourdieu, 1977). But what is culture? Culture is a contested term, due to the myriad ways of understanding attached to it. Hofstede (2001:9), for example, understands culture as "the collective programming of the mind that distinguishes the members of one group or category of people from another". Although this kind of understanding might be relevant for defining some cultural groups, it faces the danger of essentializing culture, for example to countries or particular social groups. With this, I mean that, due to continuous social interactions and globalization impacts, it is not always possible to distinguish what Hofstede terms as 'programming of the mind' between people based on the group to which they belong. A similar conception is presented by Booysen (2015:246), that culture is "a set of parameters of collectives that differentiate the collectives from one another in meaningful ways and that culminate in a set of values and behavior patterns". Although this understanding may present forms of essentializing culture, it still covers important points relevant for this thesis, that culture informs behavioral patterns of people. As such, culture represents a form of social structure, through which peoples' choices and actions are embedded, by both enabling and constraining them (Hays, 1994; Miller, Das, & Chakravarthy, 2011).

Culture represents values and norms people acquire through socialization in a particular socio-historic place, which thus results in distinguishing members of a particular society, within itself or between different societies. Culture is not static; it is rather changeable depending on time and place to accommodate the current needs of the society (Anderson-Levitt, 2012:222). Through culture, class, gender and ethnic differences – and the specific context-dependent intersection between these categories - are manifested (Dein, 2006). In this sense, culture plays a role in shaping people's identity, interpretations, attitudes towards self and others, expectations, and readiness to adapt to changes, just to mention a few.

Culture shapes individual behaviours and expectations through internalized ways of doing things (Chris, 2004:20), acquired through socialization in primary and secondary groups and in society at large. As such, culture at the collective level, draws boundaries between insiders and outsiders, while at an individual level culture as a form of socialization process is not an end product but changes according to the number and forms of socialization contexts a person may encounter. It is also important to mention that such cultural boundaries in social groups are multiple, shifting and overlapping (Lindheim, 2020). In this framework of understanding,

therefore, individuals may belong to several cultural collectivities simultaneously, based in the social contacts encountered across the lifetime. In relation to agency, culture can be one of the premises through which people's actions are regulated (Abrams and Hogg 1990, Anthias 2008:8) and understood. However, the fact that culture is acquired through socialization is interpreted in this study as an ongoing process, in which people change to adapt new ways of thinking and doing things. As such, to understand people's agency in the framework of culture, we need to also take into consideration the fluid aspect of culture as social contacts among people also increase. As such, people´s cultural orientation may simultaneously unite and separates them from their original cultural groups as they get into contact with other cultural groups. This, therefore, influences their agency.

The above discussion of the complexity of the term culture is important to have in mind when analysing findings from this study in a number of ways. Firstly, to explore individual cultural differences among the immigrant staff as a group against leader´s strategies to include them in work, and the way this process is informed by different contextual and structural realities (see chapter 4, 5 and 6). Secondly, it is used to explore the assumption of Norwegianness in the organization of care and the way it relates to individualized care for the needs of Norwegian residents who have had contact with other cultures in the course of their lives. Moreover, since culture and hence habitus is acquired through socialization, and that staff (both majority and minority) as well as the residents get into contact with different cultures as part of their socialization, it is relevant to theorize culture in terms of hybrid habitus. This is because the concept of habitus in relation to culture, is a result of different axioms of multiple intersecting structures (Sewell Jr, 1992).

The concept of culture as a form of socialization, is also useful in discussing the ways ´taken for granted knowledge´, ´tacit knowledge´, ´implicit ideas on leadership and ´social stock of knowledge' is acquired as elements shaping ´communication´ at specific work contexts. These elements are important aspects of culture which can be traced through habitus formation and hence inform agency of leaders and staff in organizing and providing care for residents in the nursing homes (see chapter 4,5, and 6). Finally, in the institutional settings of nursing homes, the concept of culture is relevant in discussing the way cultural differences and structural forces such as race, gender, and migrancy are useful in accounting for group patterns (constitution of ´us´ and ´them´) among the staff and hence inform axes of differences in shaping work processes and social relations, as I shall discuss later in the next section.

Intersectionality

In social identity processes, gender, ethnicity, skin colour and class are manifested, although these concepts can also refer to the structural level in some intersectionality studies and then understood as axes of difference rather than aspects of agents´ identity. The concept of *intersectionality* emerged in the late 1980s and early 1990s from a feminist movement to challenge the use of gender alone as a primary factor determining a woman's fate (Collins, 1998; Crenshaw, 1991; Nash, 2008; Yuval-Davis, 2006). In particular, Crenshaw's (1991) research on the discrimination and oppression of black women in the United States has made a significant contribution on the development of the concept. Crenshaw (ibid.) challenged the existing single axis of analysis in white feminist scholarship towards a multiple axis of analysis, by highlighting the interconnection of gender with other social categories of difference such as race, ethnicity, class, sexuality, and so forth, in reinforcing subordination. From its conception, intersectionality had a long interest in a single intersection of race and gender (Nash, 2008). However, with time, other concepts such as class and sexual orientation were also included as determinants of female destiny. Recently, the perspective is used to analyse both the marginalized and advantaged populations for different social divisions (Yuval-Davis, 2006), in a range of different directions, at different levels of analysis and different thematic areas (Arora, Straiton, Rechel, Bergland, & Debesay, 2019; Cho et al., 2013; McBride, Hebson, & Holgate, 2015; Mooney, 2016; Tingvold & Fagertun, 2020). In a sense, there are two strands of intersectionality perspectives. In the first strand, authors focus on individual identities while the second focus on organizational processes (Mooney, 2016).

As an analytical tool, intersectionality suggest that the combination of such social categories as mentioned above, should not necessarily be viewed as sources for adding a burden to an individual by facilitating negative experiences and disadvantages. Instead, it is a framework through which differences can be revealed, to show the way layered and multiple social identities may produce distinctive experiences, both positive and negative, among the people in a particular context. My ambition is to use an intersectionality perspective as a lens for understanding both the immigrants' individual identity formation and the way organizational processes in the context of Norwegian nursing homes can disclose structures and forms of organization and practices that shape inclusion and exclusion at the workplace. As such, my analysis employs both "inter-categorical" and "intra-categorical" approaches (Tingvold & Fagertun, 2020:5). Putting it in the field of my thesis, for example, how do different forms of social identity inform organization and provision of care among the staff and/or the other way

round? How are gender identities constructed among staff with different skin color? For example, immigrant care workers with dark skin complexion could experience discrimination at the workplace (see chapter 6). At a system level, an intersectionality perspective can be used to identify patterns of discrimination at the meso and macro levels. For example, policies where gender and ethnicity meet and create negative outcome, or subordinate positions, for people of immigrant background or for women (see chapter 4 & 6). This study uses an intersectionality perspective to "track the dynamic categories of differences" as they manifested in the nursing home working environment (Mooney, 2016:712). Finally, the intersectional perspective allows for analysis of the empirical material that capture "both the agency of individuals in making the world they inhabit and the enabling and constraining forces of the world as it has been produced" (Choo & Ferree, 2010:134).

Race, Skin colour (colorism) and ethnicity

The meaning and significance of race, skin colour, and ethnicity are socially constructed and disseminated categories, based on discrepancies in physical differences of people. The categories do not hold any stable definition, nor do they refer to any static social reality, but rather are constantly changing subject to social contexts (Spencer, 2014:2). Although the concept of race is ambiguous and contested among various authors, I use the concept analytically in this thesis as I found that skin colour plays a significant role in defining individual identity (see chapter 6). Compared with other aspects of identity, I found that race was the most obvious and arguably most sensitive aspect in the nursing home workplaces. In the literature and debates concerning immigrant integration, race, racialization and racism are commonly not acknowledged possibly due to the sensitivity they hold in contemporary multicultural societies. In particular, Gullestad (2006) maintains that anthropologists have diverted to use other terms like 'ethnic groups' and 'minority identities' instead of race, due to the negative interpretations attached to the term race since World War II.

While the concept of race is based in physical characteristics that socially form differences, the concept of ethnicity bases itself on cultural and or geographical differences (and sameness) among social groups (Spencer, 2014; Valdez & Golash-Boza, 2017; Wade, 2010). In a sense, ethnicity is also socially constructed, subject to time and space, and in accordance with social and political contexts (Wade, 2010). I use the concept of ethnicity to explore and analyse the way cultural patterns relate to and challenge an understanding of ethnic categories in multiculturally staffed working environments.

Skin colour is an important analytical concept which, because it pays attention to the intra-groups, which ethnicity and race may exclude. In other words, colorism improves "the researcher's sensitivity to important racial and ethnic subtexts and processes" such as intragroup racism (Burton, Bonilla-Silva, Ray, Buckelew, & Hordge Freeman, 2010). The colorism perspective refers to "the allocation of privilege and disadvantage according to the lightness or darkness of one's skin", thus skin colour is an important concept besides ethnicity and race, because it plays both roles between and within ethnic groups.

The ideal of implicit leadership

In order to understand and analyse the way leadership is negotiated in everyday interaction across culture, it is important to examine factors that shape staff and leaders´ implicit ideas on leadership (Lindheim, 2020). In relation to this thesis, implicit ideas of leadership are important in understanding habitus and the way it shape agency of agents in particular situated work practices. In particular, the ideals are helpful in understanding attitudes and perceptions of leaders and multicultural staff with regard to the way they evaluate good or bad leadership practices from their cultural background. To establish the essence of including this theoretical concept in my analysis, I go back to my fieldnotes.

One morning when I was doing my observation session at NH3, I was having a conversation with an auxiliary nurse, an immigrant from Africa. In the middle of our conversation, as she was responding to my question on how she thinks that the leader has helped her to improve in her work, she said.

> *"Renate is a very nice leader. She has always been a good listener and helpful. I remember when I started as a language trainee from NAV, I only had one day to practice here at the nursing home. But because I was so ambitious to master the language quickly and pursue my healthcare studies, I thought that one day was not enough to get me where I wanted to be. So, I went to her and asked if I could have one more day for practice, and she said yes. After about three weeks, I went back and asked for one more day and she just smiled and said yes. I was very happy and satisfied, you know… and that way, I mastered the language and got qualified in a shorter period of time compared to some of my other fellow immigrant members of staff."*

Such a finding indicated for me that I needed a theoretical concept to capture such implicit feelings, ideas, attitudes and perceptions on leadership practices, which may explain further leaders' agency, especially when the study involved staff with different cultural backgrounds.

I describe the feelings of the staff member above as implicit because her expectations were not outwardly spoken, although such feelings played a role in identifying and defining the leader. However, I also asked myself a question, that if it is a multicultural workplace, what are other implicit ideas of leadership for other staff? How do the ideas merge or divert, and what could be the consequence? Furthermore, how do leaders deal with and respond to such implicit ideas and practices considering their responsibility to organizational structures? An implicit leadership perspective is thus relevant in order to analyse the way staff with different cultural backgrounds experienced leadership, as well as the way leaders negotiated leadership to meet every day needs of the residents in the working place, and hence influence their agency.

Implicit leadership theories have been used to explain leadership attributions and perceptions (Den Hartog et al., 1999), that is, the beliefs held about the way leaders behave in relation to what is expected of them, although such perceptions may not necessarily be a reality or uttered explicitly (Eden & Leviatan, 1975). However, the cultural dimension in management has been gradually included into research, although at a large scale level, comparing cultures at societal levels, whereby the cultural dimension in cross-cultural management is strongly linked with values (Hofstede, 2001; House, 2004; House, Hanges, Javidan, Dorfman, & Gupta, 2004). This is due to the ever-increasing importance of establishing the way that leadership relates to cultural differences in cross-cultural leadership contexts (Ghulam, 2016).

The famous study on the relationship between culture and leadership was operationalized in the GLOBE (Global Leadership and Organizational Behaviour Effectiveness) project in particular (House et al., 2004). The aim of this project was to identify the universal and contingent leadership characteristics and behaviours in 61 nations. Founded in implicit leadership theories, the GLOBE project contributed to the 'culturally endorsed leadership theories' (CLTs), whereby the main argument raised was that the *implicit leadership ideas are culturally contingent* and culturally endorsed, and that managers need to take into account this culturally contingency, in order to gain acceptance and support from the people they are leading (Lindheim, 2020). Furthermore, implicit leadership theory is characterised with the taken for grantedness expectations of ideal leadership practices that are not explicitly uttered or discussed (ibid.). Although the theory has made a significant contribution to cross-cultural management research (Ghulam, 2016; Mustafa & Lines, 2016), it has nevertheless been criticized for not accommodating or accounting for cultural change, hence posing an essentialist stance in understanding culture (House et al., 1999; Lindheim, 2020). As Lindheim (2020) argues, such approaches may reinforce stereotypes towards certain social groups and offer a weak

perspective on the relationship between leadership and culture at workplaces. Furthermore, Lindheim (ibid.) highlighted on the essence of understanding the role dynamics of individual cultural configurations in shaping implicit ideas of leadership, based on the embodied understandings across the countries they come in contact with, between their country of origin and country of residency. This aspect is important and relevant to this thesis, to analyse the role immigrant trajectories in shaping their implicit ideas of leadership, and the way they shape their relationships with leaders and other staff. This study, therefore, will employ the conception of culture by Lindheim in understanding implicit ideals of leadership, by taking into account that immigrant staff may have different perceptions on what makes good leadership practices even when they hold the same cultural background, acknowledging the possibility of ´hybrid habitus´ formation.

Taking both the positions of multicultural staff and leaders, the analysis will not focus on categorizing good against bad leadership practices as has been the case in other studies on implicit leadership (Eden & Leviatan, 1975; Lindheim, 2020; Schyns & Meindl, 2005). Rather, my aim is to portray an open-minded picture of the way staff experience leadership and leaders negotiate leadership among the multicultural staff. In line with the perception of 'Leadership-as-practice' by Raelin (Raelin, 2016), I analyse the way management practice unfolds in the workplace, paying attention to the way leadership is negotiated, performed and enacted in daily interactions among leaders and staff at the nursing homes.

Concluding Reflections

In this chapter I have discussed important theoretical perspectives and key concepts which are relevant in the analysis of this thesis. These have influenced my understanding of situatedness of care work practices among leaders and multicultural staff. With agency and structure at the heart of the discussion, I have connected it to the theoretical perspectives of theory of practice (Bourdieu, 1977a) intersectionality (Cho et al., 2013; Crenshaw, 1990), and implicit leadership (Lindheim, 2020). In the theory of practice, habitus is well suited to study leadership practices and work processes of multicultural staff in nursing homes. Through habitus, situatedness of care work practices in Norwegian nursing homes context are understood as the framework (field/structures) through which agency of leaders and other staff is negotiated (Ahearn, 2001; Berger & Luckmann, 1966; Bourdieu, 1977, 1990, 1991). The intersectionality perspectives lay a framework for understanding the way intersecting axes of differences work together to shape experiences of minority staff and influence their agency (Crenshaw, 1990; Nash, 2008; Spencer,

2014; Valdez & Golash-Boza, 2017). The implicit leadership perspectives are also important for this study to understand daily negotiation of leadership across different cultures based on implicit ideas of leadership from the perspective of leaders and staff (Lindheim, 2020).

Chapter 3: Methodological Reflections

Introduction

In this chapter, I base my discussions on Peirce (1995:569) notion that theory informs methodology (implicitly or explicitly), through the way questions are asked, the assumptions made, and the procedures, methods and approaches used to carry out a study. However, research methodology is not made of bricks and stone walls, but rather is a flexible process, moving forward and backwards, reflecting, and adjusting to get a comprehensive picture. Based in the theory of agency (Ahearn, 2001; Bourdieu, 1977; Emirbayer & Mische, 1998) employed in this thesis, this chapter intends to discuss fundamental questions with reference to central theoretical concerns. This chapter focuses on the justification on the ways the researcher could comprehensively gain an understanding of the ways structures and context play a role to inform leadership practices, staff interactions and care practices – thus, the relationship between structure and agency. Inspired by Smith (2005), institutional ethnography approach, emphasizing research in an institutional landscape as always from a ´standpoint´ and as a ´bottom-up´, this chapter accounts for the choice of methodology and methods.

I start with a brief discussion of the ontological and epistemological assumptions framing the research. Thereafter, I present the research paradigm adopted, then describe the research design, accounting for the way empirical material used in the thesis was collected. In the last part, I describe the way I analysed the data, ethical reflections, and discuss the role of theory in data collection and analysis.

Ontological and epistemological assumptions: an overview

In conducting scientific studies, meta-questions of ontology, epistemology and methodology are always important but not always addressed. Depending on the researcher´s stance, these three interrelated aspects to inquiry constitute philosophical underpinnings about what constitutes ´the reality´, scientific knowledge and how to gain such knowledge, which then informs different strategies of inquiry and methods (Bowling, 2014).

Researchers are concerned with the nature and form of reality, and the ontological aspect of any research is the taken for granted questions from which they build scientific knowledge. Ontological assumptions are about the forms and nature of reality, while epistemological assumptions revolve around the manner in which legitimate knowledge can be developed, and what constitutes valid knowledge in a discipline (Killam, 2013). In approaching knowledge

generation through these assumptions, constructivism, positivism and critical realism paradigms plays significant roles. While I don't hold an ambition to present a debate of these paradigms, I briefly present each of them in order to locate my study.

The positivist paradigm assumes that there is objective reality out there, which is fixed, definite, observable and measurable through formal propositions, hypothesis testing and quantifiable measures (Bowling, 2014; Creswell & Creswell, 2003). On the other hand, the constructivism paradigm assumes that reality does not exist out there, but mentally constructed by individuals. As such, reality is subjective and multiple. Since reality is relativistic, understood through subjective and inter-subjective experiences of individuals, it cannot be understood through pre-defined variables, but within social interactions, in the complex human sense-making in social situations as they emerge (Bowling, 2014; Lee, 2012). Critical realism distinguishes between the two paradigms. It assumes reality as historically constituted, and that people produce and reproduce it. It emphasizes that, our understanding of the world is constructed from our experiences and perspectives, through what is ´observable´. As such, critical realism studies focus on macro social practices (historical, social, and political levels) with regard to changing social realities (Egbo, 2005).

The constructivist tradition allows the researcher to understand the way individuals make sense of their everyday lives in their natural settings (Adom, Yeboah, & Ankrah, 2016; Creswell & Creswell, 2017; Creswell & Poth, 2016), and in this case, nursing home working environments. In a sense, legitimate knowledge in most social sciences, and particularly in my discipline background, social work, takes into account the contextual and subjective meanings of individuals in a particular situation. The aim of research in social sciences is largely for understanding subjective meanings people have on particular phenomena, as opposed to the ambition of many of the natural sciences which aim at, for example, statistical generalization.

Specifically positioning my study ontologically, therefore, this study follows a constructivist paradigm, which assumes that reality is socially constructed (Berger & Luckmann, 1966). Constructivism paradigm assumes that people construct their own understanding of the world through experiences and reflecting on those experiences (Creswell & Creswell, 2003). In order to understand the phenomenon in focus as it emerge in the social world, I incorporate the subjective and intersubjective experiences of individuals positioned in a specific larger structure. More specifically, to understand the form and nature of reality (ontology) of working environments at the nursing homes (i.e., what exists), is to acknowledge that subjective experiences can provide insight into its workings. As such, the social construction of reality

means that the way people present themselves to other people is shaped partly by their interactions with others as well as their life experiences. However, there is criticism that it is not right for the constructivists to believe that all social phenomena are social constructions, because some may actually not fall in this assumption. As such, it is possible to have a constructivist approach, and yet accept that there might be a reality out there that is independent of our perceptions (Debesay, Nåden, & Slettebø, 2008; Hacking & Hacking, 1999).

In this line of thought, people have the capacity to understand and ascribe meanings to the world around them, and this understanding shapes their practices, and that it is this 'already interpreted meaning' that we as researchers are able to access. This is called double hermeneutic (Giddens, 1984), which seeks to understand what people do, the way they understand their world and consequently, the way that understanding shapes their practice. Specifically relating this to my thesis, the ontological assumption is that working environments are social contexts, involving the interaction of people who are engaged in the process and the environment within which the work is conducted. Working environments are social phenomena and social phenomena are made of people and therefore changeable. This reflects the importance of context as an important aspect to the study i.e., what is going on internally, although the same is true for contexts surrounding the working environments, such as immigration policies. Moreover, I assume that the social and organizational contexts of nursing homes inform leadership practices of multiculturally staffed nursing homes. Thus, a need for a detailed knowledge of the nature of the setting within which leadership practices occurs may relate to the ever-increasing multiculturalism among staff. Studying reality from this perspective, therefore, need an approach to social enquiry that is characterized by the immersion of a researcher into a social situation. As such "the researcher can share experiences of those being studied and better understand the behaviour, culture, tacit routines, etc., of the subjects in the social situation" (Igira, 2008:65).

My epistemological assumption was that while knowledge about working environments may come from a number of sources, such as reading publications, it is only my interaction with the environment that may provide knowledge and data needed to explain what is going on in the particular working environments in focus. In the same vein, I acknowledge that the ability of people (both leaders and staff) to consciously relate to their work practices is embedded in various forms of social, cultural, political and contextual conditions. In this regard, my main task as a researcher is to explore and question the conditions of the status quo, to bring into light

the conditions which restrict and/or promote leadership practices and care processes among staff with different cultural backgrounds in the nursing home contexts.

Methodological choices

Ontology and epistemology set a base from which a methodology for use in inquiry may be selected (Bowling, 2014; Creswell & Creswell, 2017; Malterud, 2016; Sköldberg, 2009). Reflecting on those assumptions, together with my research objectives, I needed a methodology which would allow me to do the following:

- Allow for participation in the settings I entered during my fieldwork, from which social interactions and meaning construction and interpretations would emerge in a shared manner
- Consider that the emerging of those meaning constructions would accumulate with time
- Provide a way of exploring the way participants interpreted and responded to their environment
- Explore categories of differences and power differentials in workplace relationships
- Allow for exploring contextual variations in those environments

To accomplish all the above interests, I needed a flexible methodology that would allow me to capture moments and interactions as they occurred in their natural environments. In this regard, I found ethnography to be appropriate in my attempt to explore individual, structural, and contextual aspects as they relate to daily work interactions. This forms the discussion in the next section.

Methods inspired by Ethnography

From the discussion above, context becomes a crucial part of my research. This means that it is important to apply methods which allow for exploration of contextual matters, or situated practices, within which meanings are constructed. In addition, since the study had the aim of exploring multicultural staffing in work practices, it was important to employ data collection methods which would explore implicit or tacit work routines. This further meant that, in addition to considering the views and perceptions of the workers (both leaders and other staff) within the nursing homes in this study, it was also important to also pay attention to the context features in their working environment as well as things which both leaders and other staff may take for granted. In other words, ethnographic research approach was important for

understanding relations between local institutional care practices and leadership of multicultural staff by questioning the way everyday actions of leaders and other staff are influenced by context of their specific situations. For example, task distribution follows the implicit routine that someone takes on the kitchen role or participates in taking residents for a walk, assuming that all the staff can equally manage such routines (see chapter 6). Located in health sciences, ethnographic methods are relevant in this thesis, in order to shed more light on the social aspects of inquiring qualitatively into care practices as opposed to the common diagnostic or medicalized approaches, which follow a more quantitative design.

This dissertation has a qualitative research design, aimed at gaining knowledge about the experiences, contextual and structural factors shaping leadership practices in multiculturally staffed nursing homes, focusing on the organization of daily work and interaction processes among leaders, staff and residents.

Although institutional ethnography (IE) would have been an added advantage in studying work processes in nursing homes, it was not used separately, but rather integrated in traditional ethnography used in this study. In this manner, it will not be involved in the analysis since I do not adopt the methodology or relevant key concepts. By their nature, nursing homes are public organisations embedded in an institutional landscape, as places that provide public elderly care. Therefore, institutional ethnography becomes relevant, whereby ordinary daily activity is the analytical site and starting point for investigating social organizations and mapping relations that interplay in people´s activities in the institution (Lundberg & Sataøen, 2019). Institutional ethnography was firstly established and used by the Canadian contemporary sociologist, Dorothy Smith in 1987. As she was interested in challenging mainstream sociology for its inability to start in the real world that she experienced in her conflicting academia and parenthood worlds (Smith, 1987). I am specifically inspired by the way she distinguished the traditional anthropologist approach to ethnography with institutional ethnography. Traditional ethnography intends to study the culture of people in a particular society, while institutional ethnography employ ethnography to study coordination of activities, such as work and how "…people´s lives are embedded in power structures of ruling relations" (Lundberg & Sataøen, 2019:44). Institutional ethnography establishes itself from people´s everyday local experiences "in and of institutional forms of coordinating people´s doings" (Smith, 2005:44), with an emphasis on understanding the way "actualities and problematics in people´s lives are embedded in broader social relations" (Lundberg & Sataøen, 2019:44). By the nature of this study, it has the ambition to trace the ´bottom – up´ approach to leadership practices and

immigrant inclusion amidst nursing home contexts as well as policies and regulations guiding care work, immigrant inclusion and integration through work. Moreover, through institutional ethnography, it is possible to explain "how things work and how they are actually put together" starting from everyday local experiences of people (i.e., leaders and staff) to explore the relations which connect and influence them from different localities as they organize their everyday work (Kearney, Corman, Hart, Johnston, & Gormley, 2019:18). It is about considering people as expert knowers and doers of their work, emphasizing what they do, say and know (ibid.). Such experiences work as the starting point for the researcher´s direction for further steps, by directing the ethnographer´s direction for further investigation (Smith, 2005).

In order to explore the way leaders, multicultural staff (and residents) relate to each other, and negotiate their daily work practices, in-depth investigations are required. Being both a working place for the staff (and a home for the residents), this means that employees in the nursing homes are not definite entities, but rather individuals with decisions and actions, which are regulated continuously by particular contexts. I therefore seek to explore the way everyday work processes are negotiated, organised, and carried out, based on this complex relationship of structures.

I approached the field with the assumption that such daily practices have an undetermined character among individual staff and leaders, but rather are adjusted to accommodate a particular situation. In addition, it is important also to mention that leadership practices are also influenced by several other factors, such as the current trend in management (as mentioned in chapter 1), the municipal ideals of management, the organization to which the leader belongs, and so forth. A single method approach could not give me a clear picture of what exactly happens in the course of the working day of a nursing home. In support with the theoretical perspectives framing this study, it was important to account for overlapping contexts and conditions which shape work processes in the course of the day by exploring many possible sources. In this regard, ethnographic methods were the most relevant to employ in this study.

One of the important aspects of ethnographic methods is the way it allows a researcher an in-depth exploration of the phenomena studied (Ejimabo, 2015; Igira, 2008). This is because the methods allow the researcher to spend an extended time in the field, seeing whether people are doing what they say they are doing and how they are doing what they say they are doing (Gobo, 2008; Spradley, 2016). In this manner, the researcher gains an in-depth understanding of people, the organization and the broader context within which these people are working (Reeves, Kuper, & Hodges, 2008). As far as contextual matters are concerned, this study went further to

observe physical features and arrangements of the working environment through which daily interactions occur, such as decorations in the common areas, exercise machines, routine and non-routine activities. Through ethnographic methods, the researcher may also access information which might be difficult to express verbally, such as "patterns of work practices, workflow, power hierarchies and social relationships…" (Igira, 2008:70), (see also (Reeves et al., 2008). Ethnographic methods have therefore enabled me to gain an understanding of the opportunities and challenges that arise from contextual situations in nursing homes included in this study, in addition to the social, political, and cultural complexity of these working environments. Furthermore, through ethnographic methods, I was able to explore and highlight the socially ascribed categories of differences such as gender, ethnicity and skin colour, in a multicultural working place, and the way these are articulated in daily working processes. In this regard, ethnographic methods made sense in this study as a relevant lens (McCall, 2008; Mooney, 2016) through which intersecting social identities could be explored.

Fieldwork and participant observation in Nursing Homes

Fieldwork, "the study of something in the natural environment where it occurs or inhabits" (Preissle & Grant, 2003:179), has its origin in social anthropology whereby earlier anthropologists used to go out and study 'indigenous' cultures for an 'extended period of time', doing participant observations (T. Jenkins, 1994). However, the method has gradually become popular in other disciplines, especially in social sciences and humanities, but also in the younger healthcare sciences. In this study it was then important to reflect on the way techniques for data collection relate to the research problem as well as the objectives.

Fieldwork in nursing homes presents complex environment for study, by being both a working place and a home for the elderly sick, who also get regular visits from their relatives and friends. In other words, nursing homes may be regarded to as both place and space for residents and multicultural workforce, simultaneously. Being the place for residents in which staff practice care, I had to pay attention to both professional and social aspects of care, something which was not easy due to blurred boundaries with regard to what to consider as formal or informal relations. Since this is a qualitative study in which context matters, the nursing homes involved should not be considered as representatives of other nursing homes either in Norway or elsewhere, although they can be relevant to care practice in other nursing homes. By this, I mean that nursing homes in this study are rather specific ´places´ where staff practice care than being organizational maps to trace the staff movements and actions.

Although the residents and their significant others were not my primary participants, it became obvious that the study includes them as part of the daily interactions in the nursing home as recipients of care services. However, residents had limited inclusion in this study; I only observed their interactions with staff, volunteers and relatives in the common areas of the facility, such as kitchen, hallways, the nurse station, living room and lounge, but did not include them in follow up interviews or in their private rooms. This also had to do with the research permit for the project, in which residents, as a vulnerable population, were not included as interlocuters when seeking for permission. It is for this reason, therefore, that their background information is presented in a very general manner, as a way of protecting their anonymity.

In the beginning of my field work at the first nursing home, the leader advised that I should not wear a uniform like the other staff. Therefore, I was wearing casual clothing throughout my fieldwork. The leader was concerned that the vulnerable residents would get confused if I appeared to be one of the staff. To me, that decision from the leader made sense, and since I was not striving to engage with the residents, I wanted to clearly present myself as a person from outside the institution. The plan worked well, therefore, I did the same for the two other nursing homes I went to, but with agreement between the leaders and me. Since I introduced myself as a researcher from the beginning, my role was confirmed through my different dress from the regular staff.

Participant observation was the main method for data collection in this study. My ascribed role, which was also self-ascribed, was a stranger who observed and sometimes participated and assisted the staff in work tasks. In the beginning, the aim was to get familiar with people and activities on their own terms, thereafter, gradually strategizing on special activities which would add value to important data to be included in the thesis. In doing participant observation, I started with generally observing all activities I could access on a daily basis. Although my initial interest was to follow the leaders as they interacted with other staff, I found that leaders were not present on the wards most of the time, rather they were working from their offices, which were located on the same floor as the wards they were managing, while some other time they were outside the offices for meetings. This meant that the leaders could plan for routine and non-routine activities, organize shifts, and so forth, while seated in their offices, without necessarily meeting physically with staff. I therefore explored the implication for such working arrangements in relationship to multicultural staffing (see chapter 4 and 5 for further analysis). This was the same for all the nursing homes. The only difference was that, in one nursing home, the leader had an assistant, who also worked shifts ‘on the floor’ in the wards. After observing

this situation for the first few days, I changed my focus to observe the way staff could manage themselves in the absence (or distant leadership) of their leaders. I observed the way staff received and implemented some directives from the leaders, the communication frequency and pattern as well as the variation in practice among wards with and/or without immigrant staff. Moreover, this informed me of the implicit leadership practices, as leaders separated from workers physically, as well as some form of 'informal' leadership in the wards.

Researcher's choice of activities plays a vital role in participant observation, and this is influenced by specific research questions, ethics and access, although the events and situations under observation may change over time, depending on the interest of the observer (Atkinson, 2007; DeWalt & DeWalt, 2011; Gobo, 2008). With an interest in interactions among leaders and staff (as well as residents), I had a focus on the daily organization of work including routine and non-routine activities, in order to highlight cultural and structural matters shaping those interactions and routines. However, the type of activities I could take part in and the level of participation were shaped by a number of factors. Firstly, I am not a professional care worker, thus I could not participate in professional tasks, such as medicine distribution. Moreover, due to my study focus and its ethical demands, I could not participate in tasks inside residents' rooms. Therefore, my participation was focused on staff tasks involving social activities, such as assisting (willing) residents with food and game activities like bingo, pulling and pushing their wheelchairs from one point to another, holding conversations in the lounges and lunch gatherings with other staff members. As such, I could hardly become a complete participant (Spradley, 2016).

I had to make quick reflections and decisions concerning the situation at hand or the way the particular day was organized. Sometimes, for example, activities were planned suddenly, I would say, depending on the number of staff who were at work, if it was a relatively less stressful day. Some were performed inside while others outside the nursing homes. In response, I had to choose the more engaging activity in relation to my research interest. On the other hand, I had to be flexible during some other days, when things were organised differently, for example, some of the days there were staff meetings, which I was not allowed to attend due to personal sensitive information. In the beginning of the morning sessions, which started from 7.00 to 15.00, it was chaotic and busy (see chapter 4). In such situations, I had to step aside, ask less and give leaders and the staff the space they needed. However, these were important times when I had to reflect on what hectic sessions may imply for social care, individual care strategies among the staff, and teamwork, work coordination and division of labour, which

added information for further questioning and analysis. I could further notice both explicit knowledge and norms (i.e. what people know and can communicate easily) and more tacit knowledge and norms (which goes without saying, or the taken for granted), for example the use of knives and forks for eating (see details in chapter 6) (Spradley, 2016:7).

Although I had previous experience of working in nursing homes in Norway as a student, it was important to remain as open-minded as possible. According to Spradley (2016:4) the ethnographic researcher starts with "a conscious attitude of almost complete ignorance". However, as far as being ignorant is concerned, a lot of debate exists among those who argue for a 'tabula rasa' position against those who argue for an 'informed position' when entering the field (Berthelsen, Lindhardt, & Frederiksen, 2017; Corbetta, 2003; Iacono, Brown, & Holtham, 2009). I had previous experience of working at nursing home, as an immigrant, unskilled staff member, although in a different municipality in Norway. Therefore, I have an idea of what multicultural work life can be, and this pre-understanding helped me in designing my research process and selecting the initial theoretical framework which would guide my informed data collection. What is important for me, as a researcher, is to account for these experiences (which I will do in the reflexivity section and throughout the analysis chapters), instead of assuming an ignorant position, which I could not do. However, I acknowledge that prior understanding might also be a barrier towards learning about the field. It is therefore important to acknowledge those understanding and try to figure out what the field could explicitly tell me. For example, when I heard about experiences of discrimination among the staff, I did not jump to conclusions, but rather probed more for clarification, as well as observe the working relationships among the staff, so as to account for what was presented by the staff (see chapter 5 and 6).

Despite their usefulness as accounted above, fieldwork and participant observation have undergone a number of challenges and criticism. Jenkins (1994), for example, challenges the over-assumption of the objectivity of the method, referring to how both researchers and participants work together to construct the reality under study. In this manner, both of them are participant observers, in a particular context, and therefore, research might still be biased through co-construction. In order to avoid bias, the researcher needs to employ methodological transparency, reflexivity, and awareness of the potential bias, hence presenting it explicitly and using it constructively.

Selection of the field location, inclusion, and exclusion criteria

This study is part of a larger project known as Multi Care, at the Centre for Care Research West, Western Norway University of Applied Sciences (HVL). This project had four different work packages: my independent project fell into the third, which was about "leadership of multicultural staff – an implementation study". The aim of this work package was to prepare a training program for nursing home leaders who were managing multicultural staff. The program was prepared in collaboration with the leaders themselves, staff from the Centre for Care Research and the Centre for Development of Institutional and Home Care services *(USHT – Utviklingssenter for sykehjem og hjemmetjenester)*. Together with other researchers in this work package, a post- doctoral student was responsible for preparation of the training component and carrying out focus group interviews with leaders. As I also took part in these focus group interview sessions, I could access this type of data information, some of which I have used in my analysis. I, on the other hand, had the responsibility for carrying out the fieldwork, partly for informing the training component for the leaders, while also developing my independent PhD study.

In this work package, a total sample of four nursing homes from four municipalities in Norway were included. Three were considered medium-sized while one was a large municipality. It is important to mention here, that in Norway the categorization of municipal size is that small municipals have up to 4999 inhabitants, medium municipals have 5000 – 19999 inhabitants, and those with 20000 and more inhabitants are in the category of large size municipalities (SSB, 2020). The three nursing homes were chosen both because they had a substantial share of immigrant workers, and because they represented typical Norwegian municipalities, medium and large municipalities. From this sample, I chose three out of four nursing homes, where I conducted my data collection. The rationale for choosing those three nursing homes was that they had a relatively larger number of immigrants as compared with the excluded one, although the number of minority staff varied among the different wards of the nursing homes I selected. The immigrant staff in this study were aged between 24 and 65 years old, although most of them were in their thirties, which contributed to their life experience as adults. They were also all first-generation immigrants, who had migrated as adults for various reasons such as marriage, labour, asylum and refuge. They had lived in the country between five to over thirty

years, some were married while others not (either with Norwegian partners or fellow immigrants). In the table below, I give an overview of the migrant care workers participants.

Table 1: Characteristics of the minority care worker participants, an overview

Name, age (approx.)	Region of origin	Education	Position	Years of work experience
Jennifer, 34	Africa	Student	Assistant	5
Katrina, 26	Asia	Nursing from home country	Auxiliary nurse	5
Maria, 27	Asia	Student (preparatory courses)	Assistant	7
Marcia, 37	South America	Certified auxiliary nurse	Auxiliary nurse	12
Anna, 40	Europe	Certified nurse	Nurse	7
Emmanuel, 32	Europe	Nursing from home country	Auxiliary nurse	7
Hussein, 35	Africa	Has finished preparatory courses	Assistant	7
Margaret, 65	South America	Certified auxiliary nurse	Auxiliary nurse	23
Benjamin, 39	Africa	Preparatory courses	Nursing assistant	7
Ester, 35	Africa	Certified auxiliary nurse	Auxiliary nurse	8
Judith, 43	Africa	Student (preparatory courses)	Assistant	9
Miriam, 39	Europe	Has taken language exams but not passed	Assistant	2
Joana, 32	Africa	Preparatory courses	Nursing assistant	4
Edith, 35	Africa	Student (preparatory courses)	Assistant	7
Alice, 58	Europe	Certified nurse	Certified nurse	15
Monica, 35	Europe	Certified nurse	Certified nurse	8
Sandra, 56	Europe	Certified auxiliary nurse	Auxiliary nurse	17
Mustafa, 45	Western Asia	Preparatory courses and medicine course	Nursing assistant	16
Mariam, 28	Western Asia	Student (preparatory courses)	Assistant	6
Martina, 35	South Asia	Certified auxiliary nurse	Auxiliary nurse	10

Source: Researcher (2020)

Note: in the above chart, Assistants represents a group of staff who are employed as unskilled, some with zero fixed working percentages, while Nursing Assistants refer to the group of staff with minimum two years preparatory courses (vocational education) in healthcare (in Norwegian: *helsefagarbeider*).

In addition, in order to get an in-depth understanding, I visited three departments at these NHs, one department with two wards and the other two departments with three wards, all under one leadership. I labelled these departments as NH1, NH2 and NH3, with their respective wards as A, B, C; D, E, F; and also, G, H for analytic purposes.

The length of stay at the fieldwork sites was a total of four months, ranging from four to six weeks at each nursing home department. I decided that it was enough time based on the saturation of data I was collecting, that is, when the responses to my research questions were mostly repetitive and there were relatively little new observation responses (Fusch & Ness, 2015). I spent more time in some wards than others because of staffing fluctuations, for example during winter holidays, where most of the permanent staff and leaders took a break. I did not experience any problem with the budget for my fieldwork, since I planned beforehand, and there were no significant interferences. The funding was effectively catered for by the institution I was employed as a PhD fellow.

Accessing the field

According to Dewalt and Dewalt (2011), qualitative researchers engage in practical, logistical and emotional processes towards becoming successful participants in a particular setting. In my case the practical and logistical processes of accessing the field were accelerated by my presence in the research group of work package three, as mentioned previously. Initially, the research centre administration contacted the leaders of the identified nursing homes and communicated their research interest, and there had been a preliminary agreement before I joined the group. When I started as a research fellow at the centre, I travelled to all four nursing homes, together with the post-doctoral colleague in this work package and held short meetings with leaders from those four nursing homes informing them about the research project. In these meetings, I got a chance to introduce myself to the leaders and we got some preliminary information about the organization of the nursing homes and staffing, the information which the leaders informally provided to us. It was from these initial visits that I was able to decide which nursing homes I would visit later for fieldwork.

After these initial visits, the centre arranged for a two-day meeting with all the ward leaders. At that first meeting, the centre director introduced the project to the leaders and explained what was expected to happen in the course of three years. In this gathering, preliminary arrangements were made for the future proceeding of the project. For me, that was an entrance point to the field as I had a second chance to familiarise myself with all the leaders of the nursing homes who had been selected to be included in the project. My proposal was ready, so I had clearer focus (compared with the initial visit) when I had a chance to present my plan for the data collection process. The leaders were my 'gatekeepers' in this respect, to access sites for data collection in the near future. Apart from arranging for my arrival in their nursing homes, these leaders assisted me with securing accommodation. The leaders also assisted me in choosing the relevant wards according to my study preference, that is, wards with a significant number of immigrant staff.

Before starting my data collection at the selected nursing homes, I wrote an official letter to formalize my request, introduce myself and specify the days that I was expecting to carry out my activities. I clarified my ambitions and limits, to neither interfere with the routines nor disturb residents (see appendix 3). These letters were posted on the staff notice board for information. After this we started correspondence to arrange for accommodation and other logistics, with collaboration between the centre and leaders at the nursing homes. Since the leaders were already informed about the collaborative training program, they shared the information with some of their staff, and in that way the staff also got earlier information about my future visit.

Familiarization and establishing rapport at the nursing homes

In ethnographic fieldwork the development of close connections between the researcher, the subjects and situations being studied is of vital importance in order to understand their point of view as well as what goes without saying (the taken for granted) (Atkinson, 2007; Van Maanen, 1995; Ybema & Kamsteeg, 2009). Being a stranger in the nursing home premises, I needed to familiarize myself with different people, things, and situations. On my arrival at the nursing homes, at the beginning of my fieldwork, leaders introduced me to the staff who were on duty that day. Although the leaders had already informed other staff of my plan to visit their workplace, I introduced my study the first time I attended each nursing home, and I had to do it several times more to those who had an interest in knowing. I explained about my project

differently, depending on who I met and the language level that could most easily be understood, because to some staff members, for example, it was difficult for them to understand that I was collecting data for my 'PhD study'. I had to do this in Norwegian, which was the official language at work, while some few other staff would switch our discussion to English language. As a researcher I had to adapt to the multiple audiences of the research project. Since nursing homes are workplaces with shifts running round the clock, this process took a relatively longer time because I was always meeting new faces at work, as explained earlier.

To establish rapport is a crucial element in several forms of data collection during ethnographic studies. However, what constitutes effective rapport building remains vague. According to DeWalt and DeWalt (2011:47), rapport is a state of interaction achieved,

> "…when both the informant and the researcher come to the point when each is committed to help the other achieve his or her goal, when informants participate in providing information for the book or the study, and when the researcher approaches the interaction in a respectful and thoughtful way that allows the informant to tell his or her story…"

In a sense, rapport is a process, not an end, and it is established over time, to enhance mutual understanding and trust. The researcher needs to invest in learning appropriate behaviour and showing respect to participants. Reciprocity is also an essential element of the process, whereby the researcher allows participants to tell the truth "as they see it", and the researcher must do the same in return (DeWalt & DeWalt, 2011:48). In practice, this process took a relatively long time when I was doing my fieldwork. This was because, as mentioned above, nursing homes were shift-working environments, with staff also working in positions with different percentages, so their working frequencies varied largely. Others worked permanently on weekend shifts, on every third weekend, and worked a few days during the weekdays, when there was a shortage. As a result, it was almost like meeting new people throughout my stay. However, the good thing was that I always met people at work, both old and new, and that was important for my fieldwork.

Moreover, and especially relating to participant observation, establishing rapport and breaking through to access social activities may vary among the informants, based on their personalities or other reasons. The process took a relatively different time span to get used to participants, while others were playing with a 'can't be bothered attitude'. Being a black immigrant researcher both posed opportunities and barriers in establishing rapport. To many of the immigrant staff, it was easy to get into conversation after the first few days. I therefore found

myself having more interactions with this group but then gradually gained access to the majority staff.

Practicing reflexivity in ethnography

Researchers are also cultural beings, possessing both personal and professional culture. They bring their cultural orientations to the study through the way they construct their research topic, objectives and methods, which then guide their analysis stance. In this sense, it is impossible to separate the researcher from the findings and analysis as he/she has direct influence over the whole research process (Blix, 2015). Bourdieu's (2003) conceptualization challenges reflexivity as not just being the process of researchers accounting for their lived experiences affecting their study, but going further to acknowledge and analyse the social conditions of possibilities and limits that have influenced their choices in the research process. It is important therefore, for researchers to acknowledge and clarify to their audience their personal influence on the construction and analysis of the data. My understanding on reflexivity is that, instead of camouflaging a researcher's impact on the construction of the data, researchers are required to make explicit the way they engaged themselves in the process of data collection and processing. Being reflexive therefore, refers to the process in which researchers openly reflect on the way their own values, perceptions and behaviours or presence, and those of their respondents can affect the data they collect (Papadopoulos & Lees, 2002). In relation to my study for example, being an ethnic minority in the Norwegian community, educated in social sciences from both Norway and my home country, with some experience of working in nursing homes under the majority leadership, may shape the way I construct research questions, and collect and interpret information from the participants. In a similar way, the interaction I hold with participants may facilitate or limit the amount and type of information they will provide. Therefore, it is important to account for the way in which my position as a researcher and the participants' position (which is not static) is negotiated throughout the research process.

In participant observation, reflexivity demands researchers to examine the angle from which they observe, and hence account for the relationship between the observer, observed and the report of the observation (DeWalt & DeWalt, 2011). Reflecting on my field experience, being a black minority researcher, I could get access to stories of immigrants as part of their experience in being minority staff working under the majority leadership and within the majority populated environment (see chapter 6). This, as a result, may influence the way my report will look like, as compared, for example, with the same study by an ethnic Norwegian

majority researcher. However, being a black minority researcher did also always produce barriers for me. In one of the nursing homes, for example, I met a minority staff member, who among other stories, mentioned that in that ward there were people who did not like immigrants, especially those with dark skin complexion. Imagining that I had just started to collect data from that very same environment made me behave cautiously, especially at the beginning, observing who 'might look like not liking me' through their facial expressions. For me, this was an important piece of information with which I might avoid unnecessary discomfort to such participants, by assuming that they were collectively ready and happy to have my presence. As for example, at NH1, I noticed that there was one majority staff member who would not greet me, nor would she respond to my greeting. As a result, I also tried not to get in her way during my field stay at that place.

Being a female researcher was an added advantage, especially because nursing homes are female dominated workplaces, thus all the nursing homes in which I did my fieldwork had female staff at a higher percentage than male staff members. This also was an advantage when interacting with the few male employees at the NHs, especially the black men, whom I could ask sensitive culturally related questions about challenges they face as black males working in the Norwegian nursing homes. They would, for example, give straight examples on the way they felt bad about doing what they considered as 'female work', with which they assumed I was familiar (see chapter 6).

Informal Interviews and conversations

In ethnographic studies, interviews play a vital role in understanding people. As Zussman (2004) specifies, interviews are one of the ways in which people may reveal the meanings they bring to bear on places where they live and work. Researching on cultural issues, and especially in multicultural contexts, as in this study can be tricky and challenging. Multiculturalism is a much-politicised concept and tied to immigration policies in Norway. As such, discussions in public debates often have strong moral aspects. Participant observation as a method for data collection allows for a wide range of information for the researcher, but at the same time may put the researcher at risk of interpreting and judging every aspect of observation in a subjective manner. This might be dangerous if it turns out to be against the intended meaning of the participants. Therefore, in between, semi-structured individual interviews and non-formal conversations (walking and talking in corridors or cafeteria) offers a substantial triangulation of my data. I conducted such interviews and had such conversations with all the three leaders

of the NHs, and in addition conducted twelve interviews with minority staff and four with majority staff during working hours. I conducted a total number of 19 short informal interviews, with three leaders from all the wards I was observing, 12 minority staff, and four majority (ethnic Norwegian) staff. However, due to the hectic nature of the nursing homes, these interviews were very short, ranging from five to ten minutes. The interviews were mostly based on prior observations of incidences. For the immigrant staff members, I was particularly interested in knowing their routes to Norway and the way they experienced leadership and working environment.

Informal interviewing is one of the primary means for ethnographic researchers to access more information about people's social, cultural, political and economic lives. It has an advantage of enabling a researcher to collect unbiased data from observations by inquiring more details from participants and thus enhancing intersubjective understanding (Crang & Cook, 2007:60). Informal interviews and participant observation complement each other in a sense that, interviews may provide insights about phenomena prior observation, while observations may suggest probes for interviews later (Tjora, 2006). Therefore, interviews and participant observation may bridge the gap between what people say they do and what they are actually doing, to enrich the data, but not necessarily testing for proof of what is said or observed.

In doing research in communities, researchers need to bear in mind that some participants may lack some degree of honesty and consistency and may not be sure of what they say or think. Researchers must therefore always be suspicious of the reason as to why they understand what they understand within the contingent, intersubjective context of their field work (Crang & Cook, 2007). Such a situation was vivid, for example, in one nursing home, whereby I was not aware that some cultural realities, such as food, might differ between Sweden and Norway, despite the fact that they are alike in so many ways (see chapter 6). It was not until I had a conversation with a staff member after observing the challenge, she was going through that I came to realise there were also cultural differences in the way they prepare and serve some of the food. In this manner, other forms of conversation such as interviews relate closely to observation as they offer a deeper understanding on the meanings people may attach to actions and clarifications.

In practice, my day at the nursing home would begin either with a chat at the leader's office or I would go straight to the wards if I had a prior plan. At the leader's office, I would ask for clarifications on the issues I had observed on a previous day or give some feedback. During my first few days in the field, I started with some informal conversations with the staff on general

matters about working in a multicultural environment. As the days went on, I was able to participate in some of the activities, and did my observation, although with varied degrees of participation. Thereafter, I conducted short follow up interviews for some of the participants so that they might clarify or deepen my understanding about the activities or actions, which had happened previously. I had to make an agreement by requesting that the staff member I had interest with could meet me, either at the report room, or in a quiet place in the canteen while there were no people eating.

Data recording and analysis procedures

Data recording in ethnographic studies may be challenging, especially during participant observation (Crang & Cook, 2007; Spradley, 2016). In order to write my field notes, I had several strategies. Either I would do it after the shift, if it was short, when I went back to my residence, or I would find a quiet place while at work, when the wards were quiet, and write notes. I walked with my small notebook and a pen in my back pocket so that it was easily available whenever I needed to jot down key words or short descriptions. When moving from one ward to the other, I would also stop by the lounge in between to jot down some quick notes, which I elaborated later when I had a convenient time and place. As Craig and Ian (2007:21) contend, things must be noted down when they are still fresh, otherwise researchers may risk blurring things as time passes by. I wrote my reflection points after each field day, which would guide me on what to focus or seek for further clarifications the next day. However, as far as note taking is concerned, Craig and Ian (2007:21) further caution on the danger of researchers dwelling much on note taking to get away or cope with loneliness, boredom or frustrations in doing fieldwork. This may be an obstacle to doing fieldwork. I also faced some moments of frustration and boredom in the process, and I did my best to cope with the situation and maintain focus, or at some point, I took a break and left earlier.

Data collection and analysis went hand in hand on a daily basis. This intertwining is popular in qualitative studies, where there is no clear distinction between the two processes. In Spradley's (2016:35) approach to analysis process, he maintains that "Every now and then, during a field project, you need to climb a very tall tree and gain a broad perspective on how far you have come, what tasks lie ahead, and which direction you should take". To my understanding, this implies the way researchers go back and forth in making sense of the data being collected and making necessary adjustments in the process before the grand activity of final analysis. In this regard, I was usually starting my day it the field by searching for lacking or complementary

information which I had considered important during my previous day, received either from the leaders or other staff. At the end of each day, I went back to my fieldnotes to check for trends, consistencies and gaps, then plan further for the coming days.

The field notes and notes from the interviews were written in English, the language which I felt that I was more comfortable to be quick and precise in note taking, although the activities, (most of) the interviews and conversations were conducted in Norwegian. As for the data from focus group interviews, these were collected and recorded in Norwegian. As such, I had to translate them using Google translate. However, some of the translations were misleading, thus I had to use my Norwegian language skills to edit the translations into understandable and relevant text. In the end, I took my thesis for language check in order to meet the English language standards for my thesis, since English is also not my native language.

Qualitative studies enable researchers to collect rich and comprehensive data, which needs time and focus on analysis. As for example in this study, I had data from participant observations, individual and focus group interviews. At the end of my fieldwork, the data was synthesised (for each nursing home) and the process of analysing cumulative data started. When put together, before synthesizing it, I had a total of 73 typed pages altogether. At the end of the data collection, a comprehensive analysis followed. I adopted an inductive thematic analysis approach (Braun & Clarke, 2006) to transcribe, code and analyse data, informed by an interpretive description (Thorne, 2016) to explore the potential patterns in the data. I began with reading and re-reading the data to familiarize myself with the content, looking for meanings, patterns, similarities and differences. Thereafter, I started coding the data by making categories and creating a framework of the meanings. In this, I simply used the copy and paste function of the word process in my computer.

Themes were obtained through re-reading the text several times to identify some repetition and pattern (i.e. topics that occur and reoccur) (Ryan & Bernard, 2003). I used highlighters of different colours to group such key ideas in the text. Following an inductive approach to analysis (Graneheim, Lindgren, & Lundman, 2017), I divided the texts into meaning units, which I then condensed and coded. The codes were interpreted and compared to identify similarities, and then grouped into 14 sub themes. Through a reflection process, these subthemes were further condensed to three main themes, which thus made the ethnographic and analytical chapters of this thesis. An example below may illustrate the coding process:

Table 2: Analysis procedure, an overview

Raw data	Meaning units	Respective codes	Themes
In my country **I used to work as a secretary** in a private firm, but you know, **there is no such a position here in Norway,** especially with the level of education for a secretary from my country … **After qualifying for language**, I continued to study further because I want to get at least a minimum profession in this caring job (helsefag). I have already spent 5 years now without being able to get a certificate. **I have taken exams twice and failed**, so I am redoing it this time as well, I hope it turns out well … I think it is too long and difficult, so I am not planning to take further education … by the time I get this certificate, I think I will be too old to handle more stress especially studying as a more qualified health professional. **I will just have to manage with that for the rest of my life …**	Professional background Irrelevant profession Language requirements Standardised qualification process Plan for professional advancement	Qualification for employment	Limited career mobility Structural discrimination

Language and dialects

Norway has two standard official languages (written), which are Nynorsk and Bokmål. Both of them are referred to as 'Norwegian'. However, none of the Norwegians speak exactly either of the two languages but have dialects, that is a, particular form of language which is peculiar to a specific region or social group. These dialects are divided into several categories, depending on the levels of description. Since Norwegians are exposed to dialects from a young age, they have relatively minor problems in understanding each other (as for example compared to immigrants) (Høyte, 2008).

In doing ethnographic studies, language is a salient aspect in order to understand and explain things happening in the field. The researcher needs to have linguistic abilities to influence

activities and probe for clarification purposes. Talking the talk, as put by Dewalt (2011:56), is the ability of the researcher to communicate in local language, to follow informal conversation, and to understand and join in with jokes in the communication process. However, the researcher needs to reflect more on the contextual, face-to-face, field language. This is because language use may vary both in geographical and interactional contexts (Crang & Cook, 2007). The demand for Norwegian language competency in nursing homes environment is unavoidable. This is because it is the only official language used, although some residents may occasionally prefer to speak other languages (see chapter 5). As such, my language (dis)abilities played a key role in the process of participant observation and other conversations. Being an immigrant, I had an opportunity to study Norwegian language for one year before starting my master's studies in Norway in 2010. This was my fourth language, after my mother tongue, Luhaya, then Swahili and English, which I had to learn in school. However, being standard written language from which I had to learn to read and write, I was only oriented to the written languages, particularly Bokmål. In the course of my master's studies, I had an opportunity to work at a nursing home, something that, after a series of challenges and frustrations, improved my language skills to a large extent. This worked for me further during my fieldwork for this study, whereby my prior experience of working in a nursing home enabled me to easily understand some of the professional jargon in the care sector. However, Norwegian dialects are spread regionally, and they vary according to where the person comes from. Being an employee in one part of the country (Western) at the nursing home, did not exempt me from dialect challenges. I faced challenges concerning the many of the research participants. This was because the study was conducted in three different municipalities, from different regions/parts, with different dialects, and this was fuelled by the fact that staff came from local and distant places, thus increasing the number of dialects used during social interactions. Sometimes I had to ask for clarification repeatedly on one thing, while on the other hand I would not understand the discussion unless I paid serious attention and asked participants to repeat themselves.

Ethical reflections

In doing research, it is not possible to find a simple and unproblematic method of data collection (Crang & Cook, 2007:23). In this section, I present ethical reflections on issues relevant to this study, while I will simultaneously reflect on the methodological challenges and the way I addressed or minimized them.

Anonymizing informants, places, and situations

Anonymity of informants is a key ethical aspect in research, especially those involving vulnerable and marginalized groups, such as immigrants in this case (Barron, 1999; Li, 2008). In ensuring anonymity in this study, during field notes taking and analysis, all the names were changed to pseudonyms to protect the participants. Moreover, specific names of the places where immigrants came from were generalized as Africa, Europe/non-Europe, and so forth, in order to avoid identification.

However, anonymity goes far beyond changing names and places which can be identifiable in the final report (Spradley, 2016). The use of pseudonyms does not always guarantee anonymity, especially in ethnographic studies, which include extensive details about the situations. This could be very much the case in studies involving small numbers of participants (Surmiak, 2018), such as this study. Ethnography is about observing and accounting for behaviours, or sometimes reporting about the ethnographic interviews. Given the nature of the nursing home working environments, it might be possible for leaders and/or staff who participated in this study, to identify individuals concerned, because they know each other, and some may know the story I am reporting about (or quotations) from their previous work experiences. In trying to address this matter in this thesis, I have generalized my discussions, by not mentioning particularly where the case happened (especially in cases which I have assessed to be easily identifiable and/or sensitive) or mixing up the places to blur identifications.

NSD approval/ research permit

As part of the larger Multi Care project, this study was approved by the Norwegian Centre for Research Data (NSD) (see appendix B).

Informed consent

In this study, informed consent was intended to enhance autonomy and the right for self-determination among the respondents. Apart from the general request I sent at an early stage to the nursing homes, individual consent was obtained from all the staff whom I approached for informal interviews, either orally or in written form. Although most of the respondents offered an oral consent giving their willingness to be interviewed and observed, I always carried with me some copies of the written consent form to be signed in each interview if the respondent wished.

Making immigrant workers voices heard

My ethical reflections also concern conducting a study that engages people and groups that are seldom heard (Barron, 1999), in this case minority staff at nursing homes. Immigrant staff in Norway can be regarded as vulnerable or marginalised group in terms of their meagre representation and voice in research, yet also in terms of their general positioning at the labour market in Norway. Although I had a general acceptance from the leaders to access the nursing homes, I noticed that some of the minority staff were hesitant to engage in conversations with me. For example, in one incident, a minority staff from Asia with an Arabic name refused that she was a Muslim in the beginning, and later on, after she was familiar and comfortable with my presence, she admitted that she was a Muslim. I took it easy and spent more time to familiarize myself while explaining more and more about my study and answering their doubts until they were ready to participate especially in individual interviews.

Summing up reflections

In this chapter I have presented methodological and ethical reflections of this study. I have discussed the inter-relation between ontology, epistemology, theory, methodology and methods, showing the rationality of the choices I made in the research process. I have discussed ethical issues and challenges, and the way I adjusted to minimize those challenges. Finally, I have discussed implications of doing qualitative social science research on groups in the population that are seldom heard either in research or the public discourse – immigrant care workers.

The next three chapters are ethnographic, presenting the detailed analysis of the research findings. In chapter four, I will explore the structural factors through which leadership practices among multicultural staffing realities are negotiated daily.

Chapter 4: Structural and Contextual factors shaping Agency and Work practices in nursing homes

Introduction

This chapter discusses the contextual factors that mediate, enable, or constrain inclusion of minority staff at the workplace in the nursing homes and influence work processes. Being both the residents' final home and workplace for leaders and staff, nursing homes create a complex environment, resembling a ´total institution´ (Goffman, 1961) which demands simultaneous realization of both institutional, organizational and home ambitions, attending to and accommodating both employees' and residents' needs. Leaders' and staff strategies and work practices are contained in multiple structures, made by laws, rules, norms, budget/economy, regulations, policy, reforms and guidelines, guiding nursing home organization and operation. These structures, in turn, inform actions and choices, and thus agency, at work. This chapter, therefore, focuses on the situatedness of work practices and organizational culture constituting the structures and contextual conditions shaping the working environment and work relationships among leaders and other staff in the nursing homes. The aim is to understand the context within which staff and leaders' agency is constructed in interface with social structures.

With the use of ethnographic research methods, the findings are presented and analyzed through the lens of agency focusing on the multiple structures and contextual factors that guide actions and choices among leaders and other staff. In this regard, and as discussed in chapter two on theoretical concepts relevant to this study, the conception and relationship between agency, structure and context by Bourdieu (1977), Emirbayer and Mische (1998) and Ahearn (2001) shall be employed throughout the analysis in this chapter. In particular, the chapter explores the ´logic of care´ as a composition of a number of structures in nursing homes, and the way it informs habitus of leaders and other staff in the nursing home context (Bourdieu, 1991). Moreover, the analysis explores situated and time bound work practices (Ahearn, 2001; Emirbayer & Mische, 1998) informed by policies at national level and channeled down to inform institutional and organizational regulations at the municipality level (see chapter one) and hence influencing leaders´ strategies and practices and work processes at the local contexts of individual nursing homes. Specifically, this part of the analysis contributes to the understanding of the aspect of ´context´ as an important part of this thesis for explaining agency of leaders and staff.

Although contexts can be other practices, they are commonly used for exploring situated practices in specific locations. Therefore, when using and emphasizing context, the researcher emphasizes where the practice takes place, when they take place, with whom, and so on. I choose to understand context as institutional practice which encompasses organizational settings. It is the salient overlapping situational features, both opportunities and constraints (Johns, 2006), which shape the organization of work in the nursing home working environment. In other words, context may both promote and/or limit agency at this micro level of practice. In some cases, however, in this thesis, the terms structural and contextual factors may be used interchangeably, for example, staffing levels as used in this thesis may appear to bear both structural and contextual stances. While inclusion in this thesis refers to availability and accessibility of practice in care processes, integration refers to the way immigrant staff can participate in care work practices at the same level as majority staff members (see also definitions in chapter one). These concepts shall be critically analysed to shed light on the way they inform agency of leaders and other staff from the political structures down to the nursing home contextual realities informing daily work practice.

In this regard, the main argument of this chapter is that leadership practices are both enabled and constrained by the structural and contextual factors in which nursing homes are situated, hence influencing inclusion of minority staff in daily work processes. To be more specific, empirical findings suggest that some structural and contextual aspects matter more than others in this specific working environment. For example, structural factors such as budgets, laws, and policies and reforms (such as NPM in chapter 1) on elderly care and immigration may matter more compared with norms and guidelines. Regarding contextual matters, factors such as staffing levels and resident characteristics may matter more than staffing composition and demands for specific actions from relatives to the residents.

The chapter is divided into four sections. The first section presents the recruitment processes of nursing home staff and the consequence it bears to the immigrants' work positions and shift allocations, as presented by leaders and other staff. The second section is about the number and characteristics of residents and the way it relates to organization and prioritization of care tasks among the staff, while the third section is about the role of family members and volunteers in care organization. The last section discusses distant leadership as the consequence of increased managerial tasks among the leaders which limit their hands-on leadership and physical engagement in body care processes.

Recruitment to care work and immigrant trajectories in Nursing Homes

The municipalities are main employers of nursing home staff and leaders play a key role in the recruitment process, through identify staffing gaps and professionals needed. In one nursing home, for example, I saw a leader interviewing a new temporary staff member, who would start working during the summer. However, as it is in other countries in Europe and elsewhere, the recruitment process does not depend on personal wishes of the leaders, but the established framework and processes at the municipal and even national levels. These frameworks shape the agency of leaders regarding recruitment processes. Olakivi (2019), for example, highlights the way nursing home leaders in Finland exercise their agency in the recruiting processes in terms of abiding to the structural demands, while simultaneously reflecting on the practical aspect of meeting the gap in the care labour force at their workplace. He explores the role of care work managers through the framework of their occupational agency. In this regard, the study explores agency of leaders "over structural constraints and for specific interests from the perspective of relational sociology" (Olakivi 2019:18). Through this perspective, their agency (and/or lack of it) is understood as being "a matter of constant construction", rather than being a function of things, beings and essences (ibid.). Olakivi reveals the way managers' agency in the recruitment processes is subjected to the way care recipients, migrant workers and the broader political environment are constructed and interpreted in a relationally changing manner. These relationally changing interpretations can serve many functions, including care work managers' impression of management in different situations and, ultimately, the recruitment of migrant workers to (precarious) old-age care (ibid. pg. 1).

As I have mentioned earlier in chapter one, immigrants have different starting points before they end up as care workers for elderly sick people in Norway. Whereas some enter the country through planned routes of education, work and marriage, others have refugee and asylum-seeking status, with semi- or non-skilled humanitarian migration categorisation. Depending on their starting points, the findings in this study indicate that recruitment of staff to nursing homes may take several pathways, which may also involve different actors. This, in the end, plays a role in determining their level of inclusion in work, in terms of the employment contracts they may get. As a general observation, the probability of having a higher percentage of work increases relative to the level of professionalism in the hierarchy.

The following categories, therefore, classify nursing home staff in this study. Firstly, there are those who are professionally educated in Norway, and employed as registered nurses or auxiliary nurses. Most of the majority of staff fall into this category, and they apply for positions whenever they are publicly announced. None of the minority staff in this study had such a straight route to the nursing home working area. The minority staff comprises those who were educated outside Norway and had to get their academic certificates approved in the Norwegian system before being employed and allowed to practice in a particular health profession. Most of the minority staff from EU, EEA and a few from outside Europe fall into this category. These immigrants are screened through the Norwegian system of approval of foreign education known as the Norwegian system for approval (NOKUT), one of the responsibilities of which is to accredit higher education institutions and tertiary vocational education and to recognize foreign education[20]. The process for accreditation of foreign education involves individual applications, which are then assessed and judged by the NOKUT, based on national and international networks, as well as relevant databases (Langfeldt, Harvey, Huisman, Westerheijden, & Stensaker, 2008). Most of the minority staff are in this category.

The minority staff experience this approval process in a variety of ways, as the following quotes from three different staff show.

Anna from Finland:

> *I used to work as a cancer specialist nurse in Finland. When I came here the only challenge was learning the language. My certificates were approved at the same level [as I had obtained in Finland], because they had the same standards with the Norwegian education system. But I did not want to work again in the hospital, so I decided to apply for work here.*

Katrina from the Philippines told a different story.

> *I used to work as a nurse in my country, but when I came here, I was told that I did not qualify for the position. So, after the evaluation of my certificate I was told that I could work as an auxiliary nurse, and if I wanted to work as a nurse, I had to go back to school for more years in order to qualify …*

A similar experience was presented by Emmanuel from eastern Europe:

[20] https://www.nokut.no/en/

It is very frustrating with this evaluation of certificates. For me I sometimes do not understand why they must make it difficult for us. I was a nurse back in my country, and after passing my language test I had to go through this accreditation process. Then I was told that I cannot be a nurse here, but [I can be] an auxiliary nurse (hjelpepleier). They gave me the conditions if I wanted to upgrade, and I fulfilled those conditions. But when I applied again for the approval, I was told that the conditions had changed, and I would have to start afresh to study for a nursing degree. It is sad that they keep on changing these conditions. Despite all this, when I look at what the nurses are practicing, I see that there is nothing I cannot do …

The above three quotes indicate different experiences of immigrant staff in the recruitment process, which seem to work in favor of some, while disadvantaging others. Looking at Anna's case, for example, she did not face the hustle of the approval process as Katrina and Emmanuel did. She was able to choose working at a lower skill level, changing rank from being a cancer specialist nurse in her home country, to being an ordinary registered nurse at the nursing home in Norway. As she had a relatively similar education training component, as she told me, she was easily accepted in the application of her preference. The structural needs (that is the approval process by NOKUT) promoted her agency by providing the option of her choice. This situation can be viewed as providing for individual preferences and choices but can also be seen against the generalization that immigrants do always face downward social mobility and deskilling in terms of their professional levels, due to systemic arrangements, as for example observed in the UK (Christensen & Guldvik, 2014). The only challenge Anna had to go through was language qualifications. In my observation, she had relatively bad verbal language competence, as compared to other minority staff, even those with lower skills. Although both Anna and Emmanuel were educated in Europe, they faced different experiences in their approval processes.

As a general observation, many accreditation applicants face a downward approval or total rejection of their professional levels in Norway. For example, Katrina, a registered nurse educated in the Philippines may end up being evaluated by NOKUT as deserving an auxiliary nurse level in Norway (as for example in Katrina's case above). Nevertheless, from Emmanuel's experience, it seems there might be lack of clarity in the approval process, or the minority staff may themselves find it difficult to understand the procedures and criteria for their evaluation, probably due to being new in the Norwegian working systems and procedures. Moreover, he and the other two minority staff in the quotes above were not recruited through

the help of recruiting agencies from their home countries, something which may mean that they had to navigate their ways through the accreditation processes individually. Another important point which Emmanuel highlights is that he thinks that he is capable of practicing as a registered nurse, although his ambition cannot be justified in the system requirements, so he must remain at a lower skilled level according to the set standards. My observation with regard to the ward in which I always found him placed at NH3, was that it was not easy to draw a line between the responsibilities between nurses and other staff during work, as it all depended on the way in which residents (who were labelled as the most cognitively challenged) would readily accept assistance from staff on duty. So, in this regard, Emmanuel might be right that he is doing what everyone else is doing, although that may not necessarily justify his accreditation refusal in the established system. Understanding this from the leaders´ agency in the staff recruitment process, however, Emmanuel may be evaluated as a hardworking and helpful member of staff but does not stand any chance of being awarded a position based on the qualification he holds in his official presented documents on his application for the job. These are structural demands on recruiting processes for immigrants, which the leader has no power over to change.

Researchers have explained the struggle immigrants go through when seeking accreditation of their academic achievement by exploring the situation, not only in Norway (Dahl, Lohne, & Nortvedt, 2019; Lise Widding Isaksen, 2012; Munkejord, 2017), but also in other western countries such as Sweden (Eriksson, Berg, & Engström, 2018), Canada (Hawkins & Rodney, 2015), New Zealand (Jenkins & Huntington, 2016; Jenkins & Huntington, 2015), and UK (Likupe, 2006). Paying specific attention to Norway, Nortvedt et al., (2020) have analysed the process of accreditation for immigrant nurses from outside EU/EEC, highlighting the differences in the training components. They argued that some of the training components of immigrant registered nurses from their countries of origin are similar to some extent to the Norwegian bachelor's degree, while also characterised with a number of gaps, which disqualify their training levels from being accepted directly for practice. The bachelor's degree of nursing from the Philippines, for example, is evaluated as equivalent to two years of the same degree in Norway. They pointed out that in order to get an approval for practice, nurses need to go through practice in geriatrics and psychiatry, additional language courses and courses in Norwegian health legislation and medical theory, in addition to passing a proficiency test (see also Helsedirektoratet, 2018a[21]). In general, nursing education from countries outside EU/EEC is

[21] https://www.helsedirektoratet.no/english/authorisation-and-license-for-health-personnel#required-documentation-for-language-skils,-course-and-proficiency-test%2013-education-from-outside-the-eu/eea

considered to concentrate more on science knowledge *(naturvitenskapelig kunnskap)* connected to medicine, in which aspects such as prevention of infectious diseases are given much attention. During practical placements, nursing students from this area practice more in hospitals and preventive health work, but almost never in elder care practice (Dahl, 2018). In this regard, it is understandable that immigrant nurses may need a form of training to match the requirements of the Norwegian health system, particularly those interested in practicing in nursing homes. However, Emmanuel's´ concern cannot be completely ignored, and suggests the need for further investigation to establish the relevance of what is a gap in the required training component and its relevance to nursing home work practices, in which Emmanuel (like other minority staff examples) thinks he can do everything the registered nurses are doing, although he has been denied the opportunity to practice as a nurse. There have been several studies and policy documents problematizing NOKUT´s practice[22].

When it comes to language competency, this is measured according to the Common European Framework of Reference (CEFR), and a person must prove Norwegian language competency at level B2 in an examination. According to CERF description, foreign language proficiency is categorized into six different levels, from A1 up to C2 (Nortvedt, Lohne, & Dahl, 2020). Although there is this system of approval, the study by Nortvedt et al., (ibid) observed, just as in the case with Emmanuel above, that the process is not clear and transparent to the immigrant staff. Some claimed that they had fulfilled the requirements but faced repeated rejections and continuous changes of rules, something they considered to be harsh treatment, while some thought that simultaneous rejections made it a long discouraging process (ibid). Moreover, as observed in the case of Emmanuel from EEA, similar negative experiences of immigrant health care workers in Norway have also been highlighted within groups of EU immigrants by a number of researchers, such as difficulties of nurses and doctors in obtaining credential recognition (Munkejord, 2017) from Latvia (Lise Widding Isaksen, 2012), and in Poland nurses face limited political and cultural integration (Van Riemsdijk, 2010b).

It is understandable that each country has its own way of safeguarding care services by adhering to national standards, especially when recruiting staff from outside the host country, as is the case in Norway. Similarly to Sweden, Norway is considered to have relatively more strict formal requirements than for example, USA, UK, and Saudi Arabia (Freeman, Baumann, Blythe, Fisher, & Akhtar-Danesh, 2012), (see also (Dahl, 2018; Nortvedt et al., 2020).

[22] godkjenning_utenlandsk_utdanning.pdf (riksrevisjonen.no)

Screening immigrants with foreign qualifications, therefore, may be important for making sure that those countries have qualified people who can be entrusted to provide services according to the established standards and ambitions of each country. However, the process of accreditation needs to be clearly communicated to the intended group to comprehend rather than leaving them complaining that they are being unfairly treated by the system. As Nortvedt et al. (2019) found, there has been a repeated rejection of nurses from the Philippines, even though they think they have fulfilled all the requirements, while others with similar educational backgrounds are evaluated with different decisions from the Health Directorate. Moreover, in the quote above, Emmanuel presented his frustration that the accreditation conditions often change, which was the reason for his negative evaluation. However, the new Norwegian regulation of 2017 *(Forskrift om tilleggskrav for autorisasjon for helsepersonnell, 2016)*[23] has introduced what is considered to be a mechanism for ensuring predictable solutions on implementation of credential recognition for health workers educated outside the EU, highlighting clearly the courses and additional requirements which have to be implemented within specific deadlines (see also Nortvedt et al., 2019). This could help to solve such complaints from dissatisfied immigrants in Norway. However, Nortvedt et al., (ibid) raised another concern that the suggested supplementing courses for qualification are very expensive, hence it is not realistic for immigrant nurses to acquire them, since they have to pay for these courses from their own pockets.

Looking at the accreditation processes as one of the key determinants for inclusion of immigrants in elder care work, I argue that immigrants face 'systemic discrimination', because after being evaluated, most of these staff do not manage to attain the higher professional levels due to systemic procedures, such as the high training costs of the required educational qualifications as mentioned above. Systemic discrimination might be based on policies and practices (both formal and informal, written and unwritten) which limit minority staff's ability to navigate through the upper professional ladder, thus constraining their agency (Craig, 2007; Dahle & Seeberg, 2013; Hervie, 2019; Nortvedt et al., 2020). Although the concept of systemic discrimination in employment may refer to a number of things, for the purpose of this thesis, I relate it to the conception of Craig (2007:94&96), as a form of many neutral policies and practices of the workplace such as the procedures of recruitment, hiring and promotion, which may produce disadvantage for non-dominant groups. This understanding does not necessarily reflect the original purpose of such policies and practices which were established primarily for

[23] https://lovdata.no/dokument/LTI/forskrift/2016-12-19-1732

the purpose of eliminating immigrants from the relevant labour market, but when put into practice, they create a 'ceiling' (structural factors) which works to their disadvantage (agency). As Craig (ibid) established, some immigrant staff, after being accredited to a lower professional level, cannot afford to study again due to their inability to cover expenses. Although the Norwegian government supports every citizen in education, some of the minority staff mentioned the challenge of studying in this country for three years before being allowed to apply for public funding, and sometimes having to move to another city with a relevant university, something which adds cost. They perceived these conditions as limiting their wish to excel in their career ladder.

At this point, I also want to insist that the accreditation process has nothing to do with the leaders at the local nursing home practice, although it may significantly determine the possibility of recruitment and inclusion of an individual employee. Instead, I relate the accreditation process to structural demands at the national level, which bear consequence on the manner in which leaders reach their decisions (agency) to recruit and include immigrants in work. This is because they recruit immigrants based on the accreditation results, and not the original levels of their certificates from their home countries. I therefore argue further that the process of immigrant inclusion in work by leaders is shaped by structures above the organizational/ contextual level of the workplace and by the macro-regulation to which workplaces relate. In other words, the elder care sector is already to a large extent regulated subject to labour market demands. In this regard, it is not up to the leaders to discuss or negotiate, but rather, to adhere to such conditions when recruiting minority staff. In the same vein, several structural demands shape the immigrants' navigation through employment in the nursing homes, and sometimes dictate the level of their professional destination. The general requirement for and recognition of particular skills, for example, channels immigrants into particular jobs and shapes their patterns of work (Da Roit & Weicht, 2013). As such, they are experiencing constrained agency based on their structural positions in the social field (as immigrants or labour migrants) (Bourdieu, 1977a), which subject most of them to precarious job positions (Friberg & Midtbøen, 2019; Paret & Gleeson, 2016). In the findings of this study, for example, the category of minority staff whose education is not accredited, tends to strive for posts requiring the second lowest level of qualification in the nursing home, either as auxiliary nurses, healthcare worker (*helsefagarbeider*), or to remain permanently as unskilled staff (*assistants*) which is the lowest level, with zero-hour contracts, working as substitutes waiting for random calls. The lower the level in the professional hierarchy, the less the employment

percentage, for most of the staff in this category. This means that it is easier for a registered nurse to have an 80% or more employment contract, as compared to the healthcare worker. [In this regard, therefore, this amounts to their level of inclusion in work as well as their economic status in terms of levels of income based on the monthly salary. Moreover, being accredited to the lower level of profession may reflect downward social mobility, as highlighted by Christensen and Guldvik (2014), among some of the immigrant staff. In practice, such procedures may function as exclusionary (although not necessarily intended) when put in practice, to deny certain groups from accessing and accumulating relevant social capital (economic or cultural) (see chapter 5).

The last group of staff, which also includes many of the immigrants, are those who begin as language trainees in the nursing homes, attached through the NAV[24] programs or through the adult language training courses. Some of these staff pave their way to the nursing homes by working as assistants after passing the language test. This is the lowest level in the professional ladder in nursing homes, with the least work percentage for some, while others do not secure any permanent contracts, but work on call, or on zero-hour contracts, when there is an emergency or shortage of staff. I found that this category of staff might sometimes have opportunities to work up to a hundred percent, due to regular absenteeism and sick leave of permanent staff (Elstad & Vabø, 2008; Havig, Skogstad, Veenstra, & Romøren, 2013; Tingvold & Fagertun, 2020). However, this might be a disadvantage in facilitating familiarization among such staff, because although there might be an increase in vacant shifts, they are scattered in different wards, or even departments of the nursing home. In addition, although such staff may have the advantage of gaining experience in care work in general, this cannot help them excel on the professional ladder because it is not acknowledged in the recruitment procedures with regard to staffing nursing homes.

Concurrent with this group, some other minority staff who migrated as adults for other reasons than seeking asylum or labour migration, had a relatively different entry point. Marcia, for example, who migrated to Norway after marrying a Norwegian man back in her home country, had the following experience,

[24] The Norwegian Labour and Welfare Administration (NAV, originally an abbreviation of Nye arbeids- og velferdsetaten) is composed of a central agency and elements of the municipal social service systems. It helps to provide social and economic security while encouraging a transition to activity and employment. (See https://www.regjeringen.no/en/dep/bfd/organisation/tilknyttede-virksomheter/Norwegian-Labour-and-Welfare-Organizatio/id426155/)

I came to Norway when I was 22, with my husband and the boys…back in my country, I used to work as a waitress at a hotel, but I was told that working with old people pays more…I could not speak any Norwegian at all at that time, so I had to register for formal language training… the funny thing which was also a difficult experience for me was that I was put in a class with very young people, some only 16 years, in order to learn the Norwegian language. I found it hard to make friends because I assumed that they were too young for me. I had no choice but to remain focused until I finished and passed. I then started my course as an auxiliary nurse (hjelpepleier). Then it did not take long before I got a job here at this nursing home…

Marcia started afresh after deciding to change employment from waitress to auxiliary nurse, starting from language training and then registering for the education of her choice, although influenced by the high pay she had been told about by other people. Although she could opt for finding a job similar to the one she had done back in her country, just like many other immigrants working in hotels and restaurants in Norway, Marcia chose to change her role completely and enter another professional world to earn better. This was contrary to the experience of other minority staff who were forced to opt for working in the nursing homes due to difficulties associated with finding other jobs which interested them (See also (Friberg & Midtbøen, 2019; Orupabo & Nadim, 2019; Tingvold & Fagertun, 2020; Waerness & Ringen, 1986). Like Marcia, there are many other minority staff who migrated to Norway, some with professions with which they could not easily secure relevant employments - such as being trained as a secretary - back in their home country. These people had to start afresh on the healthcare profession ladder from the bottom of the hierarchy. The important point in Marcia´s narration is the age factor and the ambition of getting a ´relatively decent job´ for most of the immigrants who migrate to Norway as adults. This study involved other minority staff who, unlike Marcia migrated in their mid-thirties or older. Most of such staff mentioned having lost interest in pursuing a higher career stage due to the long, demanding and uncertain processes, and therefore aim to remain at the lowest professional levels for the rest of their career life.

After recruiting new staff, the three nursing homes (NH1, NH2 and NH3) offer a standardized orientation for all, introducing duties, tasks, and expectations. On most wards this takes three shifts, one for each orientation. Thereafter the new staff member is expected to manage the tasks, although advised to ask as much as possible whenever not sure of what to do. Some leaders may go further and develop basic guiding information, which the new employees are given in relation to the tasks in the ward, while in some other nursing homes, new staff are left

to depend on the more experienced staff to improve their competence. In NH3, for example, a form was prepared for new staff as a working aid during their first days at work (i.e. *Huskeliste for nyansatte, vikarer og studenter/elever på avdeling…*). However, these were common for all new staff and students, and did not consider individual variations, such as culture, gender or ethnicity. Moreover, they focused more on tasks and hardly on social aspects of care. My interpretation of such arrangements was that there were not structural requirements (at the macro level) for the leaders to adhere to as it was with the accreditation processes, which is why they were not found in other nursing homes. Rather, leaders from this nursing home wanted to meet the needs relevant to their context of practice, that is, they exercised agency based on what they wanted their new staff to get oriented to in their own context.

Immigrant integration in work and society does not happen automatically. Rather, there are a number of mechanisms employed from the national level to facilitate the process, for example, offering newly arrived immigrants introduction to language courses. However, the general integration mechanisms for the immigrants focusing on promoting an egalitarian society may also contribute to a rise in social inequality in a society. This is partially due to the unaddressed structural factors, which push immigrants to the lower end of the professional pyramid/hierarchy (*immigrant niches*), based on the limited options they are left with when the politics of integration are put into practice (Dahle & Seeberg, 2013; Friberg & Midtbøen, 2019). For example, immigrant men increasingly today do the 'dirty work' (cleaning) which used to be primarily Norwegian women work (Orupabo & Nadim, 2019). Due to the considered 'irrelevant' professional qualifications and language barriers, immigrants are sieved in the recruitment and authorization process, ending up lacking qualifications necessary for opting for other job markets or sectors than the service sector. As such, they end up at the lower levels of professional positions service-professions such as in the elder care sector, which is labour intensive and always has vacancies for job positions considered less interesting by the ethnic Norwegian staff (Dahle & Seeberg, 2013). This, I argue, may be an important observation on the way implementation of integration policies may foster class formation in the assumed egalitarian welfare state (see chapter 4 for a discussion of the type of positions and work immigrants hold). Bringslid et al. (2017) and Friberg et al. (2019) argue that there is a trend of a new immigrant working class, who work in low paid jobs, or are unemployed and living on welfare benefits. I add that, this situation may relate to the ever-mentioned difficulty in recruiting and retaining the required work force in the nursing homes, and the challenges it might pose for leaders (see chapter 4). This in turn, may also limit the possibilities of recruiting

professionally competent staff as the ambition for *quality care* provision advocates, especially if there are no plans and budgets for further qualification/education for these workers.

Work positions, shift allocations and staffing levels

Allocation of shifts to staff depends on their possible work percentage as per each employee's contract, which also may depend on the professional level of a particular staff as mentioned in the earlier section. As a general matter, nursing homes in Norway bear a common characteristic of having a number of staff with very low percentage working contracts (Laxer et al., 2016). Low percentage positions affect most of the immigrants employed as assistant or healthcare workers at NH 1, 2 and 3, due to their low level of formal education, as compared to most of the majority staff who have permanent and relatively higher work percentages. In addition, the ongoing process of professionalizing elderly care in Norwegian nursing homes leads to a decrease in attracting the unskilled labor force, the assistants, who were previously an important part of the employees in this area. Consequently, most of the minority staff at NH 1, 2 and 3 hold a weekend work position, whereby they work on every third weekend, although they may get extra shift allocations in times of emergency or deficit at work. However, allocation of extra shifts does not happen on a regular basis. The excerpt below may show this,

> *"I work every other weekend on my permanent shift, although I get some shifts in between… However, this varies a lot… sometimes I have many shifts, but some other times I hardly work… so it is like that…"*
>
> **(Mustafa from Turkey, assistant, NH2)**

In another incidence at NH3, during a discussion among the staff in ward 2, Marcia, a minority auxiliary nurse commented jokingly,

> *"Can someone get sick please? I need to work more…"*

While Mustafa is employed at the least percentage, i.e. every third weekend, Marcia, despite being a skilled care worker (an auxiliary nurse), had a 50% employment contract. Both were adults with family responsibilities (as they mentioned during several conversations), and both depended on extra shifts to supplement their income and earn a reasonable wage. However, from their explanations, extra shifts are not predictable, and may fluctuate over the year. Lacking enough shifts is one factor that limits inclusion in work and subsequent successful

integration, because few shifts mean few opportunities to take part in the working environment and get to know one's colleagues and the residents. Having fewer shifts makes the minority staff appear over-and-over again as new members in a particular ward, especially for the residents. As such, they are always subjected to the decisions and plans of other staff who are more familiar with the residents. The field observation found that those staff who had relatively higher work percentages (70-100), had stable positions in the wards in which they were working, although with some minor rotations in between. This made them more familiar with residents they met regularly, and their significant others, and thus promoted the establishment of social relations. On the other hand, those who had lower work percentages (50 and below) struggled to familiarize themselves with residents and specific tasks in the particular ward. Moreover, during the shifts, they were lagging behind in taking actions, asking for permission or clarification for most of the tasks they were about to perform. Some majority staff experienced this situation as adding a burden to their working day.

Staffing levels are based on a crucial premise which determines the general care, type, and level of activities for residents that can be done during a particular shift at a particular ward (Kjøs & Havig, 2016). Moreover, staffing levels, staffing mix and characteristics of nursing homes have a dialectic relationship in setting general conditions which affect the ability to deliver care (Havig, Skogstad, Kjekshus, & Romøren, 2011). Several studies have been conducted to establish the relationship between staffing levels and 'quality of care' in Norwegian nursing homes. Although it is difficult and complex to operationalize and measure 'quality of care', studies still emphasize that there is a direct relationship between the two variables. For example, high staffing levels may allow for a higher degree of staff involvement and control over daily routines such as mealtimes and activities, as compared to when it is the other way round (Ågotnes, 2018; Ågotnes, Jacobsen, & Barken, 2017; Banerjee, James, McGregor, & Lexchin, 2018; Castle, 2008; Kjøs & Havig, 2016). In a sense, staffing levels, as emphasized in the Municipal Health and Care Service Act in Norway, should reflect and be relevant to the needs of the residents (Ågotnes, 2018). Staffing level is therefore an important contextual factor, part of the general conditions that shape the nursing homes as a context for both working, service delivery and living. Staffing level here refers to both the registered nurses and the rest of the staff present at a particular shift. To emphasize, this study was not interested in establishing staffing levels in terms of permanent staff clusters on full time equivalents *(årsverk)*, but rather in exploring the way leaders negotiated to ensure enough workforce at a particular shift, and the factors influencing that negotiation. Being institutions, nursing homes have a bureaucratic

approach to staffing levels, which may vary across different municipalities. Although there is a relative norm for the minimum and maximum number of staff per resident, per shift, (different levels for day and night) in different nursing homes, there is no national standard for staffing (Ågotnes, 2016). In this regard, staffing arrangements are contextually relevant, allowing leaders to evaluate the need justifiable for a proper number of staff per shift. The leader in NH1, for example, said that she makes sure there are extra staff on the days when there is a doctor visiting the nursing home, which makes the nurses extra busy because they have to follow up with the doctor in assessing the health of the residents and taking important information on medication or treatment routines. This was one of the reasons why there could be more staff, especially during some of the day shifts of the week, and not on the weekends. My observation was that, when there was a relatively large number of staff on a shift, more social activities were introduced by leaders or staff themselves. On the other hand, when there was a minimum number of staff present at a shift, the activities were limited to cleaning and feeding routines. However, in initiating social activities staff composition varied regardless of number. It is interesting that several studies have continuously mentioned the uneven relationship between staffing levels and number of tasks to be completed (Ågotnes, 2016; Jacobsen & Mekki, 2012; Laxer et al., 2016). However, the same result was observed in this study, leaving more questions on what exactly might be hindering proper and permanent solutions to this situation of having an adequate number of staff in relation to tasks at hand, in labor-intensive nursing homes. If leaders at all the homes have the freedom to assess and hence allocate enough staff on a particular shift, why are nursing homes still busy and hectic?

The issue of staffing level may also be related to the pressure put on leaders through NPM implementations on managerialism, which in return, shape the context for immigrant inclusion and leadership practices. Rasmussen (2012) maintains that *cost containment* has been one of the prominent foci of NPM approaches, where leaders have to operate within budgets, while providing adequate care. The extent to which this might be realistic, I argue, is questionable. Although not mentioned by leaders, one may still relate the staffing levels to fixed budgets at the municipal level (Ågotnes, 2016), which has to be accommodated by leaders in their operational daily activities. It is further questionable to relate such fixed amounts to the always changing characteristics and needs of residents (see also chapter 1), and staffing levels and qualifications, let alone if there is a need for extra training and/or orientation for minority staff with regard to professional and cultural matters related to their daily work practices. In other words, to be able to manage within centralized budget control at the municipal level, leaders

have to negotiate the balance between what is necessary and what is possible, which may then allow them to prioritize some tasks while leaving others undone at the nursing homes (see also chapter 5 and 6) (Rasmussen, 2012:185). In this regard, their choices (agency) are not necessarily individually made but controlled relative to the set standards and budgeting made by central authorities (structure). However, though viewed as problematic, staffing levels in Norwegian nursing homes scored best in terms of staffing levels in a comparative study of six countries, US, Canada, England, Germany, Sweden and Norway (Choiniere et al., 2016), see also (Ågotnes et al., 2017).

Number and characteristics of residents

The number and health conditions of the residents also comprise the context of the nursing home through which leaders and staff practice. Nursing homes are professional institutions, whose aims are defined by health legislation to provide both medical and social care for the residents, for whom the place functions as their (last) home. However, the extent to which nursing homes have served as 'homes' to the residents has been an endless concern for different scholars (Hauge & Heggen, 2008; Heggestad, Nortvedt, & Slettebø, 2013; Nakrem, Vinsnes, Harkless, Paulsen, & Seim, 2013).

In order to have a place at the nursing homes in Norway, residents must go through formal admission procedures in the municipalities. In this study, some of the residents were permanently admitted while others were admitted on a ´short time´ basis at the nursing homes. When they live in the nursing home, they share common utensils and common areas with the other residents, and follow the schedule for waking, cleaning and eating (although with some minor adjustments), with the help of staff on duty. In this regard, nursing homes may qualify for what Goffman (1961a) refers to as 'total institutions'. According to Goffman (ibid.), the term total institutions refer to social arrangements of residence and work, or a living space for people with relatively similar social situations (such as those in need of health and social care) where people are cut off from the wider society for a considerable period of time, leading an enclosed, formerly administered round of life. These institutions are mainly characterized by bureaucratic control of the human needs of a group of people and operate through mechanisms of the ´mortification of self´. By ´mortification of self´, Goffman (ibid.) refers to processes of role dispossession, programming and identity trimming, dispossession of property, name, and one´s identity kit, imposition of degrading posture, stances, and deference patterns, contaminative exposure, the disruption of the usual relationship between the individual and

their action/behaviors, and restrictions on self-determination, autonomy and freedom of action. The concept 'total institution' relates to some specific traits of the Norwegian nursing homes. Three important traits relate to blurring of spatial boundaries between: where people work; spend time for leisure activities; and where they sleep and live their more "private" lives. For Goffman, while in many societies of the world, there is a distinction between such spaces, while in total institutions there is no such clear separation for inhabitants. The concept applies to several different institutions such as monasteries, psychiatric hospitals, military compounds, nursing homes and others. Moreover, these are places where people live lives administered by others, and where some measure of "uniformization" (which could include real uniforms) takes place; where, for example, names may be substituted for numbers, such as in the military and in some of the nursing homes in this study; or people are organised based on diagnoses of ailments. Such identifiable traits may have significant implications regarding working environment and inclusion at work. such characteristics, therefore, contribute to the understanding of nursing homes as ´contexts´ within which care services are organized, the activities which are shaped by the nature of these organisations and the people they intend to serve.

In the nursing homes in this study, for example, names of residents were substituted by numbers, which were placed on each resident´s door. Even when staff were giving feedback after a particular shift, they tended to mention the number rather than the names of the residents. In this regard, it was important that the staff could recognize relevant names for the numbers attached to the residents. This, however, worked differently for different staff, whereby it was observable that the permanent staff, or those with a relatively higher work percentage, could recognize the residents by their identifying numbers in such discussions more easily than those who had lower work percentages.

In a sense, being total institutions, nursing homes are comprised of social arrangements that are regulated according to one national plan, and where daily organization of care for residents occurs under one roof (see chapter one). Such characteristics, therefore, shape the way staff conduct themselves and relate to residents and fellow staff. Since residents have a relatively limited social interaction with the outside world (Gofffman, 1964:4), it remains the responsibility of leaders and staff to plan and cater for both social, psychological and physical needs. This is to say, institutionalized care relates to the degree of coordination about work goals and practices (Artner, 2018; McEwen, 1980) by which staff engage in planning daily activities for caring of the residents. In this regard, institutionalization of the elderly care may

also be associated with the ´taken for grantedness´ of the pre-arranged and determined activities of the residents in the nursing homes. The organizational processes that act both upon residents and staff members could also socialize daily work practices of staff members. Several studies have been conducted to assess the way institutional organizations influence care practices. In nursing homes in particular, total institutions are associated with the tendency of staff to exercise rigid control and patronizing behavior (Artner, 2018), while the standardized organization of care leads to loneliness and depression due to little and/or irrelevant social activities (Malmedal, 2014).

The elderly residents in the nursing homes have individual variations, based on their health conditions, but in general, residents at Norwegian nursing homes have some kind of cognitive illness, have very low functionality, and live at a nursing home on average for two years (Drageset et al., 2009)**.** In addition to clinical diagnosis, residents are also different persons with different history, interests, habits, aims and needs. This makes the residents a heterogeneous group in terms of medical and social characteristics although most residents are from the majority population (Norwegians). As such, residents' social characteristics in general shape a local work-context into which the workers perform their tasks/provide services. However, this context is in a sense fluid because the resident composition changes due to the average length of residency, and because some of the nursing homes have spaces for short-term residents, for example in NH2 and 3. In any case, such specific contextual characteristics inform a complexity of relevant actions in the provision of relevant medical and social services to residents. This study suggests that context matters, because of the different characteristics of the residents in the wards observed, even those from the same department. This in turn, dictates the way work is organized, as I shall explain in the next section. In a sense, context relates to the temporal aspects of agency - agency in specific situations - especially to the ever-changing resident composition.

Due to the current ambition of the Norwegian government that the elderly should remain at home for as long as possible (Meld. St. 15 2017-2018), nursing homes have consequently become places for the elderly sick who cannot manage by themselves at home. As such, the working environments are labor-intensive, with a majority of residents diagnosed as ill, mainly from dementia and other incapacitating diseases (K. Christensen & Guldvik, 2014). In this study for example, the following was the composition of the residents in the wards of three different nursing homes.

NH1

NH1 was a nursing home department with three wards, a total of 28 residents and 38 permanent caring staff, with a varied percentage employment. It was a dementia department, with 10, 10, and 8 residents per ward. Among these residents, 16 were confined to wheelchairs and two were confined to bed. Moreover, two of the residents had completely lost their speech capacity, while three of them communicated with relative difficulties. According to the department leader, the age of residents ranged between one hundred and sixty-eight years.

NH2

NH2 was a nursing home department with three wards, 26 residents and 25 permanent caring staff. It was a somatic, long-term care department, although in one of the wards there were two residents who were living at the nursing home for two weeks followed by two weeks at home, interchangeably. It had three wards with resident distribution of 10, 10, 8 per ward, under one leadership and one assistant leader. The first ward had 10 residents, among which three were confined to wheelchairs and two to bed. Moreover, this ward had two residents who were on short-term residency, spending two weeks at the nursing home and the other two weeks at home, alternatively. In the second ward, there were eight residents, among which five were confined in wheelchairs and one in bed. In the third ward, there were also eight residents, four of whom were confined in wheelchairs.

NH3

NH3 was a nursing home department with two wards, 12 residents and 19 permanent staff. One ward had none of its residents in wheelchairs, nor confined in bed. However, this ward was special in the sense that it had four residents, and four staff at work during the day shift. According to the leader, this was the ward especially for ‘residents with challenging behavior’. Residents were relatively cognitively challenged. They could be violent among themselves and towards the staff. They also had communication limitations. Although this ward was described as short-term occupancy for its residents, most of them had stayed there for some years. When I was about to finish my fieldwork at this ward, one resident was transferred to another nursing home in the municipality and her place was taken by another resident who was more aggressive than the rest.

The other ward in this department also had short-term occupancies, with eight residents diagnosed with dementia and some additional health challenges for some of the residents. These were admitted for rehabilitation purposes, although some of them were perceived as permanent residents due to their old age and hence long stay. In this ward, none of them were in a wheelchair, although some used a walking aid. All could eat by themselves and had relatively sound communication competence compared to the other ward. As such, the ward was considered to be less heavy in terms of workload, in comparison to the other.

The characteristics of the residents and the conditions for admission into nursing homes shape the context for the recruitment of staff and organization of daily care work, as I shall discuss later in this chapter. Despite the cognitive illnesses and functionality differences among the residents within and across wards of the nursing homes, this study observed a common pattern of organization of daily care work across all the three nursing homes. This is to say, the day began with intensive body care among the residents before anything else. Even when some of the residents would refuse to receive such service, or slept longer, staff were always concerned to find the time when body cleaning would be done before the end of the first shift of the day. This was a fixed daily routine across all the wards of the nursing homes involved in this study. With mixed residents with varied needs, it was established that such an organization was necessary for most of the residents. In this regard, it influenced the habitus of leaders and other staff regarding the care plan for the residents. Furthermore, such established logic of elder care to influence the agency of leaders and other staff when organizing daily care tasks.

With regard to the number and characteristics of the residents, the ethnographic study could further observe the way daily care was organised across the number and composition of staff and established the way these two important aspects of elder care related in the actual practice. The staff composition at the nursing homes in this study included registered nurses, auxiliary nurses, healthcare workers, and assistants (unskilled). By their nature, the range (and type) of tasks performed in nursing homes are quite different from, for example, a hospital. They often tend to be less technical, involving less specialist knowledge, and being more difficult to monopolize than many tasks in hospitals. In this regard, one can claim that it does not require specific professional skills to clean or feed a person, unless there are other medical diagnoses, which may specify the way the tasks have to be performed. The relatively lower requirement for professional skills in the nursing homes may also explain why the medical hierarchy puts geriatrics at the bottom (Album & Westin, 2008), although this may also contradict highly

ranked medication trends in Norwegian nursing homes, with an ambition to increase professional recruitment (Jacobsen & Mekki, 2012).

In order to be able to cater for the residents' individually varying needs, leaders ensure that there is at least a minimum number of the right combination of staff at work to accomplish the tasks during every shift. However, as there are no minimum standards for staffing (or for other aspects of nursing home management), what is 'minimal' is left to the leaders' discretion (Meagher & Szebehely, 2013). This means that leaders are at liberty to define 'minimal' in their own way. However, this does not mean that Norway has lower staff coverage than in other countries, in fact it may be the opposite (Harrington et al., 2012). Still, it means the regulations in the nursing home sector in the country are more 'interpretive' than 'restrictive', which could explain leaders' autonomy in organizing the labour force depending on the contextual needs of the residents. An example given previously, of the ward in NH3 with four residents and four staff during a day shift, may relate to this variation of staffing between different nursing homes, and even within different words of the same nursing home. In such a situation, I argue that the agency of the leaders was not dictated by any authoritatively stated number of the ratio of residents to caring staff. How then did the leaders reach a decision that a certain number could mean minimum or maximum staff? I shall come back to this analysis later in the chapter.

Despite the flexibility delegated to leaders with regard to staffing levels per shift, it was surprising the way shifts, especially the morning one, were overwhelmingly busy for all the nursing homes under this study. Moreover, despite the ever-documented labor-intensive nature of the nursing homes, it was obvious to me that the there is still a need to do something about matching the number of staff to the tasks at hand, because 'understaffing' is still an issue. In addition to limited budgets for running the nursing home assigned to the leaders, I argue that leaders may also need to address the issues of poor estimation of the task force needed to complete the daily tasks, or negligence, or all these.

Depending on the number and composition of staff on a particular shift, this study established some patterns of *prioritization of tasks* in the nursing home wards as I shall discuss in the next section.

Prioritizing tasks at the wards

In general, all the wards in the nursing home departments had residents who were sick, either physically, mentally or both. As such, most of them required assistance to manage their daily life and activities such as bathing, getting dressed, eating and visiting the toilet. Since most of

the residents were confined to bed and/or wheelchairs, the body work took a substantial amount of time, especially during the day shift when all the residents had to be assisted to wake up and get ready for breakfast. This could sometimes also affect the rest of the planned activities during the day.

The following scenario from my field notes, recorded from one morning shift at the nursing home, is illustrative.

> *It was 7.35 in the morning here at NH1. We started from the nurse station, where three staff had to agree on task distribution for that day, after the leader had allocated each staff member to a particular ward. They agreed that Margaret, a minority nursing assistant, would take two residents and the kitchen, Astrid, a majority registered nurse would take four residents and medicine distribution, while Katrina, a minority auxiliary nurse, would also take four residents and would be responsible for the laundry. Thereafter, they all went into resident's rooms to start the day. Since it was time to wake and clean the residents, I decided to alternate my position between the sitting room and the hallway, in order to grasp the way staff perform the tasks, without necessarily entering residents' rooms. In this ward, all the rooms were located along and beside the hallway. All the three staff went to the laundry room where some of the utensils were kept, and each of them came out with a small basin and entered different resident's rooms. They stayed there working for a while. In the meantime, one resident got out of her room in her pyjamas walking using a walking aide (rullator). Looking a bit confused, she called, 'is there anyone here?'. No one answered. She came to the lounge and sat, after a while she fell asleep on the sofa. The ward was quiet, and the staff closed the doors while in the rooms of the residents they were attending. After a while, Margaret came with a resident in a wheelchair and placed him by the dining table. She then went back to attend the second one (on her list). The other two staff did the same with the residents and went back to attend others. Katrina, who was responsible for the resident who was sleeping in the lounge, saw her and said, 'she can continue to relax on that sofa while I attend to others first' and left. When Margaret was finished with her two residents, she came and started making coffee and preparing sandwiches for the residents. Those who were already at the table started eating, while others were still waiting to be attended in their rooms. Then Astrid came in and said to Margaret, 'I think I had better start with the medicine distribution because Håkon did not want to wake up'. Then she went to the medicine counter and started sorting out the medicine using*

the list of residents she had. She crushed tablets for some of the residents who could not swallow whole tablets and gave them the medicine. In the meantime, the alarm of the resident who did not want to wake up rang, and the registered nurse who was responsible for the medicine checked on the display screen and saw the room from where the alarm was coming. She told Margaret that she could not leave the medicine counter yet, so the resident must wait. Meanwhile, Katrina came with another resident whom she had just finished with and set her by the table in her wheelchair. Afterwards, she tended to the resident who was sleeping on the sofa. Katrina went to help that resident, cleaned her dress up and then returned with her to the dining room for breakfast. By then Margaret had finished serving breakfast to the residents, and then she went to the dining table to assist one of the residents who was not managing well eating by herself. Meanwhile, by the side of the table there was another resident who was eating by herself and had fallen asleep. Katrina went to sit with her, woke her and started talking to her and encouraging her to eat and finish. By the time the residents were finished with breakfast, Margaret started clearing the table and put the dishes in the dish washer, which was in the kitchen. The other two staff helped the residents to get to the lounge and switched on the tv. Thereafter they went back to the residents' rooms to clean, make their beds and take the dirty sheets and clothes to the laundry. By then it was around 10.45. The two staff, Margaret and Astrid, came into the kitchen, and they agreed to have a short break with a cup of coffee. I sat with them for about fifteen minutes, and in the meantime, Katrina, who had just finished putting clothes in the washing machine, came and joined us. By then, some of the residents were watching the tv while others were sleeping in their chairs. When the staff finished their short break the dish washer had just finished, and Margaret went to remove one round and put in another round of dishes. Then she started preparing fruits and diluted juice (saft) which the residents were to eat for lunch. Katrina went to the laundry and started to take the residents' clothes, which had been washed and folded, back to the rooms. Astrid went to the medicine room to do some work there, and afterwards she went to the report room to write some information in the computer concerning some residents. In the lounge, the residents were served with lunch, at around twelve noon. After serving them, Astrid and her fellow staff went for lunch break with the rest of the staff from the other two wards. Lunchtime for the staff was thirty minutes from 11.30. After lunch the staff went back to their respective wards, and I went back to the ward I had been observing in the morning. Astrid, Katrina and Margaret started to tidy up after the residents were finished with

lunch, while assisting others to the toilet. Then while Astrid went to the report room to do some work, Katrina went back to the laundry to remove and put clothes in the washing machine, and Margaret removed dishes which were in the dishwasher and put some others which were yet to be washed. In the middle of all that, I saw the kitchen staff pushing the trolleys through the corridor to the ward. They were bringing dinner. That was around 13.30. Immediately all the staff started to get residents ready for dinner. This was done collectively, except for Astrid, a registered nurse, who had to provide medicine for residents at that time. From around 13.45 until 14. 30, residents were having dinner. When they finished, some were helped to go to the toilet and then took a nap, either in the rooms or in the lounge, each resident according to his or her wish. Afterwards, the staff got ready to leave as their session was ending at 15.00. The nurse went to the report office for report exchange with the staff who were coming for an afternoon shift …

The above excerpt represents one of the many normal day shifts at the ward with what the leader considered as a 'minimum' number of staff on duty. Based on the demand to attend to the physical needs of the relatively helpless residents, I did not observe any session for social interaction apart from what took place during the mealtimes, and perhaps, when the residents were attended in their rooms. There was simply no time to create and sit for a social conversation throughout the shift. Although the staff had an opportunity to socialize during lunch break, it was not the case for the residents, who ended up sleeping. For some reason, the residents at this ward did not seem to have social interactions among themselves. Moreover, there was not any organized social activity from the volunteers, neither did I see any visitors for residents in that ward on that day. In short, it was completely dull, especially for those who were not interested in watching the tv. My perception in relation to this explanation is that, having to assist four residents, for example, most of whom were in wheelchairs, was in itself a demanding task for one member of staff, let alone other activities associated with their care, such as cleaning the rooms, feeding and medicine tasks. In this case, even if the staff might be good at initiating social activities, there seemed to be no time for that. On the contrary, it was obvious that they only had the option to pay more attention to physical or body care (Malmedal, 2014; Slettebø, 2008). In this regard, one may question the basis on which leaders determine the minimum number of staff in a particular ward, in relation to the tasks they expect to be completed in the course of the day. Although there might be policy, laws, rules, and regulations which guide the leaders in managing provision of care (structures), the local context such as

staffing levels in this case may limit the realization of those guidelines in safeguarding sufficient care for the residents. In other words, the staff, who implement those structural ambitions at the practical/ contextual level may only negotiate (agency) to meet what they consider as realistic in the course of the working day. In the observation presented above, it seems that at some point the staff had to adjust their to-do list based on the response they got from the residents and their readiness to be attended at a particular time. Placed in the reality of context, the ´field´ for care practices, and influenced by the ´logic of care´ to inform their habitus (Bourdieu, 1977), they employed ´temporal agency´ (Emirbayer & Mische, 1998) to adjust to the contextual demands, to negotiate and prioritize tasks at hand in relation to the available labour force.

When there was what leaders considered to be the lowest level of staffing during a shift (especially the day shift), leaders chose to focus on the completion of bodywork, which was mainly cleaning and feeding services and routines, while they gave less priority to social services, such as taking residents for a walk, singing or bingo sessions. In cases when there were staff shortages due to sickness or other emergencies, the leaders were less concerned if the person on cover was a majority or minority staff, skilled or low skilled worker, even though it might have an impact on the work processes, as the later discussion will show. In the first place, leaders make sure that there was at least one registered nurse available in every ward, or if that was not possible, at least one nurse in the whole department/floor with two or three wards, on any shift,

> *"We always wish to have at least one registered nurse during every shift, but it is not always possible because we do not have enough people with that professional qualification…"* **(Leader, NH1)**

Leaders' preference for having a registered nurse during every shift might be understood through the medicalization of nursing homes in Norway (Ågotnes et al., 2017; K. Christensen & Wærness, 2017; Jacobsen, 2015a), which creates a demand for highly skilled staff. This medicalization is evident in relation to the recent trends in medical models of aging in most western communities, whereby old persons are viewed in terms of physical decay and limited capabilities. That is to say, older bodies are perceived as "diseased, declining and vulnerable" (Buse, Nettleton, Martin, & Twigg, 2016:1447), and thus in need of the attention of medically trained personnel. Their ill health is one of the important consideration for their admission into nursing home care. However, such attitudes towards aging may contradict the ambition of

provision of a home-like environment within the medically oriented nursing homes. in reality, sick people are usually taken care at the hospital, and their needs being medical may contradict with the environmental aspects of a home. This political ambition of a home-like environment for the elderly sick people, therefore, brings tensions between running nursing homes as "hospitals, hotels or domestic residences" (Buse et al., 2016:1450).

Nevertheless, the leader's concern in the above quote may also be influenced by the political structures guiding operation of nursing homes in Norway. The National Act specifically targeting nursing homes with "Regulations for Nursing Homes and facilities with 24-hour service", puts responsibility on the respective institutions to have in place a physician, a registered nurse and an administrator (Ministry of Health and Care services (HOD) 1989). The ambition of having a registered nurse does not always work, as the above quote from the leader shows. In adjusting to this demand, leaders sometimes opt to have a registered nurse 'on call' (i.e., potentially available), i.e., exercising agency based on the realities in their local contexts. However, although there is this challenge of recruiting enough registered nurses to fill all the required positions in nursing homes, Norway still has more registered nurses at work in nursing homes compared to other western countries (Ågotnes et al., 2017).

Interestingly, I observed that the auxiliary nurses, healthcare workers (helsefagarbeider) and some of the assistants (who had been trained on the medicine distribution course) did also take medicine responsibilities during some shifts, although it was always the registered nurse who organized the distribution. Moreover, apart from dispensing medicine, all other responsibilities were equally shared among the staff, which meant that it did not matter whether a person was a registered nurse, an auxiliary nurse, or an assistant. In this regard, it was not clear why it was emphasized that there should be a registered nurse on each shift, because residents might not necessarily need the attention of the registered nurse in some of the wards, while all the staff seemed to perform relatively similar tasks. Furthermore, I argue that the role of those nurses in relation to residents who are, in most cases, at the edge of their lives, is hard to justify, because most of the caring activities I observed did not necessarily require a registered nurse competency, although some studies like Havig et al., (2011) have associated the relevance of increased ratios of registered nurses in nursing homes to guarantee improved ´quality of care´. In other words, the routine activities of cleaning and feeding, or even socialization of most of the residents, did not necessarily reflect the need for any professional intervention. In line with my observation, the study by Harsvik et al (2002) also found no significant effect on quality of care by increasing the ratio of registered nurses in nursing homes, although their responsibility

for reporting and office work, which is indirect care, may justify their need, as I shall discuss later. However since such medicinal tasks may be shared with other trained staff, and office work is not always needed, especially during the evening, night and weekend shifts, one may therefore question whether this has to do with the professional prestige which puts registered nurses at the top of the employment hierarchy at the nursing home, and its relevance in the nursing home context which has adopted a representation of a 'mini-hospital' for the elderly sick (Hughes, 2008; Jacobsen & Mekki, 2012). In the same line of thinking, the fact that registered nurses would take body work responsibilities to clean and feed the residents, in just the same way as the minority assistants, may further question the lack of acknowledgement of the assistant staff group in the professional hierarchy (Hervie, 2019), because in a sense, some of the caring activities do not require particular professional competences. My ambition is not to completely reject or discourage the presence of registered nurses in nursing homes, but to show the way decisions made at higher levels (structures) may influence leaders' strategies in planning for care and relate to contextual needs. In other words, I want to shed light on the way agency of leaders at the local contextual level is influenced by the standards set at the municipal and national levels (structure), of having a registered nurse on each shift. The justification of having a registered nurse at each shift may partially be due to prevention of disease complications (since the places are for elderly sick people) or deaths at the nursing home. As such, this is a precautionary measure, whereby in the absence of emergency work, nurses must take on other caring responsibilities which are usually those of other staff members. However, since in the course of fieldwork this study did not witness any such emergencies, that justification is beyond this analysis, and may need another study to explain whether it is relevant, or it could be just enough to have a registered nurse on call.

From another point of view, this study suggests that emphasizing the presence of a nurse at every shift could sometimes add to the problem of under-staffing. This is because the basic routines of lifting, cleaning and feeding residents would always need enough people in place for the necessary labour force. For some staff, having a nurse on duty on days with minimum staff cover was not a good experience. Jannike, a majority healthcare worker at NH1, commented that,

> *"...having only one [registered] nurse during an early shift can be extra stressful, especially if it is combined with unfamiliar minority staff. Nurses are always busy with office work, and that means we have to share the rest of the work here on the ward*

[between] the two of us (if they were three staff, which was considered a minimum number*) …"*

Referring to Jannike's concern, although having a registered nurse at all shifts may serve the purpose expected by the leaders or authorities which provided regulations for staffing, it may add stress to the rest of the staff because of mismatch between the tasks to complete and the available labour force. This was because although the ward was considered to have three staff on a shift which included one registered nurse, it was overlooked that the nurse had many other responsibilities which did not allow her to be on the ward and attend residents on equal terms with the rest of the staff. As per my observations, registered nurses, just like leaders, have reporting and office work, apart from being responsible for medicine and resident care at the wards. As such, they are caught between managerial and professional responsibilities. However, what choice do they have when caught up in such circumstances? To explain their choices, I go back to the implication of NPM reforms on daily work organization at the nursing homes which seems to pay more heed to he demands for standardized reporting for ensuring 'auditable' quality service than taking part in body care. I argue that this is the reason why registered nurses prioritize office work over care work, because they will be answerable if they don't 'check the boxes' they are supposed to check. During the working session, for example, registered nurses would excuse themselves to go and finish office work or attend to the doctor´s visit and let the rest of the staff proceed with other work chores at the ward until the nurse came back. Such a tension, consequently, make the considered minimum number of staff to be even less than minimum for practical body work.

My observation, with regard to what was generally considered a minimum number of staff, especially during the day shifts, suggests that there is a need for extra staff in addition to the registered nurse in order to balance the distribution of tasks. Apparently, apart from having regular office work as registered nurses, they also happened to take leadership responsibilities as delegated when the leaders were out of office for different reasons, while in addition, they were responsible for routine care tasks at the ward. I observed, for example, that if there were three staff in each ward, one ward might have one registered nurse, while the others were without one. Such arrangements led to greater stress on the ward in completing the body work for residents when there was a registered nurse on shift. In the process of adjusting to meet the most important needs, staff may consequently opt to focus on cleaning and feeding the staff, and ignore social aspects of care, which may also be important for some residents, as also observed by Kirkevold and Engedal (2006). Regardless, bodywork is demanding, involving

heavy lifting associated with care of sick residents, as for example those confined to bed or wheelchairs. Moreover, some residents have challenging behaviors due to severe dementia conditions, such as in one of the wards at NH3, something which may add challenges in accomplishing assigned tasks in time due to residents´ unwillingness to comply with the schedule.

Moreover, Jannike in the case above, also mentions an important aspect related to added workload, the presence of unfamiliar minority staff who cannot work independently. As such they depend on the permanent staff for leading the order of the day during a particular shift. I therefore understand Jannike's frustration that if the staff on duty are already few, and the nurse is busy at the office, then the care burden on the ward would probably shift to available familiar staff members like Jannike. It might even be worse if the rest of the staff were both on extra shifts from different wards. In this regard, I argue that the recruitment conditions, processes and guidelines for including immigrants in work at the nursing homes (structures), do not only challenge the leaders on planning for relatively permanent staffing on a particular ward, but also the majority (and some of the minority) staff in timely and efficiently managing the tasks in the context of their respective wards. In particular, such arrangements seem to impact on work relationships, whereby minority staff are viewed as burdening the majority staff members because of what the structural and contextual arrangements allow for work organizations.

In addition, since performance is measured by leaders focusing more on completion of cleaning and feeding tasks (physical aspects of care) when planning for care, staff are compelled to make sure they accomplish those tasks first and leave the social aspect of care unattended, because it is not as easily visible in the reporting. Although staff may opt to prioritize body care, sometimes they have to keep some residents waiting because they are busy helping others during that time (as explained in the previous case). Insufficient staffing in nursing homes has been the reason for complaints among residents, who have to wait for a long time before they can receive the assistance they need or have asked for, which for them is poor service (Bowers, Fibich, & Jacobson, 2001; Gubrium, 2012). In addition, it is associated with poor social contact with the residents, through minimized interactions, as staff are rushing to finish one and attend another resident on the waiting list. Low staffing has also been associated with less attention to leisure activities and taking residents outside for a walk (Kirkevold & Engedal, 2006; Kjøs & Havig, 2016; Slettebø et al., 2017). In this regard, comprehensive resident care is reduced to "bed-and-body routine" (Gubrium, 2012:124). Again, NPM ideologies of budget containment in the public sector may explain this. The NPM reforms advocate for efficiency in performance,

while spending less. Taken together with the reporting systems in the nursing homes, which favor physical and medical care over daily social care practices, justifies leaders' way of looking at social activities as a bonus, something which does not happen often nor regularly but only when there are extra staff.

When a particular shift had a sufficient number of staff, the other concern for leaders was the welfare of the caring staff in relation to workload distribution at the department level. A leader from NH1 had the following strategy:

> *"…You know, some of the wards here have more complicated residents and make them heavier wards compared to the others. In making sure that each employee gets relief from such heavy lifting and attending difficult residents, I always circulate them in the wards where they work on a regular basis so that everyone enjoys the feeling of working in both the heavier and lighter wards."*

It is well documented that nursing homes are workplaces characterized with relatively high sick leave among staff (Aagestad, 2017; Aasmul, 2020; Jakobsen & Sørlie, 2010). This is commonly explained by the labor-intensive and heavy workload related to care work, which characterizes these working environments. In nursing home premises, sick leave is associated with exposing staff to mechanical procedures such as heavy lifting and lifting in awkward positions, in addition to psychosocial factors related to activities in handling residents, such as emotional demands as well as hostile social behaviors (Aagestad, 2017). Sick leave, therefore, which mostly effects the permanent staff, causes absences, which in turn lead to unskilled or semi-skilled staff replacement of skilled staff (Aasmul, 2020), who mostly happen to be the minority with lower work percentages. Interpreting the quote above, it suggests that the leader is conscious of the heavy workload in the wards, which is why she is circulating staff to avoid fatigue. However, reflecting on work percentages and contracts among staff, circulating them amongst wards, can only favor staff with relatively high work percentage positions. Those with lower percentages had to take whichever shift was available because they were not sure of when they would next get another shift, and often most of such staff were minority workers. As such, fatigue is implicitly transferred to minority staff who wish to have any extra vacant shifts to supplement for their uncertain work trends. If this is the case, what could be its impact on these minority staff's work performance?

Looking further at the totality of this situation, working arrangements at the nursing homes may be exploiting some of the minority staff. This is because since they are not sure about when

there will be a next available vacancy, they have to apply for vacancies whenever they occur, or say 'yes' anytime they are approached for covering a vacant shift, while not having any formally arranged breaks in between their weekly shifts. In the long run, this may lead to fatigue or work-related health problems (Aagestad, 2017), while they still need to earn a living. Although I could not establish any absence of the minority staff which I could relate to fatigue (probably due to the limited time allocated for observation), I can still relate to the potential for fatigue among this group of staff. I observed, for example, many incidences when minority staff would take over when the majority staff were absent.

The aspect of positioning minority staff for fatigue vulnerability, I argue, may have a significant impact on their form of inclusion in work life. This is because, since integration policies focus mostly on language acquisition and access to the labour market, the mechanisms through which immigrants must adjust in the actual practice context, such as in nursing homes, are not accommodated or addressed in integration policies. This means that at policy levels the focus is on other things than working conditions, and that the aim of inclusion in work life leads to integration in society´s shadow or mutes the realities of work life for immigrants. The ideal of integration of immigrants through their inclusion in work life does not include working conditions which shape their context. In terms of agency, immigrant staff are compelled to take any available vacant shifts at the expense of their health consequences, which in this regard, is determined by the structure in terms of integration through work inclusion. However, it is important to stress that the availability of extra shifts for the immigrant staff with low work percentages is not rehular. At some point, they may work like full-time personnel, while at some other time they may hardly work at all, especially those without relevant minimum qualifications for recruitment. The potential fatigue happens based on the fact that these staff do not have choice on which ward to work at. It is all by chance, and sometimes it may mean to work at the wards which are considered ´heavy´ with a lot of lifting of weak residents. This is different from most of the majority staff, who work at relatively stable wards, with shifts planned to allow for rest in between and holiday arrangements.

In order to expand more on the way work is organized, I discuss the roles and tasks in the nursing homes in the next section.

Tasks and roles at the nursing homes - teamwork

Teamwork is an essential aspect for care work, which is also shaped the context realities of the nursing homes. Most residents in this study had physical and mental conditions which interfered with their capacity to take care of themselves. Some had single, while others had multiple health problems. For those who had multiple diagnoses teamwork was inevitable in order to handle complex situations. Some residents, for example, in addition to dementia, were confined in bed because they had limited functioning in their limbs, while others were contained in special wards because of continuous agitation. In order to clean such residents in bed (or attend to agitated residents), staff might need each other to turn them on each side or lift them into a wheelchair, and other such activities. Staff would therefore plan for or seek each other's hand when helping such residents. All the wards I visited had an alarm system (a mobile phone or a fixed system which would display a room number from which the alarm was coming), to alert the staff if any need arose. These needs could be from residents needing help in the room or a fellow staff member needing assistance from other staff. Teamwork was especially important with severely demented residents who acted aggressively, or those who were confined to bed and wheelchairs, when staff might need help assist each other in lifting them. In this particular nursing home, the leader from NH3 stressed this issue as she said,

> *"What matters here is teamwork. It does not matter if a staff member is a registered nurse (highly educated in this context) or assistant (meaning less qualified), we all have to work as a team and do what is needed…".*

The leader's concern is justified in the contents of an observation relevant to explaining the inevitability of teamwork:

> *It was around 11.00 am during the day shift at ward B of NH3. This is the ward with only four residents, who are easily agitated due to their cognitive diagnosis. One resident was already cleaned and, having been served breakfast, was sitting quietly on the sofa. After a while, she went to her room and stayed there for about ten minutes. One staff member went to check on her and came back saying that the resident was sitting comfortably on the sofa in her room. The lounge was relatively quiet, and we were having a cup of coffee with one of the residents. Suddenly the resident who was said to be sitting in her room came with something in her hands, which we realized was poop from her diapers. One of the staff stood up quickly and put on the gloves she had in her pockets (which is usual for staff in this ward) and went straight to try to convince*

the resident to go back in her room so that she could be cleaned. The resident did not want to go back and was pushing to come to the lounge. As the situation was getting more tense, and the resident starting to scream, I saw another male staff member quickly putting on his gloves and he went straight to assist the other member of staff. Together they succeeded in 'dragging' the resident to her room, where they succeeded in cleaning her up and shifting her clothes. In the meantime, another staff member who was still in the lounge also put on her gloves, grabbed the tissues, filled them with the disinfectant, which was on the doorway, and started cleaning the walls on the spots which the resident touched when she was resisting going back to her room…

When the above situation was happening, I did not hear any of the staff calling for help. They just observed the situation, and it was as if automatic that each took responsibility to do what was to be done, very quickly. Their responses and actions suggest that these staff were familiar with the type of residents they were attending, which is why they all had gloves at hand, ready for any surprise which might occur at any time.

In a sense, it is implicit to teamwork in these nursing homes that things are done together. However, teamwork is also about agreeing on sharing tasks among the staff on duty in a particular shift. This normally happens at the beginning of the morning shift, when staff agree among themselves on the way they will distribute tasks. This democratic form of task distribution was appreciated by some of the staff, as for example, one minority from the ward in the scenario above, NH3, said that the arrangement allowed them to express themselves in relation to fairness of tasks among all staff. As an example, the staff mentioned that it is possible, during task distribution, to refuse to be assigned the most difficult resident, if a person has had to attend such a resident for several days in a row.

In line with Munkejord (2019), I argue that mutual agreement and task sharing was the most important aspect of having an inclusive working environment in these nursing homes. However, and to nuance this argument, some of the minority complained that this 'team'-arrangement was problematic. The reason was that some of the majority staff would swap the names in the lists of the shift to meet their desire to work with whom they preferred in a particular ward or would continuously assign minority workers to the more problematic wards. Moreover, regardless of their readiness to engage in teams for completing tasks, some minority staff faced rejection from fellow colleagues (sometimes also residents and their relatives), based on their skin color (see chapter 5 and 6).

Teamwork in nursing homes does not always mean performing one task together, rather it may also mean agreeing to share different tasks individually. For example, one takes medicine, while the other, kitchen or laundry. In the end, the daily planned tasks would be completed. Although there was a relatively democratic distribution of tasks, I observed trends of task preferences. Several minority staff were much interested in manual tasks, the typical physical tasks, such as cleaning and feeding the residents, kitchen and laundry tasks, while the socialization aspect was a concern for most of the majority staff. In the same vein, both leaders and majority staff praised the minority staff based on the way they could manage physical tasks (body work) but not their socialization skills. This could be the reason that they preferred to take manual routine tasks to show their capabilities, while camouflaging their weaknesses in providing social care. In one nursing home for example, when I asked one minority staff member the reason why she always attended a particular resident, who was speechless and, in a wheelchair, and was considered one of the aggressive residents in that ward, she said:

> *"... You know... it is sometimes easier to attend this patient because there are less questions and conversations, so you get your job done quickly, although he may resist and take longer before you get to clean him up...but it is better than endless questions and discussions..."* (Katrina, NH1).

The excerpt above implies that the motive to get the job done is instilled in both the leaders and staff, and the minority staff use it to strategize in attending the less talkative residents who will not 'waste' their limited time. Task completion was what mattered most, especially in such labour-intensive working environments, although it might compromise other important social aspects involved in care. The concern for the ability to complete tasks was also highlighted by Munkejord and Tingvold (2019:230) as one of the key perceptions of nursing home staff competence, which was to have "the ability to prioritize and ensure that all the tasks and duties were completed in each shift". With this ambition in mind, I argue that Katrina may have been influenced (agency) by the way work culture (context) is formed and understood at the place she is working.

Katrina's strategy of preferring to attend particular kinds of residents over others drew the focus of analysis in this thesis to another level: in the next section I trace the significance of her strategies in meeting residents' needs.

"What matters to you?"

Originally, the slogan 'what matters to you?' (Observed in the nursing homes in Norwegian as "hva er viktig for deg?") emerged from England in 2012 (Olsen, Debesay, Bergland, Bye, & Langaas, 2020) as a symbol for patient-related care (that is, patient-centred care or person centred care), in addition to "what is the matter with you?". The main aim was to make a bridge between participants in decision-making, which formerly had been the responsibility of medical personnel, with the individual patient treated as a recipient of decisions made by clinicians. The slogan emphasized that clinicians need to engage their patients in making shared decisions, taking into consideration their values and preferences along with medical requirements (Barry & Edgman-Levitan, 2012). Since then, the Institute for Healthcare Improvement (IHI) has taken responsibility for spreading the question as a slogan and a symbol for patient-centred care). Gradually, the slogan has spread across different countries and has become a global movement.

In Norway the question has been a component of a political idiom to improve 'quality' in healthcare, alongside other slogans which target patient-centred care such as 'no decision about me, without me' and "creating the patient's healthcare system", (Olsen et al., 2020:2). "What matters to you?" was a common slogan for care work in all the nursing homes in this study, reflecting personal-centred care in the institutions. I saw several posters on the nursing home noticeboard, and I thought it was interesting to know more about that, and the way it is relevant to residents' care. To know what matters, a leader mentioned the importance of conversation with residents and their relatives during the admission process to the nursing home. I then asked what happens when the resident deteriorates health wise, as some of the things that matter to the resident would likely change, and the leader answered:

> *"We always expect the primary contact staff with the resident to make regular follow up on the resident condition to see and examine if there is any change in what the important thing or activity was previously…"* (Leader, NH3)

In trying to understand the point of view of the leader in the above quote, I placed those 'assumptions' in the real complex situation of the working environment and the physical and cognitive characteristics of the residents. I must say that it was hard for me to establish a direct relationship between the way daily routines were organized and this slogan. However, there were some indications of the application of the slogan for some of the residents who had interests which could easily be seen and attended to. I could, for example, note that food preferences were considered, especially the sandwich toppings, drinks, and other personal

preferences in activities like knitting, reading newspapers, and so forth. These were getting more attention from the staff, because some residents were able to raise their voices or request, for example, if their knitting materials or other preferred objects were not in place. The rest of the residents followed the common order of the day, with whatever activities the assigned personnel, volunteers, staff or leaders came up with. These extra activities mostly targeted all residents, and included bingo, singing, bible studies, mass, and other religious arrangements. When activities were about to commence residents were asked if they wanted to join, some chose, whilst others were just taken by the staff because they could not speak for themselves. As Olsen et al., (Olsen et al., 2020) pinpoint, although the term "what matters to you?" may appear as a simple question, it is complex when put into everyday practices of nursing homes and requires professional competence. The complexity of the concept lies in the fact that it is aligned with personal-centred care ambition, which is a "multifactorial approach operating at micro, meso and macro levels" (pg. 11). In addition, I argue, the question is too comprehensive and may not be simply answered by either the residents or the staff in a manner that could benefit residents. Put in another way, I mean that the response to what matters to the residents has been reduced to simply what it is possible to offer in the nursing homes as institutions, such as recruiting immigrants on a part-time basis to cater for the body work needs of residents. In addition, what matters from the residents' perspective may extend their preferences to meals and activities, to wants which may be difficult for the staff to adhere to due to ethical, practical and organizational reasons. It is therefore not clear where the borderline is in responding to this slogan (Olsen et al., 2020), for example with residents who continuously insisted that they wanted to go home, while confined at the nursing home as sick people to be cared for, while others would reject being attended by dark-skinned staff. As Olsen et al. (2020) highlight, there is a tension between what matters to the patients (in this case residents), and what matters to the professionals, and I add, what matters to the organization and care sector at large. Looking further into this slogan in relation to the nursing home environment, I further argue that in the course of the shift the heavy workload may be reduced from what matters to what works. Moreover, such matters as low staffing levels and presence of semi or unskilled minority staff may challenge the realization of the goal(s) associated with a patient-centred approach. An example of an observation from my field notes may illustrate the way what matters to the residents may be ignored by the staff due to lack of time.

> *Håkon at NH1 is a resident on the dementia ward. He is a happy man who smiles at everyone very often, regardless how many times one crosses paths with him, either when*

he is seated at his preferred seat by the entrance to the lounge, or when he takes a walk along the hallway. He likes to visit other residents in other wards and hold a conversation. Håkon introduces himself to every person he thinks he has met for the first time, sometimes doing it repeatedly to the same people (probably due to dementia). Unlike the rest of the residents in his ward, Håkon does not take any medicine, apart from the fish oil provided to all residents every morning during breakfast. When seated at his preferred place, by the entrance door into the ward, Håkon would prefer to have a conversation with everyone who entered or left the ward. I noticed that sometimes he does not receive the attention from the staff that he expects. Some would provide a quick answer and proceed with what they were doing, while others would simply ignore him completely. Today, Katrina (staff member) passed Håkon several times as she had kitchen duty, and as usual, he wanted a conversation and threw some jokes to her. After ignoring him several times, Katrina came to sit on the sofa where I was sitting and told me that Håkon repeats the same stories and questions every day, so it gets boring to pay attention to him, and after all, there is no time to listen to his endless stories.

The above situation took me back to the concern raised by Olsen et al., (2020), in the discussion about when what mattered to Håkon collided with the time and interest of the staff. Being the 'healthiest' in the ward, able to move around using a walking aide implied that what mattered to Håkon was holding conversations with staff members whenever he met them. Knowing that he is demented, staff members would respond to his need even though, in Katrina's perception, they perceived it to be boring. It is however difficult to know whether Katrina understood this need or was overwhelmed by task completion by the end of the day, as she mentions. Looking at this situation between Håkon and Katrina in relation to the agency-structure/context framework, therefore, I argue that although the political ambitions and reforms in the care sector are communicated down to the leaders in the nursing homes who then communicate them down to the staff members to be implemented, the contextual factors such as lack of time as Katrina mentions, make them hard to implement. Moreover, since minorities are always noticed as ´good workers´ by leaders and majority staff (sometimes even residents´ relatives) in relation to body tasks, such a situation may be used to understand the way Katrina responds to Håkon, knowing that she is assessed for her body work more than for social care.

The ambiguity in Katrina's response takes this discussion further to the issue of the way daily care is organized at the nursing homes.

Organization and prioritization of social care at the nursing homes

In addition to bodily assisted tasks, there were also social activities which were either organized at the nursing homes by the leaders and staff or provided by volunteers from outside the nursing homes. Since I shall discuss social activities in the next section, it is only important to mention here that body care activities were given more attention and priority as compared to the social aspects of care.

Although all residents had relatively weak health, there were routines for social activities organized at all the nursing home institutions I visited. However, apart from the fixed routines of such activities provided by the assigned responsible people from within or outside the institutions, staff could also arrange some extra activities if the responsible people could not come for any reason. The service depended highly on available and willing staff. I found that sometimes it was difficult for the leaders and other staff to balance bodywork and social activities, while on the other hand, types of activities became the area in which majority and minority staff based their strategies in the caring process. Some of the minority staff, for example, would prefer to attend those residents who were relatively weak in communication, while other staff members would opt to take on kitchen or laundry activities and hence attend fewer residents. In any case, daily busy routines dictated the type and extent of social activities which staff could offer to residents.

Apart from daily routines of cleaning and feeding, leaders had responsibility to plan and organize social activities relevant to residents' needs. This, however, also depended on the type of residents in a particular department or ward, although there was a relatively similar arrangement across different nursing homes, in terms of activities. Due to their perceived cognitive challenges, however, residents of NH3, ward G, were not included in any of the social activities organized for all other residents. Such activities were carried out weekly or monthly, and included sessions such as physical exercises, bingo, mass celebrations, bible study sessions, and so forth. Some of these activities had been assigned to special professional persons in the nursing homes, while others were taken care of by volunteers. In addition, there were celebrations of seasonal holidays and religious markings such as 17th May (the National Day or constitution Day of Norway), Easter and Christmas. These are public holidays which all the permanent staff members are entitled to an off day, or if they work on such days, they may compensate by taking a day(s) off. As such, leaders need to arrange for staff who may cover in

case there is a shortage. Since most of the minority staff members have less shifts based on their work percentages, they are always willing to take such shifts. At some point, leaders mentioned that it might happen that only minority staff members might be available, for example at an evening shift in which there are only two staff members. In such incidences concerning these special seasons of the year, leaders mentioned that they received regular complaints from residents' relatives, for example when the minority staff did not know the relevant cultural practices attached to seasons such as the colour of the tablecloths (see chapter 6), lighting candles, timely decorating of the Christmas tree and cosy decoration of interiors, Christmas soda (*julebrus*) at every meal, and so forth. However, these important markings of the seasons of the year were not included in the orientation plan in any of the nursing homes under this study, only the performance of care related to physical needs of the residents.

The birthday celebration of residents remained mostly a responsibility for the family and relatives of the residents. In addition, leaders and other staff might introduce social activities in the wards they were working in whenever there was time in between the shift. These activities were waffle baking, going for a walk inside or outside the nursing homes and so forth. However, from the study findings, for this to happen depended on whether majority or minority staff were many or few during the shift. In most cases, most of the minority staff showed less competence and interest in initiating relevant social activities. Leaders were aware of the situation, but sometimes the contextual factors did not allow them to accommodate for such needs for reasons such as emergency shifts or when the shift included only minority staff. One leader said,

> *"Having only minority staff [working] during the weekends can be problematic. I have received some complaints from relatives of residents that it is very dull here when there are only minority staff [at work] … but they have to understand that sometimes it is more important to have people on a particular shift before someone starts thinking about whether that person is a Norwegian or not. As I told you before, we need nurses at every shift, but it is sometimes not possible, the same happens when it comes to avoiding immigrants during some shifts, especially during the weekends…"* (Leader, NH1)

Nursing homes operate on a 24-hour basis providing care; hence staffing is normally organized on a shift basis (*Turnus*). Generally, there are three shifts during a 24-hour period: the morning, evening, and night shift. Due to immigrants' employment situation, most of them can rarely secure a hundred percentage job position. In this regard, most of the immigrants with lower work percentages got extra shifts from different wards or sometimes departments of the nursing

homes whenever there was a need due to an emergency concerning staff who were due to be on that particular shift. In some cases, vacancies happened due to long term sick leave for some staff. As such, minority staff were resourceful in covering vacant gaps, which happened repeatedly in these workplaces. This was because they were the most likely to be available when needed, as compared to the majority staff and some others with higher work percentages. When there was a vacant shift, the leaders strove to first find a person to cover, and according to them, it was sometimes impossible to get a replacement, something which may have forced them to recruit staff from the bureau, which, according to the leaders, was very expensive. Probably influenced by budget constraints, I argue that because minority staff were a relatively cheaper labour force the leaders prioritized them before considering what they considered to be an expensive option. Moreover, I argue that the convenience of having minority staff may also meet budget needs because of their lower professional levels, or unskilled status, with relatively lower pay, as compared to hiring a nurse from the bureau. In this regard, the concern for ensuring social activities may not be a primary concern for leaders, although the continuous lack of social activities may be associated with poor social life and cause loneliness among residents, as presented in several research studies (Barca, Selbæk, Laks, & Engedal, 2009; Bergland & Kirkevold, 2006; Iden, Ruths, & Hjørleifsson, 2015; Slettebø, 2008). Moreover, in such pressing situations, consideration of what matters to the residents is at stake because they may face staff who know very little or nothing at all about them. Although there are posters of residents' preferences and interests posted on the kitchen noticeboard or refrigerator door and in the residents' rooms (as the leaders and staff mentioned), it might still be difficult to follow these preferences, especially the social preferences of individual residents, when such unfamiliar staff are occupied with meeting basic body care needs on time.

In trying to explore what specifically happens during the weekends, for example, one majority staff started to explain, during a conversation:

> ***Ida****: Yesterday (*Sunday*) when we finished our duties because it was raining and dark, we gathered the residents in the living room. We started watching a movie with them, and meanwhile we served soft drinks and popcorn… they were very happy…*
>
> ***Me****: what was the name of the movie?*
>
> ***Ida****: …it was the movie of the big ship, which many of them know from before…*
>
> (Field notes NH1)

I then turned to the side where the minority staff member sat and asked him if he would have thought of some kind of similar activity, and he said:

> *"This is the first time I have heard about the movie… (*laugh*)… I always pray that when I have a weekend shift I have a Norwegian fellow, otherwise, the day is so long and boring for me as well…it is not easy to know what to do to entertain these elderly people entertained…"* (Benjamin from Eritrea)

My interpretation of the two quotes above is that the staff composition plays an important role in creating social arenas and activities which involve residents, and on which residents depend to a great extent, although some may choose to join or reject (Gubrium 2012). However, from my observation, organizing social activities depends on the individual staff member's initiative as it is not always on their checklist for reporting at the end of the shifts. Moreover, from the response of the minority staff and based on the observations, it is implied that having a majority staff member at work increases the probability that social activities are initiated. This, however, is unpredictable, and is challenged by the fact that since most minority staff work at weekends, complimented by relatively higher chances of having vacancies which also are in most cases filled by minority staff, then the concern of dull weekends raised to the leader by the residents' relatives is confirmed. On following up this situation, one Saturday, I dropped in at the evening shift at one ward in NH1, where there were two minority staff on duty. The following was my observation.

> *It was around 16.30 in the evening when I walked into the ward. On my entrance, I was surprised to see all six residents who were in the lounge at that time sleeping, either in their wheelchairs or on the sofa. The others were in their rooms. I found two staff members sitting on the sofa, which was located at one corner of the lounge, talking to each other, and having a cup of coffee. They said they had finished serving evening tea to the residents about half an hour ago. They offered me a cup of coffee too and we all remained seated, until suddenly one of the residents asked to be followed to the washroom. One staff member followed him and brought him back to the same seat. I commented that it was very quiet, to see if they would reflect upon that situation. One of the staff members answered 'it is always like this during the evening weekends'. Sometimes, there is not very much running around. The other staff member added '…sometimes, it happens that I work on such a shift with a Norwegian fellow, then we find something to do, like one day we picked a book from the main lounge, and we*

started singing with the residents, but I can't remember a single song now… but well, it was fun and the residents liked it very much…'

The quote above shows that the minority staff members associated dull moments with their limited capacity to initiate 'Norwegian' social activities for the residents. However, they think that since the majority staff take responsibility for initiating those activities, it is less of their own responsibility. This may be related to their limited knowledge of what they consider to be social activities, as, for example, singing from the Norwegian song book which happened when the majority staff member was present. In addition, since such moments are personally initiated, and not consistent, it is not easy for the minority staff to have satisfactory competence to initiate them in the absence of the majority staff, especially considering their irregular shift allocations. To be able to know and perform social activities is informed by the habitus of an individual, as part of culture acquired through socialization. This in turn enhances accumulation of ´social stock of knowledge´ (Berger & Luckman 1966), a recipe from which an individual may pick relevant content for the activity at hand, hence inform agency. The above quote suggests insufficient relevant social stock of knowledge among the minority staff to initiate social activities. This, in turn limits their agency as they provide care at a particular ward (see chapter 5 for further analysis on this).

Moreover, since activities related to social care are not usually accounted for in reports at the end of the shift, the minority staff may choose not to take them as a serious matter in their care practice. Implicitly, this situation confirms the regular complaints from residents' relatives that weekends are often dull especially when minority staff members are on duty. As such, this also confirms the relevance of staff member composition to provision of social care to the residents. I trace the problem of staff composition from the policies of immigrant integration and labour, through NPM reforms on minimizing costs, to structural factors shaping decisions of leaders (agency) to recruit immigrant staff members and plan for staffing in particular shifts. The combination of these facilitates the probability of having immigrant staff in a weekend (or sometimes public holiday) shift, something which may affect work processes and the type of care provided to the residents.

Family members' and volunteers' roles at Nursing Homes

Volunteers and family members of residents are officially acknowledged in institutional elderly care in Norway, among key stakeholders who play several roles in contributing to residents'

wellbeing (St. meld. nr. 47 – 2008 – 2009)[25]. In this regard, they also contribute to the context within which care is provided. Volunteers and family members of residents form a group of informal caregivers, who are by definition, "individuals who have a significant personal relationship with and provide a broad range of unpaid assistance to an older person or an adult with a chronic or disabling condition outside of a professional or formal framework" (Lilleheie, Debesay, Bye, & Bergland, 2020:2). In the EU, it is estimated that informal caregivers contribute 60% of care provision (Lilleheie et al., 2020), and in Norway, the relatives' efforts amount to around 100,000 full-time equivalents[26]. Therefore, their involvement makes a significant contribution to the quality of care received by residents (Vinsnes, Nakrem, Harkless, & Seim, 2012). However, there is very little research exploring what happens at the practice level with regard to the increased involvement of such informal caregivers (Skinner et al., 2020). Moreover, their engagement is regulated by the law to only a small extent, and there is a lack of classification with regard to their obligations, role and rights in the municipal healthcare system[14].

In this study, I observed regular visits to residents by their relatives, although not to all residents. The regular visits and engagement with the lives of the residents with whom they were related, made it evident through this study that relatives of residents contributed to seeing that residents thrive in the nursing home environment. In addition to facilitating the implementation of "what matters to you?" they also contributed to a social life which may also be related to the maintenance of a home-like feeling for residents by maintaining their connections to their families and the outside world. However, although these relatives may offer a helping hand in the caring work, their involvement was observed to collide with the way institutional care is organized, particularly in the recruiting of immigrants as caring staff. According to the findings of this study, involvement of families was a source of tensions and dilemma for leaders in the immigrant inclusion process. The leaders mentioned that, for example, some of the relatives did not agree with the fact that immigrants, especially those with dark skin, were appropriate caretakers for their older parents, even when language was not a problem (see chapter 6). Giving rights to relatives of following up and being involved in deciding the type of care their parents need to receive, may sometimes challenge the national immigrant integration policies of including immigrants in work at the local context. In a sense, there is a challenge in having laws

[25] https://www.regjeringen.no/contentassets/d4f0e16ad32e4bbd8d8ab5c21445a5dc/no/pdfs/stm200820090047000dddpdfs.pdf

[26] https://sykepleien.no/2017/05/velferdsstat-basert-pa-parorende

and regulations relevant to immigrant recruitment and inclusion in work which do not draw a clear line regarding the form and extent to which family members can engage and influence care (Lilleheie et al., 2020). As such, the overlapping structural and contextual guidelines could challenge the agency of leaders and some minority staff. That is to say, while the immigration integration and labour policies acknowledge inclusion of minorities in work, the relatives, who are also given power to influence care by the national healthcare policies, feel that they have the right to reject care staff whom they perceive as unsuitable for any reason.

Similarly to relatives, volunteers are also acknowledged in different policy papers and regulations as important stakeholders in care provision[27], see also (Lilleheie et al., 2020; Vinsnes et al., 2012). The involvement of volunteers in care for the elderly has been associated with neo-liberal ideas through NPM reforms, which emphasize cost effectiveness and management conferring objectives and results (Blix & Hamran, 2018). As such, volunteers and relatives (alternatively known as informal care takers) work to supplement and enhance formal care (Brassolotto, Caspar, Spenceley, & Haney, 2020). From the findings of this study, volunteers also had roles to play, particularly in engaging residents in social activities in a number of ways. The leaders were responsible for planning and organizing the schedules for volunteer visits. The observed activities were, for example, bible study sessions, waffle baking, coffee sessions, religious celebrations, in-house shopping, and so forth. My observation was that sometimes the volunteer groups did not come as planned, and the residents were left inactive, sleeping in their wheelchairs during the day. However, in some wards, staff or leaders were quick to come up with an immediate substitute social activity, although this would also depend on the staff composition on a particular shift. During volunteer visits to the nursing home, some staff would also join for activities, assisting residents who could not manage tasks, when there was a need. However, due to the fact that those activities were planned during working hours, sometimes the staff would just drop the residents at the place where the activities were taking place and pick them up when the session was over. And for some reasons, minority staff were observed not to be interested in taking part even when they had time to do so. The scenario below illustrates:

> *It was around 12.30 during the day at NH1 when residents were having a dancing session organized by the volunteers. All the residents (who were willing to take part)*

[27] https://www.regjeringen.no/contentassets/af2a24858c8340edaf78a77e2fbe9cb7/careplan2020_eng.pdf

from the three wards were gathered in one lounge. I was sitting in the lounge observing, and as the session ended, I went out because I was going to have a chat with the leader. As I reached the hallway just outside the lounge, two minority staff from Africa were seated on the sofa along the hallway, having a conversation and laughing. When I approached them, they asked me if the session was over, and I said yes. Then I asked why they did not join in, because there were other staff in the session. They told me that they were not interested in the old music session, and regardless, they were not obliged to, and instead decided to sit and have a good conversation while relaxing.

Although all staff may be responsible for social care of the residents, involving volunteers for the same reasons may present a fragmentation of the provision of that service, while also creating a sense of irresponsibility for some staff. Putting it explicitly as the role of the volunteers to provide a particular service may be the reason for minority staff not investing in orienting themselves to relevant social activities, with an assumption that it is not their responsibility, or as they said in the above quote, that they are *'not obliged to'*.

Although some studies have been conducted to explore the challenges associated with involvement of volunteers and relatives in the nursing home care sector in Norway, such as end-of-life decisions (Schaffer, 2007), coordination of volunteer activities (Tingvold & Skinner, 2019), and the relevance of volunteer work to the care needs of residents (Tingvold & Olsvold, 2018), no literature was found to explore the way immigrant staff may benefit from such arrangements for successful integration through work. For example, it was established by the findings from this study that when volunteers are on duty to provide a particular service, the staff would be doing something else to complete tasks before their shift ends. Similarly, when the relatives visited a resident, they would go and hold a conversation in the resident's room. There was an announcement posted on the noticeboard of all the three nursing homes in this study, that visitors should take residents to their rooms during a visit and hold their conversation there. The interaction with staff was very minimal. My take with regard to this situation is that the social activities organized by volunteers as well as the relative's visits would be a good opportunity to orient minority staff with the Norwegian culture and socialization (i.e., through habitus and increased social stock of knowledge), something which make most of these minority staff less competent (see chapter 6).

Distant leadership

Leaders are not always at the ward when care processes are proceeding. Although my initial expectation, based on my former experience as an unskilled care assistant at a nursing home, was that leaders would always be on the ward, or at least most of the time, in a day, taking part in caring activities together with other staff. On the contrary, leaders in this study did not seem to lead by working alongside other staff at the unit, but rather, managed them from a distance. Distant leadership here refers to distant from place but not distance in ´space´. The following initial observation may elaborate on this:

During my first day in the field in the first nursing home (NH1) I was having a chat with the leader on several important issues with regard to the wards with which I would be engaged.

> ***Leader****: so… are you going to be wearing uniform when you are on the wards?*
>
> ***Me:*** *I do not know actually, I have not thought about it… but I have no problem with wearing the uniforms, if it works better with the residents and other staff. What do you think?*
>
> ***Leader:*** *well, I think as long as you are not engaged directly with the residents, then you do not need a uniform. Again, I think when you have a uniform, it might be confusing for the residents, if they ask you for something, and you are not authorized to do that, they might not understand that you need to call other staff every time that happens…*

She then continued:

> *"By the way, I also never go in uniform because I do not directly engage with the residents in the cleaning and feeding activities. However, if there is an emergency and I am needed, I can put on uniform and get to work inside the wards…"*

At that time, I only thought of this as relevant to my methodological description, until I reflected on it differently when writing up my analysis. As I perceived it, the leader's statement was in a sense a declaration on distant leadership, that is, leading without necessarily being in the premises where actual care work is provided to the residents, and that is why, according to her, it was not important for leaders to wear uniforms as did the rest of the staff. In addition, the fact that throughout my presence in the field, I never saw any of the three leaders in uniforms, communicated to me that they were also least expected to take part in the physical caring process, although this particular leader's statement at NH1 implicitly meant that she was also

part of the caring staff. I then concluded that, if the probability of getting into physical caring was high, then the leaders would attend work in their uniforms, ready to take charge in the wards they were managing working with other staff. But if this is the case, how then did leaders manage the staff and care work?

My observation during fieldwork is that leaders had individual separate offices outside the wards. Most of their working days were spent there, with some few moments in the common rooms to chat with staff and residents. To relate to the nature of their daily work in the office, the leader from NH2, as we were having a chat along the corridor, when she was heading to her office after having a short conversation with a nurse in the ward, said,

> *I have so much work to do, and I feel very stressed now. I had a headache yesterday and I decided to leave earlier to take some rest. I had to take my computer with me so that I could work at home when I feel better…*

As we reached her office, she went to her computer and told me,

> *Look here, I now have 38 hours that I have already worked overtime for this month, which I am supposed to take as time off (*avspassering*), but I still do not know when I can do that… I have three meetings this week and two important reports to complete… I don't usually get time to see what is going on in the wards, but I am very grateful that I have a very good and hard-working team, so there are normally no issues …*

In the leader's narration above, she was trying to show me the way her days are occupied with many tasks to complete in the office, to the extent that she did not have time to pay regular visits to the wards. To complete the office tasks at hand, she needed to work extra hours while trusting that the team of staff she is managing are doing a good job, although this did not mean that there were not issues with regard to relationships among the multicultural staff and the residents (see chapter 5 and 6 for further details). On the other hand, she also implied that it was her responsibility to know what happens on the wards as a way of monitoring the way subordinate staff are practicing care activities, something which she could hardly do. My take on this explanation from the leader is that either this form of work arrangement exempts leaders from hands-on leadership practices, or they are forced to choose to which activities they will pay more attention at the expense of others, depending on the form on which they report and are evaluated. This is shown when she speaks about meeting and reporting activities she must attend to. The above interview from the leader, and the observations made from this study, show

that staff and work management at the nursing homes does not necessarily happen through leaders being physically present at the wards in which care is proceeding.

Increased administrative workload among the leaders is one of the major reasons leaders provide for their choice not to offer hands-on leadership to the staff they manage. This means that they are less engaged with day-to-day close management working side by side with the employees in the care processes. Leaders' involvement in resident care is limited to administration (Gubrium, 2012; Øye, Mekki, Jacobsen, & Førland, 2016; Solbakken, Bondas, & Kasén, 2019; Tingvoll, Sæterstrand, & McClusky, 2016) 2012. Similar trends have been observed both in Norway and other Western countries. As Gubrium also maintains for nursing homes in 'Murray Manor' in the US, for example, leaders seldom appear in wards, and in most cases, if they appear it is to complete administrative tasks, and not to observe residents in their everyday life with fellow residents and/or staff. The reasons are heavy administrative tasks to complete in the office or meetings to attend in and outside the office (Gubrium 2012:49-51). Although Gubrium (ibid.) does not theorize distant leadership in his analysis, he still acknowledges the way leaders organize care from the administrative level, entrusting 'floor staff' to put care of the residents in operation, following the plans put forward by the leaders. In a sense, distant leadership, I argue, is linked with implicit ideas of leadership, since leaders, to some extent, perform based on the feedback they receive from the staff members they are managing (see chapter 6).

During focus group interviews, leaders named several responsibilities in their working day, which included, but were not limited to, managing their units, economy (finances and budget), staff and staffing reporting. As per the observations, most of the leaders' day was spent inside their offices, and very little time was spent on the wards. They spend their working day either doing computer work or attending internal and external meetings. This office work, especially when they have a short time to meet a deadline, may sometimes force them to close their doors to avoid any disturbance from staff who may happen to pop into their offices for a short briefing or personal concern. They plan shifts in accordance with the staff work percentages, and when there is any staff deficiency, they use the system in which those with less percentages put their names forward as available to take an emergency duty shift on that day if needed. Consequently, leaders do not necessarily need to meet or talk directly to these staff. Moreover, some leaders' offices were located in relatively awkward areas, which did not allow for close monitoring of what was going on around the wards, even in common areas. The leaders were hardly ever in the wards, and as such, they lacked close follow up on what was happening on the ground,

relying on reports and feedback from other staff, often when there was something wrong with residents or between staff.

The difficulty for leaders of being unable to be regularly present on the wards taking part in routine care portrayed what I regard as distant leadership among the leaders. The origin of this phenomenon may be traced to the NPM reforms, which introduced managerialism across different public institutions around the globe (see also chapter 1). In turn, leaders' tasks in the nursing homes shifted from professional to managerial tasks, that is, the leaders' identities changed from care professional to general managers. In managing elder care, leaders are torn between their professional care ethos and the new economic rationale under NPM (Rasmussen, 2012a). This, as pointed out in the findings from this study above, plays a significant role in the agency of leaders as they have to choose whether to attend to care needs physically or plan and monitor it from a distance, from the office. Rasmussen (ibid.) stressed that in addition to deciding and controlling budgets, nursing homes leaders are also expected to motivate care workers, by being understanding and caring towards them. In her study, she stressed that, leaders (nursing home managers) declared that their new responsibilities allowed them to relax, as well as to discuss and plan social care with their staff, on whom they depended highly to get the care job done in the best way (Rasmussen, 2012). On the other hand, the study by Kristiansen et al., (2016) shows that when leaders concentrate more on office work, taking on more administrative roles, they end up lacking the ability to closely supervise and motivate staff in daily care. In addition, leaders in this study reported increased responsibilities due to excessive workload including reporting and budgeting, which took most of their time and led to an inability to pay physical attention to what was happening on their wards. Managing multicultural staff may therefore pose an extra challenge to the leaders, as a new dimension to management. For example, operating under strongly controlled national or municipal budgets forces leaders to manage through market-oriented funding systems, which are at odds with the need to cater for individual needs of immigrant staff who may require extra training to adjust to the Norwegian work environment. As such, I argue that agency of leaders is shaped by the NPM reforms (structure), which prioritize budgeting and economic factors at the expense of staffing and staff development needs. In addition, the demanding management forms, inspired by NPM, limit leaders' time for working closely with staff and providing leadership on various shifts, although the leaders identify themselves as part of the caring staff. As such, the NPM reforms at the national (macro) level have influenced leadership practices at the municipal (macro) level and the nursing homes, for example by orienting leaders to manage through

market-oriented funding systems by adhering to strict budgetary discipline (see also (Newman & Lawler, 2009)).

Kristiansen et al. (2016) also explored the way increased managerial tasks through the introduction of NPM affect nursing leadership in Norwegian nursing homes and identified three main changes. The changes are that leaders are leading daily care from a distance (at the office), leaders experience lack of support in problem solving, and leaders have difficulties in adapting to new managerial and technical language in reporting etc. The main argument of Kristiansen et al (2016) is that increased managerial tasks weaken nursing leadership in nursing homes. This argument bases itself on the reality that managers take more time and focus on administrative roles, such as hiring temporary staff, attending administrative meetings and ensuring reports on economy, sick leave and quality indicators, while leaving relatively little time to lead 'on the floor' according to their professional values (Kristiansen, Westeren, et al., 2016). Rasmussen (2012) highlights the same trend - that increased managerial tasks affect and weaken professional leadership among the nursing leaders. The managers end up leading daily work remotely from their offices and face a diminished ability to influence and guide enhanced professional values by being present and participating in care tasks. However, a study by Lindheim (2020) has revealed a different phenomenon, where in addition to office work, leaders were also engaging in body care of residents. Kristiansen et al. (2016) highlight that there might be a threat from NPM that the conflicting goals between managerial goals and professional goals will increase, whereby the former will overshadow the latter, and hence risk quality of daily care in nursing homes. The absence of leaders at the unit over a working day may impact on work processes while potentially affecting minority staff. As for example in chapter five, some conflicts arose between minority and majority staff, whereby the majority staff member told the minority staff that she did not want to work with her because she was black, while others would amend the hard copy roaster to change work shifts so that they would avoid working with immigrant staff. Although such matters were reported, they had already happened in the absence of the leaders.

Critical voices have emerged, challenging NPM reforms in public healthcare. The main criticism is that the reforms emphasize much about managerial and efficiency values (economic issues), while paying less attention to professional discretion and values. At the same time such reforms create tension among the care providers by imposing time constraints and standardized care delivery. Thus, the reforms have caused fragmentation of healthcare services and reduced quality of care, by not paying attention to individual needs (Kristiansen, 2016:8). Although

some studies challenge NPM reforms for threatening professional values, other studies have on the other hand approached the ideology in a relatively positive way. Instead of focusing on the way new managerial tasks challenge ethics of nursing work, they rather focus on the way nurses renegotiate their professional values under the pressure of these changes (Allen, 2014; Muzio & Kirkpatrick, 2011; Numerato, Salvatore, & Fattore, 2012). As far as nursing home leadership is concerned, NPM has shifted professional control towards a more managerial control among the leaders, with an increase in use of "performance management instruments, such as auditing, standards, staff regulations, reporting systems, clinical guidelines and a variety of incentive tools" (Hvid & Kamp, 2012; Kristiansen, Obstfelder, & Lotherington, 2016:58).

This study established that distant leadership affects work processes and staff relations in a number of ways. This is due to increased digitalization of management, which in turn has caused limited interactions between the staff and leaders. In my observation, leaders and staff were most likely to meet during the morning report exchange in the report room. However, such encounters did not happen very often. On the contrary, leaders could read the reports from their computers. Moreover, leaders were responsible for assigning staff to specific shifts and wards, based on their work percentages. When there were staff shortages and they needed people to cover, different measures were taken. Either those staff with less work percentages would write their names on the side of the list of responsible staff in the shift book, or on the digital platform through which leaders would select a person to cover. When names were written in the book, the leader had to call a person to inform him/her on the availability of the shift, sometimes calling several people because some had reasons for not being able to take that shift any more. On the other hand, if selection took place through digital platforms, there was no need for the leader to call individual staff, but rather, after selecting the name, the staff member would receive an SMS that the shift was granted. In this case, there was no verbal, face-to-face interaction between the leader and the staff.

The other space for interaction was during regular meetings between leaders and staff. During fieldwork, I only saw one staff meeting, which the leader also attended, but I, for ethical issues, did not attend such meetings. In this meeting, according to the leader, they would discuss resident welfare, and since this was not my focus, for ethical reasons I was not allowed to attend. In the other two nursing homes, I did not observe any official meeting between leaders and staff, except the regular handing-over sessions, in some of which the leaders did not participate. This could be explained by the digitization of reporting, through which leaders may access information on which to make decisions about residents, although I observed some informal

conversations between staff and leaders in cases where was a decision to make about residents. However, it might have been coincidental that during the time I was there, there were no meetings. There were regular meetings, which I knew of through information from the staff who referred to their experiences in those meetings, which the leaders also attended.

Ester, a minority staff member from Africa at NH3, for example, had this to say in our conversation, responding to my question on her experience of the way leaders were helpful in ensuring a conducive multicultural working environment:

> *… it happened that there was an outbreak in this house some time ago. It was more serious in ward A than in B. Although the leader is always the one who appoint us to a specific ward, I was surprised that every time I came to work, I noticed that my name, and the name of some other minority staff members were always changed to work in the ward which had serious infections. I took my time, then I realised that someone (a majority staff member) was playing bad games. Then one day, when we were in the staff meeting and the leader was present, I purposely asked this question. Is it only 'us' immigrant staff who should always be shifted from one ward to another without even being asked? The leader was shocked to find out that after she had allocated the shifts, some other staff might come in and change the rota to fit their preferences. The leader then seriously warned us all that no one was allowed to change her decisions regarding the work schedules, unless she was consulted.*

Although the above quote may not necessarily implicate the inaccessibility of the leaders in solving immediate issues, it implies that there might be a lot happening in the wards which leaders are managing, which is not noticed or discussed, probably due to the organization culture of increasing digitalization and less physical meetings, with most of the reporting being digitalized, leaving some issues undiscussed. As Ester, in the narration above, maintains, some staff may sometimes take advantage of the leaders' distant practice to tamper with the work plan and cause misunderstandings among staff. This situation may affect relationships, and possibly lead to tensions and misunderstandings between the minority and majority staff.

Leaders themselves confessed that they were not always able to get a grip on what happened in the wards during the shift. The following quote from one leader from NH3 during focus group interviews provides an example.

> *It can be difficult to catch what is happening on the wards. There are many tasks that take our time and that make it more difficult to keep up. I'm lucky because I have my*

office in the department, but I still cannot see everything on the wards, and I therefore depend on getting feedback. And then there may be things that I can't catch... I mostly depend on the feedback from the staff, some of which happens if something goes wrong…

The last part of the above quote implies a task-oriented kind of communication between leaders and staff, in the form of giving feedback and consulting during problem situations, which the staff think need to be reported. However, the leader, by mentioning that she cannot see everything, may imply that there are other things she wishes she could see, for which the nature of the work does not allow. Having an office in the department, therefore, does not always imply closeness to the staff, although being present in that office may also imply her accessibility when needed by staff. Although all the leaders in this study had a relatively similar work arrangement, I could see them taking short tours around the wards, exchanging a few words with staff and residents, but no continuous or systematic dialogue taking place.

Being managers, leaders are implicitly expected to attend to staff welfare and solve conflicts when they emerge. However, contextual and organizational framing of leaders show that they are not expected to be in wards for most of the time.

Concluding remarks

This chapter discusses the structural and contextual aspects of the nursing homes that influence work processes and mediate, enable or constrain the inclusion process of minority staff in work. In this chapter, I have described a number of factors that affect nursing homes as a complex context for both work and living, an example of a ´total institution´(Goffman, 1961). I have argued that ensuring enough staff for bodywork (lifting, cleaning and feeding) becomes a primary choice for leaders in situations of staff shortages, thus ensuring that 'basic needs' are top priority. I relate this to structural aspects because the policies guiding elder care dictate the type of residents to be admitted to nursing homes, i.e. those who are very sick, very old, and cannot manage their own physical care. This is through the ´logic of care´ in terms of policies and regulations, which determine the nature of the ´field´ for practice, which consequently shapes the ´habitus´ (Bourdieu, 1977) of leaders in organizing care, recruiting and including immigrants in work at nursing homes. Thus, structures are informing agency in local contexts (Emirbayer & Mische, 1998), while sometimes bringing tensions between agency and habitus of leaders and other staff in terms of what ought to be done against what can be done. Secondly, and following on from the issue of struggling to staff the wards, social activities in the nursing

homes are not a primary concern for leaders and/or staff. The problem of lack of social activity is also facilitated through the recruitment of minority staff, some of whom have difficulties in leading social conversations and activities, due to their irrelevant habitus which is characterised by an insufficient social stock of knowledge (Ahearn, 2001; Bourdieu, 1977). Thus, securing the residents' social and spiritual needs is a second priority in nursing homes and perhaps something that is only provided as a kind of 'luxury service'. Staffing levels and composition are thus an important part of the factors that shape the nursing home as a context for both working and living. Finally, over-arching these basic arguments is the issue of distant leadership, which emanates from the NPM reforms. These reforms resulted in a management shift in nursing homes, with additional managerial tasks for leaders, while limiting their capacity to offer hands-on management since they happened to mostly work from the office and had very little time on the wards.

In the next chapter, I will explore the ways communication relates to language and social stock of knowledge among the staff as a basis for social interactions.

Chapter 5: Language competency, Communication, and the Social stock of knowledge among nursing home staff

Introduction

The previous chapter highlighted the structural and contextual factors through which daily organization of work was negotiated among leaders and staff in the nursing homes. This chapter focuses specifically on communication processes which are embedded in language competence and the social stock of knowledge of agents and of the working place(s). The aim is to highlight communication and interaction processes as they unfold among the multicultural staff, leaders and residents at the nursing homes by describing cases in which challenges and/or successful communication became evident, and to discuss and analyse the ways such processes may influence the working environment and the inclusion of immigrants. In particular, this chapter will explore communicative practices and patterns resulting from the emphasis on, and implementation of, Norwegian as the official working language, assessing its implication for social interaction and relationships among leaders, residents and multicultural staff. In doing so, this chapter highlights language, social space, and organizational and cultural barriers as well as promoters of communication and interaction in the working environment.

Communication is here understood as the "process of transmitting information and common understanding from one person to another" (2010:1). In this thesis, communication is measured by observing the way daily care work processes are jointly planned, negotiated and performed, and the associated opportunities and challenges among the multicultural staff in the nursing homes. As a means of communication, language is a symbolic resource which individuals use for the purpose of achieving and conveying cultural and social conceptions of behaviour (Berger & Luckmann, 1966; Bourdieu, 1991; Tange & Lauring, 2009). It is not a mere conduit for conveying information, but the co-construction of meanings between participants in particular social interactions (Ahearn, 2001). In this regard, language competency, informed by the social stock of knowledge of agents, provides a form of social action within a context, that is ´language in context´. Moreover, language holds a dimension of power, since language use as a situated encounter between agents, that is, as a type of linguistic interaction, bears traces of social structure in which it is embedded (Bourdieu, 1991).

The main argument of this chapter is that although Norwegian language competency is prioritized (over formal competence) in the leaders' choices of recruitment of immigrants in

work, the form and content of conversation and dialogue through which staff are to manage interactions among themselves, as well as with the residents and their relatives, also matter in inclusion processes. As such, attention needs to also be given to the promoters of and barriers to communication with a focus on the context in which language is formed and used. With Bourdieu (1991:2) I understand language and language use as situated linguistic encounters "…between agents endowed with socially structured resources and competencies…".

In general, the capacity to communicate effectively with each other and with residents varies among individual staff, in both the majority and minority staff groups. In this study, for example, some minority staff showed competence in language skills when holding conversations with residents, while others did not. Moreover, language skills other than Norwegian appeared to be relevant in some situations, challenging the assumption that it was essential to stick to only one language (Norwegian) in the nursing home context. On the other hand, lack of knowledge of Norwegian culture, history and values led to lack of content in conversation, such as the actual meaning of activities and Norwegian history. This seemed to limit interactions and engagement or '*life in the tasks'* performed by immigrant staff in comparison to the way these same tasks were carried out by the majority staff. To be able to manage communication and interactions in a particular context was highly dependent on "the social stock of knowledge" of the agents which may have served as a recipe for mastering routine problems (Berger & Luckmann, 1966:57). In a sense, the social stock of knowledge entails "the knowledge of the social conventions, rules of behaviours, norms and practices" dominant in a particular community. This knowledge is shared by members of a particular social group and is transmitted from one generation to the other (Fourie, 2008:246). Moreover, the social stock of knowledge makes it possible to communicate between members of a particular social group based on a collection of shared social meanings, and these shared meanings result in the 'taken-for-grantedness' aspect of communication (ibid.). Therefore, social stock of knowledge is part of the habitus formation, which then provide important schemas for relevant communication in a particular context. This, in turn informs agency of the agents.

In working environments such as those in this study, in which individuals have different social backgrounds, however, several interesting concerns arise. What kind of stock of knowledge do minority staff have for negotiating their daily work requirements, and how is such knowledge acquired? How does the variation of stock of knowledge affect work relationships and/or processes of communication among leaders, majority and minority staff? These questions will

be explored in the rest of the chapter as the nodes for analysing the way in which language competency relates to and influences communication processes in multicultural working environments. The analysis will employ agency as a theoretical tool to understand the way staff negotiate interactions through their social stock of knowledge to facilitate communication and interaction processes in the organization and provision of care. Habitus, in particular, will be employed to explore the way differences in, and continuing socialization among the staff may determine their accumulated social stock of knowledge and hence influence interactions. In particular, habitus will be employed as a set of ´dispositions´ which incline agents to act in certain ways, based on the available ´field´ within which they act and ´capital forms´ they possess (Bourdieu, 1991:13&14). Furthermore, linguistic habitus will be employed to trace the linguistic competences of the minority staff as they progress in forming their habitus and improve their social stock of knowledge. Linguistic habitus here, refers to the individual differences in practical linguistic competences used by agents as strategic players reflecting on their abilities to dialectically use and benefit from their words (ibid.).

The chapter is divided into two main parts. The first part presents the role of language in communication at work, and different aspects of communication such as culture, diversity and dialect. The second part discuss interaction patterns among leaders, staff and residents, and relates these to language competency and social stock of knowledge.

Norwegian language and communication in the nursing homes context

Language sets premises for communication in any social setting, and in particular, it is a pre-requisite for enhancing communication ability in the workplace (Kaushik, Walsh, & Haefele, 2016). Moreover, language, which is a system of vocal signs, is the most crucial sign system of human society (Berger & Luckmann, 1966). In nursing homes, Norwegian language is the medium through which daily work is negotiated among the staff. Proficiency in language, therefore, may guarantee avoidance of misunderstandings and mistreatments of residents (Knutsen, Fangen, & Žabko, 2019), although some other factors may also challenge this assumption. Language competency is an important skill in order to enhance relevant conversation. Language competencies and communication patterns primarily focus on negotiating to meet residents' needs, and is then extended to meeting those needs, in terms of

distribution and sharing of tasks among the staff. As per the observation from this study, those needs are many, diverse and complex, including medical, social, and personal needs, which altogether form premises for interactions. At this point, it is important to mention that communication patterns in the nursing homes under this study occurred depending on the task and needs at hand, rather than forming specific regular forms, although there was some sort of formal reporting within the system through shift handovers, regular meetings, and report writing. As such, patterns and forms of interactions were continuously constructed in relation to the context. To begin with, I would like to highlight a quote from my fieldnotes, a comment from one leader, during a conversation in one of the gatherings which included several leaders from different nursing homes.

> *"I always tell the minorities (*innvandrerer) *who want to work with us, that, if they can understand my dialect* (her dialect was known to be relatively difficult to understand), *then they are ready for the job here…"*
>
> **(Leader, NH2)**

Although this would probably be spoken by the leader as a light comment, in a manner that was probably not meant to be very serious, it still reflects the way leaders emphasize the importance of Norwegian language competence as a prerequisite for minority staff to access employment at the nursing home. Other leaders raised a similar concern during focus group interviews, although they did so by pointing out that poor language competence among minority staff was a common challenge. According to the findings of this study, and from my own experience both as an immigrant researcher and, previously, as an unskilled member of staff in a nursing home, dialects create challenges for minority staff in communication processes. Norwegian language consists of a number of dialects, which are related to the geographical location of a particular community. It is therefore common for both the residents (Norwegian) and majority staff to use their dialects in daily interactions at work.

In terms of agency, language forms a basis for interactions among the staff, on which relevant care plans and actions are negotiated. It is then important that a mutual understanding between the residents, majority and minority staff is achieved through communication. However, since language is acquired simultaneous with the habitus of the agents (Bourdieu, 1991), it may result in tensions for minority staff as they struggle to adjust to the nursing home working environment. In addition, there is a difference between managing language in general and managing language use in ´context´, which may inform tensions between agency and culture.

Although language in general is a challenge for many of the minority staff in their ambitions to work in the care sector and thereafter settle in Norwegian society (Christensen & Guldvik, 2013), I argue, in line with Ahearn (2001:110), that language competence in communication covers more than language per se, as it also reflects "a form of social action, a cultural resource, and a set of sociocultural practices"; see also (Bourdieu, 1991; Schieffelin, 1990). In order to manage language for communication in a particular context, several factors play a key role. For example, in the context of residents and staff in nursing homes, one important factor is the pattern within which that communication proceeds; another is the cultural resource, a social framework through which language is formed. This then informs content for communication and socialization in that particular context. In other words, to speak about language competence needs reflection upon the use of language in specific contexts (Berger & Luckmann, 1966), that is language as a social practice (Bourdieu, 1991). As such, to be competent in language (agency) is reflected by the ability to accommodate the language needs of residents in this situation (i.e. language in context). Moreover, reflecting on the previously mentioned characteristics of residents, communication may be difficult due to complex health and social issues which may interfere with each other. As a consequence, this may lead to tensions between the staff (mostly the minority) and the residents. Those residents born before WWII, for example, may be interested in and remember most of the main historical events which they had witnessed. However, due to being sick and/or diagnosed with dementia, the residents may have limited capacities with verbal and/or non-verbal communication. Still, being born and raised in Norway may explain their dislike of engaging in communication with non-Norwegian staff, as I shall elaborate in the next sections. Before proceeding further in the analysis, however, it is important to trace the process which minority staff adopt to learn the Norwegian language before they apply for a job vacancy in a nursing home.

Learning Norwegian

the essence of bringing a discussion about immigrant trajectories in learning Norwegian language is important in this study for the purpose of establishing the role these trajectories play in informing agency of these minority study as far as communication as a working tool is concerned. All the discussed means of acquiring language skills in relation to this study, suggest a gap between competence in general language skills as opposed to relevant language skills in managing care related and social interactions of immigrant staff. I illustrate those trajectories in the next paragraph.

In order to be employed in nursing homes, this study found that minority staff take different paths to enhance their language skills, which is a basic requirement on top of their professional qualifications. One group of staff learnt the language through NAV arrangements: most of the people in this group were refugees and asylum seekers. Others, especially from the European zone, attended language training either through the recruiting agencies in their home country (e.g. Polish nurses) or by paying from their own pockets to study Norwegian language courses and pass exams such as the *Bergenstest*[28]. In a sense, there is an inequality between refugees or asylum seekers from outside Europe and those from Europe. Those from outside Europe often have to find their own ways to learn the language (see also (Brochmann & Hagelund, 2012)). Although there is a lack of literature about the impact of language courses for immigrants to Norway, it is an established fact that immigrants who take part in formal language training programmes are more likely to be competent in proficient speaking and reading Norwegian language (Hayfron, 2001). However, the extent to which such proficiency relates to the needs of the residents through the inclusion of minority staff working at nursing homes context needs further investigation.

The last group (although few in number) comprised immigrant staff who declared that they had to learn the language by themselves and did not yet have any formal language training. Nevertheless, this group showed a degree of capability in speaking Norwegian fluently, except for one registered nurse who had relatively poor pronunciation of many words and poor sentence construction. It was interesting that this staff member was employed as a registered nurse with a large work percentage. I want to emphasize here that all the staff recruited, whether in skilled or non-skilled roles, had acquired a certain level of language proficiency, and had been entrusted with the role of care worker at the nursing homes. However, during my observations of the work processes around which care was provided, several silent or dull moments and mechanical forms of language use between the minority staff and residents or majority staff drew my attention to focus more on what exactly could be the explanation for such situations. At some point, I would stop and ask myself, what is the content for language training, and how does that differ between different organizations which provide it, such as NAV and others? What content for communication did they learn which could be relevant to their work? As a general observation in this study, most of the minority staff could speak the Norwegian language reasonably well. We understood each other in our conversation, and I

[28] Bergenstest is a Norwegian language proficiency test, nationally approved and a requirement for non-native speakers who want to study any tertiary education level (college or university), or to be employed in care sectors such as nursing homes

observed the focused conversation between them and other staff or leaders. Most interestingly, none of the minority staff mentioned communication as a limitation to their interaction processes, while on the other hand, most of the leaders pinpointed language as the main problem facing most of the minority staff. Ethnographic methods were helpful in this case, to reveal such gaps, as the next sections shows. As such, I will start by highlighting the relationship between language and culture, and the way this may relate to communication.

Language and culture in elderly care; translating and naming practices

Language difficulties among people with dementia are well documented (Appell, Kertesz, & Fisman, 1982; Hart & Wells, 1997; Potkins et al., 2003). Failure to express themselves may sometimes lead to agitation, which staff try to manage. The first impression I had before and during my first days of fieldwork was that Norwegian language was the most important competency for minority staff in promoting their ability in efficient communication. This assumption was based on the way most of the leaders emphasized it from the initial gatherings for project planning, and it was the main consideration before recruiting minorities. The fact that all the nursing homes I included in this study had only Norwegian residents justified this need, as it was the key language for communication between staff and residents. Several studies have also reported on the essential role of language for efficient care provision for elderly people, in Norway and other parts of Europe (Boge, Callewaert, & Petersen, 2019; Cangiano, Shutes, Spencer, & Leeson, 2009; Falkingham, Evandrou, Palmer, & Vlachantoni; Hervie, 2019; Munkejord, 2019; Walsh & O'Shea, 2009), Canada (Bourgeault, Atanackovic, Rashid, & Parpia, 2010; Kaushik et al., 2016), Australia (Goel & Penman, 2015) and the USA (Khatutsky, Wiener, & Anderson, 2010; Kong, Deatrick, & Evans, 2010). However, from the empirical findings of this study it was evident that there is more to it than ‘simply language command’.

It is commonly accepted that language and culture are intertwined, that is, language plays a key role in culture by both shaping and being shaped by it in a simultaneous manner (Ahearn, 2001; Bourdieu, 1991; Brown, 2000; Jiang, 2000; Risager, 2006, 2007). People learn language in a specific social context, which is embedded in a form of culture, through a socialization process, and since culture is not static, language evolves as it is used in a particular culture. In this sense, forms of interaction through language may differ as a result of the physical and social

background of different individuals, based on the social contacts they have encountered. However, there might be distinct words, used in a particular culture which may not be present in other cultures. According to Bourdieu (1991), for example, language as part of habitus, its uses are tied to different social classes. For example, terms like privacy and confidentiality may reflect different meanings for different cultural groups, such as those with collectivist rather than an individualistically oriented culture (Hofstede, 2001; Zabihzadeh et al., 2019). However, this may not be the case at individual levels because socialization is a lifetime process, and individuals may possess blurred collectivist and/or individualistic characteristics. In any case, people and things around us dictate the vocabularies we use in naming and explaining. For example, a person born and raised in a desert may not have a local terminology for skiing, naming the things used in skiing, or even describe skiing as a sports activity. The same applies to types of foods, clothes, social activities and so forth. As Boas (1942) confirms, the vocabulary composition in every culture reflects the relationship between people and their natural, and I add, social environments. In other words, they are context dependent (Emirbayer & Mische 1998).

In learning Norwegian language, contextualization of vocabularies was challenging for immigrants. The following excerpt from my field notes illustrates:

> *Judith, an assistant minority staff member from Africa, had been working for 9 years at NH1 and was now studying to become a health care worker (helsefagarbeider), and so she was studying while working. She came as a refugee and was placed in a language course before she could start her formal education. When we were having a chat about her experience in studying as an adult in Norway, she said, "one of the biggest challenges I had, when I arrived as a refugee, and I still face it now, though to a lesser degree, is language. Remember I am coming from a country which does not use English in academia (we use French). And because we do not use French on daily basis, I am not very competent with that language either. I managed to learn a few English words out of interest, but I am not competent enough. So, when I came here, going to the Norwegian language course was the worst and most stressful experience for me. In order to understand, I had to translate the Norwegian words into French, and then into my home language. The interesting thing was that some of the Norwegian words were not clear to me in the French language, and even worse, they did not exist in my local*

language. Or even when I got the French translation, I still did not understand what they actually meant ['pålegg'[29] was an example] …"

Judith represents many other minority staff in the first-generation category, who arrived in the country as adults. Since Norwegian is a local national language, most of the minority staff, especially from outside NORDIC countries, had to learn it from scratch. As a general rule in many colonized countries, as was the case in the country Judith came from, an extra language is taught in addition to the national or local languages used. For Judith it was French, while in other countries it might be English. Judith's frustration started from her efforts to translate each and everything. An interesting part of her narration is when she could not find an equivalent word from the French translation into her local language. The example of *pålegg* which she mentioned made me reflect on my own language, and I could not find a suitable word, probably simply because where I grew up, bread was not part of the regular diet. In this regard, I concur with the idea that vocabulary formation and use happen in a particular physical and social environment, which may then form a basis for differences depending on the place people come from. All societies have their contextual vocabularies, some of which may exist in other languages, while others may not. Thus, language is developed and used in a particular context. The experience in the quote above, suggest that learning Norwegian for the immigrant staff extends from seeking to understand the words and their meanings attached, which can be challenging if a person cannot find a reference point. Having a direct translation may therefore not necessarily solve the problem of understanding the meaning of a particular vocabulary.

Similar findings on the relationship between language formation and context have been documented by Håkonsen and Toverud (2012) in their study on cultural influences on medicine use among first-generation Pakistani immigrants in Norway. Although not within the multicultural workforce context, their findings confirm language translation difficulties within different cultures. One of the issues of their study, was associated with difficulties of translating data collection materials. This meant that translation was limited by concepts with no equivalent terms in another language (Pakistan), or by words/concepts which were not understood and were culturally inappropriate to use in particular settings. Other researchers have also observed similar translation issues in research materials in other contexts (Willgerodt, Kataoka-Yahiro, Kim, & Ceria, 2005; Yu, Lee, & Woo, 2004).

[29] A Norwegian term referring to anything and everything that you can put on a slice of bread or between two slices to eat. However, to my experience, Norwegians usually eat open sandwiches.

Language relates to culture in terms of the values, traditions, history, and socio-cultural practices within which it is embedded. From this background, language is highly related to habitus (linguistic habitus), the routine ways of speaking, gestures, and embodied communicative actions (Bourdieu, 1977, 1991; Hanks, 2005:69), which accumulate through life experience. Among minority staff, learning the Norwegian language happens as part of their secondary socialisation, while for the ethnic Norwegians this happens during their primary socialization. since most of the minority staff in nursing homes are adult, first generation immigrants, learning a language may need extra efforts to achieve, as compared to when for example they were younger.

Within the specific focus on elderly care, such aspects of language and culture are connected and directly relate to care processes, and may influence care relationships (Cangiano et al., 2009; Hervie, 2019; Risager, 2006; Walsh & O'Shea, 2009). To insist on language competence among minority staff while ignoring the cultural aspect from which that language is acquired may and the context in which it is expected to be used be an oversimplification of the role of the social stock of knowledge in promoting adequate communication necessary for care. However, I do not want to create the impression that the social stock of knowledge is an achievement which a person may completely acquire. What I am arguing for is that the social stock of knowledge of individuals is cumulative (Berger & Luckmann, 1966), acquired through interaction processes, as people encounter a number of social environments. I therefore argue that, as immigrants are included in work on a regular basis, they may have greater opportunities to interact with their fellow majority staff and the residents. However, due to few work shifts among most of the minority staff, this accumulation of a social stock of knowledge may be delayed or inadequate because of their limited interactions within the environment through which this stock is formed and accumulated (see also Krohne et al., (2019)).

Addressing others in a polite manner

In various cultures, the way we refer to or address family members (including extended family) and relate to each other, may differ substantially. An interesting story emerged during one of the lunch breaks at NH1, when we were discussing how western and non-western ways of association may differ. Signe, a majority registered nurse had this to say.

> *My son has been in a relationship with an African girl for some years now. As we were getting to know each other, she often used to come for dinner at our place. During our conversations, she used to show me photos from her mobile phone, of her relatives and*

friends. In the process, she showed me several ladies, who were with her mother, whom she introduced to me as 'her aunties'. At one incident, I commented to her about one of the 'aunties' she showed me, that "you look like this aunt of yours". With a surprised face, she looked at me and said "but we are not related by blood, we cannot look alike" … I felt very bad that I did not understand that in her culture, as she explained, old friends with similar ages as their parents are called uncle or aunt, but not by their names as is the case in Norway.

As we were laughing, Agnette, another majority staff commented,

"Ooh, now I can relate to the reason why Janeth [a minority staff from Africa] *keeps on calling these residents 'grannie'* (mormor)*".*

In the two excerpts above, both Signe and her son's girlfriend displayed different forms of 'social stock of knowledge'. On the one hand, Signe seemed to display the individualistic culture prevalent in Norway and many other western countries, in which extended families, relatives and friends are identified by their first names, regardless of their age. This does not reflect impoliteness in the eyes of western people. On the other hand, and with my experience based on my background from Africa, it is considered disrespectful for most of the African cultures to identify people, especially those who are older, without adding a kin-prefix like aunt, uncle, and so forth, before their names, even if they are not blood-related, just as the girlfriend in the above quote describes. Another example was that several other minority staff, especially from non-European countries, mentioned the way it felt awkward for them in the beginning to call people by their first names, especially the older residents and the leaders.

The two examples above show the misunderstandings which may occur when language is used detached from the culture of its users. In this regard, therefore, I argue that habitus in terms of culture (or cultural capital (Bourdieu, 1977)) plays a role in informing our perception of politeness and respect (agency) and that this issue is displayed for example, through notions people use to address each other. This is to say, the way people perceive politeness is embedded within "the background of their own habitus" (Locher & Watts, 2005:79).

Although leaders and majority staff thought that addressing residents in kin terms was ´strange´, I never observed anyone discussing it with the immigrant staff. In the quote above Agnette commented that she now understood the reason why the minority staff name the residents the way they do, she showed that she had noticed this, but had never tried to ask why it was happening. Moreover, although several studies have documented the use of use kin-terms

addressing elder under care because they relate them to their parents and grandparents (Hervie, 2019; Jordan-Marsh & Harden, 2005), a study by Dodson and Zincavage (2007) takes another direction to understand this phenomenon. In their study about the ´family model´ at the organizational level in long-term care residential facilities in Massachusetts, US, they associated the ´fictive kinship´ in relations between staff and residents with the reproduction of exploitative and racialized relations. This situation in turn, brought tensions between managing their work as both a job and a commitment to care for a ´fictive´ family member. Although this study was not interested in exploring the family model is in the Norwegian elder care sector, I still find the model relevant in explaining the institutional care of the nursing homes, in which an ambition to create a homelike environment require care staff to take full responsibility for tasks which would have been the responsibility of the family (Hauge & Kristin, 2008). That is to say, staff members take on the responsibility of filling in the gap for absent family members of residents. However, this still does not explain the reason why it is mostly the minority rather than the majority staff, who are always noticed by majority staff to address the residents in such manners. Dodson and Zincavage (2007) explain the reason behind the racialization of this ´fictive kinship´ among the minority staff, as traceable from the historical image of women of colour working in subordinate precarious jobs as nannies and domestic servants (see also global care chains in chapter one), although, I add, related forms of politeness may also be used by majority personnel through use of Norwegian nicknames like “vennen”. Regardless, it was only the minority staff who addressed the residents in kinship terms, and for the majority staff, it does not implicate subordinate relationships between the parties as it is with the minority staff. Residents did not do it in return. That is to say, it was a one-way relationship. However, such exploitative aspects to relationships between residents and staff are highly relevant in all nursing homes, including those in Norway, although the immigrant dimension adds even more to it, as for example, they have limited shifts, they are more vulnerable employees, and demanding residents. at a macro level, therefore, the kinship naming may be tied to the understanding of linguistic habitus as attached to class and power relations (Bourdieu, 1977, 1991), in this sense, between the minority staff and majority residents.

Apart from language use in the cultural context and the insistence of Norwegian language command for immigrants, this study established some other scenarios, where languages other than Norwegian played a role in facilitating immigrant inclusion in work and social interactions in the nursing home context, as the next section shows.

Diversity, language, and communication needs

Although Norwegian language competency might be relevant in working with residents, other languages may also be of value in some situations and work in favour of residents, as the following comment from a leader during focus group interviews shows.

> *"... there was one resident in our department who could not speak or understand Norwegian, and spoke only one other European language… and it was much easier that there were two other minority staff who could speak that language, because they could talk to this resident in his language… they also helped us with preparing a list of important words and their meanings which other staff would use when both of them were not at the shift"*
>
> **(Leader, NH3)**

Although this was reported as an old case, it may still illustrate the situation, and also predict future reality, for example when these minority staff are old and admitted in their turn to nursing homes. It challenges the idea of taking for granted that Norwegian language is the only relevant competence for working in nursing homes, and that immigrant care workers present a challenge to work in nursing homes due to their poor command of the Norwegian language without looking at other language competences they possess which may function to rescue a critical situation such as the one presented by the leaders in the above scenario. What might be the situation if no one at the nursing home could speak or understand this residents' language? Looking at it from the leaders' side, they were challenged by the structures, the political ambition of prioritizing competency in Norwegian language as the requirement for immigrant recruitment in work and for successful integration in society later. In the context of this political ambition, those two-minority staff would not qualify to work in the nursing home with their home language competence, despite the fact that due to globalization and migration, the assumed homogeneous society no longer exists in most of the western countries (Vertovec, 2007), including Norway. It is therefore important to question the relevance of those politics to the current realities. In the contextual reality of this particular nursing home, the leader allowed the minority staff to share their 'other' language skills, pushing the limits of the regulations which use Norwegian solely as the official language at work, which was not helpful in this particular situation. This was an official regulation for the staff but not necessarily for the resident who could not speak Norwegian. Regarding agency therefore, there is 'space' for the leader to interpret the rules in a flexible manner in order to meet special needs of some residents,

although this does not count as an added value to competence of immigrant staff. In particular, the temporal aspect of agency worked for this situation, to act on emerging contextual demands which were not predetermined, although it was not established as the norm to be considered in future care plans. From this backdrop, in such an incident, knowledge of a foreign language (i.e. the hybrid habitus of the immigrant staff, through accumulated social stock of knowledge through socialization) worked to facilitate the inclusion of immigrants in work, and her agency, although such inclusion cannot enhance integration of such staff in the Norwegian society based on the political interest to integration (Vassenden, 2010).

Some nursing home residents have spent part of their lives in countries other than Norway, and they sometimes talk about their previous life experiences. When they encounter minority staff who have been in the places they have been, it becomes an opportunity for them to reflect on their lives. As such, this creates an interesting social moment for them, and some of them wish to be attended by such minority staff. In NH1 for example, I met Martina, a minority staff member from Central America. She had been in the country for 8 years and could speak reasonably good Norwegian. She was fluent in Portuguese, which happened to be the favourite language of one of the residents in the ward. Every time she was at work, the resident preferred that she attend him so that they could hold a conversation in Portuguese. Majority staff joked that she would be '*speaking Portuguese with the old man*' she was attending in the room, and thus the cleaning session would take *an extra hour*. Regardless, every time tasks were distributed, her fellow staff would assign her the same resident because they knew he liked to meet with and speak to Martina. In one morning session, for example, when all the staff were busy with the cleaning routine, as I was sitting in the lounge observing the situation, two of the three staff who were on duty that morning came out. This was their short conversation:

> ***Bente:*** *Where is Martina?*
>
> ***Katrine:*** *She is still in Håkon's room*
>
> ***Bente:*** *Ooh, as usual… they must be enjoying their Portuguese session*
>
> ***Katrine:*** *Yes, and it will take an extra hour before they come here for breakfast… (*laughter…) *…But then Håkon will have one of his best days when the day starts with a conversation with the 'Portuguese lady'*
>
> ***Bente:*** *Of course, he always looks forward to days like these…*

As straightforward as it looks, the above conversation indicated that although all the residents happened to be ethnic Norwegians, some of them had a knowledge of other foreign languages, which they probably learnt when they were still young. They seemed to enjoy being taken back

in time, when they had such an opportunity, and this seemed to be meaningful for their social wellbeing, as the staff commented that '*Håkon will have one of his best days*'. Taking a step further back, two reflections may be extracted from the above situation. The first reflection concerns the way Martina adjusted herself to meet extra social needs in the interest of the resident. Although it is an established fact under the regulations that Norwegian is the official language among the residents and staff, Martina went outside these regulations to provide extra from what was required of her, and she had thereafter regarded this as an important aspect of care, at least for that individual resident. In relation to agency, Martina pushed the flexible contextual demands of her job, as long as they were not harmful, to provide important social and emotional satisfaction to Håkon, the resident. She extended her practice from the established ´language in use´ at work, to ´language in context´, responding to the preferences of this particular resident.

In any case, my argument with regard to the above situations is that language proficiency for minority staff who are not Norwegian may function to facilitate, rather than to constrain, provision of care to residents, and in this case, it can also add a value which immigrants can offer, as an important resource in elder care. This argument is similar to what was observed by Cangiano et al., (2009) in their study of the role of immigrant care workers in the elder care sector in the UK, whereby it was established that staff competence of languages in addition to English, which is the official working language, was important to meet the communication needs for other residents who needed it. In this regard, I add, language competency may also function to promote socialization and social care which is a neglected aspect in most of the caring processes, when referring to minority staff, whereby emotional needs of the residents may also be accommodated (Gubrium, 2012). As an example, although Martina's employment was based on her Norwegian language competence, she could still navigate through her cumulative social stock of knowledge and hybrid habitus and adjust to make a valuable care moment to this particular resident.

The second reflection is about time consciousness among staff in the busy morning session, which may relate to the contextual factors guiding care work part of which were discussed in the previous chapter (see chapter 4), and the way staff perceive the situation that their fellow colleague is spending more time on one resident 'just to speak Portuguese'. It is worth here to pose a question: what is care? How long should it be provided for each resident? Does care work distribution consider individual social needs when negotiated among staff? The case above indicates that Martina might be inconveniencing her fellow staff in a busy morning shift

by spending ‘more time’ than expected on one single resident. In explaining about time consciousness as a factor of culture, Grossman and Taylor (1995:64) maintain that “time isn’t money to everyone”. Whereas in most western communities, like Norway, all activities are time related, in some non-western countries culture, social interactions and relationships are considered to be more important than inflexible punctuality. It is therefore normal to find some care workers taking time to socialize with residents and relatives before helping residents to bed.

In the same vein, Martina in the case above implies what she believes to be the essence of care takers´ relational responsibilities with residents. They need to establish communication, trust and care relations, all of which takes time. Therefore, this scenario may not only be about someone speaking another language, but it may also be about issues that cause more tension as a result of a combination of differentness (foreign language) and time scarcity to maintain relationship with residents.

Martina’s case is not the only one which illustrates the way minority staff use their unacknowledged skills which are helpful in their work. Another example was the resident in one of the wards which was perceived to be ‘difficult’ and mostly agitated. In this ward there was one resident, whom according to the staff, was a former English primary school teacher. Reminding her and speaking to her in English was one way to calm her down, as the following field notes extracted from my journal show.

> *It was around 09:00 in the morning, I was sitting on the sofa in the lounge with one of the four residents, just the two of us, while two other residents were still sleeping, and one was being helped with showering. One staff member was in the kitchen preparing some sandwiches for the residents. All of a sudden, this resident in the lounge started asking for some yoghurt. The staff in the kitchen (which was a few steps from where the resident was sitting) responded to her that she would soon bring her breakfast. A few seconds passed by, then she repeated, “I want yoghurt”, this time louder. The third time was even louder, and she started standing up and sitting down several times, restless in the chair, screaming “I want my yoghurt, where is my yoghurt?”. When the staff member came in holding a small tray with some sandwiches, a cup of coffee, and a small yoghurt, it was too late, because the resident was already very angry, and she pushed the tray away. All the food was now on the floor. All of the sudden, one of the staff (minority) who was helping a colleague to shower another resident came running in. They both helped the resident to sit back on the sofa and gave her yoghurt. She did not*

start eating, but looked anxious, trying to stand up again. To my surprise, that minority staff member began an English conversation, asking the resident about the name of the school she used to teach, how many classes per week, and so forth. The resident started to calm down as she answered a series of questions from the staff. After a few minutes the staff changed the focus, when her fellow staff member came in with more sandwiches. She asked the resident if she wanted to have her yoghurt with a sandwich and then a cup of coffee. The resident agreed and she started eating quietly. An interesting comment from the fellow staff member, a middle-aged majority staff member, was that "it was nice that you came through and changed her focus to her interest. With my poor English, I could not have thought of any sentence to start with". Then they both laughed…

In the above situation, the majority staff member could probably have found a way of calming down the resident, apart from using English language as did the minority staff member. My intention for bringing this up is, however, to show that other languages are also useful, and bringing a different approach when they are accessible to the residents by promoting social conversation and calming down agitated residents as in the case above. It is indeed language in context, which also exemplifies temporal agency when staff handle residents´ challenges which are diverse and broad. Like immigrant staff members, many residents may have different life trajectories, which may allow them to know languages other than Norwegian and they may therefore enjoy practicing these languages with staff members who care to listen and hold a conversation. Moreover, the scenario above suggests that, to comprehensively manage communication in the context of nursing homes staff need to know the residents, know what they like and the life they have had, which depends on regular encounters between staff and residents.

In relation to national integration policies, the scenarios above highlight the gap between the ambitions of integration politics at the macro level and the actual challenges facing immigrants in local contexts (micro level). Furthermore, the situations show the mismatch between the way care is defined in policy and the associated standardised care practices, which do not necessarily meet some of the individual residents´ needs although all the residents are ethnic Norwegians. Although there are care policies for ´person centred care´ which aim at personalizing care, this study could not establish its relevance in some nursing home care practices, particularly in the area of social care. In general, the scenarios confirm the criticism on integration as a process which relies on and reinforces protection of a *uniform* ´imagined community´ of the majority

society (Rytter, 2019), which does not actually exist. This is because the Norwegian community is itself not socio-culturally uniform, but includes differences fuelled by globalization processes which lead to migration of workers (see also chapter one). in the same vein, acknowledging such diversities among the residents may facilitate the inclusion of immigrant staff as á resource´ and not as challenging the imagined equilibrium.

In the following section, I discuss further the way the social stock of knowledge relates to interaction with residents and among the staff in the nursing homes in this study.

Using Norwegian language in social interaction with residents

When Caris-Verhallen et al. (1999) pointed out that when people interact with others, they gain support, comfort, love and affection, necessities for all human beings, they also stressed that no study has yet indicated that such needs will diminish with age. Interaction plays a big role in making people feel comfortable, valued and appreciated. By the nature of their work, NH staff spend most of the time with residents, as compared to other groups such as visitors, volunteers and residents' relatives. in their work roles they are therefore an important source for residents to receive the social attention they need. This study draws attention the way social interactions were negotiated based on language and social differences in multi-culturally staffed nursing homes. Although the primary focus of this study is the staff, by necessity studying staff and staff interaction implies paying attention to the focus of their work and interaction, the residents they care for (see chapter 3). Residents' needs are the focus of the caring process, and whatever the leaders and other staff organize and plan is to cater for the residents' needs by delivering care services. Residents, the recipient of care services, are therefore part of the interaction processes, which go on in the daily work processes. It is therefore obvious to include the staff's interaction with them in the analysis. As already mentioned elsewhere, some residents in this study had difficulties in communicating due to some sensory challenges such as cognitive impairments and hearing loss, which consequently affected their form and level of interaction.

As a general observation, interaction with residents involved both verbal and nonverbal types of communications. Verbal communication depended mostly on the capacity of residents to express themselves or hold a conversation, using both bodily and verbal forms of language. Moreover, the type and forms of interaction basically was determined by the task at hand, either during routine activities or emerging during the shift.

Topics for social conversation

Residents always have their topics of interest for conversation, revolving around their lives, their partners', children' and grandchildren's lives, food, weather, and other previous personal experiences. However, most of the time, they do not start talking about those topics, unless there is a staff member who can trigger the discussion. There were a few exceptions to this, such as a resident in one of the short time resident wards of NH3, which had relatively cognitively capable residents. I observed that in some of the wards, if there was no one to initiate an interesting conversation, residents were sleeping in the lounge as early as 12:00 during the day. Indeed, one may conclude that it is normally the staff who initiate conversations with and among the residents (Gubrium, 2012) to enhance social engagement. However, Hubbard et al., (2003) challenged this assumption by highlighting that instead of considering institutional care settings as places characterized with social isolation in relation to the hectic routines among the staff, it is important to acknowledge the fact that some residents may occasionally interact, especially those with less severe disabilities. This study observed both conditions, although the former was more evident in several wards.

Due to the nature of the working day (see chapter 3), conversations between staff and residents during the working day happened mostly during the routine activities of cleaning and feeding. It is from these premises where interactions would emerge. In analysing forms and context for conversation, I will employ the three categories as put forward by Saldert et al., (2018:5), which are *task-central interaction, task-related interaction, and non-task related interaction*. In task-central interaction, the main goal of the caring staff is to get the task accomplished; while in task related interaction, the aim for conversation is engaging the resident in the task performed; and in non-task related interaction staff bring up topics unrelated to the task at hand. Specifically, task-central interaction was more of an instrumental form of conversation, where residents are informed about what is going to happen, like breakfast, lunch or dinner time, time to be taken to the toilet or regular social activities, reminding some to finish their meals, and so forth. This kind of information did not necessarily trigger social conversation between staff and residents, or even among residents themselves, as some would just agree by words or nodding. However, it depended on the responsible staff leading the activity to be able to add some social aspects to the conversation, that is, give life to activities, as will be presented later in the mealtime section. In a sense, staff would 'upgrade' the conversation to *task-related* interaction. An example of this type of conversation is illustrated here in two scenarios. In the first scenario, the staff member at NH1 takes the initiative to engage residents in a discussion based on a

created activity she came up with. The activity seemed interesting to the residents and they joined in the discussion while taking part in that activity. On the other hand, the second scenario shows two staff members initiating a conversation which did not seem interesting enough for the residents to join in.

Scenario 1:

> *It is 12.35, residents have just finished their lunch. Hjørdis, a majority staff member, took one of the residents for a walk outside the ward. This resident was confined in a wheelchair. When they came back after a while, the resident was carrying (on her lap) a bag full of apples they had picked in the nursing home garden. As she came in this was the conversation in the lounge (which was connected with the dining area and kitchen):*
>
> ***Hjørdis**: So… people (*'folkens*' as she put it), today we are going to make 'eplemos'… what do you think?*
>
> ***Resident**: Wow…that will be great… It has been long time since I have made that…*
>
> ***Hjørdis**: So, if you agree and want to make it as you said, I need a recipe from any of you… any idea?*

The discussion was now focused on how to make it. Then other residents (and I) came together by the dining table and stared to peel apples. Those who could not manage to peel were also seated and participated in the conversation. Later, when it was ready, all the residents were served, and had several comments on the dish.

Scenario 2:

> *I was sitting by the dining table with two other minority staff at NH2. The residents were having breakfast quietly at the table. Then the minority staff member, a male staff member from Turkey and a female from Africa were having a conversation about war and terrorism episodes. After a short while, all the residents were quiet. One of the staff turned to one resident and said,*
>
> ***Staff**: ooh we are talking about war and terrorism in our countries which is now getting in the headlines… do you think it is interesting to hear about?*
>
> ***Resident**: no, not at all…*
>
> ***Staff**: ooh, fine then, you do not have to… I just noticed the way you all were quiet*

The two different scenarios above imply that interaction among staff and residents has something to do with the topic at hand, or the content for discussion. The first case involved an activity/task that several residents could engage in, either by peeling or just sitting together with those who were peeling the apples, and hold a conversation, while the second situation was more of a conversation without any activity. In the first scenario, my take is that residents could choose not to respond to the majority staff member if they were not aware or interested in the topic brought up. The 'wise' choice of the topic, which was familiar to the residents, facilitated their engagement in the activity and discussion, because it was part of their socialization from their days before coming to the nursing home. Contrary to that, it may be understandable for them not to relate to stories of terrorism in different parts of the world, which is probably not an interesting theme in the Norwegian and world history of their time. Since most of the residents were born before WWII, a time which terrorism was not established as a ´concept´, which gained much popularity across the globe after September eleventh (9/11) attack in the US. In addition to awareness of communication needs, the staff also need to be aware of suitable topics for conversation with residents. However, due to difference regarding the important events in their lives as part of their socialization, communication barrier is inevitable.

It is also established in the study by Walsh and Shutes (2013) that lack of a shared cultural outlook such as history, customs and care approaches hinder strong care relationships, as in the situation above about terrorism. This may consequently explain the dull and silent moments in the wards which are attended by immigrant staff, although dull moments may also be due to other individual and contextual reasons, such as labour intensiveness, even when there are only majority staff during a particular shift. But how do staff manage to come up with interesting topics for the residents? Social stock of knowledge may be relevant in this case. To gain social stock of knowledge, I argue, in addition to general language skills, immigrants would benefit further from learning the historical and cultural events relevant to elder care for better inclusion in work. As such, their habitus (i.e. linguistic habitus) would to a certain degree relate to that of the residents as far as social interaction is concerned, that is, meeting the contextual demand of language. Such social factors as interaction with residents may add value to a sense of homelike environment by making nursing homes a place for connection and socialization with all staff members. Although their historical, cultural upbringing or context are certainly due to habitus, agency is also at play which an interactive space between staff and residents is provided in nursing homes. I argue therefore, that, at some point, what is assumed as inclusion of immigrants in work may just mean to make them ´present´ at work for the sole purpose of

complementing the manual workforce. Specifically speaking, there is a clear tension between agency (the minority staff who have a relatively good enough command of the Norwegian language to initiate conversation) and structure (the context which dictates the relevant and useful forms and content of language for social interactions). At the macro and meso levels of immigrant integration through inclusion in work lie the politics and procedures for language training, while at the micro levels of the local nursing home wards lie the context specific content for conversation and interaction.

Apart from language competence and social stock of knowledge among the staff, this study established that other factors may also influence the practicability of social interactions at the nursing homes. In addition to the busy nature of work at nursing homes, the extent to which staff are expected to meet social needs of the residents (such as engaging in conversations) is questionable. My participant observations showed that there was no set time in the routine activities for social interactions with residents, leaving only mealtimes for this. All other social activities were left as the responsibility of the family when they visited the residents, or the volunteers, and sometimes one assigned person (Aktivitør). For this matter, it was not easy to find all the staff at the shift taking part, some who were willing and had time would take part, in part or fully, while others would be doing other things or taking a mini break. It was also not clear for me how to determine the exact time to observe social interactions, which specifically involved all the staff. However, regardless of the missing specific time frame for social activities, I could focus on those few opportunities which could reflect social aspects. Leaving a room for individual staff choice to initiate conversations or social activities in the course of the day, was arguably the reason as to why most of the majority staff took this chance because they had somewhere to begin based on their social background, while minority staff were lagging behind, and sometimes used the chance to have conversations among themselves, and not thinking to include the residents. Such contextual factors, such as not having an explicit schedule for social interactions among staff and residents, together with the busy nature of the workday, I argue, functioned to limit meaningful social interactions in the nursing homes.

Not only verbal, but also non-verbal language played a significant role in communication with the residents. This is discussed in the next section, in relation to sign systems and tacit knowledge to ensure resident safety.

Dialogue without words, sign systems, tacit knowledge, and resident safety

Although verbal language is an important aspect of communication across cultures, non-verbal language plays an equally important role, especially when working with elderly residents such as in this study. According to Hubbard et.al., (2002:156) nonverbal behaviour comprises 57 to 97% of interaction in adult communication. Similar to verbal communication, this form of language may have cultural framing as it emerges from the socialization process. The way we communicate with our bodies, therefore, may have roots in our cultural groups. As DeVito et al., (2000:152) insist, "non-verbal communication is highly influenced by culture", as for example, people from different cultures may respond differently towards a particular situation. Non-verbal types of language which may differ among different cultures include touch, silence, space, eye contact, body movements and so forth (Argyle, 2013; Caris-Verhallen et al., 1999; DeVito et al., 2000). Furthermore, other vocal language such as hissing, snarling, and mumbling may not mean anything, unless they are integrated into the available sign system (Berger & Luckmann, 1966). The role of non-verbal communication includes: conveying interpersonal attitudes and emotional states; supporting or contradicting verbal communication; and functioning as a substitute for language, in times when speech is impossible (Caris-Verhallen et al., 1999:809).

Communication between staff and residents in the nursing homes in this study took various forms. Some residents could communicate their needs or hold conversations - they had sound language capacity to express themselves, be understood by the staff and they could also understand the staff. For others, however, competency in verbal language and communication was a challenge, where some would speak ´irrelevant´ words to make an understandable sentence. As such they used their body movements and expressions to convey information to the staff. In a sense, non-verbal communication in interaction among staff and residents was significant in some wards and with particular residents, by either supplementing verbal communication or as the only form of communication through which interactions had to occur. The following three scenarios illustrate this issue.

Scenario one:

> *It was 09.00 a.m. as I entered ward B of NH3. I came face to face with a resident who was coming towards the door, but then she changed her mind and walked back. This resident is always on a walk, she walks throughout the day, and the staff say she also*

walks during the night if she is not asleep. The staff related her walking preference as being associated with the fact that she was a former athlete, and she had won several trophies in younger life. After walking back and forth for a long time, I noticed that she was walking with one shoulder up and the other down, hardly lifting her feet from the floor, but no one could stop her walking. When I asked the staff later, for the reason she walked like that, they said that she does the same, when she is tired, especially on a day like that when she had not slept the previous night (according to the night shift report). By this time there was no other resident in the lounge. Jennifer, an assistant staff member from Africa, was sitting by the dining table. After walking seral times around moving several rounds repeatedly saying, 'I am going home', she (the resident) went straight to Jennifer who was sitting on a dining chair. Jennifer looked up at her and the resident looked at her and smiled. Jennifer smiled back. Then the resident said some words, which were not clear, and Jennifer seemed not to understand. While Jennifer looked at her with a continued smile, the resident got angry and started shouting at her in words I could not comprehend. She then grabbed Jennifer's hand and started telling her words which were not clear. Jennifer politely asked, 'can you free my hand?'. The resident kept on holding it for a while, then started crying and went to sit on a sofa. In the meantime, another two staff who were in other residents' rooms came quickly to help out after hearing the noise from the resident. They asked Jennifer what had happened, and if she was hurt (probably knowing that residents may become aggressive). Jennifer explained briefly that she was okay. Meanwhile one of the staff members, who was a majority registered nurse, went to the resident who was still crying and mumbling words which did not connect. She knelt down and tried to speak to her. She told her that it was okay and held her hands. The resident gradually calmed down and after a short while she stood up and started wandering around again. They tried her with a glass of diluted juice (saft)*, but refusing to sit down, she drank a bit while on her feet, then again started her endless walking. As she was left to continue with her walking, the staff stopped for a minute to talk about the situation among themselves. Then I had an opportunity to ask for more explanation of the situation. The majority registered nurse, who tried to talk to the resident said, "she is like that… we take it as it comes, no specific response to a particular action. Sometimes it works, sometimes it doesn't… we try the best we can and help each other because it does not always work with one staff member".*

Scenario two:

It was a morning shift at W3 of NH1. Katrina, a minority auxiliary nurse came into the lounge with a resident, whom she had just finished cleaning and dressing. She brought him into the lounge to have breakfast with other residents, although he was put by the window (where he always sat). The resident was then served with breakfast, which he ate with Katrina's assistance. When he finished, Katrina cleared the table and went to assist another resident who was sitting by the table with other residents. After a short while, the previous resident started shouting, 'nei…nei…nei…'. The immigrant member of staff, Katrina, went to try to see what was wrong. She tried to ease his trousers, then adjusted his leg on the wheelchair, but the resident kept on screaming. By that time other residents started complaining about his noise. While trying things out, Katrina removed the brakes of the wheelchair and decided to take him back to his room. Surprisingly, just when Katrina removed the brakes, the resident stopped screaming, and went quietly to his room. As Katrina came back, I asked her how it went, and she said, "it was okay… we know, when he starts screaming, it is time to take him back to his room. Sometimes, he does not want to be around people, especially when the lounge is almost full…"

Scenario three:

At NH3, ward B, there was one resident who had difficulties in verbal communication due to serious dementia, although she seemed to be the physically strongest of all due to her relatively younger age. This resident would say just one set of words whenever she did not like what was going on, otherwise she would be quiet for most of the time. It was interesting how staff could mobilize everything this resident preferred. I noticed that she had a fixed way of being attended, and because she was 'impatient', everything had to be in place or done fast for her. When someone went to help her with the morning clean up, that person made sure that her cup of coffee and jam sandwich was ready or being prepared by someone in the kitchen. When she comes out of her room, she always goes straight to the same seat with a small table beside it. As she sat, a staff member came with her breakfast, and she ate quietly until she finished, without saying a word. Immediately after finishing she was served with a cup of diluted juice (saft). If anything came late, she started shouting the same phrase "jeg må slappe av" (meaning "I have to rest"). *Interestingly, there was always a girl toy at the far end of the table at which her breakfast was set. After finishing breakfast, or sometimes before, she would pick up*

that toy and cuddle it like a child, smiling at it. Every staff member seemed to know that, and whoever was on duty made sure that the toy was close. I asked one of the staff how they came to know that she liked that toy, and she said that they just found out that she always picked it up whenever it was close and seemed to enjoy it, so they decided to make it available for her. But no one knew why she liked it or the story behind that, and surprisingly enough, I did not get an answer on who brought it into the nursing home.

The above three scenarios exemplify the way staff, both minority and majority, deal with residents with verbal communication impairments. While the first and third scenarios were from the ward labelled for difficult and mostly agitated residents which always had all the exit doors locked, the second scenario was from a general dementia ward at NH3, where all the residents would sometimes sit together in a lounge. In those differing scenarios, it is hard to determine whether the pattern of communication is verbal, non-verbal, or a combination of the two. In a sense, although the residents could utter some words or phrases, they were not only opposite, but also irrelevant to the situation at hand. the reasons the staff gave for their responses suggest that sometimes communication was based on guessing or trial and error. Therefore, I would rather say that communication was based on individual evaluation of the situation and hence a choice of response, or a series of trial responses. This was because sometimes staff could not give concrete reasons of why they had decided to act in a particular way.

The staff responses resonate with what Kontos and Naglie (2009) refer to as tacit knowledge, the use of embodied selfhood as a source for caring practices. Being embodied means that knowledge is learnt through continuous exposure to particular caring practices to the extent that it becomes part of practice without having to think about it (the taken for grantedness of habitus). For example, in scenario one, where the staff member took action to kneel before the resident, telling her that it was okay and holding her hands until she stopped crying, reflected the nurse's ability to communicate with the resident, making meaningful connection, which in turn helped to calm the resident down. The significance of this connection, according to Kontos and Naglie (2009:696) derives from the meanings conveyed directly by the body, not the semantic content, and in this manner, communication therefore resides in the body's capability, which then implies that caring arises from the ability of the body to apprehend tacitly and convey meaning.

On the other hand, the above scenarios demonstrate that staff get into focus the social and cultural habits, movements, and other physical signs of the residents. This was evident when the staff encountered instances where the resident's previous occupation instilled them bodily

dispositions to move and act in a certain way -for example, when the staff related the resident's continuous wandering in the ward to her previous athlete and hiking activities. In this regard, the scenario implied that knowledge of the life history of the residents enabled the staff to respond by being sympathetic with their behaviours instead of, as in this example, forcing her to sit down. Put within Kontos and Naglie's (2009) perception, knowledge of residents' history enables the staff to recognize a particular resident's socio-cultural bodily dispositions, as well as to facilitate practitioner's creativity to grasp and engage in useful activity. It is additional information which is important to guide the actions (agency) of the staff members, apart from their professional knowledge. But how do staff know residents´ history?

During my observation and interaction with leaders and other staff, I asked them that question out of curiosity, and they generally said that their awareness came from the regular conversations they held with relatives of residents, in addition to the brief life history found in their personal files, and some information hanging at the back of the residents´ door. Considering this reality alongside the way the staff handled agitated residents, I argue that both of the staff (Katrina, the minority auxiliary nurse, and the two other majority staff in scenario one and three) had equal opportunities to understand the residents and try successfully to calm them down through the acquired tacit knowledge. On the other hand, Jennifer represents many other unskilled and semiskilled minority staff, who work irregularly on different wards depending on available vacant shifts and are challenged when it comes to getting used to residents´ special communicative behaviour. Thus, Jennifer had a more limited capacity to intervene successfully when encountered with such challenging contexts.

Moreover, as mentioned earlier, dementia adds challenges to communication among staff and residents, especially when residents lose verbal communication capacities, or say something contrary to what they mean. According to Potkins et al., (2003:1002), language skill impairment is a common characteristic for people with dementia, which may also result in development of troublesome behaviour (agitation) and possible compromise of individual social skills. Jennifer, for example, had this comment on her experience as a minority working on the ward with severely demented residents at NH3,

> *"I think the cultural challenge comes in with respect to the kind of residents we have here. They have psychiatric issues; it is difficult for me to sometimes understand what they say or need because they cannot say it clearly or do not necessarily mean what they say. Sometimes they do strange things which I cannot relate to, for example crying out of nowhere… and with my limited Norwegian vocabulary, it might be very difficult to*

find some words to calm them down when they get aggressive or refuse to eat. However, I am grateful that in this ward we help each other, and so I can ask for help from any of the majority staff…"

In addition to verbal communication, non-verbal communication is also "culture specific and contextually bound" (Jootun & McGhee, 2011:42). In relation to habitus, I argue that people communicate without words based on the way they were socialized. Drawing from the difference between the socialization environment of the residents and that of minority staff (although for them the process is still going on), it is not surprising that they may interpret each other differently from the intended message. In the quote above, although Jennifer relates the challenges caused by her lack of Norwegian vocabulary to her ability to be able to calm down agitated residents, she still highlights the challenge of interpreting residents´ nonverbal communication. This is shown when residents lack verbal communication capacities, but their actions are still attended to by the staff using both words and actions.

Furthermore, Jennifer acknowledges the language aspect of communication as a barrier. However, by my interpretation, the above quote also indicates the unexplained 'aggressiveness' and other problematic behaviour like 'refusing to eat' which the resident may portray. Such behaviour does not just happen, there must be a reason, as established in psychology, and behaviour is a form of communication (Alvarez, 2016). The resident in this case represents many other such residents in nursing homes, who have verbal communication challenges. Being able to interpret such forms of communication is therefore an important skill for the staff. That is to say the staff need to have competence in interpreting such non-verbal communication, to be able to understand and relate such behaviours which may mean hunger, pain, sleepy and so forth. There must be a reason behind a resident's persistent urge, for example, to want to leave the ward/nursing home, wonder around, throw stuff and so forth. The question is the extent to which staff are *equipped* enough to understand and *respond* according to the needs of the residents, that is, to be able to exercise agency relevant to this particular context based on the professional knowledge. The point I want to make here is that the problem of interpreting nonverbal communication may affect minority more than majority staff, because it is not only about finding the right words to say, but also being able to interpret residents' behaviour. This is traced from their recruitment processes and inclusion in work. Having lower percentage positions immigrants are forced to take a long route to attain a career qualification, such as having to attend and pass language courses before enrolling in formal health education. This has caused some of the minority staff to lose interest in studying for higher level qualifications

in language, healthcare and dementia knowledge. Consequently, they may lack necessary professional skills for attending dementia residents. This is to say, the complex structural demands within which the immigrant staff find themselves at entry and on the professional ladder, disadvantage their efforts. This in turn holds them back at the level they can practice with minimum competence. As for Jennifer, she has developed a reliance on the more competent and experienced staff who are available to give her a hand whenever she needs it. However, this may create a tension in situations she has no competence to address, while overburdening other qualified staff during a particular shift.

Mealtimes

Mealtimes are one of the crucial events in the nursing homes, probably because of the organisation of everyday life in nursing homes with limited other (social) activities. Mealtimes creates a context for communication between the staff and residents. It is important to promote interaction and conversation during mealtimes and to maximize effective nutritional intake among residents (Aselage & Amella, 2010). Mealtimes are a basis for initiating conversations among residents and staff, for example by judging the food, before, during and after meals through non formal conversations (Gubrium 2012:172). As per this study, residents were interested in knowing what was on the menu, especially for dinner. The menus were available for a period of time (a week for example) and were hung on the refrigerator door or kitchen notice board. Residents looked forward to what was to be served, and some had special preferences. One of the minority staff, Benjamin, for example, used this opportunity to encourage one resident to go for a walk to build up his appetite so that he would enjoy his favourite meal, as this conversation shows:

> ***Benjamin****: … so today is meatballs for dinner, your favourite…*
>
> ***Resident****: ooh, is that so? I cannot wait to enjoy it…*
>
> ***Benjamin****: well, but for you to have your best appetite, I suggest that we go for a walk, and then when we come back dinner will be ready…*
>
> ***Resident****: Of course, let us go now because I really need to be hungry to enjoy my favourite meal*
>
> **(Field notes, NH1)**

During mealtimes, staff would also engage residents in social conversations. However, there were variations in the extent to which such social arenas were active. The following extract from the field notes on my first day of data collection illustrate what I experienced.

> *It was dinner time at NH1, around 13:40hrs, and I decided to take a round of the three wards. It was my first day, so as a 'stranger' in the nursing home, I could not take part in the activity of providing meals. I started in the first ward and noticed that there were three staff, who, according to their way of speaking, and confirmed later, were all ethnic Norwegians. Two were sitting at the table with the residents, assisting two out of three who could not feed themselves - the third resident was assisted by her husband, who had come for a visit. One staff member was helping with medicine distribution. Lots of conversations were going on, mostly on what was on the menu, which was fish cakes. One staff member asked residents if they had liked that type of food when they were young and how often they would now eat it if they could choose. The residents mentioned other types of food that they used to like, and one resident suddenly said that she liked most of the food, except the tomato soup, which her parents had forced her to eat. The session was lively with laughter from the residents, the staff, and the guest (who visited his wife).*
>
> *After a while, I went to the second ward. I noticed that it was quiet as I approached. On my arrival, I saw five minority staff, one from Europe and four others from non-European countries. One male non-European staff member was sitting at the table, helping one resident to eat: he had a small plate in front of him and was eating as well. The other Asian staff member was helping another resident who used a wheelchair away from the dining table where all other residents were sitting. The European minority staff member was standing by the medicine trolley, organizing medicines for some residents. The other two staff were just sitting on the sofas. The only words I heard from the helping staff were words such as 'open your mouth', 'are you full?', 'do you want a drink?'. To my surprise, the other resident who was being helped at the other end of the lounge fell asleep right beside the helping staff member, who then started laughing as she said to her "hey, you sleep in the middle of dinner? Wake up… we are not finished yet…"*
>
> *After a while, I left for the third ward. Here, the dinner session was almost finished. All the residents were served dinner and were eating by themselves, though many sat in wheelchairs at the dining table. Two residents were served in their rooms. It seemed that they had already been given medicine. There were one majority and two minority*

staff. One staff member was putting dishes in the dishwasher, while the two others, one European and one non-European immigrant staff, were sitting on the sofa talking amongst themselves. As I got close to them, I could hear them talking about their next shifts and the way they were tired from the hectic day during which the doctor had visited the ward. After a while, they started helping their fellow staff to tidy up the table for some residents who had finished their desserts and those who said they were full. Then they took some residents to their rooms (those who wanted) to take a nap, while only two who did not want to take a nap stayed in the lounge, one asked the staff to turn on the tv while the other took her knitting stuff and started to knit.

As I was analysing this phenomenon later, several reflections came to mind. The first one was the difference in the way conversation happened at mealtimes in the three wards. In the ward with only majority staff at work there was much engaging conversation which included the residents. On the ward, with only minority staff, there was what Caris-Verhallen et al., (1999:808) term "task-related" communication as opposed to the "socio-emotional" type of communication (see quotation above). The staff were neither holding a social conversation with residents, nor among themselves. In the third ward, since most of the residents were able to eat by themselves, staff took time to sit and have a chat among themselves, leaving the residents to eat quietly. Like the staff in the second ward, they were watching from a distance, ready to clean the table when the residents had finished.

Looking at these three relatively different scenarios, they suggest that staff composition influences the form and extent of conversation that is likely to occur between staff and residents at mealtimes. The majority staff showed more social capabilities which I relate to the social stock of knowledge, which enabled them to engage residents in conversation more easily than the minority staff. In this case, I am not convinced that the difference in language competencies among the staff is the reason for this variation, considering that the minority staff did use short phrases to stimulate the eating process for some residents. In addition to differences in their social stock of knowledge, some other factors may contribute to the silence. The differences might be caused by staff tiredness towards the end of the day and remaining quiet as a way to relax. However, if that was the case, why were the majority staff members holding sound conversations with residents whilst on the same shift? In addition, why would two other minority staff sit and talk together while the residents were having dinner by themselves? I do not think there can be a comprehensive answer to all those questions. However, picking findings from the content of conversations among majority staff and the residents in the first ward, their

conversational activity may be related to their capacity based on their social stock of knowledge about Norwegian food culture and history, which they share with residents (Berger & Luckmann, 1966).

Negotiating skills in regulating residents' behaviour

When it comes to residents with sound minds, it can also be difficult for some of the minority staff to have sufficient vocabulary to attend to their issues and/or engage in conversations. At some point, staff are required to be firm or determined in giving directions to the residents or implement medical directives from the doctors. However, they are expected to do it in a relatively diplomatic way rather than using coercion, which is unethical. In actual practice, this form of interaction is not always smooth, especially for minority staff who may have limited negotiation skills, especially with residents who might be tricky. This was observed in interaction between a resident and a minority staff.

It was soon after breakfast, when one resident who had diabetes and was not allowed more than three and a half slices of bread wanted more food from Ester, a minority staff member from Africa. In addition, there was a daily assignment of one staff member to document what this particular resident had been eating in the course of the day for breakfast, lunch, dinner and snacks. The list was always hung in the kitchen. The following was the conversation.

> ***Resident**: can I have more food?*
>
> ***Ester**: but you have eaten already…*
>
> ***Resident**: but I am still hungry…*
>
> ***Ester**: you cannot have more than you already have…*
>
> ***Resident**: I know I had some bread, but I am not full, and I need more food… don't I have a right to eat?*
>
> ***Ester**: yes, you have a right and you have eaten already… you know you are not allowed to have more than you are asking for…*
>
> ***Resident**: even if I am not full?*
>
> ***Ester**: (irritated…) well, the doctor knows that what you had is enough for you and I cannot offer you anything more.*
>
> ***Resident**: (also angrily) … I said I am still hungry, and I need more food… so go ahead and give me some. I did not come here to starve…*
>
> ***Ester**: I have already documented that I have given you what you are supposed to have, and I cannot give you anything else…*

The above quotation may illustrate some instances in nursing homes when staff may enter into challenging situations as they try to balance their professional and social skills to help the residents. Although the same decision would have also been made by a majority staff member, the conversation still implies a conflictual rather than a negotiating situation. Following orders from the doctor, as the staff member puts it, compelled her to reject the resident's request. On the other hand, one may think that limited negotiation skills hindered by language competence may have been a reason for not giving room to discuss the decision with the resident to reach an agreement, without necessarily causing her to get angry. In this ward, for example, both majority and minority staff were speaking about some of the residents (including the one in the case above) who were quick to ask the minority staff for foodstuffs in short supply or 'unhealthy foodstuffs' (in relation to their health status as in the case above), in the knowledge that the minority staff could not manage arguments due to language challenges. Some residents got away with this while others were harshly denied: the latter then blamed those staff for not being friendly, as in this case study. If this is correct, then staff need to be equipped with negotiation skills in order to persuade residents to make good choices for their health. However, from another angle, the situation described above may imply an unfair treatment of residents. As nursing homes are usually the residents' final home, they may choose to take risks with their health, just like other members of society, rather than being forced to be healthy throughout. This also reflects the implication of medicalization of nursing homes (see also chapter one) from the national level (structures) which is channelled down to the practice level, where staff choose to stick on medical prescriptions and refuse to be flexible to accommodate the interests of the residents. This in turn creates tension between caring staff and residents.

As an example, this same resident was also labelled as a chain smoker, and the staff had to hide the lighter to control her smoking intervals as advised by the doctor. This sometimes-caused irritation because the resident would choose to demand a lighter before the recommended time. I observed that there were differences between the times when the majority and minority staff had to handle the situation. The quotation below is an example of a conversation between this resident and a majority member of staff.

***Resident**: can I have a lighter? I need to smoke*

***Staff**: is it time yet?*

***Resident**: ooh, there are just fifteen minutes remaining, so no problem…*

***Staff**: but do you know if you smoke fifteen minutes earlier then you might end up having two more cigarettes a day… imagine the count after a week, a month, and so forth…*

***Resident**: well, I know, but it is just two cigars, not that dangerous (smile)…*

***Staff**: but you are already carrying the danger in your body, which we are trying to minimize… don't you think it is unfair if I let you smoke while I know the bad impact I am doing to your body?*

***Resident**: I am an old woman, I will die anyway, and no one will blame you for my choice (laugh…)*

***Staff**: you know my dear, it does not matter what anyone will say afterwards, but I am here because I am trusted as a professional who will take good care of you on behalf of your family, so for me that is very important to keep in mind throughout my shift, everyday…*

As they continued to have a friendly conversation, fifteen minutes passed by, and the staff member told the resident that she could have the lighter because the time was up. They also agreed to go for a walk after lunch, and when they came back, the next smoking time was delayed by twenty minutes, without the resident recognizing it. She was happy as she had been taken to a nearby shop where she had worked during her working life, and she had been given a jacket as a present from that shop. For me, this situation showed the competence this staff member had with regard to negotiating with the resident without necessarily getting into a conflict. In the first conversation with the minority staff, mechanical forms of information giving characterise the interaction, contrary to the second case with the majority staff, where there is a relatively smooth negotiating conversation and neither of the parties got irritated.

Handling challenging situations

Apart from giving orders or regulating residents´ behaviour, sometimes staff members find themselves in a situation where they have to assist residents to overcome or cope with challenging situations. Conversations and communication with residents may sometimes involve extreme emotional experiences, which may require extra skills to handle. During my fieldwork, one resident, who was relatively younger than the rest of the ward, lost her mother. Her husband came to break the news, and it was unfortunately done when most of the residents were having breakfast at the table. According to the staff member who was present, though by then in the kitchen, the resident's husband was supposed to take the resident to her room and

break the sad news there. However, there was some chaos as other residents were saddened by the news, but later they were calmed down by the staff. After a while, the husband left. The resident was still expressing pain for the loss, and was continuously moving around, sometimes crying. As it was the morning session, all staff were busy, mostly in residents' rooms, except for Marcia, a minority staff member who had kitchen responsibility on that day. She occasionally came out and looked at the way in which the resident was grieving, but she could not help out. After coming in and out of the kitchen to look at the mourning resident, she then decided to approach her. The following was part of their conversation,

> ***Marcia****: hi Åse, I am sorry for what you are going through…*
>
> ***Åse****: thanks, it's okay…*
>
> ***Marcia****: did you expect it?*
>
> ***Åse****: no, my mother was fine, I did not hear of any sickness, it is very sudden.*
>
> ***Marcia****: ooh, I am so sorry… how can I help you to make you feel better?*
>
> ***Åse****: no, there is nothing you can do… I just want to be left alone…*
>
> ***Marcia****: alright then… if you need anything just let me know… or if you need to make a call to someone you wish to talk to, I will be in the kitchen…*
>
> ***Åse****: okay, thanks*

She gave the resident a hug and then left her sitting alone on the balcony. When she came back inside, I was sitting with other residents in the lounge, and she said to me,

> *'It is sad that this poor woman has to face such a painful moment in the middle of strangers. I did not even know what to tell her to make her feel better. It must have been easier if she had been at home where she used to live before coming here, but you know, these are the things these people take so lightly… in my country, she could have been with family and relatives who would sympathize with her'.*

Mourning loved ones is one of the cultural aspects which differentiate the way societies do things. As the above quotation shows, this minority staff member understood the pain and frustration associated with losing a parent, and she used her limited cultural resource to convey her regard and her offer to help the resident. She was helping to fill 'Norwegian gaps' through a more emotional/family-oriented way of mourning. Had she known more about local traditions as she implied in her narration she might have found another way of being of more help, although she managed to handle the situation well by calming the resident who was hurting. (I

note that I am not aware of the traditional ways of mourning in Norway). She compared the situation with her home country, where such incidences were handled collectively, surrounded by family members and relatives, to Norway, where at this point, it was the institution which took over the role of the family to console such a resident. To many of the minority staff, especially from non-European countries, the whole idea of putting elder people in an institution is perceived negatively, because they are not used to such arrangements. The elderly people are normally cared in families, with relatives, and not in the institutions. Regardless, in the quotes above, Marcia with her few years´ experience in studying and working in Norway, has managed to find a way to attend a resident who had lost a loved one. This is not common in nursing homes as most of the deaths are of the residents themselves or their partners.

Accent discrimination

Some residents displayed negative attitudes towards minority staff members, as did some relatives of residents during interactions (see also chapter 6). Although all the minority staff members in this study could speak the Norwegian language, they also had individual accents which could easily distinguish them from ethnic Norwegians. This was probably because they were all first-generation immigrants, most of whom migrated when they were adults or in their early twenties. The 'strange' accent of the minority staff had some implications for the communication processes. Several minority staff members mentioned the way that residents would question or reject their help, even before they could proceed with care tasks. Ester, a staff member, from Africa, for example, commented,

> *There was this resident I went to attend one morning. Just as I got into her room, she asked, isn't there a Norwegian to help me today? I said good morning, and instead she repeated the same question. Then I told her that unfortunately it is me who was going to help her wake up and get ready for the day because there are not enough Norwegians to help all the residents on their own. Then after that, you know we have to explain to them everything we do for them or what they have to do by themselves, but every time I said something, she said, 'I don't understand what you are saying' - as she put it in Norwegian, 'jeg skjønner ikke hva du sier'. But you know, I* [the staff member] *just continued patiently, explaining to her everything I was doing in assisting her until we finished, but it was so disappointing.*

> Then I asked her, 'don't you think that the resident probably could not understand you, as she said?' She replied, *'she was just playing games. She always does that, but when she is at the table with others and I ask her, for example, if she wants another sandwich, then she understands and responds.*

Although the rejection by the resident could be for other reasons such as skin colour (see chapter 6), this quote highlights the challenge the minority staff member faces based on her accent, when the resident pretended not to understand her while the staff member was sure that this was not the case. The situation above shows that regardless of the resident's negative response, the minority staff member had to find a way to get the work done despite the disappointment she faced. This particular minority staff member opted for an instrumental kind of communication, explaining what was going on to the resident, but not necessarily engaging in a social form of conversation. The important thing for the staff member in the situation above was to get her work done, while the form of interaction was influenced by the unreadiness of the resident, which restricted the staff from applying any soft skills (if she had them) to make the session friendlier and more pleasant. Regardless, the staff did not give up on providing care to that particular resident. However, my further interpretation of this situation concerns the extent to which the issue of this resident's right to choose whom to attend her, may or may not be associated with use of force (coercion) by staff in the institution in a sense that this particular staff member, for example, forced the resident to be cared for by someone she did not want. Furthermore, in an environment of labour shortages as in the nursing homes, leaders planning staffing for every shift are challenged to meet resident preferences.

Similar findings of accent discrimination were observed by Shutes and Walsh (2012:91), at nursing homes in UK and Ireland, referred to as 'user preferences for who cares'. In their study, they highlighted that, although migrant care workers were employed to compensate for the difficulty in recruiting UK/Irish-born workers, on the other hand, older people did not like to be cared for by minority staff due to what they referred to as strange accents, among other things, which made it difficult for them to understand. Such claims were also justified in the study by Näre (2013a:6) in which 'foreign accent' was a disadvantage for the minority staff in recruitment in the Finnish elder care sector. Although some immigrants may learn and manage the local dialects in their new country of residency, it is not the case for many others. In the study by Grossman and Taylor (1995) for example, they emphasize that although nurses educated from countries outside America may speak English, they may not necessarily be

acquainted with the idiomatic expressions, slang words, or regional accents as are native dwellers.

Looking at this relationship between minority staff and residents through the lens of agency and structure, I argue that, although immigrant staff are perceived to be an important resource in providing elder care at the structural level, their presence in care work is challenged at the level of practice in the context of nursing homes. When residents refuse to be attended by 'strange accent' minority staff members, they make it difficult both for the minority staff to do their job and the leaders to plan for staffing amidst shortages of majority staff. Furthermore, when the residents insist that they do not want to be attended by minority staff members, they add stress to the majority staff, who have to take the responsibilities and attend them. In the end, this may affect inclusion of immigrants in work, while creating tensions between the minority and majority staff.

Accent discrimination was also associated with the time when minority staff had to answer the phone during shifts. Some relatives of residents would quickly ask if they could speak to the Norwegian staff. Emmanuel, a minority staff member from eastern Europe at NH3 had this to say, when we were having a conversation during lunch break:

> *It happens to me often, especially during the weekend, when I am responsible for carrying the main phone with me. Most of the relatives of residents will always ask me if they can speak to a Norwegian staff member who is with me on the shift. There was this woman* (he mentioned the resident with whom the woman is related) *who hung up the phone just because there were no Norwegian staff on that day, even before I could explain that I can listen to her concern. Even when 'they' come for a visit, some will always look for a Norwegian staff member to speak to. But one thing these people forget is that we are the one who attends their parents on a daily basis. It is difficult to understand this mistrust …*

The above quote suggests that accent discrimination leads to harsh treatment of the minority staff by residents' relatives as well as mistrust as he explains, including sudden hanging up a phone which is hardly a pleasant way of ending a conversation with someone. Interestingly, although Hervie (2019) found in her study that minority staff faced accent discrimination from staff and relatives of residents, in this study accent was not mentioned as being an issue in communication by the leaders and other majority staff. Then why was it an issue for the residents and their relatives? This could suggest the need for another study of immigrant

inclusion in care from the perspective of residents and their relatives, in order to establish what exactly is the issue. This is because accent is a manifestation of differentness and cue for exclusionary practices. Accent discrimination may affect inclusion of immigrant staff because of limited access to some conversations and work. This also may bring tension among the majority and minority staff whereby the majority staff find it to cause more workload.

Interaction with leaders

Due to having many managerial responsibilities which kept ward leaders in their offices for most of their working hours, their interaction with other staff happened either during shift handovers, in scheduled staff meetings, or during lunch breaks (but no interaction between the leader at NH2 and the staff took place for all the time I was there). Leaders interacted very little with both staff and residents in all the three nursing homes under this study. Leaders' interaction on the ward was limited by being busy with office work, and sometimes being out of the office to attend meetings. Leaders mentioned that they were open for any staff member who needed their attention whenever they were at the office. This was an opportunity for the staff to drop in for a short conversation during the shift. However, this option seemed not to work well for some of the minority staff. In addition to language issues, leaders maintained that some of the minority staff could have had better language skills, but they were not good at coming forward to speak their mind, and they did not consult very much, as compared to the majority staff. During a focus group interview, when leaders were responding to the way they attend to multicultural staff concerns at work, a leader from NH3, for example said, *'…it is so difficult, we cannot step in further… they are not as good at opening up as we are…'.* By this, the leaders meant that the majority staff found it easier to consult the leaders when they had a concern, while most of the minority staff members tolerated situations and reported only when matters were worse. This difference of attitude could be related to the way leadership is perceived differently among the minority staff (see chapter 6).

In several incidences, for example, minority staff, especially from non-European countries, were generalized or stigmatized as sometimes not being able to provide their point of view, especially when they did not understand some information. A leader from NH1 commented,

'"We tell them to ask if they do not understand, but we know that they did not understand after they do something contrary to what they were asked to do…"

Some of the leaders mentioned that some immigrant staff seemed to believe that if they continuously said that they did not understand information, they might be disqualified from the job. Thus, the fear of losing their jobs hindered them from asking questions that could help them to do their job better. Such a behaviour is also commented on in the study by Grossman and Taylor (1995:65), that in some cultures (Southeast Asian nurses in the example), people may say "yes" while they actually mean "no" in order to avoid annoyance, disagreement or lack of understanding. In addition, contrary to the western cultures, values of social harmony and emotional equilibrium are deeply ingrained in an indirect communication style in most of the non-western cultures. It is all about culture, in what people have been socialised, which informs their habitus.

However, I argue that this stereotyping attitude - of leader and majority staff seeing the minority staff as a group without individual differences - may be problematic. My observations in this study suggest that it is important to also examine contributing factors to such a perception, based on the minority staff's different backgrounds and starting points which need to be assessed at individual level as single cases. Some of their past experiences, for example for the refugees, may have affected their ability to trust. Such claims, therefore, need to be investigated at an individual level instead of general assumptions. Some tend to be quiet and reserved, as Maria from Philippines at NH3 said,

"I come from a very abusive family. My parents, who also mistreat and fight each other a lot, mistreated me as a child. When I got a Norwegian man, I thought that my life would be better. However, things went bad, and we are now separated. I have a three-year-old daughter to take care of, but my husband was threatening to take her away from me because he says I am a bad mother. My life is very depressing, and I am a reserved person, I keep my problems to myself unless I am seeing a professional…"

Looking at Maria's situation, she might be having trust issues, after the persons she trusted let her down. Coming from an abusive family, she could also have been affected psychologically, which may result in her behaviour of keeping things to herself. Her quietness was interpreted by the leader as humble and kind. Maria was on language training via NAV, but also working as an assistant in one of the wards. The leader and other staff recognized her as a very quiet person who learned things slowly, without knowing her personally and the struggles she went

through, which seemed to limit her abilities to engage in social interactions. During my study, I always found her in the kitchen, and she explained that work in the kitchen was more comfortable for her. The ward had a relatively larger number of residents who could interact, but she never sat with them for a conversation, even during break time. Although I held all conversations and interviews in Norwegian, Maria requested that we do the interview in English because she was more comfortable with that. In a nutshell, the shallow understanding and interpretation of immigrant staff behaviour by the leaders might be due to limited interactions between them, arenas which could gradually enhance building trust and opening up. This suggests further that leaders are managing human beings, though a social relationship which cannot be reduced to computerized communication, in terms of reporting and applying for extra shifts. Reserved and quiet people like Maria may need further assistance to avoid self-isolation, which may affect their inclusion in work and further integration in the community. Furthermore, lack of understanding underlying reasons for different behaviours as in the case of Maria may be grounds for poor socialization among staff, which would sometimes create tensions at work.

Similar to social investment, linguistic investment is also mediated through the habitus (Shin, 2014). Coming from different parts of the world to Norway, as well as taking different pathways to learn the language, minority staff could form and reshape their linguistic habitus. The notion of habitus, however, is important to examine in the ways in which social class intersects with other social categories such as race, ethnicity, and citizenship in the context of language learning (Bourdieu, 1991). As in the case of Maria above, her current experience in Norway may interfere with her efforts to learn the language effectively. Being an immigrant, Maria´s habitus is shaped by intersecting axes of differences such as race, ethnicity and migrancy, which then affect her agency in the social field and in the context of her workplace, particularly when she is struggling to learn Norwegian language.

Interaction among the staff – social arenas

Staff spend a long time at work. As such, socialization is inevitable as part of completing their working day routines and tasks. Apart from interacting during task completion, the staff were also observed to interact in several social arenas. Ward staff members might interact during lunch break or intermediate breaks, while some staff also met to socialize outside working hours. Findings of this study show that the variation of organization of the work tasks of the day could either facilitate or limit social interactions among the staff. In NH1 for example, lunch break was organized in such a way that all the staff members would gather in one room

and eat together. During this period personal and social conversation would prevail, and when the leader was around, the session would be more active as she was triggering some interesting discussions, some of which would facilitate cultural consciousness among the staff. On the other hand, such gatherings did not necessarily engage some of the staff, depending on the topic at hand. Since my study was focusing on multicultural working environments, I was more interested in observing the topics and forms of conversations which were including or excluding minority staff. In one incident, for example, there was a topic of buying Christmas presents because it was late October. This discussion was mostly occupied by the majority staff who were present on this day. The rest of the staff were all non-European, who remained quiet throughout the discussion. When there was a pause in the discussion, I asked one minority staff member about his plans for Christmas, and he replied, *"I am not a Christian, so this is not for me. Instead, I am looking forward to coming to work if they are short of staff".* Another minority staff member added, *"I am a Christian, but in my country, it is not a big deal. The best we can do is go to church and cook a nice meal we can afford. I have never heard of anyone in my family talking about presents or the like".* In this regard, I realised that for these two staff, there was not much for them to contribute to discussing or proposing presents for Christmas. This situation may be related to the habitus and the social stock of knowledge as the actors´ socialization in different cultural contexts and social fields has led to different dispositions for acting in situations in different cultural contexts and social fields (Bourdieu, 1991). This, further, suggest that the habitus and its embodied dispositions will shape agency in situations, as it is in the context under discussion here. The minority staff, although they know about Christmas celebrations, mark it differently from the Norwegians as the celebrations relate to Christianity. This seems different from Christians from the minority societies, who just adopted the religious marking of the day without spending money on presents. In this regard, therefore, it is understandable that the minority staff may have little, if anything to share in the discussion about Christmas presents, although they may have other celebrations in their cultural traditions where they share presents. Since culture is not an end, the minority staff (especially from the global south) may accumulate enough social stock of knowledge to shape their habitus, which will then promote their agency in celebrating Christmas (and probably some other celebrations) the Norwegian way (Ahearn, 2001; Bourdieu, 1977a; Emirbayer & Mische, 1998b).

As with the residents, interaction among staff also might be more or less interesting and involving based on the topic of discussion. During one of the lunch time gatherings, for example, there was a discussion on gender roles among men and women in different societies.

This discussion drew interest from both Norwegian, western, and non-western minority staff. They challenged each other on the way past gender roles of men and women no longer fit the current situation.

My general observation after visiting all the three nursing homes was that social interactions among the staff did not just happen, but there was a context through which those interactions and forms of discussion were supported or discouraged. In this particular nursing home, lunchtime breaks were arranged for all staff at the same period of time, and this created an environment through which staff talked about different topics as they socialised. Moreover, the topics for discussion also played a role in the degree to which staff were engaging in the discussions. This was contrary to the other two nursing homes, as I shall discuss later, in which breaks were arranged differently.

However, since the conversation among staff was in Norwegian, the discussion topics seemed to sometimes leave some minority staff isolated, due to their limited cultural and language skills. In other instances, their relatively minimal social stock of knowledge amounted to what Tange and Lauring (2009:227) call "thin communication" in the social use of language, which they refer to as a situation whereby people are confined to a narrow range of linguistic registers in their foreign language, which may have a negative impact on their social use of language. This may cause them to abstain from social practices, by withdrawing from things like gossip, small-talk and story-telling sessions, which are important for establishing and maintaining social bonding (see also Kaushik et al., 2016). In such situations, inclusion may not necessarily happen by putting people together in a group to discuss issues. Sometimes people may be excluded for other reasons than thin communication skills as mentioned above. This facilitates self-exclusion even when present in a group. Social exclusion, furthermore, may happen when a person becomes part of a social conversation with people speaking the language which is unspoken or unfamiliar for that person. Immigrants, therefore, face a risk of being socially excluded (Marinucci & Riva, 2020). Such aspects of social exclusion in this context may bear consequences in the integration process in general by setting unhealthy social relations among the minority and majority staff. Rytter (2019:678) argues against such one-sided approaches to integration, which promote the categories of "host and guests" and hence asymmetrical relations between majorities and minorities.

Moreover, I observed that communication patterns were also related to personal social relationships among the staff. Most of the majority staff knew each other outside work. They had connections based on their previous lives, such as having gone to the same schools and

universities, being related by family or having the same friends. Moreover, others had social connections due to being parents of children going to the same schools, teenagers who were friends and so forth. In contrast, most of the minority staff did not know each other or the majority staff from before, although some had connections and country organizations with compatriots from the same country (especially from Africa). For example, when I asked Jennifer, an assistant from Africa, about whether she meets with ethnic Norwegians to improve her language skills, she said:

> *"I do not hang out with majority people/staff after work. We meet at the canteen during lunch break. Otherwise, it is hard to even see my neighbour, especially now that it is wintertime" (-* meaning that people stay more indoors than outside as compared to when it is summer or other seasons).

Jennifer's explanation reveals the limited social interaction among the minority and majority staff in working hours. Contrary to NH1, Jennifer was a staff member at NH3 where even lunchtime organization was not as helpful in facilitating interactions as it was in NH1. Paired together with the contextual reality of nursing homes, being labour intensive and busy throughout the day (see also chapter five), there is hardly rom left for social interactions among the staff in general. According to her, it is also difficult to interact with the majority staff after work because they are not making themselves available.

On the other hand, some majority staff thought that it was difficult to interact with some of the minority, even outside work arrangements. When I had a conversation with Bente, a majority staff member at NH3, she said

> *… some of the immigrants are not willing to integrate themselves. They keep their distance, do not seem ready to mix with Norwegians, and we cannot force them. For example, there is this immigrant whom I met at the parents' meeting at school, he sat on the corner of a bench, with earphones and loud electronic sound. Therefore, there was no way one could approach him for a conversation …*

Looking at the two situations above, I argue that there might be a lack of common understanding on what and how one may present oneself to be considered available for conversation. Both Jennifer and Bente thought that their counterparts were not making themselves available although none of them went further to say whether they had tried to approach the mentioned people to confirm their assumptions. They both expected a certain behaviour from each other to establish if they were ready for interaction or not. However, neither of them seemed to make

efforts to see if a person might reject another staff member even when approached. This situation of assumptions and prejudices may interfere with the whole aspect of immigrant inclusion and later integration in work and the whole society because it creates barriers to communication and socialization. Different expectations of how conversations may take place may be shaped be dispositions and what they are used to in other contexts. As such, the social stock of knowledge and habitus plays a significant role.

Contrary to NH1, in the other two nursing homes, NH 2 and NH 3, lunchtime was arranged in the nursing home canteen, whereby each staff member would sit to eat with whomever he/she wanted. The arrangement of the canteen allowed people to sit in small groups, based on the size of the table and numbers of chairs available. In such instances, interactions among the staff were fragmented into small groups, and I observed that the same group of staff tended to sit together during most of the break times. Moreover, staff members from the same ward did not take lunch breaks at the same time, but took turns, by negotiating among themselves. Consequently, this arrangement influenced the probability that staff would meet each other regularly, as well as their leaders, although I noticed that some staff members would consult each other on whether to take the first or second lunch break so that they were sure to meet. On the question of leaders´ presence during lunch break, in NH2 for example, I did not see one instance when the leader had lunch with other staff, as whenever present at work, she either had lunch in her office or in the canteen, after all other staff had finished their lunch. On the contrary, the leader from NH3 was observed to have lunch with other staff in the canteen for most of the time she was at work, and she would sit with different staff on each occasion. In this regard, enhancement of regular meeting during lunchtime was not standard in all the nursing homes, rather, it was left in the hands of the leaders in individual nursing homes wards to decide.

Such arrangements of lunch break among the staff at NH2 and NH3 could sometimes result in what Kaushik et al., (2016:21) conceptualize, quoting (Marschan-Piekkari, Welch, & Welch, 1999) “language clusters” among the staff, referring to “informal gatherings or alternative linguistic groups formed by the speakers of the same native language in a second language environment”. In one instance, for example, I observed three minority staff who were from the same African country sitting together, and as I approached their table, I noticed that they were speaking their mother tongue. They jokingly said to me, ‘*it is nice to breathe out from a long Norwegian stressful conversation session in between work’*. For them, holding a Norwegian conversation throughout the caring session was too demanding and tiring, so they felt that a break inbetween was useful. Such an attempt might be related to an opportunity to avoid

cognitive fatigue by switching to the language which was considered more comfortable for them (Raatiniemi & Mehus, 2012). Similarly, a study by Grossman and Taylor (1995:65) describes the urge for immigrant staff to speak their native language with each other as a comfort in their struggle to adjust to a stressful working environment. Since the minority staff are speaking in their own mother tongue during break time, not when they are attending residents or interacting with majority staff at the nursing home it raises questions as to why the majority staff get concerned. If it does not pose any threat, then I think it is okay for them to use native languages during break time as a way of dealing with stressful shifts, just like the ethnic Norwegians do.

However, some of the leaders interpreted the use of other languages at work, apart from Norwegian, as problematic and advised some immigrant staff not to speak in their mother tongue during break, as it was raising suspicions among fellow staff that they could be saying bad things about them. Such a perception may arguably imply that there is lack of trust built between the majority and minority staff groups or within the staff group as a whole, although there were no supportive findings for this from this study. Reflecting on integration processes, therefore, the way minority staff are compelled to adhere to the official language use, even during break time, facilitates more social assimilation than integration (Aleksynska & Algan, 2010), contrary to the aim of integration and egalitarian policy in Norway (see chapter one). In the study on integration processed in Denmark, Rytter (2019) argues that such demands to integration have the tendency to focus on specific groups, especially those from the global south. This evokes racialised bias to integration in which aspects of ethnicity, culture and race are interconnected with asymmetric integration processes. In his study, Rytter (ibid.) stresses that, contrary to immigrants with German, Swedish or American background, "integration is evoked in critical discussions of the norms, values and practices of everyday life among Muslim immigrants and refugees from Africa, the Middle East and South Asia…" (Rytter, 2019:685).

In other incidences, the collective lunchtime arrangements were not preferred by some of the staff. Based on the intensive nature of the work shifts, some of the staff thought that lunchtime was a time for a break from the chaos of the early shift, especially for those who were attending relatively difficult residents. One minority staff member, for example, was always observed sitting alone during lunch break on the sofa, which was put in one of the corridors, while the rest of the staff sat in groups in the canteen. When I asked him why she sat by himself, he said,

"You know, it is very stressful on the ward throughout the day, as you have seen. So, during this break time, I prefer to have a total rest of my mind before I go back for another stressful session…"

With the exception of NH1 where it was a 'must' that all the staff should sit together during lunchbreak, the other two nursing homes left it open for the staff to choose whether to gather with fellow staff or not as the quote above shows. In my opinion, although it might be reasonable to let people choose the way they want to spend their break time, such freedom may limit social interactions among the staff and possible increase social distance. For some of the minority staff who also have difficulties in mixing with the majority staff, such arrangements may also facilitate exclusion and poor socialization at the workplace. Moreover, in such 'loose arrangements' of break times, some staff would even use the time to do their personal things, as the following scenario from NH3 shows.

I left earlier on this day because the leader told me that there were kindergarten children coming for arranged painting activities with the residents. Since there were other people engaged in the organization of the activities, who did not know about my presence, I chose to leave during lunch break. On my way to the bus stop, I met two minority staff, one from Africa and the other from Asia. They were in their uniforms and carried two big plastic bags. I was surprised to see them in town, although it was not a long distance from the nursing home, but I did not expect to see them there during working hours. So I asked them what was happening, and one of them replied, "I just had to come with my friend because she asked me to show her the shop where she could buy the things she told me about". I then asked if it was okay for them to be in town in the middle of the working day, and she answered, "lunchtime is our own time. We do not have to be at the canteen. We are free to use our time to do whatever we want, as long as we are back on the ward in time…"

At some point, socialization among the staff may depend on and require individual initiative, particularly for minority staff. However, some of the minority staff such as Maria and Jennifer from NH3, who were not on the frontline during social interactions may suffer social exclusion and possibly poor integration. As per my observations, while some minority staff await to be approached by the majority, others take individual initiatives to interact and engage in social activities. The following two scenarios from NH3 show this:

Scenario one:

> *In my interview with Jennifer, an assistant minority staff member from Africa, I wanted to know her challenges in adjusting to Norwegian life, since she told me that she faced lots of challenges in dealing with cultural issues at the workplace. She said, "I depend solely on my daily work here at the nursing home to learn whatever I need to learn about Norwegian culture. Otherwise, when I get out of here, and with this wintertime, I hardly ever see even my neighbour…"*

According to the above explanation, Jennifer depends on her shift to learn about Norwegian language and culture, which from my experience in the field, is not realistic, simply because she is an assistant, with very few work shifts, in which she is rotated in different wards. This topped up with the busy schedule at work, and the type of residents, who were categorized as agitative (when I met her twice), makes her ambition even more difficult to meet.

Scenario two:

On the other hand, when I indirectly asked Marcia from South America about difficulty in interacting with the 'reserved' Norwegians, she said,

> *"…for me, I just like to get things done instead of complaining and waiting… I do not wait for people to do it for me. For example, on several occasions, I have invited some of my Norwegian friends for dinner at my place… I cook for them food from my country, and we eat together and have fun. After this, some people invite me to their places in return…"*

Contrary to Jennifer, who seems reserved, Marcia is outgoing, self-initiated and daring. Her efforts seem to have worked for her and she has several friends from both ethnic Norwegian and other immigrant backgrounds. Consequently, defining minority staff as a single group without acknowledging such individual differences may be problematic in planning for inclusion. In addition, in both of the scenarios above, for example, the staff may accumulate their social stock of knowledge necessary for improved communication and interactions, although to varying degrees. While Jennifer may take longer to achieve her goal due to her strategy, Marcia may on the other hand take a relatively shorter time to improve.

However, Marcia also had her observation on the way things are done in the 'Norwegian' way, contrary to what she was used to in her home country, as the excerpt below highlights.

> It was during the day shift at one of the wards in NH3, and one of the staff was having a birthday. She made cupcakes from home and brought them to be shared among the staff at work. In between the shift, she came in and gave us some cakes and then left. As we were eating, Marcia commented, *"I do not understand this Norwegian way of celebrating birthdays. That someone who has a birthday must bake… it is very awkward… in my country, if I have a birthday, it is the responsibility of my friends to celebrate me, so they take all the responsibility of baking or giving presents, but here… (sigh)"*

My take on this narrative from Marcia is that, although she was commenting on what she perceived as an awkward celebration of one's birthday, the topic raised interaction among the staff. She had something to comment upon because a fellow member of staff brought cupcakes to share at work on her birthday. Such social interactions may add value to staff relationship and immigrant integration in general. Since working places are also arenas for socialization among the staff, such arrangements set ground for social interactions and inclusive environments particularly for the minority staff.

Chapter conclusion

The aim of this chapter has been to explore the inclusion of immigrant staff through discussing the way communication and interaction processes unfold at the multiculturally staffed nursing homes. Communication and language use are understood as social practices embedded in and shaped by specific contexts, yet aspects of agency and habitus are also informed by the social stock of knowledge (Ahearn, 2001; Bourdieu, 1977, 1991). The discussion has shown the way situated language brings tension in the habitus, between structure and agency, which henceforth affect inclusion of immigrant staff in work and integration in general. I have discussed communication between various actors at work in the Nursing Homes and argued that although language competency is important for workplace inclusion, so is competency in cultural and social content for conversation and dialogue. That is, the 'social stock of knowledge' is of key importance for navigating through interesting topics to initiate and proceed with conversation. I have shown through ethnographical material the ways communication between leaders and staff, staff and residents, staff and staff, not only take the form of words in conversations but that observations of other staff behaviour and utterances can also be interpreted. In particular, I have shown that it is not enough for leaders to essentialize Norwegian language competence in

recruiting immigrant staff, because the form and content of conversation and dialogue through which staff are to manage interactions among themselves, as well as with the residents and their relatives, also matter in inclusion processes. I have identified several barriers to the communication process that ultimately could hamper the quality of care provided at the NHs, yet also the inclusive potential at these workplaces. These barriers could be categorised into language, cultural and organizational form such as poor relevance between language training and language use necessary in nursing home context, dialects and accents, poor understanding of Norwegian culture and history among the minority staff, distant leadership, and increased digitalization. Yet, I have also identified the inclusive potential and practices at these working places such as more physical availability of leaders at the wards, increased room for socialization among leaders and staff, and so forth.

In the next chapter, I will present an analysis on the way multiculturalism and identity relate to everyday care work in the nursing homes.

Chapter 6: ´Norwegianness´ and the organization of a multicultural workforce in Nursing Homes

Introduction

The extent to which the Norwegianness aspect of nursing home practices accommodates, or challenges multinational staffing is an important overall question for this study and will be addressed in this chapter. By Norwegianness I refer to discourses and practices that are used in dichotomizing 'Norwegian' and 'non-Norwegian'. According to Vassenden (2010:748), this discursive conception contains several ´sub´ dichotomies that signify difference and that need to be untangled analytically. The first dichotomy concerns *cultural* opposition between being Norwegian or non-Norwegian, referring to a variety of traits, such as ways of being and thinking, modes of understanding, cultural codes, patriotism, religion, language, linguistic skills, values, and so forth, which are related to "cultural stuff" (Vassenden, 2010:745). The second is the dichotomy around *ethnicity*, referring to boundaries and categories. A third dichotomy - *whiteness against non-whiteness* – which overlaps with the second (ethnicity). The fourth and final dichotomy is about the virtue of *citizenship*, which emphasizes the civic version of Norwegianness. I understand that these four dichotomies are at play in dynamics of diversification and recognition at the nursing homes, and that they inform the way such diversification and recognition is embedded in subjective experiences of non-Norwegian staff in the process of inclusion in work at the nursing homes.

The main argument of this chapter is that the traditional homogeneity in Norwegian society has led to a taken for granted perception of the organization and provision of elderly care in the welfare state, despite the current multicultural composition of the population and the increasing multicultural staffing at the Norwegian nursing homes. In this regard, the organization of bodily and social care services for residents in nursing homes, apart from following the politics guiding care, is also characterised by Norwegian cultural norms, values, and beliefs, such as religious practices, traditions, gender roles and so forth. These can be broadly termed as the norms of Norwegianness, some of which are spoken, others are unspoken, yet they are taken for granted and naturalized by its members in everyday life (Gullestad, 2006). Through these essentialized practices, there is a construction of categories of 'us' and 'them' among minority and majority staff. It is from this backdrop that leaders and multicultural staff negotiate their social

identities[30] through daily working practices. In addition to ´context´ and ´communication´ aspects forming the organization of nursing home care, this chapter add a dimension of ´culture´ in analysing immigrant inclusion processes and care practices.

Through intersectional perspectives, this chapter uses identity attributes of race, skin colour, gender, ethnic background and religion as axes of differences that intersect and contribute to unfavourable positions in the nursing home context and the wider labour market in general. As such, these qualities influence inclusion processes of the minority staff in work. In exploring those identity factors, this chapter employs the analytical concept of habitus as a signifier of ´embodied structures´. The habitus is articulated in a person´s behaviour as certain dispositions will direct choices and agency and could be tied also to culture.

This chapter is divided into two main sections. The first section explores the cultural aspects of Norwegianness, and the taken-for-grantedness in planning and organizing care among leaders. I focus on cultural practices, the shared perceptions of how people behave in a culture on a routine basis (Frese, 2015). The second section discusses the identity processes embedded in the organization of care work, specifically focusing on gender, skin colour, and ethnic background.

'Norwegianness' and the taken-for-granted aspects of culture

In discussing Norwegianness aspects of the nursing homes in this study, this section focuses on several cultural traits of the Norwegian culture (apart from language which has already been discussed in chapter 5), which shape organization and care practices in the nursing homes. These traits include, but are not limited to, religion (Protestantism), food (types, preparation and serving), important celebrations of the year (religious and non-religious). Norwegianness is symbolised and ratified as an 'unspoken' principle for competence in the nursing home context (Dahle & Seeberg, 2013:83). For the minority staff, this is an added skill needed (implicitly) on top of the language competence which is emphasized in their recruitment process (see chapter 4 and 5). As per observations from this study, the way care is planned and organized does not formally recognize social-cultural differences among the staff. To establish the

[30] In this thesis, identity and social identity concepts are used interchangeably.

potential differences in culture between Norwegian and non-Norwegian staff, and the possible challenge to Norwegian socialization and culture, I use the experience of Hussein, a refugee from Africa, who found himself landing in Norway, in a somewhat interesting way.

> *"I used to work in a shoe factory back in my country. One day when we were at work, soldiers ambushed us, because our company was suspected of being in support of the opposition party. Some of my fellow colleagues were shot to death, and the rest of us were sent to prison. After six months in prison, I managed to escape with other prisoners, and by then… you know, you can only run for your life. Back then, I never knew there was a country known as Norway, I had never heard about it in my entire life. When we were walking and sometimes offered a lift along the way* [fleeing through the desert route of Libya and to Italy] *we were talking with other people about where we could travel to. Then I heard some people talking about this country as a place one could come to. That's how I knew of it…"*

Although I had a long conversation with Hussein, I just picked this section strategically to highlight one among many other similar immigrant routes to discovering Norway as a destination. While some immigrants have a relatively clear journey to Norway, such as migrant workers and those married to Norwegian partners, others, like Hussein, have a different route, which makes a drastic change to their life in so many ways. The important point I want to make here, is the relatively little or lack of knowledge of the new environment, marked by the difference between the global south from where he came, to the global north where he now resides. From the time Hussein left the boundaries of his country, everything was new, both in terms of physical and social environment. Since he had no plan with regard to where to escape to, coming to Norway seemed to be a reasonable option, based on advice from his fellow refugees. Entering the host country, Hussein had to learn a new life in almost every aspect. The process of negotiating his identity started with the need to learn about language, ethnicity, religion, cultural codes, just to mention a few. This process of acculturation in general may take time and involve moments of cultural shock, yet Hussein is expected to adapt and manage all the duties relevant to his job description as if he was familiar with Norwegian ways of behaving and doing things.

Although my conversation with Hussein was conducted in the Norwegian language, which he spoke well, he also mentioned (and I observed) that some of his struggles related to adapting to what I would term as new culture, in terms of the way things had to be understood and done in his workplace, even after working in Norway for several years. I shall explain this in detail later

in this chapter. Hussein, in this case, coming from a third world country, may represent the group of minority staff who have to negotiate through various aspects of Norwegian cultural values and norms, some of which they have never been in contact with before. However, I think it is important to mention at this point that Hussein's journey and the social contacts encountered until the moment we met, may have had an impact on his cultural orientation and hence the way he identified himself in relation to others. This means that his actions and the way he perceived himself have been shaped and reshaped, hence distinguishing him from the person he used to be when he was in his home country. As Gupta and Ferguson (1992) maintain, culture in the form of practices is an ongoing process, not a disconnected phenomenon, but rather, it is subject to change and to be changed by individuals, as they cross borders from origin to new places. In the same line of thought, the continued process of learning and unlearning cultural practices reflects the continued formation of habitus at an individual level. However, actors might experience and encounter tensions as they adjust to the new ways of understanding and doing things.

Cultural features in the Norwegian nursing homes

Nursing homes in Norway may be considered as cultural spaces for interpretation, socially constructed and reconstructed, through daily routines and various reforms and measures imposed by the government (Næss, Havig, & Vabø, 2013). Although the study did not seek to establish the extent to which they were a true representative of a Norwegian home, the study did aim to establish the way *physical arrangements* had a role in facilitating or hindering inclusion of multicultural staff. Without dwelling much on the architectural arrangements, this study focused on the interior decorations, meal preparations, timing and serving, as well as social interaction in the common areas of the nursing homes in order to detect the values and ideals underpinning the nursing home as a Norwegian home. It is in these surroundings that work has to be negotiated among the minority and majority staff, as well as interactions between the staff and the residents. Moreover, such surroundings and arrangements were important to assess in order to analyse the way minority staff members negotiated their identity as they related to the surroundings.

Home-style

The nursing homes included in this study were relatively similar with regard to architecture, room organization and interior design. The hallways and lounge areas (common areas) were decorated with historical artefacts reflecting the history of Norwegian society, heritage, and culture. Except for the ward at NH3 with seriously agitated residents, which was minimally decorated, other wards were decorated with hanging pictures and objects ranging from kitchen utensils to paintings related to outdoor activities such as skiing. The living rooms had a television, armchairs, sofa set, a coffee table, dining table with chairs, bookshelves with old storybooks, and most of the tables were covered with colourful tablecloths. The dining tables were decorated with flowers and candlesticks, although candles were not always lit. Such elements mark a typical private Norwegian interior, at least for the generation which lives in these nursing homes, compared to a living room in, for example, Africa (Hauge & Heggen, 2008). In mentioning this, I am not trying to essentialize Africa as having common cultural values, just to pinpoint that there are some cultural similarities among African societies, as is the case for Western societies. In Africa, for example, and in particular in Tanzania, from where I come, although there might be a number of families who have been in contact with Western cultures, candle lighting, televisions, storybooks and the like are not a necessity for many of the middle- and low-class families. Although the mentioned items might be present, they are not highly attached to the daily lives of people, as for example is candle lighting during dinner in Norwegian families. To some minority staff, some traits of the home-ideas of the nursing homes appear to be typically Norwegian and are relatively new to them. Moreover, these customs in the nursing homes reflect middle and/or high class values and are not merely Norwegian or Western as such. For example, Ester, a minority staff member from Africa, had the following story.

> *It was Christmas when I was on the evening shift with a Norwegian staff member. It happened that, when the residents were having supper, one of them spilled yoghurt on the tablecloth and it was then stained. When they finished, I had to remove that tablecloth. Then I went to the shelf and picked a very nice yellow tablecloth and covered the table again. By then my fellow staff member was in the other ward helping with medicine distribution. When she came back, she said, as if in shock, "oh my goodness", and suddenly removed that tablecloth. She went to the shelf and brought a red one with white stripes and covered the table again. Unknowingly, I commented, "why did you*

have to change it? After all the yellow one looks much better than this [the red and white]" ... then the Norwegian staff member replied, "no matter how it might look, we can never have a yellow tablecloth at Christmas ...". It was at that time I came to realize that such a small thing as a tablecloth can be a big deal…

The above quote does not only signify the Norwegian way of organizing a home, but rather culturally distinctive features of how exactly a home should look in a particular season. Such Norwegian cultural codes were unknown to Ester. For her, any 'nice' tablecloth would be perfect for a big day like Christmas. But for the majority staff member, colour was even more important than the quality of the tablecloth. Without necessarily intending to explain the reasons for cultural disparities among the above two staff members, my argument rather focusses on highlighting such cultural differences in illustrating the way that the Norwegian ways of organizing a home (formalized and taken-for-granted patterns of values) can emphasize the 'difference' between majority and minority staff members. The scenario above illustrates the way culture and identity unfold among the staff members at the nursing homes. The cultural 'stuff', tied to cultural codes, religion and values in celebrating Christmas in Norway were alien to Ester. Without explaining in more detail, the reason why there could never be a yellow tablecloth on Christmas, Ester was left surprised by the way such a ´small thing´ could matter. Such differences, which reflect Norwegianness, may therefore result in tensions between minority and majority staff as in the case above.

Home-like environments are believed to provide residents with a homely feeling even when they are actually living in "institutions". In addition, spatial arrangements and physical equipment in nursing homes are also tied to bodywork of the residents. That is to say, the spatial dimension (i.e. physical spaces and concrete artefacts of the nursing home) and embodied dimension (i.e. bodies of residents, staff members and leaders) are inter-related (Hujala & Rissanen, 2011:440). For example, in some nursing homes I observed that there was a time when staff members would put on music or television for the residents who wished to have it that way. However, Hauge and Heggen (2008) maintain that this ideal of putting old things and other arrangements in the common areas of the institution just for the sake of bringing old memories to residents may not necessarily work, as they were not involved from the start in choosing those items. Moreover, since the lounges are common areas for all residents, they may not necessarily bring about home-like feelings for residents. However, in this study such arrangements were observed to initiate some discussion among staff and residents, although not always in a pleasant manner as in the case with Ester above. Some of the staff, especially the

majority, as they walked residents through the hallways or when seated in the lounge, would ask them about those decorations, and at some point, this would lead to an initiated conversation. On the other hand, most of the majority staff did understand some of the decorations while some of them did not, or what they were used for, and some even seemed to pay no attention to them as they walked the residents along the hallways. Since these items were unfamiliar to immigrant staff the decorations did not invoke any significance for them to bring into social conversation with the residents. Minority staff were therefore not able to engage with this aspect of Norwegianness.

Food and culture in Norwegian Nursing Homes

In any society, food is attached to culture and identity, ranging from how the food is produced, on what the staple food is based, the type of food people eats, the way it is prepared, served and eaten, and the function of particular foods in social, ritual and religious situations (Almerico, 2014; Anderson, 2014; Montanari, 2006; Waldstein, 2018). It is further about the number and types of meals people have, and the time at which those meals are served, although this may have variations among people within the same cultural group. However, due to the complexity attached to what amounts to a typical food in a particular culture, I want to make it clear in this section that food habits and traditions can hardly be essentialized as being particular within a certain group of people. This is because culture in terms of food traditions is not static, but changes with time even within a particular community (Amilien & Hegnes, 2013). However, I relate food culture with Norwegianness in the sense that it is a local and contextual practice, within which minority staff have to negotiate and adapt to as they work in the Norwegian nursing homes. moreover, in the nursing home context, ´Norwegian food´ was more popular in the residents' menu. As such, I relate this with Norwegianness which appeared to play a role in inclusion and exclusion of the minority staff, while also acting as a basis for identity negotiation.

Meal preparation, serving and food preferences

Meal preparation arrangements varied among the nursing homes in this study. In NH1 and 2, meals, especially breakfast and dinner, were prepared from the common kitchen of the nursing home, and then distributed to the wards by the specially employed kitchen staff, who were all ethnic Norwegians. The ward staff had responsibility for serving meals and feeding residents

who needed assistance, and for preparing lunch and snacks, which were mostly bread, fruits and drinks. These were either ordered on a weekly basis, or sometimes staff would order ingredients and choose to bake for the residents, when they had time. In NH3, on the other hand, food was delivered on a weekly basis from the centralised municipal kitchen where the staff warmed the food in the stoves and microwaves in the ward kitchen before serving to the residents. However, staff had responsibility for preparing sandwiches to be consumed by residents during breakfast, lunch or supper. The toppings (*pålegg*) were ordered on a weekly basis from the caterers, and it was the responsibility of the staff member who was working in the kitchen to make the orders, prepare the sandwiches and take into consideration the preferences of each resident. The processed orders were submitted on forms to the leaders for the finalization of the ordering process for all wards they were managing. The forms included a ready-made list, which a responsible employee has to go through and tick the items needed on the ward and the quantity. The task of ordering might fall on any person on the day shift, and it was normally the one who was responsible for the kitchen on that day, although other staff would also be consulted in the process. Such an arrangement, providing staff with a grocery list to tick, was useful because it simplified the ordering process and reduced chances of forgetting items. Moreover, it worked for the minority staff members who otherwise would have had a struggle to learning the Norwegian names of the groceries, although I observed some of them consulting the majority staff to cross-check their orders before submitting them to the leaders.

On preparing and serving snacks and lunch to the residents, staff had to use the ordered ingredients to make fresh snacks or serve the finished ones. Most minority staff preferred to serve the ready-made snacks, while the majority staff members would sometimes opt to make something fresh, for example baking cakes, pancakes, scones, and waffles. In doing this, they could sometimes engage the residents, and at the same time create socialization on the ward. In some of the wards, for example, some majority staff were discussing the way residents were served similar snacks consecutively simply because the minority staff were at the shift over the weekend and could not make anything fancy. This might be due to limited cultural ´stuff´ in terms of their social stock of knowledge when it comes to minority staff competence in preparing Norwegian food and snacks, since it is new for them.

All the staff were responsible for serving meals to residents, and they did it cooperatively. There was no specific arrangement for who should attend a particular resident, and this was only negotiated at the moment when the meals were about to be served, and at some point, it just

happened by chance that a particular staff fed a particular resident. Staff were aware of each resident's preference, and thus served them accordingly. Lists of food preferences were posted on the kitchen board or hung on the door of the refrigerator. This was especially helpful for new staff who were not familiar with residents' preferences, or if a person had forgotten about it. Sometimes, some of the residents were asked if they wanted anything different from what was listed as their preference.

Food and culture are interconnected factors and may mark important social identities for people. In nursing homes in Norway for example, it also matters what the residents eat and (or drink) on Easter, Christmas, and the national day. This is part of their customs and identity, which may be different to other cultures. Embedded culture as embodied, means that people become attached to food as to other aspects of life such as religion and language. Bourdieu, for example, writing about distinctiveness and food preference, argued that the kind of food a person likes is tied to class (Bourdieu, 1984). This implies that food socialization may also be attached to habitus, the embodied structures which provide agents with certain dispositions or inclinations (i.e. food habits) (Bourdieu, 1977). Thus, food is an important part in defining people's cultural identity and class (Kittler, Sucher, & Nelms, 2011:5).

In some cultures, for example, cold lunch is common, as it is in Norway, while in some other parts of the world, people are used to a hot lunch. Similarly, other cultures have one large meal, while others have two in the course of a day. Again, some candle lighting during meals, or table arrangement of knives and forks might be more relevant for western communities and certain social classes whilst being irrelevant for others. For example, most families in Africa would sit on the floor, eat using bare hands, from a common large plate, regardless of their class. Such differences attached to food and culture are articulated amongst the nursing home staff and are linked to immigrant staff inclusion by way of challenges they face with regard to preparation of food and snacks, and the way food is served. Social arrangements of food may not necessarily hold any specific meaning but are just the way things are in that particular culture and are therefore not thought of as something to explain to others but rather are taken for granted. However, this does not mean that people of one culture cannot eat food from other cultures, as for example, pasta and pizza are popular in Norwegian supermarkets and restaurants, although they were not originally Norwegian., and may not necessarily be an interesting choice for many of the residents. In this regard, culture may be regarded as more or less shared within a society, while there may be general differences, as for the food preferences for the older residents. Since immigrant staff represent a multitude of backgrounds, from different continents and countries,

an important question to ask is how do different expectations of meals and other events play out between immigrant staff of different backgrounds? Since the immigrants are employed to work with residents in nursing homes where meal sessions are vital, they are expected to orient themselves to the regular and special types of foods consumed by the residents in the course of the year as well as to the way they are treated and served. I shall explore this in the discussion below.

The nursing homes commonly served typical Norwegian slow-cooked food called *´husmannskost´*, which is a common type of food for the older generation. For the nursing homes which receive this kind of food, the staff were responsible for heating it up in the oven before serving to residents. Some other food types were difficult to chew and had to be mashed or blended to be suitable for residents with dental issues. While some orientation on food culture might take a relatively shorter time to learn about for the minority staff, some might take a relatively longer time, first because the menus change, and secondly because minority staff members have relatively fewer and irregular shifts during which to orient themselves to particular food. However, sometimes leaders and other majority staff took the arrangement of food and meals for granted, assuming that it was simple to prepare and feed the residents, until some problems arose, as one of the leaders commented.

> *"...we had some issues previously, especially with some of the immigrant staff, about not knowing which foods to heat up in the oven and which to serve at room temperature..."*

In my observations, the food to which the leader above was referring had no instructions on the way it should be prepared and served, contrary to other foods we buy in supermarkets, which may have guidelines for their preparation and preservation. It may need time for immigrants who are not used to such kinds of food to be familiar with the warming and serving procedures. On the other hand, this may be easier or not a problem at all for most of the majority staff who are used to such types of food. As mentioned in chapter three, the standardized training of new staff - which takes three shifts - may not be enough, especially for minority staff to have acquired all important information with regard to food preparation. Moreover, due to limited number of shifts for many minority staff, and the regular change of task distribution, less practice in the kitchen may disadvantage their competence with regard to food preparation for the ever-changing nursing home Norwegian menus. As such, I argue that small part-time positions for immigrant staff reflect the interplay between organizational arrangements and ethnicity in creating disadvantages. Since meals are delivered for particular time servings, a

mistake with one ingredient may affect the meaning of a particular meal, especially for the residents who are used to a relatively familiar taste from specific food. In other words, mistreatment of food may result in missing the basic traits related to the food such as "sensory characteristics, edibility, familiarity and palatability" among the residents (Jagne, 2020:26).

In the quote above, task distribution among staff took for granted that minority staff knew how to prepare food before serving, while the minority staff may have assumed that since food was brought as finished from the municipal kitchen and put in the refrigerator, it would be wise to heat it up before serving. Furthermore, the quote suggests that leaders perceive culture as an achievement, rather than something which is gradually built through accumulation of social contacts (Gullestad, 2006). That is to say, minority staff are expected to be able to differentiate which types of food need to be heated and which might be eaten cold, just because they happen to be in Norway and work in the nursing home, without necessarily setting grounds for the learning process on how to acquire that competence. Contrary to that, I argue, minority staff may gain competence with regard to food culture if they are continuously and regularly exposed to activities related to food preparation, warming and serving. In this manner, they can be socialised in food culture and facilitate their useful inclusion in work and integration in Norwegian society.

An interesting note is that food preparation and food culture also appeared to be a challenge to minority staff from Europe and neighbouring countries quite similar to Norway. The following situation was observed one day at a ward in NH1 when staff were about to serve dinner.

> *Two of the three staff were immigrants, one from Sweden and the other from Poland. The majority staff member was a student on field practice. Then, when the two minority staff were about to serve dinner, the majority student was in one of the resident's room. As I was observing them, the two minority staff were stuck on deciding which food portion was to be served as sauce on the potatoes and which one to serve as desert, because they both looked similar, 'white creamy sauce'. After discussing for a while, they agreed among themselves, although they were not sure if their decision was right. When they had served one resident, the majority student staff came back, and they asked her about their concerns -only to find out that what they had served as an accompanying sauce to dinner was the dessert, and the one they left for dessert was actually the sauce to be served with the potatoes.*

Although in the above observation there was no observed tension between the two minority staff, I still observed the taken-for-grantedness in the process of planning for care and the consequence it may bear on the residents. They negotiated how to serve the dishes based on their assumptions of right way to do so. They did not wait to ask for clarification from the majority staff until she came back, after they had already made their ´wrong´ decisions. Such an incident may suggest lack of cooperation between the staff, or that the minority staff just wanted to play smart, to show that they were competent. Since the majority staff member was a student on practice, they might have felt awkward as senior staff to ask the junior.

Entrusting minority staff with education levels and language skills to be recruited in nursing homes may, I argue, present a structural problem in planning for and organization of care processes in the nursing home contexts. The two minority staff in the above case were both nurses, with high working percentages and similarly to other majority registered nurses, they were near the top of the nursing hierarchy, entrusted with a number of ward and office responsibilities. However, although they might hold high level qualifications fitting for their professional positions, it seems that their competence with regard to food culture had been overlooked since they had to guess to serve dinner.

Food culture is also about when, where, and how people eat, which may differ substantially. The following observation from NH1 may illustrate the situation,

> *A minority staff member, Hussein, was responsible for assisting one resident who could not eat by herself. It was beef and boiled potatoes for dinner on that day. Due to the nature of the food and the health condition of the resident, Hussein had to cut the meat and potatoes into small bits before feeding the resident. As he used the knife and fork to do the procedure, he was obviously struggling to get it done, and the food was in a mess, and some was spilled on the table and floor. As he noticed that I was looking at him doing it, he slowly said to me, 'you know, we don't use these things in Africa* [referring to the knife and fork]. *We use our hands, and it is much easier that way… when I started working here, I had to learn in which hand I should hold each of 'these', and the way I can go about cutting food and eating. Believe me, you might think this is still poor, but I am proud that I have improved so much'…* [then we laughed].

In the above situation, Hussein may represent many other minority staff members with a similar cultural background, although the situation cannot be used to conclude and label all others, because there were many other minority staff who could manage such a task well. Looking at

Hussein's situation, it is taken for granted that he is capable of feeding the resident he is assigned to. With no assistance, he is trying to manage by himself, a task he had never been exposed to before he came to Norway. For him, using a knife and fork was a new skill he had to acquire as he entered the Norwegian community and worked in elderly care. Since it is implied that he has not been provided with any former training on how to use knife and fork to eat, or in this case, feed the resident, he takes his time to learn. Examining guidelines for orienting new staff in work provided by one of the leaders, I did not see any content on orientation related to food preparation and serving. This confirms the argument that the recruiting and integration processes take for granted that all new staff, both minority and majority, are aware and capable of managing basic skills of food preparation and feeding the residents who need assistance.

In the last comment, however, Hussein appreciated the way he had improved since his first experience. The only concern here, I would say, was the way such sensitive and important matters were ignored in training and orientation for new staff Hussein is right, that many families in Africa do not use knives and forks to eat food. In my experience, being born and raised in Tanzania, for most families, the utensil used most is a spoon, for consuming liquid foods like soup or porridge, although some may drink with the mouth straight from the bowl. It is therefore not common to find table knives and forks at the dining table in an ordinary African family. Moreover, caring for children and sick people, which includes feeding them, in most of the African families, is done by female persons in the family and not by men. As I shall explain later on identity processes, Hussein had to learn a completely new role as a man from Africa, on his own. Socialized in a new way, Hussein is learning to use the knife and fork as important tools for feeding the residents, although probably learning the hard way, in comparison with what would have been the case if he had been taught from the beginning of his work life at the nursing home. Another point is that Hussein would have managed better through trial and error compared to the standard he has achieved if he had a higher work percentage, which would have enabled him to practice regularly. This aspect of learning may, however, highlight the way cultural practices are always in the process of formation, through socialization, where people may learn to do different things as they cross different geographical areas and come in contact with different cultures.

Our geographical location may also influence the type of food(s) we eat based on its availability. A minority staff member from Eritrea, for example, commented during lunchtime break, in the staff conversation.

"… I never ate fish before I came to Norway. In my country, in order to reach the place where I can buy fish, I have to drive for about nine hours by a private car…you see, fish for me was then very expensive… so even the ideal image of a fish I had was from the books I read in school. But coming here, everybody eats fish, and I like it too, although I cannot say it is my favourite meal…"

In this gathering, almost all other staff were surprised to hear such an experience, a person living more than thirty years of his life, without having tasted fish in any form. This may show the way people may take some things for granted, such as assuming that everybody knows, has access to, and eats fish, let alone knows the number of fish species existing in different geographical locations. With relation to culture, the concern for the minority staff above, of never having eaten fish before, may be understood in what Heatwole (2006) conceives as *'cultural ecology'*, in which culture holds a relationship with the physical environment. In this regard, the author argues that diversity in the natural environment, such as climate, natural vegetation, soils, landforms, (and water bodies as in the quote above), is the reason behind cultural differences, based on the relevant mechanisms used by human beings to develop adaptive strategies to satisfy their basic needs such as food, clothing and shelter. Among other consequences, this has resulted in a variety of differences in production, preparation and consumption of food. In this regard, cultural ecology may be evident at local, regional and global level, as is the case, for example, in different parts of the country from which this minority comes, and furthermore in Norway. In relation to habitus formation, therefore, cultural ecology may also add a structure within which "sources of schemes of perception, thought and action" are shaped to inform agents´ experiences (Bourdieu, 1990:54). Relating this cultural ecology and the quotation and observational notes above with immigrant inclusion and work processes at nursing homes, I argue that the presence of immigrant staff challenges the Norwegianness and taken for granted organization of care. Since food and meal sessions were part of social conversations, the staff are assumed to be conversant with food varieties served to the residents. The way that all other staff were surprised suggests the taken for grantedness among them, whether majority or minority, that fish is a common food and known to everyone. Although the study did not establish any tension between this staff and his fellows, or with the residents, it still communicates the implication that taken for grantedness may potentially affect work processes at the nursing homes.

Filling the gap - social activities in and outside the routines revisited

The issue of social activities is partially discussed elsewhere in this thesis (see chapter 4). However, it is also relevant in this chapter in terms of the cultural dimension of the social activities in the nursing homes, and the way they are negotiated in the multicultural staffing environment. Although most of the physical and social activities in the nursing homes in this study were planned and organized through cooperation of leaders and some volunteers, some other activities were organized and initiated by the staff themselves, especially when the volunteers assigned did not show up. This, however, is with the exception of one ward of NH3 with residents categorized as cognitively challenged, who thus could not take part in group activities with other residents from other wards. Social activities were usually arranged through agreement among staff who were on duty on a particular shift, and they were mostly organised within wards, and sometimes included residents from the whole department. In NH1, the leader took the initiative and asked staff on duty to do something extra for the residents, while in NH2 and 3 I did not observe such specific arrangements. The activities would range from different easy games, baking, singing, watching movies and so forth, which would happen depending on the available workforce, not on regular or pre-determined basis. Most of the initiators of such social activities were the ethnic Norwegians, although at some point, some minority staff members would also give a hand in the process. The following conversation with one majority staff member at NH1 illustrates,

> ***Staff****: Yesterday (Sunday) during the evening shift, we made a cake for the residents, you should eat some, it is very good.*
>
> ***Me****: Okay, thanks. Do you bake every Sunday?*
>
> ***Staff****: No, we just decided to do it because it was quiet and there was not much to do. Therefore, we thought it was good to make something nice and fresh for the evening coffee instead of using the ready-made cakes. They [residents] were very happy, and they liked it… we do it sometimes for a change, if it is not a busy shift, to try to bring more life in here. Otherwise, it can be boring for the residents and even for us…*
>
> ***Me****: How could the situation be if you were working with a minority staff member, with regard to creativity and making the day less boring?*

> ***Staff****: If I am here, then we can work together to make things work, because I know many Norwegian things… but if there would be two minorities, I think they have very little to do… it is about background, you know…*

The issue of having a quiet and ´boring´ shift for residents due to having only immigrant staff is often mentioned by leaders, staff and residents´ relatives. In addition, my observation on one weekend and even weekdays where only minority staff were on a particular ward confirmed the same, although dull sessions may also be the result of other reasons. Since my ambition was to explore the role of cultural factors in promoting work processes, I had to seek for explanations for such moments.

My interpretation of the above conversation is that the majority staff member understands and uses her cultural background as a Norwegian, who knows much about what can make a difference for the residents in the course of a day, especially baking in this case, the social competence she has 'embodied' (Norwegianness) through her socialization in the majority culture (i.e., the cultural stuff, the social stock of knowledge and the habitus). The staff member highlights two important issues which may relate to culture while also stressing the time factor as a determinant for planning and providing something extra to add 'flavour' to the days for the residents.

Although the majority staff member might be right about her assumptions, she implies the prejudice she holds, that minority staff cannot bake or make snacks. This prejudice illustrates the way the majority may perceive minority staff, which also may affect their social relations at work. For example, prejudice hinders majority staff in asking questions to find out which snacks the minority are used to making in their home country and give them chance to bring their knowledge to work. Prejudice, as it stands among some of the majority staff, may promote exclusion of minority staff in some social activities, just by assuming that they cannot perform some ´Norwegian´ tasks. This may further the tendency of minority staff to invest and engage more in the manual work and body-work aspect of care than social care for. If allowed, I think some of the minority who cannot bake would come up with other ideas from their home countries, which would probably be liked by the residents (see later in this chapter).

On the other hand, the time factor might also have implications when it comes to giving minority staff the chance to learn and practice accordingly in the working environment. A useful question is, for example, how can those minority staff be empowered to have a wider knowledge of the Norwegian culture? To what extent have they been included in work so that

they have enough time to practice and learn important skills such as cooking and baking? In answering such questions, my take goes back to the structural factors guiding recruitment and inclusion of minority staff in work (see chapter 4). To be able to grasp important social activities (and cultural stuff) immigrants need exposure to that culture, taking part in activities in a relatively regular manner, experiencing things, and trying them out (and failing). Even though minority staff might learn about some aspects of Norwegian traditional foods, it is another thing to be able to prepare and/or serve them. The limited shifts for most minority staff, which consequently limit their inclusion frequencies, may consequently affect their learning processes about the new culture.

Going for a walk outside in nature is a common activity in Norway in general and it is also practiced in nursing homes. With the exception of one ward in NH3 where residents had significant cognitive challenges, all the others had a day of assisting residents to take part in this important and well-known activity. The leaders, for example, would suggest that residents should be taken for a walk on a particular day, or staff would decide to do it themselves in the course of their shift on a particular ward. This was done by following those who could walk by themselves a reasonable distance, usually inside and sometimes outside the nursing home, depending on the weather or available work force. Those who were confined to bed or to wheelchairs were pushed around by staff. In performing this activity, there was a remarkable difference between majority and minority staff. Firstly, most of the minority staff would strategize to assist those less physically capable residents such as those in wheelchairs, and those who had speech difficulties. Secondly, even when they chose to assist the relatively able-bodied residents, the walk was relatively quiet, fast, and mechanical as compared to when it was done by the majority staff. Differences between majority and minority staff with regard to the way they performed tasks became visible in such situations, although it did not become evident whether such situations were felt as problematic by majority staff and leaders (see chapter 5). With regard to choosing residents with speech difficulties, I have also discussed in the previous chapter that minority staff members prefer to assist those residents who cannot push them into discussions or negotiations they cannot manage due to time constraints and limited language competencies. Since the work organization allows for negotiating on this aspect, the minority staff are therefore exercising their agency to make themselves relevant at their workplace. Since going for a walk is considered as important in the socialization of Norwegians (Williams and Kattenborn, 1999) and not most of the minority staff, its significance

and attached meanings may not necessarily be well communicated to the minority staff (i.e. taken for granted), something which may justify the way minority staff respond to that activity.

Different social activities were organized on different days, for different groups, though sometimes including all the wards. Moreover, some of the minority staff members who had relatively low work percentages and shifts were moving from one ward to the other, depending on where there was an available vacancy. In this regard, they were always acting as relatively new to the ward, and some had to ask for every next activity they had to do. It may have been difficult for them to get consecutive shifts on one ward and to have been able to have a continuity of new things they could learn in relation to culture. This also depended on the number of staff on the shift, and whether the shift was busy, as the quote above shows. Without experience, minority staff members will remain with limited competencies when it comes to social care, leaving the burden or responsibility on the majority staff members, who are already socialized to carry out the activities, while allowing for 'dull shifts' when there are only minority staff. Within the current arrangements, my observation was that there is a tendency to assume that certain responsibilities are for majority staff members, and that minority staff members were not making efforts to cross the line and show their extra capacities. This, I argue, is probably due to acceptance of the regular prejudice they receive from majority staff as in the quotation above, which may have made them give up on making extra efforts to learn and implement, whenever possible.

On the other hand, the above conversation suggests that having a mixture of majority and minority staff members during the shift is useful in order to balance cultural gaps when it comes to providing relevant services to the residents. Or we could argue that the leader could have planned easily accessible tools for immigrant staff members to enable them to make waffles, snack or other foods during quiet times at the weekend. This would also facilitate their inclusion in work.

However, some of the minority staff members did not just wait passively to be told what to do or be allowed to do in situations by the majority staff. Some of them were curious and asked for help from the majority staff. Therefore, is not proper to generalize that all minority staff are equally incapable, slow or the like. The following excerpt may illustrate.

> *Margaret, an auxiliary nurse from South America, has worked for 23 years at NH1. She wanted to make waffles for the residents during lunch, which could also be shared among the staff during a special Friday lunch* (fredagskos)*; however, she was not sure*

about her skills and the recipe. So, she came to another ward to ask if anyone could assist her with the 'best recipe' (because in her ward she was the only minority staff member). One of the majority staff volunteered to explain and then wrote down the recipe for her. She went back and made the waffles, which were shared among the residents and some staff during lunch.

The first interesting point from the above excerpt was that even after 23 years of working in a nursing home and probably more years of living in Norway, Margaret still doubted her skill in making waffles. Making waffles is very common in the nursing homes. In this scenario, it seems that mixing majority and minority staff during a shift may add value to learning about culture, through everyday interactions and activities, while facilitating work processes and staff relationships. It is an area where minority staff have the opportunity to maximize their social stock of knowledge necessary for their agency in social activities related to resident care. Margaret made waffles with the help of a majority staff member, something which may imply that she learned from her and in the future, might eventually manage on her own.

However, what if she made something from her home country South America? The residents would probably like it, and hence compliment the idea of 'immigrants as a resource' when it comes to bringing new ideas such as food. In one study from a nursing home in Norway, for example, where minority staff had the flexibility to create a hot lunch for residents, the residents liked it: even those with eating problems ate enough (Munkejord, 2019). Unfortunately, such flexibilities are not formally acknowledged in care planning although they seem to work to the advantage of the residents (as for example offering more than Norwegian language skills among the minority staff in chapter 5). It also enhances cultural knowledge among the staff, both the majority and minority, which is an important aspect of a smooth working environment, instead of stressing and maintaining Norwegianness.

This scenario and other findings from this study suggest that integration of immigrants through inclusion in work is practically one-sided, of embracing Norwegianness. This may further exclusion rather than inclusion, by fostering a system where immigrants manage Norwegian ways of doing things, thus reinforcing and/or widening asymmetrical power structures between the minority and majority staff (Gullestad; Rytter, 2019). Even when staff have the opportunity to work cooperatively they have to do it the Norwegian way, although the context may sometimes allow for some flexibilities as observed by Munkejord (ibid.) and regarding language competence (chapter 5). Thus, there is a tendency to foster an unbalanced relationship between the minority staff members as inferior and less competent, and the majority staff

members as superior when it comes to social care in particular (Tingvold & Fagertun, 2020). In other words, the intersection of nationality and ethnicity produces axes of difference which intersect to produce a disadvantage for minority staff inclusion in work.

Important celebrations and times of the year

Replicating Norwegian cultural practices, nursing homes celebrate all the important calendar days in Norway. Customs, in terms of traditional ways of doing things or behaviour specific to Norwegian culture (i.e., cultural stuff), characterise these events. These include religious (Christian-Protestant), political and birthday celebrations. Political and religious markers are characterized by special activities, dress-code, décor, special foods and so forth. These characteristics imply Norwegian identity and heritage, and hence they constitute an Norwegianness aspect of the nursing homes. Minority staff members need to orient themselves to these important markers and act accordingly, although they seem to slip their mind, or some are not aware of them at all, and may hence function to limit or completely affect their inclusion in work. According to the leaders, some of the minority staff members lag behind in attending these celebrations and times of the year, sometimes causing complaints from the residents and their relatives. Such things as not knowing the colour of a tablecloth during Lent and/or Easter, lighting candles according to the weeks of Advent/Christmas were mentioned. Minority staff have to learn this through observation and regular practice, although this might be a disadvantage for those with relatively low work percentages, who may not come across such practice during their first orientation, because it cannot cover one or all seasons of the year. For the majority staff, the seasonal celebration mood comes automatically, probably because they have been socialized in this culture from their childhood, it has become '*habitual'* and/or *'embodied' (Uberoi, 2015)*, accumulated in their social stock of knowledge, to inform their cultural stuff (Vassenden, 2010) and habitus (Bourdieu, 1977a), and they most probably do it as well in their private homes, so they do not need to be reminded. Although there are more majority staff members than minority who may take action to prepare for such special activities beforehand, with staffing challenges leading to presence of only minority staff may arise, for example forgetting to light the candles even if they are on the table.

Despite the challenges highlighted in relation to adjusting to Norwegianness, minority staff members were praised by the leaders as being resourceful and providing care in a relatively different but positive manner as compared to the majority staff members. The following quotes

were extracted from the focus group interviews as the leaders were responding to their positive experiences with the minority staff.

> *"…We have many good examples too… Many have good attitudes towards the elderly from home and have a different calm attitude with them. We* [meaning Norwegians] *stress more about time, to get things finished on time and not otherwise. They* [meaning minority staff] *have more tranquility, and show sincerely that they care, and we see that in many, especially the men, they manage to take care of the old. They radiate calm and empathy. The Norwegian people do, too, but there is something extra… And it can almost be frustrating for the others: "What are you doing in there that takes so long - standing and waiting". While they just take the time and take it easy with them..."*
>
> **Leader, NH2**

> *…Some of my immigrant staff have a completely different respect and care for the old people than we Northern Europeans have, and this means a lot to my department. It is important to highlight these as well.*
>
> **Leader, NH1**

> *…Yes, and there are probably more positive than negative things, most of the minority employees are good, positive, liberal and exemplary when it comes to attitudes. But I have some that aren't too.*
>
> **Leader, NH3**

> *…The work ethic and efforts of those who do not have Norwegian origin are good, they have a different attitude and stand up to the job.*
>
> **Leader, NH3**

Although the above quotes indicate the strength and importance of having minority staff at nursing homes, the same quotes highlight the construction of 'us' and 'them' in the working environment, referring to the contrasting ways of providing care by minority and majority staff members. In doing that, leaders explain how they perceive care processes between minority and

majority staff, and express appreciation that the minority staff do not bother much about time but take extra time to make sure that they give extra care, and the leaders appreciate that this is relevant care. This, however, happens within the hectic and labor-intensive shifts, which may sometimes be disappointing for the majority staff. This therefore, suggests a possibility that the excessively submissive attitude of the minority staff is affecting working relationships between the majority and minority staff members, although the same seems to work well for the residents who need such attention as well as the staffing challenges facing the leaders.

But what can explain such ´special´ attention of the minority staff members to residents? Apart from being a paid job, caring is a family responsibility in most non-European countries, whereby family members are obliged to take care of their elderly parents (and relatives) without any financial payment in return. This is part of their socialization since childhood, and it is also often a characteristic of quite different welfare arrangements, as these countries do not have a welfare state as do the Nordic countries (Hervie, 2019). This socialization with regards to family relations, therefore, is a part of the habitus in terms of the way they perceive and relate to the elderly in general and older kin in particular. In my country, Tanzania, for example, it would be shameful for a family to send their old people or relatives to an institution, although there are easily accessible institutions there. Taking care of them within the family is part of showing them love, respect and being responsible. The only people who are sent to the institutions are the poor and destitute, who happen not to have families and/or close relatives to take care of them, and hence they are very few. On the contrary, the Norwegianness aspect of care may be linked to less family engagement in the care of their elderly people, the responsibility for which is taken care of by the municipality (see also chapter 1). The institutional care of old people may present a relatively new experience for the immigrants, particularly those from non-European countries. However, in doing their jobs, those minority staff members exhibit particular dispositions when relating to the residents based on their habitus, which in this regard feels different for the leaders and other majority staff members.

Similar findings have also been highlighted in the study by Isaksen (2012) on the experience of Norwegian leaders recruiting nurses from Poland. The leaders perceived Polish nurses as

> "…a stable, hard-working workforce taking advantage of fewer of their welfare rights than Norwegians. They were more willing to work overtime, at weekends, and during religious holidays… they got a better work ethic and being less demanding than 'native' nurses" (Isaksen 2012:64).

The above perspective by Isaksen suggests that immigrants are indeed a solution to the labour crisis and cost containment in the elder care sector.

On the other hand, however, the consideration of minority staff as a resource, especially during the holidays and sudden vacancies, when it was difficult for leaders to obtain adequate staffing, was given a second thought by the leaders. They discussed this submissiveness of the minority staff, in the middle of considering them as resourceful and hard working. This was in relation to the way minority staff were considered as being always ready to take extra shifts in comparison to the ethnic Norwegians, similarly to the quote above by Isaksen (2012). In the middle of praising immigrant staff during the focus group interviews, the leaders from both NH2 and NH3 raised the following concern.

> ***Leader NH2****: … And then it is important for us leaders not to take advantage of it* [referring to the perceived submissiveness of the minority staff in accepting all kinds of shifts]*, because we know that there will be a free shift on Christmas Eve, no one wants it, but we know that if we ask the minority staff member, we know she does not say "no" but maybe she does not like to have that shift. It is important for us leaders to be aware of the challenges, that we might be pushing them into overworking stressful lives, just because they cannot say "no" for some reasons, it is quite scary…*
>
> ***Leader NH3:*** *Yes, it is true, it is important to establish whether they actually want to take that shift, or they want to appear capable and impress us (the leaders).*

Although the leaders explicitly discuss the submissiveness of the minority staff when it comes to taking extra and 'awkward' shifts, which would otherwise not interest the majority staff, they do not present any strategy to enhance the immigrants' ambition. It is implied that this may continue for as long as they face the same labour shortage at those times of the year. The fact that leaders know that minority staff will not say 'no' for a Christmas eve shift, and still go ahead and ask them, may imply the exploitability of the minority staff. This 'exploitability' is according to Friberg and Midtbøen (2019:325) the key characteristic that makes immigrants popular with their employers, as being more flexible, cheaper and docile, as a result of their fewer options in the labour market. Moreover, while this access to such 'special' shifts may look like a 'privilege' enabling immigrant staff to earn more, it may also function as an 'oppression' enhanced by the multiple interplay of migrancy, labour market and integration politics (Tingvold & Fagertun, 2020), the intersecting factors which work to disadvantage minority staff members, and influence their agency by putting them in the position of not being

able to turn down offers or opportunities to earn more money. Putting it another way, some minority staff with relatively low work percentages, with uncertainty of getting regular extra shifts, have to apply for, and accept extra shifts in order to make a decent living. Furthermore, this could be due to the conditions under which individual staff are employed, and the asymmetric power relation between majority and minority staff, which make minority staff say "yes" to every shift vacancy. In a sense, the reasons for making choices are complex, and all this complexity shapes the agency of the actors. Thus, within a framework viewed from an intersectional perspective, the whole scenario may present the way interwoven axes of difference such as class (in terms of low income due to low work percentage) and ethnicity (being minorities) are shaping the way the minorities are positioned in the working life.

Implicit ideas and practices of leadership at the multicultural workplace

From the empirical material of this study, it was established that the leaders did not have any particular formal training in leading multicultural staff, although they mentioned having some content of leadership training during their nursing education. Responding to the question as to why the leaders felt the relevance of the intervention study which they took part in, for example, leaders from NH2 and NH3 had the following comments.

> *"…After all, we have worked on the knowledge about leadership for several years, but not with a focus on a multicultural working environment, there have been too few, but more will come. I thought I've done the right things, but I see now that there are more things to go into…"*

> *"…It (implementation study) shows that it is an important topic. With me, it can be the opposite, when we have foreign residents. And then they may not want us. It is important that we start thinking about the way we can relate to it… not only with the minority staff, but also minority residents"*

> *"…It is difficult to lead people who are different in many ways. I try to treat everyone equally; everyone is worth the same even though everyone is different"*

The fact that these leaders were still practicing in their role as managers of multicultural staff, suggests that they were actually taking actions to accommodate the differences they perceived.

Since this study had the ambition of exploring what was going on in the middle of this lack of standardised leadership training on managing multicultural staff, some implicit ideas on leadership emerged from the empirical findings. These ideas played a role in informing agency of the leaders, based on the opinion from the staff they were managing. Although some of these implicit ideas are also addressed elsewhere in this thesis, I specify them here as well as a means to say something about Norwegianness attributes of leadership and the way it is perceived and experienced amidst multicultural staff.

In my interaction with the minority staff, I observed that they had both positive and negative perceptions of the way leaders conducted themselves. In my initial visit to NH1, for example, when I explained to one majority staff member about my purpose for being at the nursing home and the objective of my study, she responded, *"I think it is an interesting study and very important. I hope it will help our leaders to lead us in a much better way…"* The staff are observers and recipients of leadership practices, and therefore assess the way they are managed as a group although they do not necessarily comment regularly on it. The words of the majority staff member above suggests that although the leader was doing a good job, there was still hope and need for improvement(s). However, it was not established whether the leaders at any point received such evaluations from the staff members to guide and develop their future leadership practice.

Although my general observation of the way staff perceived their leaders was more positive, there were also some negative comments, especially among the minority staff, such as for example from Monica, a minority registered nurse at NH2, who said,

> *A leader should do her job, she must act as a leader, otherwise things do not work here. I think the leader is too soft, so there are some other majority staff members who pretend to be leaders, coming here and dictating things…*

Monica's concern was about the leader letting other majority staff members take the leadership role, which made her uncomfortable. In this regard, Monica associates this kind of leadership practice with poor working relationships among the staff and poor leadership. The leader at this nursing home was the least engaged with the staff, as compared to the other two nursing homes in this study, by way of being more distant both physically and with planning and discussion of issues. This could relate to Monica´s concern about the reason for presence of ´informal´ leaders. The presence of informal leaders at nursing homes is well documented in several studies (W. Eriksen, 2006; Førland, 2016; Hervie, 2019). While some may work to

facilitate tasks at hand, others are received negatively by the rest of the staff members and given names such as 'small bosses' (Førland, 2016) and 'backstabbers' (Hervie, 2019). The actions of the informal leaders may consequently affect relationships among the staff members and the working environment at large by way of blurring roles and responsibilities.

Hussein from NH1, on the other hand, had a positive experience of the leader and other staff when he had to learn the Norwegian language. He was very grateful for the support from the ward leader and fellow staff on his journey towards his new life. He said,

> *"…We have a very good leader here, who wants to see everyone getting an opportunity to learn and be better, even though sometimes the nature of the job wants us to engage in almost everything. But my fellow staff have also been very helpful, especially the Norwegians. Since I started this study* [to be a health care worker, 'helsefagarbeider'] *some of them were interested to know how I was doing and the challenges I was facing. One majority colleague, for example, would take time to explain a lot of things and sometimes give me some tasks which she believed would be in my exam… but I must say, the leader also advises the majority staff to be of help to us, so it is to her credit in the first place …"*

To Hussein, a good leader meant one who is helpful, being fair, giving opportunities to everyone, and encouraging a supportive teamwork to make everyone better at work. At this nursing home, the leader was engaged with the staff members. Every time she was at work, this leader made efforts to be present during lunch gatherings among the staff, and during resident activities organized by staff members.

Supporting my point of view, Emmanuel from NH3 appreciated his leader as a good listener. He was referring to a new resident who had moved into the ward from another institution, and according to Emmanuel and other staff, that resident was considered extremely aggressive. They tried to bring her into the lounge three times, but as soon as she entered the lounge, she would start throwing things at other residents, even sometimes removing the pictures hanging on the wall, and she already had broken one of them. They had to decide to start locking her in her room, where she remained very quiet and a bit friendlier to the staff. So, he used the example of this resident to assess the leader as he said,

> *Although we are people from different backgrounds here, we normally find a way to work things out, especially in this ward with very challenging residents. Moreover, I feel that the leader trusts me and listens to my opinion every time I consult her. For*

example, with this new resident, it was me who suggested to her that she remains in her room and not be allowed to join others in the lounge because of her extreme aggressiveness. The leader accepted this, and that is why you see we keep her in her room throughout the day.

To Emmanuel, the leader was good because she listened and accepted his suggestion, although he is an immigrant. The leader is also perceived as being cooperative in finding solutions for issues arising with the staff, a listener who trusts her subordinate staff members.

Although in all the quotation above there was no comment from the leaders, the messages from the minority staff with regard to what they think as being proper or improper makes sense in general. The concern for Monica, however, as opposed with the rest, who appreciates leadership practices, suggests the traps and gaps existing in NPM with regard to managing multicultural staff through in nursing home contexts.

In the next section, I focus on the social identities as they emerge and hence are negotiated in a multicultural working environment.

Negotiating social identities through race, skin colour, religion, gender, and ethnicity

Race, and the ways race is made relevant as a category of difference in various contexts, is socially constructed. Thus, race as a concept lacks a common meaning, apart from referring to colour/skin tone, which was evident in this study. Race categorises humans according to their shared genetic heritage based on external physical characteristics like facial features, skin colour, and hair texture (Murry et al., 2004:82). Therefore, we have general racial categories such as white, black, Asian and so forth. However, such conceptions may be problematic if considered as a sole framework for defining individuals as it may cause stigmatization, racism and oppression of certain groups. racism, therefore, is the result of treating people according to their races. Racism as complex as it is, can be marked through skin colour, ethnicity, culture, language and religion (Grosfoguel, 2016). In this study, it was easier to associate skin colour with ethnicity and even culture, because all the minority staff happened to be first generation immigrants, and they were referred to as black versus white immigrants in relation to skin

colour. However, this did not mean that traces of racism were also evident, primarily from the leaders and staff points of views.

Although the residents and their relatives rejected some of the minority staff (see chapter 5), some immigrants complained that they were not given a chance to do their job as they were instantly rejected due to their skin colour (being black). In analysing such situations, an intersectionality perspective is useful in identifying specific axes of difference that intersect and shape ´black´ immigrants' exclusion in work. When situations arose where skin colour was the issue at the workplace, it did not matter if the immigrant staff was competent – they could not perform their job and was excluded.

There has been a change in the way immigrants are referred to in Norway. From referring to all people who come from outside Norway, whether they are Swedes, Danes or North Americans, to becoming redefined with reference to an 'implicit code' which defines people of "third world origin, different values from the majority, dark skin, a working class background (unskilled or semi-skilled work) …" (Gullestad, 2006:175). In this study, the construction of 'us' and 'them' emanated from different social relations among the majority and minority staff as well as between minority staff and residents and/or their relatives. Some of the relevant aspects have been discussed elsewhere in this thesis, although with different implications. In this section, the discussion focuses on the way minority staff are perceived to challenge some aspects of the status quo of Norwegianness in the nursing home working environment. Skin colour issues were raised in all three nursing homes, both by leaders and minority staff, especially related to dark skin colours of staff from Africa. During focus group interviews, leaders responding on their experience with leading multicultural staff were reflecting on the dilemmas they face with regard to planning and allocating staff on a particular shift. With regard to residents, a leader from NH2, for example commented:

> *"…I have mixed experiences… Many older people today may have challenges in accepting, not so much the language, but more the skin tone* [hudfarge]*... Residents may refuse to be attended by those who have dark complexions, for example. If you come from Serbia or Albania and look a little like a Norwegian, it is easier for residents to accept this. It is an important part of my job to prepare employees for this, that they can meet residents who are 'racist', because we have experienced that. I receive little feedback from relatives and residents about language".*

Although language has been mentioned by leaders as a general challenge among minority staff, in the nursing home above this problem was less serious. Most of the minority staff in this nursing home had a relatively higher language competence compared to the other two nursing homes. As mentioned by the leader above, having a dark skin was problematic, whereby skin complexion was tied to ideas of being Norwegian, which then determined the level of acceptance from the residents. Skin colour was linked by residents to ethnic background, whereby for example, minority staff from Europe and Asia were relatively accepted, something which was different for those with dark skin complexion (i.e., African minority with dark skin complexion). Other staff, with relatively lighter skin complexions would '*pass*'[31] for white and there was less of a problem for residents.

Although racism was mentioned several times by leaders and minority staff, I realized that they were referring more to skin tone/colour whenever they were talking about immigrant staff and situations of racial abuse in their working environment. In relation to inclusion of immigrants at work, skin colour posed a challenge to their acceptability to residents as in the case above. This means that minority staff members with dark skin complexion were identified by residents as not being proper care workers, something I relate to racism (Grosfoguel, 2016). Such a situation may affect work processes as organised by leaders, while putting more pressure on the majority staff who may take over tasks related to these residents. Thus, stigmatization based on skin colour negatively affects the staff and the leaders.

Interestingly, for this leader above, her intervention was one-sided, by warning the staff with 'dark skin' to be ready to face this form of discrimination, but not presenting the ways she is prepared for such situations. If nursing home residents are given the right of user participation concerning their welfare, why is it difficult to do the same with regard to the welfare of the minority staff and discriminative actions? Such one-sided ways of addressing problematic behaviours of residents could also mean that leaders are part of the discrimination by not being able to find permanent solutions and principles for solution of such situations. However, this could be due to lack of relevant policies in place to protect immigrants against racism at work. As such, there are no official guidelines for addressing the matter and immigrant staff are forced to accept such discriminations at work.

[31] To 'pass' or 'passing' is a sociological term used to refer to a situation when a member of one racial group is classified and accepted as a member of another racial group (Pease, 1996).

In NH3 during a focus group interview, the leader, responding to the question of dilemmas in leading multicultural staff, faced the same challenges, but reflected on the matter differently.

> ***"…*** *and I also have some residents with dementia, so it is a bit the same group, but I have experienced individual residents who have racist attitudes… and it's very difficult. If you have dementia as well, then it does not help that I go into the situation and say… you listen here... But it is much more difficult when we have relatives of sick residents doing it… I do not understand these relatives, that they have 'xenophobia'* (translated from the Norwegian word - fremmedfrykt)*, I really do not like that, that they have so different values than me... it is a challenge for me as a leader and as a person, and that may apply to some employees as well. That is the way it is, but I get very provoked. We have had cases of relatives who refused to have their mother attended by someone with dark skin… And then we talk to them (relatives) and say that discrimination is totally unacceptable, here everyone is worth just as much independent of skin colour."*

The quotation above, like the previous one, reveals that skin colour is the main social category for residents in defining the minority staff and is crucial for their relative acceptance or rejection, irrespective of their professional competence, although they are recruited according to the national laws and policies of the country. Although the leader in this case confronts the residents' relatives, still nothing is done to the residents because of their health status, as the leader puts it. Regardless, since there was no antidiscrimination policy available in any of the nursing homes I visited, it might be hard for leaders to stand on what they believe in with regard to the discrimination actions, and even future ones to come. One leader, for example, mentioned that when she once tried to confront the relative of a resident who was refusing for her relative to be attended by a black coloured staff member, she said, *"it is not my fault that these black people are here, what I am saying is that I do not want them to attend my parent"*. The agency of the leaders is exercised in organizing and managing care at the nursing homes, based on multiple, intersecting structures and contextual realities. However, in a situation like this, racial abuse may shape agency, because it affects the possibility of conducting care in a good manner, since racism represents actions and practices of exclusion. Therefore, lacking proper guidelines for addressing discriminatory behaviours may affect working relationships between some minority staff, residents and their relatives, creating tension at workplaces.

Based on the discussion above, I find that the strong resistance among the ethnic Norwegian nursing home residents to black staff needs to be investigated further. The way black people are disqualified, in the eyes of residents and relatives (sometimes even staff), from being the

right people to provide care, may say something about notions of Norwegianness and also about proper care. What is it with the black skin colour? How is it interpreted or understood among the 'white' majorities? What are the attributes attached to being black that make it a threatening identity? Most interestingly, why is different skin colour okay for the leaders and most of the staff, who are also the majority, while a threat to some of the residents and their relatives?

According to Gullestad (2006:232), interpretation of differences, such as skin colour, emerge from historical specific processes as human beings try to interpret what goes on around them. As they live, people try to categorize other people, things and situations into different groups, where everything has to fit in a particular box (Douglas, 2003). In this regard, prominent visible features of difference are not universal, but are specific and culturally produced and reproduced through transitory and ever-changing negotiations and are invested with particular meanings. Moreover, the presence of black people in Norway is considered to be relatively new, because many people in the country still remember the first time, they met a black person on a face-to-face basis (Gullestad, 2006b), which may probably be more relevant to the elderly people in the nursing homes. What skin colour and the attached prestige signify may be "the ways in which the socially advantaged and disadvantaged play out attitudes of cultural superiority and inferiority ingrained in their habitus in daily interaction" (Reay, 2004:436).

Precisely pinpointed by Jönson (2007), discrimination based on skin colour (referred often to as racism) in the elder care sector is also an issue in Sweden. Paying more attention to the older care recipients' rights to choose the form and provider of care, gives an implied permission to tolerate racial abuse, while on the other hand, pushing the discriminated to tolerate those actions. Further, Ryosho (2011), (see also Dodson and Zincavage (2007)) highlighted similar trends in the United States of racial discrimination (skin colour) by older residents against the care providers based on lifelong prejudices which triggered fear of the unknown, distrust and hatred. As such, hierarchies of race, ethnicity, and social class contribute to conflict in caregiving and working relationships in nursing homes.

From an intersectional perspective, skin colour and ethnicity present two axes of difference, in addition to gender, which I will discuss later. These dimensions of identity contribute to creating and maintaining 'us' versus 'them' among the nursing home staff, and also a 'superior' versus 'inferior' relationship between the minority staff and the residents (and their family members) (Dodson & Zincavage, 2007).

In trying to understand resident reactions to and actions towards black minority staff, I refer back to the brief history of immigration to Norway as described by Andersson (2012), which is further detailed in chapter one. Norway started to receive immigrants in the late 1960s. Relating this reality to the general age of the residents, it might imply that this generation had less probability of having social interaction with immigrants in their younger years. As such, dark-skinned people are perceived as guests who do not conform to the expectation of the host (Douglas, 2003). This aspect may also relate to perceptions and negative attitudes towards black minorities as being due to the imagined sameness, the 'doxic' forms among the Norwegian populations, setting the boundaries between 'us' and 'them' (Gullestad, 2006b). As these boundaries are set, they thus limit the agency of the concerned minority staff members, who regularly face rejection at work. This further affects their inclusion in work and integration in Norwegian society as they are always perceived as unwelcomed strangers (Rytter, 2019).

In the following quote from my field notes at NH3, Ester, a minority staff member from Africa interpreted the response which she got from a resident as racism.

> *In this ward with 'aggressive' residents at NH3, four staff were on the day shift, three of them were minority, one black, while the two others were European, with light skin tone. Three minority staff were sitting in the lounge with one resident. The majority staff member went to the report office, and other residents were in their rooms. The resident started to ask for some yoghurt from one of the staff, but she was told that she could not have it because she had just finished three 'cups' before lunchtime. She told this staff, pleadingly, "I could be your mother, just give me some more yoghurt". After being unsuccessful, she turned to the other staff and the same interaction happened. The staff told me that this resident does that when she gets agitated, and sometimes they try to create some activities for her like reading (*because she used to be an English teacher*), so that she can forget about food for a while. Then after a while, she turned to the minority staff member from Africa with the same request. Similarly, to the other staff, she also said 'no'. Then the resident told her, "I could be your mother, but I am not black". All the staff were quiet for a while, then that staff member turned to me and said in a low voice, "this patient is a racist, did you hear what she just told me? She has done that some other times too". She then turned to the resident and said, "you know, you can be a mother to all of us here, it has nothing to do with our colours, don't you think so?" The resident repeated her previous answer, "I could be your mother, but I am not black". The staff turned to the side; her expression appeared to be annoyed…*

Although the story started by asking for yoghurt, it ended with feelings of discrimination for the minority staff member. She related her different treatment compared to the responses given to her fellow minority staff with her dark skin complexion or 'black' colour as put by the resident. However, it was not possible to establish if the resident by saying those words meant that she would refuse the yoghurt if it was brought by the non-white staff. It was the staff who rather showed that she was no longer interested with negotiating with the resident on the matter at hand, although she mentioned that it had happened several times. Such provoking responses seem to affect care relationships between the black minority staff members and the residents.

Religious identity

Religion as a dimension of identity was also evident in this study, on the part of the residents and minority staff, particularly non-Christians. To begin with, I came to realize that some of the residents were not aware of other religions apart from their own, which appeared for many to be Christian (Protestant). I concluded this based on the religious arrangements at the nursing homes, which included Protestant mass celebrations, prayer songs and bible study sessions for residents. In the quote below, I give an example of a resident from NH2, who did not know what a mosque was.

> *As they were sitting around the table after breakfast, one resident was quietly reading a newspaper. Some of the staff were also sitting by the table and talking to some other residents. As he was reading, immediately, the resident asked loudly, "what is a mosque?". It took a few seconds before one majority staff member started to explain the meaning to that resident, who claimed that he had never heard of or seen a mosque before in his entire life. The staff told him that it is a place where the Muslim people, another religion different from Christianity, goes to pray. She tried to explain giving an example of one of the large mosques in the country, which is located on the way when driving to Oslo.*

In trying to make sense of the above quote, I had to go back to the literature and statistics, to find out the time when Muslim immigrants came to Norway and the trend of their increase. As mentioned, the first immigrants to Norway were from Pakistan in the early 1960s, who came as labour migrants. Assuming that by that time most people from Pakistan were most likely to be Muslims, one may conclude that those migrants were also Muslims, because they came from that country. However, because it was in the beginning of the history of receiving immigrants from outside Europe, this type of migrant may have been too few to reside in most places in

Norway, as it probably still is today, that immigrants, especially refugees, are made to settle in certain areas which may not necessarily be the big cities. As for example, when I visited one of the nursing homes in a relatively small municipality, I was surprised to see that there was an asylum reception, right by the side of that nursing home. Although I did not ask about the exact age of the resident whom I refer to in the above quote (due to ethical issues), the concerned resident seemed to be relatively older than other residents I saw in this study in general. In this regard, I can understand that he may never have come across any Muslim minority in his active age life. This was different for the staff, who were relatively younger, and could explain to the resident what a mosque was. In my opinion, the resident was 'blind' or had very limited knowledge about the other religions which are part of the current Norwegian society, as part of its culture. At some point, this cultural blindness may be associated with what the leaders also mentioned during interviews, that some of the residents were reluctant to be attended by Muslim staff who were wearing head scarves at work. In a sense, this 'cultural blindness' could also be considered as part of Norwegianness, making people implicitly expect Christianity to be the rule, to be 'natural' (Vassenden, 2010). In other words, it is part of the Norwegianness, where everything should be similar, and where Protestantism is the 'norm' at least amongst the older generation. It is from this backdrop that the presence of minority staff with other religions than Christianity may face challenges at work, something which may affect their inclusion.

On the other hand, some Muslim staff commented on the types of food they had to engage with when feeding the residents, especially food with pork, as pork is '*haram'* (polluted, not pure) and not '*halal'* (pure) in the Islamic religion. As one of the minority staff, Hussein, said, whoever works in the nursing homes is okay with all the food types which residents eat. This may illustrate that there are elements of taking for granted 'food issues' at an everyday level at the nursing homes among the leaders and majority staff. When talking about the challenges he came across as a Muslim working at the nursing home, he said,

> *"... when we work in these places, there are some things that we are not expected to question, they are just there, and we just have to follow the way they operate… For example, for me, I am expected to feed the residents with foods that may incorporate pork… I just do it even if it is against my religious belief. One thing I console myself with is that as long as I am not eating it, then it should be okay if I feed the residents, because they are my number one responsibility when I am here…that is what I am paid for…"*

In the above quote, Hussein is compelled to negotiate his religious stance against the Norwegian working environment, through what Gullestad (2006:180) refers to as "unacknowledged religious flavour" or "secular religiosity", by which even the numerous secular Norwegians take Protestant Christian ethics for granted. His reflection concerning 'unquestionable things' he had to come to terms with may imply the way either his concern is taken for granted or neglected in the Norwegian nursing home context. For him, it is a matter of 'take it, or leave it', meaning that because of the way work is normalised in this aspect, he may either choose to stay and work unhappily, or go and find another 'friendlier' job elsewhere. However, as mentioned, working in the nursing homes remains the most practical way of securing a job in Norway for immigrants like Hussein. His agency is contained in the limitations posed by structural factors in terms of the policies guiding labour market and integration. In this regard, Hussein negotiates his religious identity and finds a coping mechanism, by consoling himself that it should be okay as long as 'he does not eat the food with pork'. This would never be understandable in Islamic society, as it is 'haram', not only eating, but also preparing and feeding, even sharing utensils which have been contaminated, even if those utensils were washed (Asif, 2018; Kamali, 2013). More interestingly, I observed Hussein using coffee cups and glasses which were also used by all other staff and some residents, something which would have not been the case if he had choice or control. Hays (1994) recommends against treating agency as being subject to rigid structures like a solid wall, forcing people to abide to rules and regulations like robots. Rather, social structures are creations of human beings, moulded through their participation, and such structures are both enabling and constraining, providing people with a basis for power and self-understanding. At an individual level, people may choose to act based on the number of options in a particular environment, as it is for Hussein in this case. I believe that this could be painful for him, but, after navigating through his world of choices to see what would work better for him and achieve his intended goal, this is probably the only way to secure a stable job and take care of himself and his family. Looking at his situation in the context of temporal agency (Emirbayer & Mische, 1998a), Hussein may have made his choice by reflecting on his past experience of being a refugee, taking a dangerous route to Norway, and all the risks he had to go through to escape the dangerous life in his home country. In his present situation, Hussein may have evaluated the choice and power he had, with regard to the working environment, which forced him to adjust his actions and bury his religious needs, even if they may mean a lot to him as a person. Alternatively, being less powerful makes him choose to adapt to customs less threatening to his lifestyle and identity and keep customs and habits of greater importance. This aspect may also inform us of the fact that people adapt

to different cultures subject to time and to the social contacts people encounter (see chapter 3). As such, habitus formation (Bourdieu, 1977) is a continuing process and not an achievement. In addition, on the future aspect of agency, Hussein may be projecting how the future might be for him, based on the limited job opportunities he has as an immigrant, and hence may be choosing not to complain publicly or show any resistance, so that he can remain in his job for as long as he may want. Alternatively, he might be expecting that things might change in the future, where he might find another less 'humiliating' job or be exempted from 'haram' activities at the nursing homes.

However, what if he was consulted by the leader and fellow staff on his concerns? What would be different, if anything? It may obviously be difficult for leaders to change the residents' menu just to fit his religious requirements, because that may not be for the leaders to decide, as they are also working under municipal and state guidelines to meet the needs of the residents, and not those of the staff.

Looking at Hussein's experience from another angle, he has managed to adjust to the demands of his job. His religious identity has been negotiated to accommodate his desire to maintain his job. In this regard, it makes sense to agree that identity formation is a process, which is never completed, achieved or lost, but rather, individuals use the resources of language, history and culture, towards the process of becoming, rather than being (Hall & Du Gay, 2006:11,13). In a sense, identities form and reform throughout our lifetime (Holland, Lachicotte Jr, Skinner, & Cain, 2001). As far as agency is concerned, identities may be regarded as possibilities for agency, in a sense that persons may be caught in the tensions between histories, which may impinge upon them. Hussein has adapted to his new life as a Muslim from Africa, living in Norway and working in the Norwegian nursing home. He still maintains his Islamic religion, but also adjusts to the new life demands on his career (i.e. hybrid habitus). A person practicing Islam more rigidly may not understand this situation, but it is the reality for many others. This indicates that religiosity as part of cultural identity, is flexible in relation to context and situation.

Gender and daily work

Among the salient identity issues that emerged in this study, and that shape the work and working environment, is gender. In an intersectional perspective, gender is understood as an important axis of difference. In this study gender is used together with other categories of difference (skin colour, migrancy, ethnicity and religion) to analyse their intersections in the

process of minority inclusion and/or exclusion in care work. In all the wards where I was conducting my study, there were only four men, all employed as permanent staff, whereby two were from Africa and two from Europe, but no ethnic Norwegians. This could substantiate the assumption that nursing homes are workplaces dominated by women, and care work is naturalized as female (Fagertun, 2017). In one of the conversations I had with Signe, a majority staff at NH3 who has worked there for a long time (25years), I asked her whether there have been any Norwegian men working there. She said that ethnic Norwegian males usually start to work here, but as a starting point for looking for better options, and so they leave as soon as they find these. Reflecting on gender distribution in the care sector, care has always been associated with women (e.g., global care chains), who have continually occupied a larger staff composition in this sector (Giles et al., 2014; Lise Widding Isaksen, 2012; Yeates, 2004). An interesting issue, however, is the reason why immigrant men still find this type of job valuable for them, and the way they negotiate *gender norms* in this type of work.

The concept of gender norm refers to ideas, standards and expectations to which women and men generally conform within a particular society. Norms are fluid and changeable, yet also constant and something people become familiar with through socialization within a particular culture (Sallee, 2013; Sherman, 2009). Norway is a country that over the last 40 years has focused on gender equality, and through work and family policy a range of measures are implemented to facilitate men and women's equal participation in work such as for example a guarantee to have a place for children in the kindergarten (Rugkåsa, 2012). The labour market remains strongly gendered and gendered norms shape work life experiences (Orupabo & Nadim, 2019; Tingvold & Fagertun, 2020). Moreover, due to the ambition of balancing caring roles with participating in working life, a larger percentage of women opt for part time jobs, in order to contribute to the family income, while maintaining the role of domestic responsibilities. In a sense, they focus on maintaining the dual earner family norm, which is an ideal for gender equality, while simultaneously maintaining the ideal of motherhood (Bjørnholt & Stefansen, 2019; Mósesdóttir & Ellingsæter, 2017). Although there has been a big adjustment with regard to gender norms and women's increasing engagement in paid work in Norway, the situation is not the same in non-Western communities, and I must say, especially in Africa where I come from (Bourey, Stephenson, Bartel, & Rubardt, 2012; Cislaghi, 2018; Gottert et al., 2018; Mantell et al., 2009), although there are some gradual changes in the trend. Based on this understanding from my past and present experience on gender roles, especially in the African context, I purposely asked for the experience of men working at the nursing homes.

Benjamin, a minority staff member from Africa, responded to my question on how he experiences care work as a man in Norway;

> *…it is hard for me to find another job* [different from care] *in this country. So, it is okay for me, at least I have a job through which I can manage my life and my family. But, you know, this work is odd… when I travel to my country, I always tell my friends that I work in a hospital, not with the old people, because if I tell them what I actually do here* [laugh], *it is going to be a very big story there… that I am a man who cleans and feeds the old white people…*

A similar experience was also presented by Hussein:

> *… well, you know, this kind of job … is okay, but it is a bit weird …[*laugh*]… for people like us. I mean, a black masculine man like me, with a wife and children, to do this women's job of cleaning and feeding old people … sounded like a nightmare at first … I could not believe that it was me doing this kind of job … but then, I realized that it was the only option I have. I just console myself that doctors in my country do a relatively similar job of attending sick people, which I am also doing here, though in a different way …*

Both Benjamin and Hussein present the compelling factors which made them end up working at nursing homes. It seems that they both see the job at the nursing home as their only option/chance of a job in Norway, despite the fact that it is an 'odd' job for them. In such a situation they have to negotiate with their self-understanding as masculine men doing ´women´s work, thus having employment that does not align with their self-identity. Although Benjamin has a job which pays him well enough to earn his living, he perceives it as a degrading job in his conception of a relevant or prestigious job for an African man. In this case, the job is financially rewarding, while socially degrading. In his statement the phrase about 'a man cleaning and feeding' may reflect the stereotyping of care work as being for women (see also chapter 3).

Moreover, the two quotations above illustrate that gender and ethnicity intersect in positioning immigrants in labour. Care work associates the awkwardness and, perhaps, the frustrating feeling that Hussein cleans and feeds old people, just like Benjamin. Their roles would be regarded as a women's job in their country, care is feminized, unpaid work. They perceive it as 'shameful' for a 'masculine' person to do feminine work, and because of their employment they do not fit in the 'male box' of their home community (Douglas, 2003). African minority

men may experience cultural shock with regard to gender roles when entering employment in paid care labour, as also found by Hervie (2019).

The nursing homes in this study do not pay particular attention to gender differences in work task allocation. All staff are expected to take part in all caring processes in the same manner, regardless of their sex, ethnicity, religion and so forth. It was the established norm in this workplace context. Both men and women were responsible for cleaning and feeding the residents, taking on kitchen chores, and so forth. All the tasks were supposed to be distributed and shared in an equal and just manner among staff. Based on their national differences, in this study, men from Europe had relatively less difficulties adjusting to work tasks as compared to men from Africa. African immigrant men had to learn almost every work task afresh, starting from the language of care to cleaning, feeding and other related activities of care. Benjamin, a male minority staff member from Africa, mentioned that he had never worked in a kitchen before he migrated to Norway. Coming from Africa, the only son among five siblings in a female dominated family, he had never been in a situation that could force him to clean, cook for or feed anyone, because in his culture, that was women's work. Interestingly, he was one of the few minority staff who were praised by some of the residents. The context, both the Norwegian labour market and the nursing home working environment, has compelled him to learn and perform to his best so that he may secure his job and earn a decent living. One day, for example, at NH1, he came to assist one resident, who asked to be accompanied to the washroom, and when they came back, after a brief conversation with her fellow residents, I heard her saying, *"he is very smart"* [Norwegian: *'han er veldig flink'*].

However, in the other scenario, during lunch break, staff were discussing who would be responsible for baking for the next cosy Friday lunch among the staff, which they termed in Norwegian '*fredagskos'*[32]. The following was the conversation.

> *One majority staff member suggested that the same minority male staff (Benjamin) should do it, and some other staff agreed, adding that he has never participated in that. He refused the suggestion, giving the excuse that he never baked before coming to Norway, and even when he tried to do it at home on several occasions, it has always turned out badly. Finally, he said, "this is easy for females, to learn different recipes,*

[32] Fredagskos is clearly a very Norwegian thing, obviously an element of Norwegianness. In comparison to learning how to prepare and serve different types of meals, fredagskos may exemplify a greater challenge, of understanding and relating to complex Norwegian symbols.

because, in the first place, they have always been in the kitchen, so they are adding to their skills, unlike me, who has had to learn to switch on the cooker"

In analysing the above situation, I can pinpoint key gender norms for the majority culture which manifest in the nursing home working environment. In Norway, male children are socialized to take household chores equally with female children, and there is no room for having females staying home as housewives, because all have roles to play in earning a collective family living (Gullestad, 2006b; Rugkåsa, 2012). This is contrary to most of the African families, where it is more common that gender roles are tied to specific tasks for males and females. Although Benjamin has adjusted to manage some of the caring tasks, which are also part of the female gendered roles, he still finds it difficult to manage baking. As he said, when came to Norway, he did not even know how to switch on the cooker. Moreover, such a response by Benjamin, that kitchen things are much easier for the girls, may have consequences for the work relations between minority and majority staff members, such as a continued stereotype that some social activities are for majority staff while the relatively manual and physical activities related to care are for the minority staff members. This may also explain the attitude towards certain tasks among the immigrant staff and what they prefer to take part in care work.

Being a male care worker, combined with dark skin complexion, shaped negative experiences of rejection for the male minority staff. We thus see that gender, migrancy and race/skin colour intersect and create unfavourable positions for male immigrants in the feminized care sector.

The 'dark-skinned male' carers

The perspective of intersectionality can here be used in order to highlight another axis of difference which shapes work experience of minority staff - the black '*male'* minority. Skin colour was intertwined/interlocked with gender in influencing male staff inclusion and/or exclusion in care provision. The following comments from the leaders, collected through a focus group interview, may offer a good starting point for discussing this issue,

Leader: *I have some male dark-skinned employees, about whom we have received feedback from relatives, about washing private parts ... that they are against it, being done by a black man … we get most of this form of resistance related to the washing of private parts being done by male dark-skinned people ... they don't like it and they don't want their parents to be attended that way by the dark-skinned male …*

Me*: Often?*

Leader1*: Much is about this same issue. And it's hard to relate to. Because you have to respect everyone. And there are often relatives who think the best but don't know so much, who may speak on behalf of their mother, but then the mother is okay with it.*

Leader2*: Nothing special from relatives for me. With me, there are residents themselves who announce that they do not want to be attended by dark-skinned men. But not from relatives ...*

In the above, I see that black male staff at the nursing home seem to be positioned as workers in three different ways, first by being immigrants, second by being black and third by being males in the care sector, which is a dominantly female sector. Sometimes, male staff are seen as 'gender intruders' in a female-dominated workplace (Hervie, 2019). A further interesting part in the above quote is that leaders 'repeatedly' refer to 'cleaning private parts for female residents' as being awkward for either the residents or their relatives, or both. Yet, what is so special with black men cleaning residents' private parts? The concern of leaders was still an alarming issue for this study as it bears an implication on the inclusion of male immigrant staff members in work and integration processes as a whole.

In trying to understand the position of men in the care sector and their subsequent rejection, I find that race, in terms of skin colour, interlocks with gender and migrancy and creates discriminatory practices which consequently position these men at the bottom of the hierarchy in the workplace (see also Näre 2013). Historically, the ideal care worker in Western societies was a "white, middle aged, heterosexual woman with a working-class background" (Hujala, Rissanen, & Vihma, 2013:145), although this ideal is gradually changing, with a few men working in the care sector (and because immigrant women increasingly work in the sector). In particular, the situation has changed even further in other service sectors, where immigrant men now emerge as ideal workers in the cleaning industry, a sector which has historically been dominated by women (Orupabo & Nadim, 2019). The rejection of black male staff related to cleaning private parts of female residents may be linked to stereotypical images of black men as associated with crime and rape, and assumptions of having a more violent sexual nature than white men (Bitsch, 2019; Bitsch & Klemetsen, 2017; Gullestad, 2006). However, I still think this issue needs further investigation, something which was beyond the scope of this study.

Concluding remarks

In this chapter, I have explored the ways multicultural staff and leaders negotiate their daily practices within a context dominated by *Norwegianness*, and I have argued that the traditional homogeneity in the Norwegian society has taken for granted the organization and provision of care, hence created 'us' and 'them' in the nursing home working environment. The discussion has showed that the presence of minority staff challenges this taken-for-grantedness and Norwegianness of the working environment, but also that immigrants adjust to work tasks and the working environment. Cultural practices like food preparation and serving, social activities and marking of special events of the year were explored, revealing the gap for minority staff with regard to Norwegian cultural stuff (Vassenden, 2010).

The discussion also highlights *social identity processes* which emerge in the course of daily undertakings, and their implications for the organization and provision of care. I have discussed race, skin color, gender, ethnic background and religion as axes of difference that intersect and give shape to unfavorable positions both in the wider labour market and in the nursing home workplace (Crenshaw, 1990; Nash, 2008). Through an intersectionality perspective, I have shown how being an immigrant man of dark skin complexion doing women´s work breaks gender norms and its implications, and have argued that migrancy, gender and race interlock and form exclusion and unfavorable positions at the work place. I have shown the complexity of culture and identity in shaping choices and actions of leaders and multicultural staff. By highlighting overlapping identities among minority staff, and the instability of culture and cultural practices, I have argued that the social stock of knowledge is cumulative, and not a finished product, and that, the immigrant staff may acquire this knowledge to shape their agency, only if they are given time and exposure to such important cultural practices at the nursing homes. The analysis in this chapter has also highlighted the dilemmas facing leaders in planning for work, by the rejection of minority staff by some majority colleagues, residents and their relatives, especially of the dark-skinned staff in general and dark-skinned male staff in particular. Leaders face challenges facilitating engagement of minority staff into cultural practices at the working environment due to other structures which are guiding their management, such as employment regulations of minority staff which push them to the lower end of the professional hierarchy, with low work percentages. This forces minority staff to depend more on applying for and accepting any available vacant shifts which, it is considered, are more for the benefit of the institution covering the required labour force for body care at the

expense of social care, while simultaneously facilitating exploitation of immigrant staff. Other challenging dimensions could be related to knowledge of historical events that are important for many Norwegians but could be hard to learn about and understand. Food preparation and serving, although very important and discussed in this chapter, may still be seen as an easier matter.

Chapter 7: Contributions and Conclusion

Introduction

The main objective of this thesis has been to identify, describe and analyse how, in what ways, when, and where multicultural staffing informs cooperation, inclusion and communication among staff in care service delivery in the nursing homes context. More specifically, the thesis sheds light on what role the form of leadership plays in negotiating diversity at the nursing home – a workplace embedded within a larger context of the welfare state. Looking at the way work is planned and carried out in the nursing homes, I argue that the process of immigrant inclusion in work, and their resulting capacity to cope with the demand of their work does not solely depend on their cultural differentness or competency, but also other facility specific and contextual factors in which the working environment and nursing home as an institution is embedded.

The inclusion of minority staff at work, and the organization of care in the Norwegian nursing homes, is informed by a number of political frameworks both at national and municipality levels. In this study, these are identified as structures and local contexts within which care work is planned, organized and provided. These in turn, influence strategies of leaders in recruiting, including and managing staff to meet the local contextual needs of the nursing home – thus, structures and local contexts shape leaders´ agency. Tracing the process of immigrant inclusion in long term care work is a continuation of tracing global care chain trends in different western countries which benefit from the 'cheap labour' of migrants, especially of women from the poor countries (chapter 1). I have highlighted those immigrants, to a larger extent, work in the long-term care sector than in most other sectors, and that immigrants often have more vulnerable positions, frequently holding small part time positions. However, I have also shown that they do not necessarily represent 'cheap labour'. By contrast, for example, people employed at nursing homes in the UK may earn as low as one third of people working at hospitals, a difference in wage that does not exist as such in Norway. Moreover, wage differences between different types of nursing home staff may be huge in the UK while relatively low in Norway (Christensen & Pilling, 2014). Hence, the trend of hiring cheap labour may not be the main point from the employers' perspective in the Norwegian context as it is in other countries like in the UK.

At the national level in Norway, welfare policy plays a vital role in regulating inclusion and integration of immigrants while also setting standards for elderly care with regards to

organization, workforce, formal qualifications, provision, etc. Due to stiff competition in the labour market, which affect most immigrants, and the relatively low or irrelevant professional and education level of many immigrants from their home countries, many are compelled to take on work they can access as unskilled workers – such as care staff at nursing homes while others may have an initial ambition of working in this sector due to the relatively better economic and social rewards as compared to any paid labour in their home countries. In establishing what this combination of increasing immigrant staffing in the nursing home staff implicate for leadership and working environments, this thesis has highlighted the three key issues of context, communication, and culture, with regard to immigrant inclusion in work at three nursing homes. In addition to presenting these key concerns, this chapter also highlights the theoretical and practical contributions of this study, while also outlining potential policy implication for minority integration through work inclusion and improving nursing home diversity leadership. The last part of the chapter presents the limitations of the study and thereby envisions future areas for research and ends with concluding remarks.

Summary of key findings

The central concern for this thesis is to understand the way leaders and multicultural staff organize and provide care for the elderly sick in the nursing home institutions, and how immigrants are included in work. In exploring this aim through ethnographic approaches in three nursing homes, three key findings encapsulate the objective of this thesis. These key findings were analysed in the framework of agency and structure (Bourdieu, 1977, 1990). Through the use of the concepts of habitus, culture and social stock of knowledge, the study highlighted the tension between agency and structure when minority staff negotiate to adjust to the contextual needs of care practices at the nursing homes (Hays, 1994). Through this, an intersectional perspective was used to highlight multiple axes of differences which intersect to shape immigrants' experiences in their working environment (Cho et al., 2013; Crenshaw, 1990). The key findings are as follows:

- **Context: Staffing policies, allocation of shifts and exclusionary practices**
  There are several facility specific/organizational and contextual factors through which leadership practices in managing multiculturally staffed nursing homes and care organization is embedded and shaped. Facility specific factors are such as 24/7 running of the facility, while nursing homes being both working places and home characterizes contextual factors.

- **Communication: Mismatch between language competence and communication realities.**

  Although the process of immigrant inclusion in work overall stresses Norwegian language competence, spoken language is only a partial requirement for meeting social care needs of nursing home residents and fostering interactions among staff, as communication by other means also is important. In the same vein, understanding of foreign language may also play a significant role in meeting social needs for some of the residents. In this study, social stock of knowledge was established as an important aspect needed for the minority staff to be able to pick an interesting topic for conversation. Moreover, through social stock of knowledge lies important aspects of tacit knowledge and cultural competence for facilitating communication at the workplace.
- **Culture: The Norwegianness form of organization and provision of care**

  The Norwegianness, that is, majority culture taken for granted norms and values, way of organizing and delivering the care services leads to formation of 'us' and 'them' at the workplace in a number of ways, such as in cultural and identity processes. The implications of formation of ´us´ and ´them´ at the workplace include discrimination based on aspects of skin color, ethnicity and accent which influence immigrant inclusion and work processes.

On context: Staffing policies, allocation of shifts and exclusionary practices

This study has highlighted several contextual factors which shape leaders' strategies to recruit and manage staff at nursing homes. At the structural level, politics related to immigrant integration in work such as conditions for access to the country, requirements for formal professional qualifications and language competence had significant role in determining the way and levels which leaders could recruit and include immigrants in work. Staff with formal qualifications were most likely to get relatively higher work percentage positions and therefore work on stable and predictable shifts at specific wards irrespectively of majority or minority background. On the other hand, staff without professional qualifications (in positions as *assistants*) and some of the semi-professionals (*helsefagarbeidere/ licensed vocational nurses*) had lowest and unpredictable shifts, which made them to shop for extra shifts from any ward in the department. These two categorical differences influenced the way such staff could

familiarize themselves to the residents, fellow staff, and specific activities or ways of working at a particular ward. In general, this study has emphasized the way subordinated work in elderly care at the nursing home is designated to immigrants and the way immigrants negotiate their identity within this elderly care labour force (Hervie, 2019). In a sense, staffing policy – such as allocation of shifts, allocation of tasks in teamwork - favors mostly the majority staff while subordinating the minority. This is because current staff policy does not promote immigrants qualifying to high employment percentage and it sems to contribute to rejection by fellow staff, residents and relatives to the residents.

Moreover, since most of the immigrant staff migrated to Norway as adults, the demand for formal professional qualifications left some of them at the lowest level of the professional hierarchy, both in the labour market and at the nursing home as a workplace. Due to difficulties associated with acquiring those formal or higher qualifications, most of the informants to this study have given up to study further, hence ending up in a distinct category of nursing home staff with lower or no professional qualifications (see also Hervie (2019)). This study established that, the share of immigrants with either no (relevant or recognized) formal education is higher among immigrants than the majority population in the nursing homes included in this study. Moreover, the road towards formal education is more difficult for immigrant staff due to the specific requirements associated with access to education such as language proficiency and private funding. Factors such as the long time need to use on collecting hours to qualify for ´helsefagarbeider´ for the immigrant staff with small work positions made it difficult for them to advance in their career.

At the facility specific level, in addition, training was another observed issue influence immigrant inclusion in work. This is with reference to only three shifts of orientation before one is expected to perform 100% in the job. Such an arrangement could hardly be realistic to all new staff, but more difficult for the immigrant staff who come from different cultural backgrounds. In the same vein, nursing homes were observed to be busy working environments, labour intensive, while understaffed. Such situations dictated prioritization of tasks where social care came as a bonus not an important part of institutional care.

Another key issue which emerged was the acknowledgement and involvement by the staff and leaders of volunteers and relatives to the residents as the key people in nursing home care provision. This study found that the right, specifically for the relatives to the residents, to influence care at the nursing home (user participation) was sometimes a source of challenge and dilemmas facing the leaders in their efforts to achieve immigrant inclusion at the workplace.

The main issue was the rejection and mistrust towards immigrant staff from some of the relatives, which specifically involved prejudice to dark skinned minorities. Leaders were challenged to deal with ensuring sufficient staffing for each shift, while getting pressure from the relatives (and sometimes the residents) on what specific staff they considered as an ideal caring staff for them and who they rejected.

Lastly, although the welfare state has reformed elderly care through several political reforms[33], nursing homes remain labor intensive working environments. The recent policy stress on older people to live at home for as long as possible and thus strengthening home based care, has resulted in that the admitted residents to nursing homes are relatively seriously sick and in need of total care. In this regard, this study found that most of social care is given less priority at the expense of body work for the staff. This also brings forth a dilemma on the ideal staffing levels relevant to the care needs of the residents, which has to be decided by the leaders within the limits of their fixed budgets.

Drawing these key findings together, the study employed the theoretical tools of agency and structure to analyze the situated practices of leaders and multicultural staff related to the contextual realities of the nursing homes. As such, policies guiding immigrant integration through inclusion in work and policies on organization and provision of elder care, regulations and facility specific factors are governing the organization of elderly care work and immigrant inclusion in such work. Nursing homes form a ´field of practice´ (structures) within which the habitus of leaders (and minority) staff is negotiated to inform practice (agency) at the nursing home context (Bourdieu, 1977).

On communication: The mismatch between language competence and communication realities

In the politics of immigrant integration in Norway, language training is one of the basic requirements (Kulbrandstad, 2017). This may be considered as important for enhancing further social inclusion in work as well as communication for successful integration as insisted in the politics (Gullestad, 2006; Kulbrandstad, 2017; Rytter, 2019). In a sense, this political emphasis on language competency becomes the primary requirement in recruiting immigrants in nursing homes, where they must prove their language competence before their professional

[33] https://www.regjeringen.no/contentassets/196f99e63aa14f849c4e4b9b9906a3f8/en-gb/pdfs/stm201720180015000engpdfs.pdf
https://www.regjeringen.no/contentassets/af2a24858c8340edaf78a77e2fbe9cb7/omsorg_2020.pdf

qualifications may be considered. Proving their language competency is done by the leaders through formal qualification certificates and/or through interviewing before employing them. However, this thesis observed some mismatch between language competence and communication realities in the practical settings of the nursing homes. This is to say, the empirical findings revealed that communication in nursing homes, both between staff and between staff and residents, goes beyond language management, both for majority and minority staff, although to a varied degree language was less problematic for most of the majority staff. Although the basic competence requirement for recruiting minority staff at the level of municipality and nursing homes in particularly insistent on language management, the study revealed a gap between this ambition and the actual reality at the level of practice. Specifically, this study made it evident, for example, that being able to initiate and take part in a social conversation requires an additional 'social stock of knowledge' (Berger & Luckmann, 1966) in terms of language management, from which an individual may pick an interesting or relevant topic for conversation with both fellow staff and residents. Due to variations of age and cultural background among the staff, this requirement was difficult to meet, while sometimes being the reason for rejection of immigrants by the residents and even the relatives to the residents. In a nutshell, emphasizing language management with an exclusion of the cultural basis from which terms and words are constructed has revealed several challenges in communication, specifically 'language in context', which could be relevant for the residents who have lived their lives in a specific historical and cultural era. On the other hand, however, other languages apart from the emphasized Norwegian language have been observed to be the basis for creating useful social interactions for some of the residents, who happened to have life experiences outside the country, although these competences are not formerly acknowledged in the recruiting and care work processes.

Apart from verbal communication, findings of this study also revealed the importance of managing nonverbal forms of communication, especially because some of the residents had lost their communication competences in the form of utterance of clear and meaningful sentences, as a result of cognitive impairment. Responding to such forms of communication may require a form of competence, which in this study, was observed to be a challenge to some staff, both in understanding and responding accordingly. The analysis relates this challenge to inadequate professional training among the staff, especially to most of the minority staff with relatively lower levels of education (or unprofessional) which may expose them to low or lack of competences related to communication with dementia residents, in addition to a limited social

stock of knowledge from which they could interpret such language patterns. Moreover, some of the permanent majority staff were competent in interpreting such nonverbal communications of some residents based on their experience as they had worked relatively longer with them (i.e. tacit knowledge), contrary to the minority staff, who continuously shifted from one ward to the other, applying for extra vacant shifts to complement their low work percentages.

By using the concept of habitus, and specifically ´linguistic habitus´ (Bourdieu, 1991), I have shown how communication is dependent on many different factors and, I have analyzed the way language competence relates to the accumulation of social stock of knowledge through continued socialization to inform agency of the immigrant staff in communication processes (Ahearn, 2001; Emirbayer & Mische, 1998).

On Culture: The Norwegianness form of organization and provision of care

In this part of the thesis, I argue that the way elderly care is planned, provided, and managed in the nursing homes reflects the typical Norwegian way of doing things, starting from the architectural design and interior decorations, meal preparations and serving, social activities and celebration of important markings of the year. By the term ´Norwegianness`, I draw on the understanding of Vassenden (2010), Gullestad (2006) and Rugkåsa (2012), and use it as an analytical tool for explaining the taken for granted aspects of care, work and communication. Minority staff recruited in these working environments need to learn such ways of work and doing things because some happen to be extremely different from their previous socialization. Again, being able to learn new cultural practices, depends greatly on the exposure of a person to a particular practice to be able to observe and take part in several repeated and regular opportunities. However, this was difficult for most of the minority staff who had relatively fewer shifts and hence lagged behind in initiating or engaging in relevant social activities. Moreover, the rigidness in doing things the 'Norwegian way' at the nursing home was often the source for the emergence of an 'us' and 'them' categorization among the Norwegian and non-Norwegian or western and non-western staff. ´Us´ and ´them´ categories is understood in this study as an area of dichotomy presenting differences between Norwegians and non-Norwegians at work (Vassenden, 2010). This dichotomy is evident through identity processes discussed in frameworks of culture, gender, skin color and ethnicity. However, the study established some identity issues also were revealed in this matter, especially in relation to skin color, gender and ethnic background. Identity is understood as a social construction through which individuals

and groups of people are distinguished in their social relations with other individuals and groups (Jenkins, 2014), and used in this thesis as a means to analyze the axes of differences intersecting to shape immigrant experiences and inclusion and/or exclusionary practices at work Categorizations were grounds for discrimination against the minority staff, either by residents and their relatives, or fellow staff, through the 'us' and 'them' construction embedded in Norwegian cultural practices and normalized work processes at the nursing homes. Specifically, some minority staff would face single, double, or triple minority status depending to the way they were identified by others at the workplace. Firstly, by being a foreign staff from wherever outside Norway, followed by being a foreigner with or without observable distinctive skin color (black or dark skinned), and lastly being a dark-skinned male, would all play their part in acceptance or rejection in various forms and contexts.

In the analysis of this key finding, an intersectional perspective (Cho et al., 2013) was used to present the way axes of differences acted together in shaping experiences and positioning of minority staff and influence their agency and positioning the workplace as they adjust to work in the nursing homes characterized with Norwegianness ways of organizing and providing care. Such intersecting axes included gender, race, skin color and ethnic background, which framed experiences of rejection and discrimination against the immigrant staff by the residents and their relatives (sometimes even by the majority staff).

Practical implications for nursing home leadership and immigrant inclusion in work

This study took place in nursing homes. In Norway, such institutional settings are differently organized between different municipalities (Ågotnes, 2016). In this regard, the outcomes of this thesis practical implications are more specific to the nursing home settings, although I do see the potential for its applicability in other practical workplaces, where work is based on commonly shared routines and procedures involving people with different cultural backgrounds. At a more abstract level, this study may also offer a contribution by informing policy gaps. There are three key practical contributions arising from this thesis:

As a first contribution to practice, this thesis highlights the need for re-direction of the immigrant integration and labour policies to fit specific contexts. Norway depends significantly

on increasing recruitment of immigrants in the elder care sector. This calls for investment in leaders' competency in managing the resulting culturally diverse workforce, although some studies have also commented on this essence (Lindheim, 2020; Munkejord, 2019). I have highlighted this need by discussing the challenges and dilemmas facing leaders in managing multicultural staff, as a result of labour deficiency amidst institutionalization of older people who have significant healthcare needs. Such factors as the rejection and discrimination of immigrants by fellow staff and residents, immigrant staff poor participation in social activities, and the constant need for shopping extra shifts among the minority staff, may indicate that integration policy does not reach all the way down to practices at the workplace. In addition, the leaders stated explicitly that they have general leadership training, but nothing in particular when it comes to multicultural staff. For them, this was identified as a challenge, leading without paying attention to cultural diversity matters. Moreover, lack of formal training on managing cultural diversity among the leaders emerged in this thesis as one of the reasons for differences in leadership practices and forms of leadership. As for example, while the leader at NH1 insisted on collective lunchtime in one common room which would allow for interaction among all staff members under her presence (if at the office), the leader at NH2 was even hardly having a lunchbreak with the staff, who would have it either in the ward at the nurse station or in the canteen; and the leader at NH3 would motivate staff members to have lunch in the canteen, but taking turns so that the residents are not left alone. To have a standardized form of immigrant inclusion, I suggest that municipalities develop their own inclusion and diversity policy for managing their multicultural staffing.

This thesis also contributes to the research literature on multicultural work environment realities and challenges. In Norway, for example, there is an increasing research on this matter (Fagertun, 2017; Gullestad, 2006; Hervie, 2019; Lise Widding Isaksen, 2012; Tingvold & Fagertun, 2020), although still few, especially on leadership of multicultural staff in nursing home contexts such as (Lindheim, 2020; Munkejord, 2019). This knowledge is not only relevant to Norway, but also to many other western societies, which depend highly on immigrant recruitment in the elder care sector, particularly nursing home institutions (Dodson & Zincavage, 2007; Giles et al., 2014; Walsh & Shutes, 2013) (see chapter 1). In my study, I have explored both the way multicultural workforce can be an advantage and the way it may pose challenges in organization and provision of care, both for the leaders and staff. Specifically, this study has shown the way minority staff may also be resourceful by giving extra service over and above what are considered official requirements, such as language skills, especially

for the crucial times when non-Norwegian residents are admitted, apart from the formalized Norwegian as a working language. This, and other identified strengths, may be formalized and acknowledged as important competences in recruiting immigrants for care work, rather than only focusing on preserving the majority norms and ways. This would create an attunement to diversity which, as I observed it, does not exist at the current moment.

Throughout the analysis chapters, my contribution is on the ongoing staffing level and skills composition in nursing homes, a question raised in different studies (Ågotnes, 2016; Jacobsen & Mekki, 2012), and the way they relate to the reality of the required task accomplishment in a 24/7 work shift organization. Although there are no definite regulations on what minimum or maximum staffing in nursing homes should entail, this did not necessarily mean that there does not exist unwritten norms about appropriate staffing level, or that leaders and staff are exempted from regular hectic shifts. Leaders, responding to organizational and budgetary factors which are determined by higher authorities, do have choices when recruiting and arranging for sufficient staff to cater for both physical and social needs of residents. The employment of part time staff with very low work percentages, although it may be budget efficient, has also revealed the unpredictability of staffing compositions per shift and impacts on possible planning for social activities. Specifically, I have highlighted the challenge faced by leaders when municipal staffing policy is paired with immigrant recruitment, such as the complaint from the residents and relatives on the cultural incompetence of the minority staff on one hand, while on the other hand, the limited chances of learning new cultural practices at work in the field due to relatively lower shifts. This is both a political and practical question. It is political in the sense that it has everything to do with exactly what immigrant integration is all about, national budgets for training, and the national qualifications approval processes for immigrants. At the practical level, this is about the way work is organized around the shift at the nursing homes, the time allocated to orient staff in various residents and their specific needs and relevant activities, and so forth. Furthermore, it is also about immigrants and their opportunities for inclusion in work and for earning a decent living wage.

Theoretical and methodological contribution

The foundation for my theoretical contribution to the research field is a combination of theoretical concepts in analyzing multicultural staffing and leadership forms related to work practices in nursing homes. I argue in that as a theoretical concept, agency should continue to be explored and applied and that it could potentially benefit from a wider range of other

theoretical perspectives. The theoretical framework used in this thesis contributes to existing understanding of agency in explaining activities of actors in a number of dimensions, both from the leaders and the rest of the staff, as well as from the organizational and contextual stance. In exploring agency of leaders and staff with focus on cultural differences, I have employed an intersectionality perspective to understand the way care work is negotiated within the overlapping and interlocking of social categories such as gender, race, and migrancy. Although research specifically has focused on discussing intersectionality either at an individual level (Crenshaw, 1991) or from the institutional point of view (Seeberg, 2012) this study has tried to bring both analytical levels into play, by highlighting how individual identities overlap/ are tied together with institutional practices to influence opportunities and choices.

Methodologically, through the study design of ethnographic fieldwork grounded in a 'bottom-up' approach, this study has highlighted leaders' experience of managing multicultural staff and important aspects of multiculturally staffed working environment. The ethnographic study employed in this thesis has made it possible to explore and come up with a comprehensive picture from the perspective of the leaders and staff on one hand, through their narratives, and the care service practices through participant observations in daily work processes on the other hand. Most of the studies in this thematic field study leadership separately (Dahle & Seeberg, 2013; Kristiansen, 2016), and majority and minority experiences separately (Christensen and Guldvik 2014, Hervie 2019, Munkejord, 2019), and are mostly based on data from individual and focus group interviews. This study took the approach of including all three parties mentioned above simultaneously, and it thus adds the benefit of including participant observation to explore what people may narrate in the interviews. In addition, this study included staff at all levels, that is, skilled, semi-skilled and unskilled. Moreover, the aim of this study was not to measure an effect of some planned interventions, as is the case for many studies in the health sciences field (Albarqouni et al., 2018; Bowling, 2014), but rather to explore both leaders and staff experiences of working in a multicultural environment. As such, the study benefited from the inspiration of institutional ethnography (Lundberg & Sataøen, 2019; Smith, 2005), an engagement which allowed for thicker understanding of nursing home as a ´place of study´ and from the position of the staff. Employing an ethnographic approach inspired by institutional ethnography, the study was able to gain a comprehensive understanding of implications and consequences of the minority staff´s positioning at the nursing homes in negotiating work tasks. Moreover, from a ´bottom-up´ approach, this study benefited from the

importance of investigating social realities from a standpoint and a position in an institutional landscape.

Limitations of the study and suggestion for future research

Since this study aimed primarily to include leaders and other staff as respondents, I have mentioned earlier that it became obvious that I could not completely exclude and ignore the nursing home residents because they were the central focus for what leaders and staff were doing. In this regard, most of the empirical data involved the way work was negotiated with residents as a point of reference. Moreover, the study involved three nursing homes as case studies. Therefore, this study faces the limitation in terms of ability to generalize, because it includes only few nursing home units. Yet the study has the advantage of including many informants, spending a long time in the same place getting to know people and discover important connections to inform the study.

My position/ the way I positioned myself, and the way I was ascribed roles in the nursing homes could also pose a limitation in this study, related to my own cultural background. Being an immigrant of 'black' color, in the working environment dominated by 'white' majorities, some of whom disliked black people (see chapter 4 &6), was the reason for stepping back in moments when I felt that I was not welcomed during my fieldwork. This is a methodological challenge in participant observation that the researcher is dependent on the role she is given in the local community where she stays for fieldwork (Corbetta, 2003; Crang & Cook, 2007; Spradley, 2016).

The empirical findings presented in this thesis have revealed several issues with regard to the interplay between elderly care and welfare politics, multicultural staffing and leadership practices. Some of these issues are worth further exploration as discussed in this section.

Although there exist a few studies on leadership of multicultural staff at nursing homes in the Norwegian context, such as the study by Lindheim (2020), there is a need for more such studies both in Norway and other Western countries which recruit immigrants in elderly care so as to extend the understanding of leaders' experiences on leading a culturally diverse workforce, and its consequence on organization and provision of care. This is to acknowledge the contextual specificity of qualitative studies, which are not for generalization purposes, but for understanding, and perhaps comparing actors' actions in specific practical contexts.

Concurrent with the above, since research and policy inform each other, more research is needed to bridge the gap between policy makers and researchers. Specifically, by paying attention to the contextual needs in elderly care in nursing homes and the labour market, as identified by researchers, rather than exclusively focusing on the general policies focusing on healthcare and the welfare state, which do not necessarily attend to the realities of care in nursing homes and the consequent dilemma facing the leaders. From the empirical findings of this study and from literature reviews, it became obvious that there is very little specific researched information regarding the quality of caring relations between minority staff and nursing home residents based on cultural misunderstandings in the Norwegian context. This also extends to their relationships with leaders and other majority staff.

Finally, this study has encountered some aspects related to different forms of discrimination at the workplaces. The issue of discrimination against skin color and gender facing minority staff had not been comprehensively addressed by the leaders, causing unfriendly work relationships among the minority and majority staff, nor has it been specifically addressed in research on working environment at nursing homes in Norway. This study therefore shows the existence of racism in workplaces, specifically highlighting issues of dark skin colored staff, and the need for further investigation, since it is considered as *the* topic which is always silenced in the Norwegian political debates (Gullestad, 2006).

Concluding remarks

This thesis has presented a theoretically and empirically informed interpretive and critical study on the interplay between elderly care, leadership practices, multicultural staffing and labour integration politics of the welfare state in everyday work practices of the three nursing home contexts. The study is empirically based on leadership and everyday care work practices in eight wards of three nursing homes in Norway. within an overall theoretical framework of agency and structure, the temporal view of human agency and habitus formation (Ahearn, 2001; Bourdieu, 1977, 1991; Emirbayer & Mische, 1998; Hays, 1994), complimented with an intersectionality perspective (Cho et al., 2013; Crenshaw, 1990) and a perspective on implicit ideas on leadership (Lindheim, 2020; Schyns & Meindl, 2005), have been applied in order to analyse patterns and significant elements of the way daily work is planned and negotiated among leaders and multicultural staff in a way that does not privilege deterministic ideas. Leadership and daily work practices among the multicultural staff were analysed to understand the facility specific and contextual factors guiding immigrant inclusion and care provision

(chapter 4); the role of language and social stock of knowledge in communication processes (chapter 5); and the identity processes and construction of 'us' and 'them' in the dominant Norwegian culture of care organization (chapter 6). In sum, I argue that by exploring the interplay between leadership practices and multicultural staffing, this thesis contributes to future debates about immigrant integration through work inclusion in the elderly care sector and about the management of culturally diverse staff.

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Appendix A: Request for fieldwork

INVITASJON TIL DELTAKELSE I STUDIEN *The role of cultural consciousness and knowledge development in managing multicultural staff in Norwegian nursing homes*

Senter for Omsorgsforskning Vest ved Høgskulen på Vestlandet (tidligere Høgskolen i Bergen) leder og skal gjennomføre et forskningsprosjekt om rekrutteringsprosesser, inkluderingstiltak og arbeidssituasjoner ved norske sykehjem. Dette i lys av at en økende andel av pleiere/tilsatte ved sykehjemmene kommer fra andre land enn Norge - med de utfordringer og muligheter dette kan innebære.

Jeg ønsker å observere og etter behøv følge opp med individuelle intervjuer av sykepleiere, helsefagarbeidere/hjelpepleiere, assistenter og tilkallingsvikarer som opprinnelig kommer fra andre land enn Norge, det være seg som arbeidsmigranter, flyktninger, ekteskapsmigranter eller annet. Jeg ønsker også å observere samhandling mellom avdelings-/virksomhetsledere og de ansatte generelt og jeg kommer til å stille spørsmål også om bakgrunnsdata

Data materiale vil bli tatt opp på bånd og notatbok, og behandlet konfidensielt. Svarene dine vil sammenfattes med svarene fra de andre intervjuene, og det vil ikke være mulig å kjenne deg igjen publikasjonene. Lydopptakene skal slettes innen prosjektslutt. Det er frivillig å delta i studien. Du kan trekke deg underveis når som helst og uten begrunnelse.

Min studie inngår som en del i et større forskningsprosjekt finansiert av Norges Forskningsråd. Prosjektets overordnede tittel er «Multicultural workforce in Nursing Homes: Contemporary challenges, opportunities and potentials for the future in the Norwegian municipal care sector» (MULTICARE). Studien er godkjent av NSD (Personvernombudet for forskning).

Takk for hjelpen!

Appendix B: NSD Feedback and approval

Frode F. Jacobsen
Senter for omsorgsforskning, vest Høgskulen på Vestlandet Postboks 7030
5020 BERGEN

Vår dato: 15.03.2017 Vår ref: 52258 / 3 / BGH Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 17.01.2017. Meldingen gjelder prosjektet:

52258

Behandlingsansvarlig Daglig ansvarlig

Kunnskap og trening av leiarar for multikulturell stab (Improving leadership of multicultural staff: an implementation study)

Høgskolen på Vestlandet, ved institusjonens øverste leder Frode F. Jacobsen

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 31.12.2019, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Kjersti Haugstvedt

Kontaktperson: Belinda Gloppen Helle tlf: 55 58 28 74 Vedlegg: Prosjektvurdering

Belinda Gloppen Helle

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

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NSD – Norwegian Centre for Research Data | NO-5007 Bergen, NORWAY | Faks: +47-55 58 96 50 | www.nsd.no

Personvernombudet for forskning

Prosjektvurdering - Kommentar

INFORMASJON OG SAMTYKKE
Formålet med prosjektet er å utvikle og pilotere et undervisnings- og veiledningsopplegg i forhold til kunnskap og trening av ledere i sykehjem for en multikulturell stab.

INFORMASJON OG SAMTYKKE
Utvalget (ansatte, ledelse ved sykehjemmet, beboere og pårørende) informeres skriftlig og muntlig om prosjektet og samtykker til deltakelse. Informasjonsskrivet er godt utformet, men det bør legges til at datamaterialet skal oppbevares frem til 31.12.2021 for mulige oppfølgingsstudier.

DATAINNSAMLING
I følge meldeskjemaet skal datamaterialet samles inn ved bruk av personlig- og gruppeintervju og deltakende observasjon. I epost og i telefonsamtale med forsker, datert 15.03.2017, er det avklart at det ikke skal registreres personopplysninger om beboere/pårørende under observasjon.

Selv om det ikke behandles/registreres personopplysninger om beboere/pårørende under observasjon kan det være nødvendig å signere en taushetserklæring i forbindelse med observasjonene. Det er opp til prosjektleder å avklare dette med aktuell myndighet.

Personvernombudet forutsetter at prosjektet er klarert og godkjent av sykehjemmets ledelse.

TREDJEPERSONER
I forbindelse med intervjuene kan det fremkomme sensitive opplysninger om tredjepersoner (ansatte med multikulturell bakgrunn). Behandlingen anses nødvendig for formålet, da det i mange tilfeller vil

være vanskelig for informanten å besvare spørsmålene uten å identifisere involverte tredjepersoner. Vi forstår det slik at fokus vil være på informanten og dennes opplevelser. Vi forutsetter at det kun registreres opplysninger som er nødvendig for formålet med prosjektet, og at disse anonymiseres fortløpende så fremt det lar seg gjøre. Vi gjør oppmerksom på at forsker i utgangspunktet har en informasjonsplikt overfor tredjeperson dersom personidentifiserende opplysninger skulle fremkomme og bli registrert. Personvernombudet finner derfor at opplysningene kan behandles i henhold til personopplysningsloven § 8 d) og
§ 9 h). Personvernombudet forutsetter at tredjepersoner informeres i den grad det lar seg gjøre.

TAUSHETSPLIKT
Ansatte ved sykehjemmet og ledelsen har taushetsplikt, og det er viktig at intervjuene gjennomføres slik at det ikke registreres taushetsbelagte opplysninger om
enkeltbeboere og deres pårørende. Vi anbefaler at dere er spesielt oppmerksom på at ikke bare navn, men også identifiserende bakgrunnsopplysninger må utelates, som for eksempel alder, kjønn, tid, diagnoser og eventuelle spesielle hendelser. Vi forutsetter også at dere er forsiktig ved å bruke eksempler under intervjuene.

Prosjektnr: 52258

Personvernombudet legger med dette til grunn at dere ikke innhenter personopplysninger om pasienter eller deres pårørende, og at taushetsplikten ikke er til hinder for den behandling av opplysninger som finner sted.

SENSITIVE PERSONOPPLYSNINGER
Det behandles sensitive personopplysninger om etnisk bakgrunn eller politisk/filosofisk/religiøs oppfatning.

INFORMASJONSSIKKERHET
Personvernombudet legger til grunn at dere behandler alle data og personopplysninger i tråd med Høgskolen på Vestlandet sine retningslinjer for innsamling og videre behandling av personopplysninger. Ettersom det skal behandles sensitive personopplysninger, er det viktig at dere krypterer opplysningene tilstrekkelig.

PROSJEKTSLUTT OG ANONYMISERING
Forventet prosjektslutt er 31.12.2019. I epost og telefonsamtale med forsker er det avklart at informantenes kontaktopplysninger skal lagres frem til 31.12.2021 for mulige oppfølgingsstudier.

Innen 31.12.2021 skal innsamlede opplysninger anonymiseres. Anonymisering innebærer å bearbeide datamaterialet slik at ingen enkeltpersoner kan gjenkjennes. Det gjøres ved å:
- slette direkte personopplysninger (som navn/koblingsnøkkel)
- slette/omskrive indirekte personopplysninger (identifiserende sammenstilling av bakgrunnsopplysninger som f.eks. bosted/arbeidssted, alder og kjønn)

- slette lydopptak

Vi minner om at mulige oppfølgingsstudier må meldes til personvernombudet minst 30 dager før oppstart.

Appendix C: Interview Guide – Immigrant Staff

Interview Guide

Topic: The Role of Cultural consciousness and knowledge development in managing multicultural staff in Norwegian Nursing homes

**Before the start of every interview, researcher will discuss issues of consent and other relevant information with participants.*

Introduction: (explore the route of the participant to Norway)

- How did you come to Norway?
- How did you know about this country?

Work:

- What is your professional background? Where did you get it from?
- How did you get employed in this place?
- What is your experience as an immigrant staff in this working place?
- What is your experience with your leader?