

# The co-creation of situated knowledge

Facilitating the implementation of  
care models in hospital-based home care

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In recent decades, it has become standard for health care, both medical treatments and nursing praxis, to be based on research, so-called evidence-based care. Healthcare has increasingly come to operate on an evidence-based paradigm, with its rationale that research should have a stronger position. This applies not only to changes in treatment routines, but also to views on how patients and their relatives should be treated, and what constitutes the best, most appropriate care. The implementation of research-based knowledge in care praxis has proved difficult and cannot be said to happen by itself. It is therefore crucial to further develop existing implementation methods, in order to facilitate the application of research findings in practice by integrating them into existing care praxis (Barrett 2004; Saetren 2005; Richards & Rahm Hallberg 2015).<sup>1</sup>

Thus, the research-based knowledge to be implemented in a healthcare setting amounts to an ontology of sorts, which brings with it certain ways of considering such entities as healthcare, patients, treatment, and so on (Law 1996; Mol 1999, 2002). A consequence is, when research-based knowledge is to be put into daily practice—when the research model is to be translated into care practice—there is a risk that differences of opinion will arise if these

findings are misunderstood, obstructed, or result in unintended practices; dissent then becomes apparent when implementing new care models, where research-based knowledge conflicts with the values behind the health professionals' existing practices, habits, and ideas (Nilsson et al. 2018).<sup>2</sup>

This chapter explores the potential of using ethnographic methods to support medical personnel who are in the process of replacing existing practice with a new research-based care practice—in other words, when an new evidence-based care model is operationalized (see also Woolgar 1988; Ashmore 1989; Bragesjö 2004). The method presented here centres on offering support to the member of the medical team who is to facilitate the actual implementation—the so-called facilitator—so the team can better understand the processes at work (Tiberg et al. 2017). The purpose is to highlight how ethnographic methods can make the facilitator's task of driving the implementation easier.

### Research-based, evidence-based

Before describing the ethnographic method, the project and the importance of implementation in the healthcare sector will be discussed by addressing the growing interest in scientific evidence (see Irwin in this volume). Internationally, there has been a move towards evidence-based healthcare in recent decades (Bohlin & Sager 2011; Richards & Rahm Hallberg 2015). This is in part because evidence-based healthcare is thought to promote equitable, high-quality care by reducing variations in healthcare provision, which might otherwise leave some patients without access to the best available care. Another reason is that there is a gap between healthcare praxis and the research findings that are available, which leads to care that is less effective and, at worst, harmful to the patient (Svensk sjuksköterskeförening 2016). This is the case made by the WHO (2006), concerned by the challenges facing health services because of increasingly stretched resources.

The example presented here is an evidence-based care model

designed to promote alternative learning outcomes for families with a child recently diagnosed with diabetes. In the study that forms the basis of the model, families felt satisfied with the care and information about diabetes and its treatment they received while they were in hospital, but problems arose when they were discharged. Once home, they felt that what they had learnt was inadequate in the home environment (Wennick 2007). In response, a new care model was designed and tested that is better suited to the various families' daily lives, specifically to improve the families' ability to care for children in a way that maintained good blood sugar control over time. This new evidence-based care model was termed hospital-based home care.<sup>3</sup>

Closely focused on each family's needs, hospital-based home care is a tailored adaptation to lifestyles and habits, designed to help families rapidly and successfully integrate diabetes care into their everyday lives. The defining property of the care model is that it should be possible for families to sustain routines learnt in the initial phase of the disease over the long term. This is achieved by healthcare staff helping parents and children learn on their own terms, rather than by overwhelming them with facts according to a predetermined script. Healthcare professionals have a long tradition of being the experts on how to manage diabetes, but have often operated on the assumption that families will simply follow instructions and adapt their lives to suit the information and advice given. However, patients and families do not always choose to do so; instead, they do what fits their own lifestyle. Hospital-based home care is about trying to improve on this approach so that medical personnel listen to the needs of individual families, and concentrate on supplying the necessary information. Doing so together families and professionals can find a way to manage insulin therapy that both maintains a steady blood sugar level and is within the bounds of reason for the family and child to adapt to (see Hansson in this volume). Hospital-based home care is therefore predicated on families themselves asking for the information they need to manage a range of everyday situations,

and learning from others' experiences, putting that information into practice (Tiberg 2012).

What does this new approach demand? It can involve learning how to calculate the right amount of insulin relative to what the children have eaten and how much exercise they have taken that day, how different foods affect the child's blood sugar levels, and how to reverse an episode of low blood sugar. The ambition is that families should stay in hospital no longer than necessary to stabilize the child's blood sugar levels. When they feel ready, they should be given every opportunity to return home to learn how to handle their new situation in a home setting. Hospital-based home care is thus intended to organize healthcare in a way that makes diabetes care more accessible.<sup>4</sup>

The model has been evaluated in a randomized controlled trial by a health science research group, comparing hospital-based home care to existing diabetes care (Tiberg 2012). The study established that the use of hospital-based home care was associated with positive outcomes. Parents were reportedly more satisfied with the information they received, and in addition there were health economic benefits. The study also found that fathers showed a greater, lasting involvement in the child's care. As it was a randomized controlled trial, hospital-based home care thus approaches what in healthcare would be considered an evidence-based model. In other words it is the healthcare model which, based on the available research, could be considered the best suitable paediatric diabetes care practice for those with a new diagnosis.<sup>5</sup> The model can also be said to meet modern healthcare standards, as patients are given greater opportunity to influence their own care (participation) while also being given more responsibility for their own health (self-care) (Nordgren 2009; Alftberg & Hansson 2012). The operation of hospital-based home care can thus be understood as a way of organizing healthcare in a manner that reflects a certain understanding of what modern healthcare is, central to which are opportunities for the rationalization and prioritization of the healthcare sector's finite—and thus limited—resources. In consultation with the research group, the

hospital where the study had been conducted decided to proceed with the implementation of hospital-based home care.

When the ambition is to offer patients evidence-based care, it is essential that the care model itself—here, hospital-based home care—with its necessary modifications to organizations and care methods, is translated into care practice. This often requires complex changes to be made to healthcare operations on many different levels. Implementation being a slow process, the changes are unlikely to be immediate or even apparent, and that merely adds to the complexity. The personnel in, say, an endocrinology department first need to be made aware of how they currently handle patients and their relatives, before gradually changing how they go about it. Since it is difficult to change everyday healthcare practices, there is a focus in implementation research on what prevents and promotes change (Rycroft-Malone et al. 2013). The ability to see not only the opportunities, but also the stages and challenges of any implementation process, is crucial to realizing change and improving the care on offer (Nilsson et al 2018).

This chapter is not concerned with the various steps involved in implementation, but rather how the ethnographic method can be used to support the changes that implementation entails.<sup>6</sup> We set out a method with which to identify the less successful implementation processes and the differences of opinion that can otherwise mount up, presenting the organization with challenges. The ethnographic method was applied as two ethnologists—Kristofer Hansson and Gabriella Nilsson—observed healthcare staff meetings where the implementation of hospital-based home care was discussed, while a medical team facilitator—Irén Tiberg—was present to support the process of change. Hansson and Nilsson subsequently observed clinical encounters between medical staff, patients and their relatives.

## Diffraction and ethnographic methods

We argue that linking traditional ethnography to the theoretical concept of diffraction (see also Haraway 1988, 1992, 1997; Barad 2007; Johnson 2020) offers a fruitful method with which to examine

the implementation processes of evidence-based healthcare practices. The term diffraction is taken from physics, and describes how light, encountering an obstacle, spreads out rather than propagating in a straight line. Similarly, an implementation process can be understood as diffractive, with a variety of understandings made visible during the process. Instead of focusing only on the anticipated and desired processes of change and on the difference that is thereby generated, with the diffractive method the ethnographer can identify the various forms of differentness present (Jackson & Mazzei 2012; Wiszmeg 2017). This differentness is actively evoked when ethnographer and facilitator together problematize the implementation process. The method highlights that knowledge is not a one-sided entity, but rather, as the ethnologist Andréa Wiszmeg notes, something ‘highly situational and fluid, with varying durability’ (2017, 74).

How, then, to translate the theory into actual practice? There is a risk in assuming the facilitator’s task is limited to communicating the care model to the healthcare personnel who are then to change their care practices. Applying the diffraction method, however, makes it possible for the ethnographer to be involved in the various relationships that constitute the implementation process. Through these relationships, we argue, new knowledge can be generated with which to understand the ongoing processes (see also Winther 2017).

Metaphorically, the method can be likened to the ethnographer holding up a lantern in a dark room (Barad 2007, Wiszmeg 2017).<sup>7</sup> In this metaphor, there are two ways for the ethnographer to hold the lantern: holding it still, the light can be used to study the room while moving around; swinging it about, the lantern itself and the play of the light come into focus. The first way to hold the lantern can be compared to traditional ethnography, where the ethnographer studies the cultural expressions that appear in a specific context; the second way makes the lantern—the implementation—the object of the study, not just the means of the study. Swinging the lantern makes it possible to see not only the implementation process, but the various actors’ understandings and knowledges of the process.

The lantern's sweep is what results in the dissemination of different knowledge, as Wiszmeg writes:

This takes into consideration how the participants hold, in a metaphorical way, the ethnographer firmly or loosely, but also what kind of knowledge they gain by doing so and what they can set in motion. If we presuppose a boundary between the ethnographer and the 'other', we should remember that the ethnographer is not only holding, but is also being held. Much like the ethnographer, the 'other' will use the research situation to explore the world surrounding them, together as well as separately. The researcher, too, will be the researched. (Wismeg 2017, 76)

From this perspective, not only is there a reflexive approach to the implementation under study, but—or perhaps instead—the ethnographer, together with the facilitator, forms—and evokes—a situated knowledge (Haraway 1988). This is not knowledge in terms of the ethnographer being a neutral observer of an ongoing process, but knowledge arising from situational relationships of which ethnographer and facilitator alike are part. Ethnographically speaking, the diffractive method creates knowledge, which, as Wiszmeg (2017) points out, is the result of both reflection and a disruptive process (see also Mellander & Wiszmeg 2016, 103). Wiszmeg therefore argues that 'It is part of the ethnographers' quest to trace the differences that matter in the subsequent interference patterns' (Wismeg 2017, 78).

How can this be done methodologically? In our case the method consisted of many different steps. The ethnographers were present in the initial phase of the process to observe the staff meetings at which the facilitator first presented and discussed the planned implementation. After every meeting, the ethnographers wrote down their observations, and the facilitator read and commented on the texts. Through this reading, a positional shift was made possible where the ethnographers no longer studied a defined object, but together with the facilitator explored the ongoing process of

implementation. It is primarily this material that is presented in this chapter. Subsequently, based on joint experiences from the ethnographic material, two interviews were conducted with the facilitator in order to further explore the possibilities and limitations of the implementation—of swinging the lamp rather than holding it still. The entirety of the collected material shows how ethnographers and facilitator together sought new experiences, so increasing the understanding of this particular ongoing implementation process. For the purpose of this chapter, two themes have been selected where these processes were especially evident.

### The daily business of implementation

Applying the diffractive ethnographic method, two empirical examples have been selected where the ethnographers and the facilitator together created a new understanding of the implementation process. These examples, representing situations of ‘messiness’ and ‘vagueness’, highlight how the facilitator was given the opportunity to actively relate to the processes that had been initiated.

#### *Messiness*

The first meetings the facilitator held with the paediatric diabetes care teams that were to implement hospital-based home care, can be viewed as a learning process. This learning process not only included the presentation of a new way of thinking about care and clinical encounters, but was also a negotiation (Fixsen et al. 2005). In order for a sustainable change to come about, it is crucial that from the first there should be an understanding of how and why the change should be implemented, as well as a desire for change (Weiner 2009). For this reason, it is crucial that time is allocated for in-depth discussions between all the personnel involved and the facilitator, and that the latter is being alert to the assumptions and *modi operandi* that the new evidence-based model might call into question. This matters particularly if the model is likely to challenge working methods that



are the basis of the staff's professional identity (Nilsson et al. 2018). Previous research within the project indicates that this is often a very demanding process for the facilitator (Tiberg et al. 2017).

In implementing hospital-based home care, the facilitator began by holding regular information meetings with personnel from two hospital departments (here called Team I and Team II). The teams consisted of different professional categories: paediatricians, paediatric nurses, dieticians and social workers. The aim was both to inform them what the new model would entail in terms of actual care methods and to negotiate a constructive approach to the implementation of the change. At the information meetings, it became clear that staff shortages were felt to be an obstacle to implementation, but equally that staff initially found some of the fundamentals of the model problematic—earlier discharge from hospital, for example. Here it was important that the facilitator gradually changed her way of communicating with the staff in order to mitigate what they saw as ambiguities and contradictions, and to prepare them mentally and emotionally for the changes to come. The latter has been singled out in implementation research as 'readiness for change' (Weiner 2009).

In order for the facilitator to fully relate to what happened at the staff meetings, not only were the ethnographers present as observers, but their resultant ethnographic texts were made available to the facilitator, which she read and annotated. This enabled her to relate to the ethnographic descriptions in the course of the project. The example here is of an observation, commented on by the facilitator, which concerned the departments' prospects for change. At this point, the discussion had turned to staff shortages in the health service in general, and in the departments in particular, as the reason why it was difficult to implement all the changes they wanted to see. Here this change was about one form of patient monitoring they wanted to try in both Team I and Team II:

The discussion changes direction, and now there is a conversation about staff shortages in the hospital and that staff are finding it

difficult to arrange cover because they are so short-staffed. At the same time, the hospital has imposed a recruitment freeze on all departments and clinics. I was a little unsure about the transition between the various discussions at the meeting, but think it is the senior consultant who changes the topic the group is talking about. Suddenly they are discussing who should do what about the most recent patient monitoring when staff shortages are so severe. It is the senior consultant who drives the discussion, and everyone seemed to agree. One of the nurses tried to solve the immediate practical problem by saying that as she was not working 100 per cent she could increase her hours if it would help. They conclude that there is no solution to be had, but the discussion has at least raised the problem. It is very clear, from my perspective, that Team I is in a difficult situation.

The facilitator's comment upon reading: Spot on—it's like a fog smothering the team's whole being, at the same time as what is said in this discussion is hollow words. The same views have existed the same way for the 13 years I have been in the team, and although the situation has gradually deteriorated and never been as bad as it is now, words have become pretty much meaningless. There is a resignedness about it all—we cannot influence the situation but still have to try and find solutions and continue the business of improving.

By being present from the start, the ethnographers had the chance to capture how the discussion about the implementation of hospital-based home care was introduced, and what opportunities and limitations the personnel identified. These opportunities and limitations did not necessarily have anything to do with the implementation itself, as seen here, but as readers of this ethnography we could see from the senior consultant's way of describing the shortages of personnel, that theirs was a demanding situation that was unlikely to be made any easier by the team simultaneously having to change the way they worked. That said, in this instance the facilitator was well aware of the situation, and could confirm

the ethnographers' observations, putting into words a sequence of events that long predated this specific situation. How did this way of identifying and talking about limitations and opportunities impact on the implementation itself?

First and foremost, this type of diffractive ethnographic observation can problematize the idea that implementation is the 'mainstream of innovation within an organization' (Greenhalgh et al. 2004, 582). 'Mainstream' becomes a metaphor for implementation as a process of change that can be redirected relatively easily, depending on the innovation to be introduced; a metaphor that likens such a process to a stream, and one where it is easy to redirect its flow. However, as much of the literature stresses, healthcare is noted for its 'messiness' (Woolf 2008; Hertzum et al. 2017). This messiness, we argue, must be addressed in any implementation process. Though messiness too, obviously, is a metaphor, it is a metaphor that shows the opposite: what is running counter to what is expected or not working at all; what is refusing all attempts to redirect it or is redirected far too quickly.

The facilitator, together with the observing ethnographers, could make the processes of implementation visible in a way that either strengthened the centripetal 'mainstream' forces or actively try to relate to what is collectively defined as its 'messiness'. By choosing the latter situated knowledges of various kinds were constructed, that would help with other approaches when the facilitator next met the group. The ethnographic text is not only a way to make the things the facilitator cannot see or relate to visible, but it also confirms the facilitator's existing perspectives, which might need some thought.

In looking for alternative perspectives on the implementation—creating fresh contextual understandings together—one of the ethnographers chose to conduct interviews with the facilitator, in part to go over the facilitator's comments on the ethnography. By doing so, they arrived at further situated interpretations to apply to the ongoing implementation process. The ethnographer reading the facilitator's annotations, quoted above, aloud, preceded this section of the interview:

Facilitator: There is a helplessness.

Ethnographer: There is a helplessness to this. We cannot influence the situation, but we still have to try to find solutions. Continue with the changes. But then it's...

Facilitator: It's really difficult. It really is.

Ethnographer: But it's down to the entire hospital management. That's all you see in the media ... healthcare scandal.

Facilitator: And we're powerless in the face of it. A bit dejected. I think so. We are a bit dejected by it actually.

Ethnographer: But for Team II it's ... even though it's the same hospital [after a reorganization], they're a bit better off ... or is it the same for them?

Facilitator: Well it's because last autumn... Team I is a slightly larger team than Team II, and we've had two full-time diabetes nurses in each. I used to be one of the ones in Department I. In Department II there was the diabetes nurse who was one of the first diabetes nurses in Sweden. A tower of strength, such a support ... She's been an incredibly important member of their team in Department II. She retired in the autumn and then the resources for the diabetes nurses halved. [...] Which means this spring the resources for the diabetic nurses have been thin on the ground. When it comes to doctors too things are really tight. So all told, this spring the staffing situation has been truly awful. [...] It's a major obstacle, and at the same time so you're powerless. Oh yes, we're working on it, and the idea is that soon things will be back to us having two full-time positions. There's something going on behind the scenes that we don't really know about. I feel a bit as if you have to try to look past it and do what we can in the meanwhile.

Together, the ethnographer and facilitator help find a form of interchange which gives them an idea of the current situation in Team I and II. By holding the lantern together, they create an understanding of what is going on in the background, behind the actual implementation process. This means not only that the ethnographer has a better idea of what is going on in the implementation process,

but that the facilitator has the chance to get new insights about the process of change that is underway—putting feelings into words and finding different explanations for them. It does not have to be limited to things that are already known if not understood, however, as the method can also be used to make previously invisible processes visible.

### *Vagueness*

The facilitator was not always aware of exactly what she had communicated at staff meetings, but rather, as the second example shows, it became clear when she read the ethnography afterwards. This not only made any issues visible, but also put them into words. The following ethnography illustrates the course of events:

The facilitator mentions that the project can be seen as individualized care and in the same breath says that this is ‘a bit vague’, I have no idea what she means by vague. Is she referring to some general context at this particular workplace which means individualized care has been seen as being vague? Or is it that she wants somehow to reduce the value of her own study, that it’d make it too important in relation to all the problems they’re facing now, such as the staff shortage? It’s crucial to avoid pop psychology, but the connection between vagueness and individualized care says something about how a project is presented.

Facilitator’s written comment upon reading: Given your reaction I am embarrassed by my choice of words, and at the same time very grateful to be able to read it. The reason I use the word is that I think (and have heard lots of times too) that individualized is felt to be very abstract and nobody really knows what it means. One standard comment is that’s what we do already. I use the word because I think I take some key people with me as they are (diabetic nurses and to some extent even doctors) by using their terminology. The majority of these people have heard me present the study findings several times, and the term ‘individu-

alized care' is a central concept. Every time I talk about this with people in the teams, I try to find other ways of expressing myself so that they can see or understand the meaning of the concept.

The facilitator went on to list the advantages of the new care method to be implemented—better blood sugar levels, beneficial for the children discharged to go home, happier children and families, and it all costs less—and here the emphasis was no longer on the 'messiness' of healthcare, but rather on the way the facilitator presented the key features of the new hospital-based home care model. As an ethnographer, it is possible to observe not only what is said, but also the context in which it was said and how people react to it, both physically and verbally. By drawing up a detailed account of the process, it becomes possible for the facilitator to revisit and reflect on the situation later.

Implementation that focuses too much on the mainstream metaphor risks accounting for the process in an overly simplistic fashion where, for example, the facilitator can relatively easily communicate an evidence-based care model to the personnel who are to put it into action. In research, knowledge is often talked about in terms of knowledge translation, as just such one-way communication (Engelbrechtsen et al. 2017). Yet as the example above makes plain, there is not necessarily so simple a transfer when hospital-based home care is 'translated' from one individual to the next in real life; rather, it is a complex process, coloured by both the facilitator's own approach to the implementation of hospital-based home care, and the sense healthcare professionals make of what is said at staff meetings of the kind described here.

In the interview, this formulation is a topic of some discussion between the ethnographer and the facilitator. Further layers of interpretation were added to how the facilitator could relate to the ongoing implementation process. As the facilitator said,

My aim is they should see or understand the meaning of the term [individualized care]. Because when you read it like this, that word

sounds utterly stupid. As you wrote ... introducing individualized care ... well, it's just vague. So that I realize it doesn't seem very professional. My focus is always to try to meet the people in that room where they are. I don't think it's such an odd choice of word for them, actually. [...] So, you've got something that's very abstract and you don't understand, and you... I sometimes feel that there is a genuine interest, actually, if you only knew how. But you don't know how. So I reckon this is definitely harder. We've come back to it several times. How can I somehow contribute to this change of attitude?

The facilitator ultimately asks the most important question—how can she drive the changes needed for the implementation process. With ethnography, it is possible to make this process visible *and* to reflect on it afterwards. It is this reflective work that offers opportunities to create situated knowledge together of a kind that can alter the ongoing process. The ethnographers draw one form of understanding from the actual observation, and another form—or multiple forms—when the facilitator comments on events by annotating the ethnographic texts. When they then talk through the observations and the facilitator's written comments, a further form of situated knowledge is achieved. Here knowledge is not just something that is in circulation at staff meetings, but which all parties involved must work with far more actively throughout the implementation process, creating situated knowledge together on a variety of occasions, in the realization that such varieties of knowledge are a way forward. How the facilitator was affected on each occasion, and how the varieties of situated knowledge fed back into the implementation process, are things that are harder to quantify retrospectively. The point of this chapter is to explore how an approach in which a facilitator and ethnographers work closely together might further the implementation of a new care method, but at the same time their collaboration amounts to an important ethnographic fact, which can be adduced in the cultural analysis of the implementation process.

## Conclusions

With changes to a variety of healthcare practices, the implementation of evidence-based models has become increasingly common. Implementation can be understood as the process by which a care model—in this instance, hospital-based home care—translates into a new care method, but it is also a theoretical perspective which concentrates on how change transpires. The purpose of this chapter has been to show that such changes are often opaquely complex, which gives weight to the argument that continued in-depth research on implementation processes is needed. What should be singled out is the importance of research that focuses on the significance of context—or organizational culture, if one prefers—in whether or not an implementation process will lead to sustainable change.

The chapter explores the possibilities open to ethnographers and facilitators to band together to create situated knowledge that can benefit the implementation process. The term diffraction is suggested as a possible method with which to generate a variety of situated knowledges during a process (Haraway 1997; Barad 2007; Wiszmeg 2017). Just two examples have been discussed here, but the working method is unlimited in scope, and a wide variety of themes could result from joint efforts of this kind.

One finding is the way in which the various processes are best understood. Three different perspectives on knowledge are apparent, each of which brings home the full complexity of implementation, and shows how the proposed method can be understood in relation to processes of knowledge and change in general—from evidence-based knowledge, via care models and care practices, to situated knowledge:

(i) In a contemporary perspective on healthcare, scientific, so-called evidence-based knowledge is evidently a primary category—knowledge with capital K. When it comes to healthcare research, this knowledge can best be described in terms of a model for practice, here a care model. In this chapter, hospital-based home care is the care model implemented.



(ii) For evidence-based knowledge to be operationalized, the resultant care model must be reframed as a care method, adapted to the specific care context in which the model will be applied. This translation process can vary in problematics or scope, depending on the readiness and willingness to change. Regardless, there is inevitably a point at which the different care methods meet—the method supported by the model and the method (the professional knowledge) already in operation in the healthcare context—which here was hospital-based home care and the traditional hospital care. The reason for the implementation is to replace the previous care method with the new evidence-based method. In order for this to be successful, we would argue that it is necessary to think not in terms of replacing traditional care outright, but rather to try to achieve a coalition of the two methods in what we have termed situated knowledge.

(iii) By using the method we propose here, where the ethnographers and facilitator work diffractively, knowledge is generated which draws on both the evidence-based model and the professional knowledge already found in the context of the new model's implementation. It is co-created knowledge that combines all the evidence, with its potential outcomes, in the specific context where it is implemented.

Diffractive ethnography is largely reliant on ethnographers daring to abandon their personal reflexive interpretations—which easily create a distance to the study object (Barad 2007; Wiszweg 2017)—to meet the person being studied partway in a joint interpretation. Together they hold the lantern so that the facilitator, the other, becomes an important factor in the way situated knowledge is generated, influencing the processes of change that are already underway by the simple act of seeing them.

## Notes

- 1 We wish to thank Andréa Wiszmeg for her comments on earlier drafts of this chapter.
- 2 Implementation research identifies four main factors as having an impact on implementation: (i) innovation; (ii) how innovation is communicated; (iii) time; and (iv) the sociocultural system in which innovation is implemented (Rogers 2003).
- 3 Our account of the implementation process enlarges on our previous publication 'Att implementera tillgänglighet i vården' ('Implementing accessibility in healthcare') in Hansson & Nilsson 2017.
- 4 The Swedish Health and Medical Services Act of 2017 (Hälsö- och sjukvårdslagen 2017:30) said of accessibility that 'Healthcare must be provided so that the requirements for good care are met. This means that care in particular should be readily accessible.'
- 5 At the same time, it is important to acknowledge that a single study does not constitute a sufficient basis, but together with other research with similar findings the evidence becomes stronger. Central to this are proven experience and a consensus among the professionals who provide the care that children will do best in a home environment as far as possible. The crucial question is thus whether it is safe for a child newly diagnosed with type 1 diabetes to be at home rather than in hospital. This was a source of anxiety for some of the nursing staff who were to work with hospital-based home care, and led some to resist its implementation (discussed in greater detail in Nilsson et al. 2018).
- 6 The implementation process can in theory be broken down into different steps, from preparatory work to full implementation as a sustainable practice. In brief, they can be said to be (i) installation, (ii) initial implementation, and (iii) full implementation. This chapter is based on the division of the implementation process presented in the survey 'Implementation Research: A Synthesis of the Literature' (Fixsen et al. 2005; see also Rogers 2003).
- 7 We draw on Andréa Wiszmeg's reading (2017) of Karen Michelle Barad's philosophy where Barad's stick becomes a lantern, linking it to an older ethnological trope of the searchlight (see Daun 2010). As Barad says of her metaphor, 'One need only remember here the sensation, often cited by psychologists, which every one has experienced when attempting to orient himself in a dark room with a stick. When the stick is held loosely, it appears to the sense of touch to be an object. When, however, it is held firmly, we lose the sensation that it is a foreign body, and the impression of touch becomes immediately localized at the point where the stick is touching the body under investigation' (2007, 154).

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