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**DISCOVERING AND ENGAGING WITH THE EMOTIONAL CONTEXT OF
ACTION RESEARCH: A PERSONAL JOURNEY**

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**A THESIS SUBMITTED FOR THE DEGREE OF
STRUCTURED PHD**

**CITY UNIVERSITY
SCHOOL OF HEALTH SCIENCES**

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DECLARATION

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ABSTRACT

This thesis consists of five elements which, when taken together, articulate the journey of personal and professional development I have undertaken as an action researcher, and convey the emotional context of this type of work. The foundation for my development journey was the undertaking of a three year action research study which aimed to improve the care for older people on two rehabilitation wards in an acute NHS trust. Analysis of findings provided theoretical explanations of what helped and hindered staff from engaging in practice change, with the report presenting a neat and straightforward process of investigation. My experience of undertaking the study was, however, far from the neat and straightforward process articulated, with it being a complex, difficult and painful undertaking which had a personal impact on me.

The thesis progresses from the research report to explore and critically reflect on my personal experience of undertaking the action research study, and engages with the experience of other action researchers through a secondary analysis of the literature. Through this work the emotional context of action research is highlighted for all those involved in the process. It is argued that attention to emotions throughout the action research process is essential for both participants and researchers to ensure that the care and support required to manage them can be provided, and to enable such emotions to be used as data that can further inform the field of study. Although the importance of recognising the emotional context of action research is articulated in this thesis, there is a dearth of literature in relation to it. It is concluded that more needs to be written on this aspect of practice so that those new to action research can be made aware of the importance of the emotional components inherent within it, and can ensure that appropriate strategies are in place to enable them to engage with, learn from, and utilise such emotions to further inform their work.

The messages in this thesis will be of relevance to those considering, undertaking, supporting and supervising action research studies. In addition, due to the similarities of action research processes, contexts and topic areas to other methods of practice change, they will also be relevant to those involved in general practice development activity.

COMMENTARY

INTRODUCTION

The structured PhD is based on five individual elements which include a research report, case study, critical review of the literature, dissemination artefact and plan, and a preceding commentary which places the work in its overall context and outlines its implications for future practice. The elements presented in this thesis are in relation to:

- an action research report of a study designed to improve the care for older people on two rehabilitation wards in an acute NHS trust
- a case study of my personal experience of undertaking this action research study
- a critical review of the literature with regards to the experience of others in undertaking action research
- a paper prepared for publication and a plan of how my work has been, and will continue to be, communicated to others

This commentary presents an overview of the above individual pieces of work which were undertaken sequentially, not concurrently, with the time when each piece of work was carried out being identified in the subheadings. The commentary outlines how each individual piece influenced, and is linked to, subsequent elements. Through taking the elements together it demonstrates how I have developed a greater knowledge and understanding of the process of action research, achieved personal and professional learning and growth, and have a unique contribution to make to the body of knowledge on action research practice. It is written using the metaphor of a journey as I feel this is what I have been on throughout the process of this work. This journey commences with my starting point as a novice action researcher ('setting out'), progresses through my travels where, through the use of critical thought and reflective processes, I developed knowledge and understanding of the complexity of my action research experience ('the rocky road', 'retracing my steps', 'finding direction' and 'exploring further'), and concludes ('reviewing the route taken') with a summary of my own personal and professional learning and development ('my personal learning journey'), how what I have learnt offers an important and unique contribution to the current body of knowledge on action research ('adding to the map of action research'), and how this contribution has the potential to inform the wider literature on practice change ('sharing the map with others').

Through representation of this journey the overall argument of this thesis is presented, with this argument being recognised, explored, refined and articulated as the journey progresses. I argue that there is an emotional context to action research that is largely absent in the literature. I suggest that this emotional context needs to be recognised, articulated and legitimised within this research paradigm to ensure that all those involved are adequately

supported within the process, their emotional safety is protected, and they are able to positively utilise this context to gain further understandings of the field of study.

MY JOURNEY

Setting out (Commenced 2000)

My action research journey began when I secured the post of lead research and development nurse: care for older people as part of a funded action research project designed by City University in collaboration with seven participating NHS trusts. To accompany me on this journey, although having no previous experience of action research, I did bring clinical and practice development experience in care for older people and rehabilitation, and some experience in qualitative and intervention research. As I set off on this trip I considered that I had the relevant experience and skills to undertake it and felt confident in my ability to forge a straightforward path to its destination, however the road that lay ahead encompassed a complex development and learning journey that I never anticipated.

The rocky road (2000 – 2003)

The first part of my journey involved the undertaking of a three year action research study in one of the above mentioned NHS trusts which aimed to improve the care provided for older people on two rehabilitation wards. The action research report from this study provides a comprehensive and logical account of process, outcomes and theoretical explanations of what helped and hindered practice change on the two study wards. Final analysis suggests that staff were originally in a state of learned helplessness that was preventing them from engaging in development activities, with the non-conducive rehabilitative context within which they were working, lack of control over this, and lack of a voice within the organisation leading to them feeling powerless to effect care provision. Differences between the two wards are articulated in the report with one (Oak ward) appearing calm, ordered and willing to engage in practice development initiatives, and the other (Elm ward) appearing disorganised, chaotic and unable to participate in change activities. Further analysis, however, revealed surprising findings that although some changes in practice were achieved by the end of the study on both wards, it was on Elm ward where this was most apparent. It identified that, following initial unsuccessful attempts to improve practice, giving the staff on this ward the opportunity to 'tell it how it is' for them working on the ward, together with the overall facilitative approach used within the study, enabled them to experience the senses of security, belonging, continuity, purpose, achievement and significance. It is suggested that such a facilitative approach that encompassed the senses framework (Nolan et al 2006) helped staff to feel safe enough to work within the chaos and move out of a state of learned helplessness into one where they were able to engage with change.

Although the report provides a comprehensive story of the research study, following the writing of it I experienced discomfort in the thought that something was missing from the account. Further reflection on the data collected prompted me to consider that what was missing was my personal experience of undertaking the study. Although the research report reads as a neat and straightforward process, the reality of undertaking the study was not. The process for me was much more complex and chaotic, and was a difficult, painful and emotional experience riddled with struggles, challenges and personal disappointments at what was able to be achieved. Although recorded in my field notes, this experience failed to make its way into the research report and remained hidden at the back of my filing cabinet for two years after study completion. During these years, however, I remained troubled by my action research experience. It was only through this passage of time and a more positive research encounter that I was able to re-visit my field notes in an attempt to address my ongoing discomfort.

Retracing my steps (2005 – 2007)

Revisiting my field notes led to me writing my story of what it was like for me undertaking the action research study, which forms the first part of the case study element of this thesis. This story identifies a tumultuous time during which I struggled with my personal need for structure and progress within a research methodology which requires a flexible and responsive approach. This struggle was accompanied by role conflicts that threatened my identity, values and beliefs, together with frequent periods of frustration, destabilisation, demotivation, demoralisation and despair accompanied by feelings of personal failure and inadequacy. Engaging with my story was not easy. It resurfaced the raw emotions that I had buried and tried to forget making it a challenging and painful activity. In addition, it highlighted how many of the actions I took influenced the study process leading me to question the overall validity of its findings and whether the claims I made were now unsubstantiated. This led me to doubt my own capabilities and performance in the role with which I was personally disappointed. Due to the discomfort raised through this process I was unable to engage with any further analysis at this time, and my story was put aside with my field notes for another six months. During this period I became a lecturer in adult nursing and started to have conversations with colleagues and those from other institutions who had undertaken action research studies. Many of these had also experienced difficult journeys which had not been included in their study reports, with this leading me to consider that this was potentially an important aspect of action research and that through further exploration of my story significant learning could be gained.

Finding direction (2008 – 2009)

With this in mind I revisited my story, the further analysis of which forms the discussion section of the case study element of this thesis. By doing so I identified similarities between the experience of staff working on the rehabilitation wards for older people and my experience of undertaking the action research study with them. Discussions with colleagues who had engaged with the work of the Tavistock Institute prompted me to engage with the psychodynamic literature within which I identified a theoretical explanation for the difficult, painful and emotional experience I encountered together with a greater understanding of the study context as a whole. I identified that not only was I experiencing my own stress and anxiety in a new and unfamiliar role, but that through the psychodynamic processes of denial, splitting and projection I was also experiencing the stress and anxiety of the staff on the study wards I was working with which arose from the nature of their rehabilitative work task together with the stresses and anxiety projected onto them by their older patients. I also identified that in the absence of this knowledge at the time, and through the psychodynamic process of projective identification, I identified with these projected stresses and anxieties, acted them out, and became helpless with the staff. This enabled me to recognise that my experiences and emotions were a reflection of what was going on in the field of study, and that by attending to these I could gain a greater understanding of the study context and the internal worlds of the participants. Although I did experience some positive feelings throughout the study in relation to the successes achieved and the relationships I built with staff, it was the analysis of the difficulties, struggles and emotions I experienced in undertaking it that was more meaningful to me, and which informed my learning and enabled me to move forward.

Psychodynamic theory also provided further insight into why staff struggled to engage with change to accompany the learned helplessness that I suggested they were experiencing. It is recognised that when the amount of stress and anxiety experienced by staff becomes too much to bear, as well as using projective mechanisms they also attempt to protect themselves from it through the use of socially structured defence techniques. These are ways of working which serve to restrict the amount of physical and emotional contact staff have with individual patients thus protecting them from their own feelings about their patients together with the projections of those in their care (Menzies Lyth 1988). These practices can be seen to work against a rehabilitation philosophy of engagement, facilitation and attention to social and psychological aspects of care, with them therefore needing to be dismantled for changes in rehabilitation practice to take place. This would be difficult for staff to do, however, as dismantling these defensive practices can potentially result in the resurgence of the intolerable anxieties from which they are trying to protect themselves. This further insight into the co-existence of learned helplessness and psychodynamic processes within the study, and their contribution to an understanding of why staff struggled to engage with change, is articulated in the dissemination artefact element of this thesis.

Reflecting on my experience of undertaking the action research study, identifying a theoretical explanation of it, and gaining a greater understanding of the study context was enlightening for me. It was also accompanied by a sense of relief as I was able to look more objectively at what had happened and detach myself from the self-blame and discomfort that I had carried with me since study completion. It also heightened my interest in this aspect of action research and left me wondering if my experience and learning was unique or if other action researchers had reported similar stories. These questions prompted me to further explore this aspect of action research.

Exploring further (2010 – 2011)

My heightened interest led me to undertake a critical review of the literature on the experience of undertaking action research. It identified a gap in the literature with regards to the personal experience of researchers in undertaking action research studies, with a secondary analysis of papers that did exist identifying many difficult action research journeys undertaken in a wide variety of contexts. Many of the difficulties and challenges exposed in these papers were consistent with the writings of other action researchers in respect to working with competing stakeholder agendas, balancing control and participation, managing multiple roles, and experiencing uncertainty. It was also identified, however, that what was missing from this body of knowledge, and what my secondary analysis of the literature had to add, was the personal impact that experiencing and trying to manage these difficulties and challenges can have upon the researcher. Papers identified a vulnerable and highly emotional experience resulting from a need to sacrifice personal values and beliefs, the disruption of pre-existing relationships, identify conflicts, intrusion into personal lives, the process of self-reflection, and a rollercoaster ride of ups and downs.

Reflection on this analysis identified similarities between my own personal experience of undertaking an action research study and that of those included in the secondary analysis of the literature, with us all being exposed to comparable struggles and discomforts which had an intensely emotional impact on us. This legitimised my experience and, as well as providing me with some closure of my difficult action research encounter, highlighted that there was an emotional component associated with undertaking action research. In respect to this I recognised a need for an ethic of care for action researchers together with a need for more to be written on the personal experiences of undertaking such studies to encourage wider engagement with this aspect of action research practice.

Reviewing the route taken (2011 – 2012)

My journey as an action researcher has been one of challenges and struggles accompanied by enlightenment, together with personal and professional learning and development.

Through critical reflection on and gaining a greater understanding of it I have arrived at a place where I feel able and obliged to share this learning with others. This commentary has so far tracked the learning and development journey I have undertaken through the process of my doctoral studies. This is now expanded upon in relation to the learning I have gained about myself as a person and how I am utilising this to inform my current practice ('my personal learning journey'), what my work has to contribute to the body of knowledge on action research ('adding to the map of action research'), and how this contribution has the potential to inform the wider literature on practice change ('sharing the map with others').

My personal learning journey

Throughout my journey I have not only gained learning in relation to action research practice, but also in relation to myself. It is recognised in the reflexivity literature that learning about oneself can be an uncomfortable experience (Finlay 2002, Pellatt 2003), however by doing so I have been able to develop and engage with new and more effective ways of being and doing. As I progressed through my journey I identified my preference for structure and control in my work, the high expectations I have of myself and others, and my constant strive for perfection. I also recognised that by acting in these ways I constructed restrictive working boundaries that reduced the capacity for flexible, creative, opportunistic, relevant and motivational working and learning for both myself and others. The positive role of chaos in contributing to learning and change has long been recognised (Wheatley 1992) and is articulated in the research report element of this thesis, with the role of emotions in contributing to an understanding of the field of study also being articulated in my doctoral work. Through undertaking my learning journey I recognised how addressing these aspects could contribute to more effective practice in my work as an adult lecturer with a focus on care for older people.

In my lecturer role I have made a conscious effort to bring my emotions into my awareness and listen to what they may be telling me about the situation I am in. This has enhanced my relational work with colleagues whilst also enabling me to engage with the internal world of my students. I have become much more flexible and innovative in my teaching and learning methods, with structured teaching giving way to more reflective, open discussion and exploratory sessions where students are encouraged to explore their understandings and feelings in relation to their practice experiences and I am able to work with them where they are at as opposed to where I want or expect them to be. This is accompanied by the integration of the senses framework (Nolan et al 2006) into my approach where I strive to create opportunities for students to experience the senses of security, belonging, continuity, purpose, achievement and significance so that they feel safe, supported and contained within these learning processes. I have also become more relaxed as a person and, instead of constantly fighting for perfection, I now create time for reflection with this often resulting in me allowing myself to just stop and let things be. I also recognise the contribution that

psychodynamic theory has made to my learning journey. As well as it providing me with an explanation of my action research experience, it has also enabled me to learn from and work with my feelings and emotions and engage in the new ways of being and doing I have articulated.

Adding to the map of action research

Although it is advocated in the research and reflexivity literature that researchers should write themselves into their research accounts this is often missing from published papers and reports, with those that do include it mainly doing so to enhance the perceived rigour of their studies. What is missing from these accounts is the experience of undertaking the study from the researcher's perspective. The action research literature does address the experience of undertaking such studies in relation to the challenges and difficulties that arise through attempts to change practice, however what is missing from all but a few of these accounts is the personal impact that working with these challenges and difficulties can have upon the researcher themselves. This thesis demonstrates the learning that can be gained by writing the researcher into the account, and outlines my experience of undertaking action research which is derived from a unique data set including three years of personal field notes. Comparison of my experience with that of others through a review of the literature identifies that I have something important to say which contributes to the body of knowledge on action research. This contribution lies in the recognition of the emotional context of action research and its importance to action research practice.

Putting emotions on the map

Action research is recognised as complex and 'messy', with the importance of 'mess' as a vehicle for learning and change being articulated (Cook 1998, Cook 2009, Mellor 2001). From the work presented in this thesis it can now also be concluded that working within such a process can be a difficult and emotional journey that can have a personal impact on those involved in it. Much of this can be associated with the emotional context within which such work is undertaken. This emotional context can include the environment in which the research is taking place, the nature of the work of participants and area of study, and the process of change itself. This thesis recognises the importance of the emotional context of action research and argues that it needs to be recognised and legitimised as an important aspect of the research process to ensure that those involved in it are supported throughout the process, can capitalise on its potential to gain further understandings, and can prepare themselves adequately for the undertaking of such studies.

The importance of attending to the internal and emotional world of participants to effect change is demonstrated in this thesis, with a facilitative approach that created the senses of

security, belonging, continuity, purpose, achievement and significance for staff enabling this to take place. With reference to psychodynamic theory I now argue that the merits of this approach were in its ability to contain the anxieties and emotions of staff which was essential for them to feel safe, supported and enabled in the action research process. It is therefore key that action researchers work in ways with participants that contain their anxieties and emotions if they are to be able to fully participate in the action research process.

As well as attending to the internal world and emotions of participants, I also argue that the same attention needs to be afforded to action researchers. My experience, together with findings from the review of the literature, identify that working within emotional contexts can take its toll on researchers and expose them to emotional risks and dangers (Dickson-Swift et al 2008) from which they need to be protected and supported. Although the review of the literature highlights a variety of self-care support mechanisms utilised by action researchers to help them through their emotional journeys, I argue that addressing the emotional context of action research for those undertaking it needs to go further than this. Support mechanisms need to be provided that enable emotions to be adequately contained and for researchers to feel safe within the action research process.

The importance of containing emotions to support those involved and make them feel safe within the action research process is therefore recognised here, however I also argue that the process of containment serves a further purpose. This thesis identifies that the emotions experienced by researchers are often a reflection of what is going on in the field of study. I argue that support mechanisms are required that have the ability not only to contain these emotions but to help researchers explore their origins thus enabling them to understand them, work with them and utilise them to further inform the study itself.

Psychodynamic theory has played a major part in the learning articulated in this thesis. I argue that, through its attention to the processes of containment and learning from emotions, psychodynamic theory has a potential role to play in action research practice, and that its contribution to this type of work warrants further exploration. I also argue that, in the absence of such expertise being available to action researchers, other approaches need to be identified that could be used to contain emotions and enable those involved to feel safe within the process. The potential of the senses framework to contribute here also warrants further exploration.

The findings of this thesis also have something to say about the preparation required for those starting out on an action research journey. Those that have written on the teaching of action research recognise the importance of learning by doing (Grant 2007, Levin & Martin 2007, Sankaran et al 2007) but do not comprehensively address the emotional context of this methodology, which suggests that those embarking on such a journey may not be prepared for this aspect of action research practice. I argue that action researchers need to know that this emotional aspect exists, that it is a legitimate part of the action research process, and that it

has an important role to play so that they can ensure appropriate self-care and containing strategies are in place to support them throughout their work. I also argue that for this to happen, and for new action researchers to engage with this aspect of practice, current action researchers need to write about their personal experiences and do so in ways that are accessible to others starting out on similar paths.

Sharing the map with others

The findings in this thesis are not just relevant to action research, but also have relevance to others involved in similar change processes. Those involved in practice development also have a focus on change, use democratic and participatory approaches, and practice in similar contexts to many of those addressed in action research. It is suggested, therefore, that those facilitating such work are exposed to the same emotional context as action researchers. This emotional element has not featured in reviews of practice development (e.g. McCormack et al 2006) and is something that warrants further investigation within this body of knowledge.

STRUCTURE OF THE THESIS

Although this commentary articulates how each thesis element influenced and links with those subsequent to it, each one is presented as a stand alone piece. The reader will also notice inconsistencies in the presentation of each piece which is intentional. The research report, following the executive summary, is numbered and structured in a traditional format for ease of reading, and to allow reference to individual sections to be made throughout the report and the rest of the thesis. The case study and critical review of the literature are presented in a more thematic and narrative style which is more suited to their content, with original numbering being rejected due to it being felt that this deconstructed the overall context of these elements. The dissemination artefact, as per requirements for this PhD, is written in the style of the journal it was prepared for. In addition, as I progressed through my journey and gained further learning and insight, earlier elements were not revisited or amended in light of this. This was intentional to demonstrate the progression I have made throughout my journey in relation to my thinking, analytic and writing skills. Finally, it needs to be recognised that the theories that informed this thesis are what interested and resonated with me the most. I make no apologies for this as they are the theories that have informed my development and made me who I am today. This is not to say that others in the same circumstances would have followed this path, and that by travelling an alternative route may have ended up in a completely different destination.

RESEARCH REPORT

IMPROVING CARE FOR OLDER PEOPLE: AN ACTION RESEARCH STUDY

EXECUTIVE SUMMARY

INTRODUCTION

The population is ageing, and with this ageing population comes an increase in chronic illness and a need for rehabilitation and intermediate care. Unacceptable variations in standards and provision of care for older people are, however, ongoing (Davies et al 1999, Department of Health 2006a, Health Advisory Service 2000 1998, Robinson & Banks 2005, Standing Nursing Midwifery Advisory Committee (SNMAC) 2001) together with a recognition of the need to develop rehabilitation practice and the role of the nurse within it (Nolan et al 1997, Robinson & Turnock 1998, Royal College of Nursing 2000, Sinclair & Dickinson 1998). This three year action research study attempted to address these issues and set out to improve the care provided on two rehabilitation wards for older people in an acute NHS trust.

AIMS AND OBJECTIVES

The aims and objectives of the study were:

Aim

To improve the care for older people on two rehabilitation wards in an acute NHS trust.

Objectives

To identify the care needs of older patients and their carers on the two rehabilitation wards.

To identify where gaps in care existed.

To devise, implement and evaluate practice development initiatives to address these gaps in care in collaboration with participants.

To identify the lessons learned from attempts to improve the care for older people in these settings.

To disseminate these lessons learned to others working in similar care environments.

CONTEXT

The study took place in a culturally diverse borough which had one of the three highest deprivation and death rates in London, and was the fourth most deprived borough in England and Wales. The acute NHS trust was recognised as being under-funded and under-established with respect to the nursing workforce and suffered from the nationwide problems of recruitment and retention of staff. The two rehabilitation wards for older people on which the study took place (Oak ward and Elm ward) were based in an old Victorian hospital whose services and facilities were decreasing in preparation for future closure and a move to the main general hospital site three miles away where the majority of acute trust services were located. The staff working on the rehabilitation wards were therefore separated from the main hospital site and activity.

Both rehabilitation wards for older people were mixed sex 'Nightingale' style wards of 21 and 22 beds. During the early stages of the study Elm ward was relocated on the same hospital site with little notice to ward staff. With this relocation came an increase in bed numbers from 21 to 29, patients with a wider variety of medical and mental health conditions, and changes to the nursing team. The nursing staff establishment did not adequately reflect these changes. Vacancy factors for both wards increased over the course of the study.

The average age of nursing staff on the study wards was 48 years. Out of the 24 staff from whom biographical data were collected, 22 had previous experience in care for older people and 8 out of the 14 registered nurses had recordable qualifications in older people nursing. However, only 7 of the 24 staff had previous experience in rehabilitation nursing with only 2 having had any actual training in rehabilitation care. Only half of the nursing staff on the study wards were there through personal choice, with the others being relocated there following organisational changes.

METHODOLOGY

An action research approach was used within the study to effect practice development through a collaborative approach to change. Action research has been described as 'a period of inquiry, which describes, interprets and explains social situations while executing a change intervention aimed at improvement and involvement' (Waterman et al 2001 p.11), with its main features being its participatory nature, its democratic impulse and its contribution to social science and social change (Meyer 2000). It is perceived as being a useful approach in health and social care settings (Hart & Bond 1995).

The main participants in the study were the registered nurses and health care assistants (jointly referred to as nurses, nursing/ward staff), patients and carers on the two study wards, and the senior nurse and general manager (jointly referred to as service managers) for elders

services. Other members of trust staff also became involved in activity cycles as the study progressed.

A multi-method approach to data collection was used throughout the study. Methods used included:

- formal meetings and discussions with nursing staff
- semi-structured interviews and focus groups with nursing staff
- structured nursing staff questionnaires
- semi-structured interviews with service managers and senior managers
- semi-structured focus group and interviews with patients
- semi-structured interviews with carers
- quality of care and quality of interaction audits
- clinical audits
- participant and non-participant observation
- the recording of field notes

Quantitative data were analysed using descriptive statistics. Qualitative data were thematically analysed. The quality of data was assessed through attention to the principles of credibility, transferability, dependability and confirmability (Lincoln & Guba 1985).

Ethical approval was gained from the local health authority research ethics committee. The researcher also worked within the 'principles of procedure for action research' ethical framework outlined by Winter and Munn-Giddings (2001).

FINDINGS

The context of care

The study wards presented a challenging working environment for staff, with their layout and condition being considered as non-conducive to the rehabilitation care for older people. Both wards were considered as being inadequately staffed to provide the care required by their patients both in relation to nursing and therapy input. A lack of adequate support services was also evident in relation to domestic and ward based administrative staff. Rehabilitation philosophies did not permeate the wards with a lack of understanding of rehabilitation being identified amongst nursing staff. An enabling culture was not evident with routines and speed prevailing over a facilitative approach. This was accompanied by a focus on meeting the physical needs of patients at the expense of the social, psychological and emotional aspects of care. Some staff expressed that they did not feel valued, cared for or supported in the organisation, and that managers had little interest in the issues they faced on a daily basis.

Action cycles

Baseline data collection identified specific areas of care which needed to be improved. From this the staff on the study wards identified areas of development they wanted to work on to improve the rehabilitation care for their older patients in the form of action cycles. Oak ward identified four action cycles:

- To improve the standard of patient transfers to the rehabilitation wards.
- To meet the patients' needs for sleep, rest and activity more effectively.
- To improve the urinary continence care for patients.
- To improve the evidence based practice skills of nurses.

Work on the action cycles met with varying degrees of success, however some achievements were made. These included the development of a patient transfer form and ward information booklet for patients and carers, the provision of some social activities on the ward, a review of continence products, and greater attention to the fluid intake and individual toileting regimes for patients. It was recognised, however, that these achievements were down to the work of a few motivated individuals of the ward team with the majority of staff exhibiting a lack of interest, motivation and commitment to participate in development activities.

Elm ward initially identified two action cycles they wanted to work on to improve the care for their patients:

- To improve team working on the ward.
- To improve the general standard of care for patients, particularly those whom staff find it most difficult to care for.

Work on both areas was unsuccessful, with lack of participation of staff playing a major part in this. Following increasing concerns regarding the general standards of care on the ward, nursing staff and service managers were given the opportunity to explore the current issues and challenges surrounding the rehabilitation care for older people in this setting and develop an action plan to address them as part of a third action cycle:

- Tell it how it is: using a case study approach to identify current issues, problems and challenges surrounding the care for older people in this rehabilitation setting.

As a result of this action cycle improvements in team work, care standards and relationships between staff and patients, together with the provision of more patient focused care, were stated by staff. A social space was also created on the ward where the provision of some social activities took place. These achievements were accompanied by an increased commitment, motivation and readiness amongst staff to continue to improve and engage with change.

Evaluation of the study process

Staff and managers reflected on the study process during exit interviews. Some staff and managers had high expectations of the study which were not met. They were not familiar with the change process and how long it could take. The participative approach and responsibility placed upon them in relation to change activities came as a surprise to them together with the lack of power I, as a researcher, had within the organisation. Staff also expressed other difficulties they had trying to improve rehabilitation care when they were working in areas that were not functioning as such with regards to facilities, resources and multiple patient health conditions. Lack of participation and ownership by many staff in relation to the change process also hindered development and affected the motivation of others.

Some positive outcomes were, however, achieved in the study, and staff commented on the facilitating factors that they felt enabled some staff to engage with change and improvements in practice to be made. Key in these were the presence of a catalyst (the researcher) to help staff diagnose current problems, come up with ideas to address them and help get them started, together with the constant presence of a neutral researcher who could give time to staff and provide leadership, encouragement and support. Enabling staff to focus on areas of practice development they wanted to work on together with a flexible, ward based approach to development activities were also considered to be facilitating factors, with the achievements staff made along the way motivating them to persevere and participate further in change activities.

DISCUSSION

From the study data it is suggested that staff on the study wards were originally in a state of learned helplessness (Seligman 1975) which was preventing them from engaging in change activities, with the context within which they were working, lack of control over this, and lack of a voice within the organisation leading to them feeling powerless to effect care provision. However, there is also evidence to suggest that some staff on Oak ward and, towards the end of the study, the staff on Elm ward had started to move out of this learned helplessness state into one where they were ready to engage with and implement some changes in practice. Application of 'The Senses Framework' (Nolan et al 2006) to evaluation data provides a theoretical explanation of what enabled this movement to take place, and suggests that through a facilitation approach that enabled staff to experience the senses of security, belonging, continuity, purpose, achievement and significance they were able to improve the rehabilitation care of their older patients. It is also suggested that such a framework presents a potential theoretical approach for the facilitation of practice development in general, and that its utility in this context warrants further exploration.

LIMITATIONS OF THE STUDY

Limitations of the study were explored in relation to published guidance on assessing action research reports (Waterman et al 2001). The following specific questions are considered pertinent to the limitations of this study:

- Was consideration given to the local context while implementing change?
- Was the relationship between researchers and participants adequately considered?
- Were data collected in a way that addressed the research issue?
- Were steps taken to promote rigour of the findings?

RECOMMENDATIONS

Recommendations for practice

The purpose of the two study wards needs to be defined. If they are to continue to function as rehabilitation wards, and do so effectively, the resources and environments of care need to be addressed.

The effects of continuous organisational changes on individual staff, teams and patient care need to be recognised. Further organisational changes need to be discussed with staff and adequate preparation for such provided.

The trust needs to work with its staff in ways that enable them to experience the senses of security, belonging, continuity, purpose, achievement and significance if they are to be able to engage with change agendas and effectively meet the needs of their patients.

The trust has decided not to continue the research nurse post. How staff are to be supported in further practice development, both on the study wards and in the trust as a whole, needs to be identified.

Organisations need to explore and identify the reasons why staff are unable to engage with change initiatives to enable the implementation of appropriate facilitative interventions.

Recommendations for teaching

Ways to promote and facilitate informal work based learning need to be identified, which can accompany more formalised teaching, to enable staff to reflect, learn from and develop practice on a day to day basis.

Recommendations for research

Learned helplessness theory provides an explanation of why staff in this study were unable to engage with change. Consideration of this theory in similar contexts may be helpful.

The senses framework as a theoretical framework for the facilitation of practice change warrants further exploration.

1. BACKGROUND TO THE RESEARCH STUDY

1.1 The study in context

The population is ageing, with the number of people aged over 85 years being set to double in number by 2020 (Department of Health 2006a). Older people are the main users of health services, however the standards and provision of care for older people have been the focus of a number of reports which detail ongoing unacceptable variations in standards of care provided to this client group (Davies et al 1999, Department of Health 2006a, Health Advisory Service 2000 1998, Robinson & Banks 2005, Standing Nursing Midwifery Advisory Committee (SNMAC) 2001). Changes in care practices are required to address these variations. The launch of the National Service Framework for Older People (Department of Health 2001b) started this process, with a recent review recommending further developments (Department of Health 2006a).

This research report relates to a three year action research study undertaken in an acute NHS trust. The study was part of a larger action research project, funded by the Central and East London Education Consortium (CELEC), which was undertaken in collaboration with City University and seven NHS trusts (4 acute NHS trusts, 2 primary care trusts and 1 mental health trust). This larger project aimed to coordinate and evaluate the creation of seven practice development posts (lead research and development nurses), one in each trust, to implement locally the National Service Framework for Older People (Department of Health 2001b) and improve the care provided for this client group. I was employed as one of these lead research and development nurses. The objectives of the larger project were:

- To coordinate and facilitate seven practice development posts in a variety of health care settings, each with the central objective of promoting evidence based nursing for older patients.
- To demonstrate evidence based practice linked to the National Service Framework for Older People.
- To plan, implement and evaluate the process and outcomes of change in the care of older people, using an action research approach.
- To facilitate learning, cross fertilisation of ideas and partnership between trusts through regular seminars and workshops.
- To provide academic guidance and support for the management of change.
- To provide a channel for information flow between experts and practitioners.
- To facilitate links between local and national networks related to the care of older people.
- To provide a collective project evaluation for the funders and to disseminate study findings both locally and nationally.

Each lead research and development nurse was responsible for carrying out an evidence based action research study in their respective trust. As well as collecting data specific to our individual projects we also collected the same general baseline and evaluative data using structured audit instruments to allow cross comparisons across sites to be made.

This research report focuses on my individual study which was undertaken in one of the acute NHS trusts. The remainder of this section briefly outlines the profile of the borough and NHS trust in which the study took place, together with the process through which the study sites within the trust were identified and the profile of these areas. This will provide the reader with the background context within which this individual study was situated.

1.2 Profile of the research area

1.2.1 Population profile

The NHS trust in which the study took place served at the time a total population of 243,737 of whom 8.94% were over the age of 65 years (Office for National Statistics 2001). The population of the borough was culturally diverse. With regards to older people at the time, 85% of those over 65 years were white Caucasian (see table 1), however the number of older people from ethnic minority groups was predicted to increase over the following ten years (Office for National Statistics 2001).

**Table 1 Population of older people in the borough by ethnic group
(Office for National Statistics 2001)**

Ethnic group	65-74 years	75-84 years	85+ years
White	10507	7206	2608
Black Caribbean	846	183	23
Black African	88	18	7
Black Other	28	5	5
Indian	1091	344	45
Pakistani	263	56	10
Bangladeshi	189	26	5
Chinese	66	24	5
Other Asian	88	32	6
Other	44	12	5
Total	13210	7908	2720

The borough had one of the three highest deprivation and death rates in London, and was the fourth most deprived borough in England and Wales (local public health profile). The poverty profile of the borough described the deprivation suffered by many of its older residents. It had the highest proportion of older people in London lacking basic amenities such as an inside toilet or sharing the use of a bathroom. Two thirds of households containing older people were dependent on housing benefit, and more than a third lived on income support. Also, 44% of older people in the borough suffered a long term illness or disability, with over 5000 older people with long term illness living alone (local Joint Investment Plan for Older People).

1.2.2 Trust profile

The NHS trust was an acute hospital trust with 555 beds. It was recognised as being under-funded and under-established with respect to the nursing workforce, and also suffered from the nationwide problems of recruitment and retention of staff. The nursing and midwifery vacancy rate was 18.5%, with 259 of the 663 nursing and midwifery staff employed at the time approaching retirement age (see table 2). The nursing vacancy rate in care for older people services was 21%. Reasons for poor recruitment and retention included lack of available accommodation for those wanting to live and work in the borough and lack of affordable housing, the hospital sites not being easily accessible by public transport, the trust being in an outer London weighting band, and difficulties recruiting people from the local population due to its diversity.

Table 2 Number of nurses and midwives aged 45 years and above

Staff	Age Range					Totals
	45 - 50	50 - 55	55 - 60	60 - 65	65+	
Unregistered	17	18	11	9	3	58
Registered Nurses	55	45	41	6	-	147
Registered Midwives	13	21	15	5	-	54
Totals	85	84	67	20	3	259

Health care provision was based on two sites. Services dedicated to care for older people included two 28 bedded acute care wards on the main general hospital site, and two rehabilitation wards on a smaller hospital site approximately three miles away. The hospital in which the rehabilitation wards were placed was an old Victorian building whose services and facilities were decreasing in preparation for future closure and a move to the main general hospital site, which was at the time undergoing PFI development. The staff working on the rehabilitation wards were separated from the main hospital site and activity.

1.3 The study sites

1.3.1 Identification of study sites

At the beginning of the study I undertook an exercise to map services for older people within the trust and borough as a whole, identify gaps in service provision, and highlight potential study sites which had a perceived need for development. This involved speaking to 36 individuals within the acute trust including senior nurses, general managers, ward and department sisters and charge nurses, specialist nurses, professional development nurses, geriatric consultants, those in professions allied to medicine and other support services such as volunteers and health advocacy. Meetings were also arranged with nine community based statutory and voluntary services including social services, age concern and the borough's community health council. Negotiation of the use of the potential study sites identified was undertaken with the trust project lead, service managers, ward sisters and ward staff in these areas. It was agreed that the study would take place on the two rehabilitation wards for older people. This decision was influenced by the reduced opportunity for development of these wards from other sources due to their separation from the main hospital site, and the national rehabilitation agenda which was forefront at the time. To maintain anonymity the names of the rehabilitation wards have been changed and, for the purpose of this report, they will be referred to as Oak ward and Elm ward.

1.3.2 The rehabilitation agenda – need for research

As previously stated, the population is ageing. With an ageing population comes an increase in chronic illness and need for rehabilitation and intermediate care. This need was reflected in UK policy at the time of the study with the NHS Plan (Department of Health 2000b) taking forward recommendations from the National Beds Inquiry (Department of Health 2000a) by investing in intermediate care services, with a focus on rehabilitation in hospitals, to promote independence and improve the quality of care for older people. The National Service Framework (Department of Health 2001b) further supported this, with standard 3 focusing on the implementation of a new range of intermediate care services and effective rehabilitation services to enable early discharge from hospital and the prevention of unnecessary admission to long term care.

The national interest in rehabilitation at the time of the study was also reflected in local policies for East London and the City. The East End Plan (East London and the City Health Authority (ELCHA) 1999) focused attention on the development of intermediate care over ten years, with the borough's Joint Investment Plan for Older People containing objectives to improve rehabilitation services for older people in order to maximise independence and the opportunity for people to remain in their own homes following illness and increasing disability.

A review of the rehabilitation literature by Nolan et al (1997), however, highlighted many unanswered questions and gaps in the literature in relation to rehabilitation practice which have also been recognised by others. Firstly, difficulties defining rehabilitation, and a lack of consensus over what it comprises, have been identified (Nolan et al 1997, Robinson & Turnock 1998, Sinclair and Dickinson 1998), with a dominant physical and functional orientation towards outcomes overriding recognition of the essential affective, cognitive, existential, biographical and temporal components of care (Nolan et al 1997). Domination of a medical model within rehabilitation further intensifies this issue, with Nolan et al (1997) identifying a need to focus on health and well being as opposed to solely on illness and disability in rehabilitation practice.

It has also been identified that the nurse's role in rehabilitation is limited, underdeveloped and poorly defined, with many nurses seeing rehabilitation as lying predominantly in the therapist's domain (Nolan et al 1997, Royal College of Nursing 2000), and Nolan et al (1997) considering that nurses often do not possess the knowledge and skills required to adequately perform in a rehabilitation context. With regards to this Baker et al (1997) state that rehabilitation training for health and social service professionals is inadequate and haphazard, with a need for a greater emphasis on rehabilitation training and education being recognised and advocated in the literature (Baker et al 1997, Robinson & Turnock 1998, Sinclair & Dickinson 1998). These issues need to be addressed by the use of methodologies that are responsive to the needs of nurses (Baker et al 1997), whilst also meeting the requirements for continuing professional development set out by the Department of Health (1999). In relation to the rehabilitation literature, Robinson and Turnock (1998) state that more emphasis is required on research and evaluation in relation to rehabilitation practice to further develop and improve the current evidence base.

1.3.3 Study ward profiles

Elm ward was a 21 bedded ward situated on the ground floor of the hospital, with Oak ward having 22 beds and being situated on the first floor. Both wards were mixed sex with equal numbers of designated male and female beds. Both wards were also of the old 'Nightingale' style with bathrooms, toilets, utility areas, clinical areas and nurses' stations being situated at the far ends of each ward. Bed spaces were organised in the form of a 'bed, locker, chair' layout, with neither ward having a day room. The entry doors to the wards were kept locked with access being via a buzzer system that connected to the nurses' station.

During the early stages of the study Elm ward was closed and relocated to a larger ward area on the second floor of the hospital which had, up until this time, constituted an orthopaedic ward. The rationale for this move was under-use of the orthopaedic beds and a lack of medical beds on the main general hospital site, with the change being instituted with less than one week's notice to staff. With this move the bed complement on Elm ward was increased

from 21 to 29 beds and the client group changed with seven of the beds being designated for general medical rehabilitation as opposed specifically to care for older people. The nursing team also changed as, also due to closure, staff from an acute medical ward were transferred to work with the existing team on Elm ward. The clinical area to which they moved presented other distinct environmental challenges. It was more cramped than the previous ward with a severe lack of storage space that was disjointedly spread throughout the ward area. Its design made the observation of patients difficult and increased the distances nurses had to walk to access clinical areas. Elm ward also had to adopt the name of the ward they moved to thus losing the links with their previous identity (however, for the purpose of this report they will continue to be referred to as Elm ward). Also, at this time, the existing ward sister on Oak ward left and was replaced by an acting ward sister transferred from the acute medical ward which had closed. This meant that the new acting ward sister joined the study after access to the ward and the study proposal had been negotiated and agreed.

Staffing establishments for the two wards at the beginning and end of the study are represented in table 3. The nursing staff establishment on Elm ward did not adequately reflect its increase in bed numbers, and vacancy factors for both wards increased over this period of time.

Table 3 Ward establishments and vacancy rates at the beginning and end of the study

Ward	Beginning of study				End of study			
	No of beds	Establishment (WTE)	In Post (WTE)	Vacancy Factor	No of beds	Establishment (WTE)	In Post (WTE)	Vacancy Factor
Oak ward	22	19.57	17.22	12%	22	22	16.57	25%
Elm ward	21	18.39	17.99	2%	29	20.21	13.8	32%
Total	43	37.96	35.21	7%	51	42.21	30.37	28%

Further information regarding the nursing staff working on the two study wards was collected from 24 nursing staff participants during the study. Their average age was 48 years (range 38 years – 59 years), with the ethnic mix of staff reflecting the diversity of the borough (see table 4). Staff had worked on their current wards for an average of five years and nine months. Although 22 out of the 24 staff had previous experience in care for older people, only seven had previous experience in rehabilitation nursing. Eight out of the fourteen registered nurses had recordable qualifications in care for older people, however only two had any previous training in rehabilitation care. Only half of the nurses on the wards were there through personal choice, with the others being relocated to the care for older people rehabilitation wards as a result of organisational changes.

Table 4 Staff ethnicity on the two study wards

Ethnicity	Black Caribbean	Black African	White	Indian	Other Asian
No. of staff	8	7	7	1	1
%	34%	29%	29%	4%	4%

2. AIMS AND OBJECTIVES OF THE STUDY

The aims and objectives of the study were:

Aim

To improve the care for older people on two rehabilitation wards in an acute NHS trust.

Objectives

To identify the care needs of older patients and their carers on the two rehabilitation wards.

To identify where gaps in care existed.

To devise, implement and evaluate practice development initiatives to address these gaps in care in collaboration with participants.

To identify the lessons learned from attempts to improve the care for older people in these settings.

To disseminate these lessons learned to others working in similar care environments.

3. METHODOLOGY

3.1 Action research

An action research approach was used within the study to effect the development of practice through a collaborative approach to change. Although this approach was agreed by the funders, project director and NHS trusts participating in the larger study prior to myself and the other lead research and development nurses coming into post, its appropriateness in relation to this particular study can be identified. Action research has been described as 'a period of inquiry, which describes, interprets and explains social situations while executing a change intervention aimed at improvement and involvement' (Waterman et al 2001 p.11). Hart and Bond (1995) perceive action research as a useful approach in health and social care settings with it being considered as particularly appropriate where problem solving and improvement are on the agenda. They also suggest its consideration by those in health and social care agencies who wish to improve professional practice and standards of service provision.

The main features of action research are its participatory nature, its democratic impulse, and its contribution to social science and social change (Meyer 2000). It is concerned with doing research with and for people rather than on people (Reason 1988), with all stages of the research being carried out in partnership with participants involving them in both the change and research process. It is a problem-focused approach to change and is context specific, addressing issues in the reality of everyday practice that are current and of particular relevance to participants (Hart & Bond 1995, Meyer 1995). It also studies the process as well as the outcomes of change thus enabling the identification of what facilitates and hinders the development of practice. Through this, and its potential to generate theory (Winter & Munn-Giddings 2001), action research can help to bridge the gap between theory, research and practice (Holter & Schwartz-Barcott 1993).

Due to its participative and democratic nature, action research differs from other types of research. Winter and Munn-Giddings (2001) explore the differences between general qualitative and quantitative research and that of action research, with the former two analysing supposedly static situations from a position of detachment. Within these, efforts are made to avoid the inquiry having any impact on the situation being investigated and the researcher is clearly distinct from the people being researched. They state the purpose of action research, however, as being not only to improve the understanding of a situation but also to engage in an attempt to change things through working in a collaborative way with participants, and describe what is learned through the change process itself.

3.1.1 *My role as a lead research and development nurse*

3.1.1.1 *My Background*

I am a registered nurse educated to degree level (RGN; Dip (HE); B.Sc. (Hons) in Nursing Studies). Following registration I took up a staff nurse post on an acute medical ward where

my passion for care for older people was forged, with me requesting to be allocated as the key nurse for those patients over the age of 65 years. I then continued to pursue a career in care for older people progressing to senior staff nurse level in an acute care area and then to that of ward sister on a rehabilitation ward for older people. At the time of the study I had nine years post-registration experience in care for older people services, with two and a half of these being undertaken in a rehabilitation setting.

I also brought to the lead research and development nurse post four years of practice development experience, three of which were in the role of lecturer practitioner. The lecturer practitioner post enabled me to consolidate my clinical and leadership skills in working with staff to develop care practice whilst also providing me with the opportunity to further learn and enhance my skills in a practice development context. It also enabled me to gain educational skills and disseminate my learning and knowledge to others through teaching at pre-and post-registration level, together with undertaking the role of course leader for the ENB 298 clinical award (Elderly Care).

My formal research experience was more limited than my experience in care for older people or practice development, and consisted of two main studies. The first was a six month qualitative study focused on the lived experience of older people with Chronic Obstructive Pulmonary Disease (COPD) undertaken as part of my degree in nursing studies. The second was a six month intervention study focused on the implementation of continuing care guidelines in an acute NHS trust which was undertaken as part of my role as a ward sister.

I applied for the lead research and development nurse role whilst in my third year as a lecturer practitioner. At this time I had started to experience tensions between the roles of lecturer and practitioner, with my time starting to be 'swallowed up' by the formal lecturing side of the role at the expense of working clinically with staff to facilitate the development of practice. I also started to feel isolated in the role due to the team of lecturer practitioners with whom I commenced the post moving on to other roles in the university or trust, or leaving altogether. My motivation for applying for the lead research and development nurse post therefore included the opportunity to work with a team of researchers with whom I could share learning and experience, together with the opportunity to continue working clinically with staff in care for older people settings to develop practice and improve my knowledge and skills in undertaking research.

3.1.1.2 My responsibilities and approach in the study

The main responsibilities of my role in this study were to:

- explore, with participants, areas of care to be developed
- coordinate cycles of activity
- collect and analyse data

- provide ongoing feedback of findings to study participants
- monitor and reflect on the change process

Although action research encompasses some key characteristics (as outlined in section 3.1) it is recognised that there are many different approaches that can be used within it (Chisholm & Elden 1993, Hart & Bond 1995, Holter & Schwartz–Barcott 1993). In an attempt to bring together these differing approaches and reach some clarity about this methodology, Hart and Bond (1995) composed a typology of four types of action research to serve as a guide to practice based on the approaches used within them. Each of the four types is placed on a continuum ranging from ‘experimental’ through ‘organisational’ and ‘professionalising’ to the ‘empowering’ type and is discussed in relation to seven distinguishing criteria which recognise that action research:

- is educative
- deals with individuals as members of social groups
- is problem-focused, context specific and future orientated
- involves a change intervention
- aims at improvement and involvement
- involves a cyclical process in which research, action and evaluation are interlinked
- is founded on a research relationship in which those involved are participants in the change process

(Hart & Bond 1995 p. 37-38)

The approach that I set out to use within this study fell within what Hart and Bond (1995) classify as the ‘professionalising’ type of action research. This is described as being practitioner focused, professionally led and informed by an agenda grounded in practice, with the process consisting of a spiral of cycles which are opportunistic and dynamic. This approach, I feel, was influenced by both the structure of the wider project and my professional background and experience. The decision to undertake the larger project and the individual studies within it was made at senior manager level, with lead research and development nurses being employed to undertake the work. This top down approach could be seen to point to an ‘organisational’ type of action research, however the absence of pre-defined management agendas and problems, and the brief for the lead research and development nurses to work with staff in clinical areas to identify their individual issues and improve practice in relation to the older people they specifically cared for, points more towards the ‘professionalising’ type of action research. The distinguishing criteria of the ‘professionalising’ approach also closely mirrored the way I had worked in previous practice development roles and was the one with which I felt most experienced in and comfortable with.

My researcher position within this study was considered as involving both insider and outsider aspects. I could have been considered as an outsider through never having worked in the specific NHS trust before, and through being employed to specifically undertake this research study. However, through my career experience as a hospital nurse, and one who had worked in both older adult and rehabilitation areas, I could also have been considered as having insider knowledge and skills relevant to this study. Also, each lead research and development nurse was given the choice on appointment of whether they wished to be employed on a trust or university contract. For the purely practical reason of avoiding a break in NHS service I decided to take up a trust contract. I was therefore working as an employee of the trust which could have been seen to enhance my insider status.

As well as the formal data collection activities undertaken (to be described in section 3.2) I was also in regular contact with the staff on the two wards participating in the study and visited both wards whenever I was on site. This enabled me to get to know the staff and for them to get to know me, as well as maintaining a constant presence, to reinforce that I was there to work with them as opposed to just collecting data on them. It also provided the opportunity for informal conversations and discussions with staff together with impromptu coaching in relation to action implementation. This enabled a work based learning approach to be incorporated into the study where learning took place within the context of the daily work of participants. It is stated that work based learning promotes practice driven learning and encourages the practitioner to apply theory to practice, to think about aspects of their practice which could be changed, and guides them through the change process. This provides an opportunity for them to develop reflective skills and identify the underpinning knowledge, often implicit, that informs their practice (Dewar & Walker 1999). It can therefore be seen that work based learning is an approach compatible with that of action research, and was thus appropriate to use within the study.

3.1.1.3 Academic support

Structured academic support was provided for myself and the other lead research and development nurses in the project. Protected weekly study days took place at the university during which we met with the project coordinator to review the progress of individual studies, discuss practical issues and share ideas. A needs led training programme also took place on these days with us being given the opportunity to decide what topics and sessions we felt needed to be included. A monthly action learning set, again facilitated by the project coordinator, was established to provide peer support and an arena for reflection on the research process and individual studies. We were all also provided with regular individual academic supervision by either the project director or project coordinator.

3.1.2 Role of participants in this study

As previously stated (section 1.3) the study took place on two rehabilitation wards for older people consisting of 22 and 29 inpatient beds. The main participants in the study were the registered nurses, health care assistants, patients and carers on the two study wards, and the senior nurse and general manager for elders services. For the remainder of this report, unless the data specifically demands it, the registered nurses and health care assistants will be referred to collectively as nurses and nursing/ward staff, and the senior nurse and general manager will be jointly referred to as service managers.

Overall 47 nursing staff took part in the study by virtue of being situated on the two study wards. Six of these joined the study once it was already underway, and nineteen left before the study had completed. Of these nineteen, eight left due to moving out of the area, three retired, four left due to long term sickness, three left nursing altogether (moving into IT, physiotherapy and a family business), and one left for family reasons.

The patient participants on the two study wards were all over 75 years old and were transferred to the rehabilitation wards from the main general hospital site following admission for acute medical treatment. The criteria for transfer was for one or more of the three following reasons:

- they required a prolonged period of rehabilitation (e.g. following a stroke)
- they were taking a long time to recover from an acute condition (e.g. chest infections such as pneumonia, heart failure, urinary tract infections or falls) and thus required some rehabilitation input and recuperation time
- they had complex discharge planning needs due to ongoing social issues which were present before their acute admission and needed to be resolved before they could return home

Other members of trust staff also became involved throughout the study as cycles of activity commenced. These included the geriatric consultants and physiotherapy staff based on the study wards, the urology clinical nurse specialist, the clinical governance coordinator, the head of quality, the voluntary services manager, the ward sisters and staff on the two acute care for older people wards and, for one particular action cycle that was implemented trust wide, the nursing staff in all adult clinical areas in the trust.

3.1.3 Project steerage

A steering group was established to monitor study progress. It was used as a mechanism to feed back and discuss process issues arising from implementation of the study and to plan actions to address these. The steering group consisted of:

- the trust project lead (chair)

- myself
- the project director for the larger action research project at City University
- the director of nursing
- nurse representation from both study wards
- one of the service managers for the two study wards
- the head of physiotherapy
- one consultant geriatrician
- a representative from the local carers association

3.2 Data collection

This section relates to the formal data collection methods used within the study. It needs to be recognised that the action research process is not linear but is a cyclical and dynamic process in which the strands of inquiry, action and evaluation interact (Hart & Bond 1995). For ease of explanation, however, and to enable the reader to make sense of this complex process, the study will be described in relation to three phases of activity – the exploration phase, the action phase and the reflection phase. Throughout the three phases a variety of qualitative and quantitative data were collected.

3.2.1 *The exploration phase*

The purpose of the exploration phase was to identify the context within which rehabilitation care was taking place, the quality of care that was being provided, where gaps in care existed, and the current issues and concerns of participants. It was also intended to provide a baseline from which to measure change over time. The data gathered were used to inform the second action phase of the study. A multi-method approach to data collection was used including:

- formal meetings and discussions with nursing staff
- one focus group with nursing staff
- Monitor 2000
- the Shortened Quality of Interaction Schedule (SQUIS)
- patient focus group and interview
- carer interviews
- observation
- field notes

Monitor 2000 and SQUIS were used by all seven lead research and development nurses in their individual projects in an attempt to obtain some consistency of data regarding care for older people across all seven participating trusts.

3.2.1.1 *Formal meetings and discussions with nursing staff*

Sixteen formal semi-structured meetings accessing 35 members of nursing staff (16 from Oak ward and 19 from Elm ward) were held to obtain their views on current rehabilitation care provision and issues that were a concern for them. Data were recorded through the taking of field notes that were subsequently incorporated into an interim report which was distributed to participants for verification. One semi-structured interview exploring the same areas was also held with a member of nursing staff on Elm ward before they left the trust at the beginning of the study. The interview was audio taped, transcribed and checked for accuracy.

3.2.1.2 *Nursing staff focus group*

One semi-structured focus group with nine nursing staff was held on Elm ward, following the ward move, to further explore some of the key issues impacting on the rehabilitation care provision for older people. Data were recorded through the taking of field notes which were subsequently typed up and distributed to participants for verification of accuracy and further reflection.

3.2.1.3 *Monitor 2000*

The quality of nursing care being provided on the two study wards was measured using the validated Monitor 2000 audit tool (Fearon & Goldstone 1995). By using it in conjunction with other Monitor tools (Senior Monitor and EQUATE) the auditing of specific areas of older adult and rehabilitation care was also achieved. Ward staff were invited to review the tool and customise it to their specific areas. Data were collected through documentary analysis, non-participant observation, and structured patient, carer and nursing staff interviews in relation to six different areas of nursing care against which achievement scores were based:

- Admission, assessment and care planning.
- Meeting the patient's physical needs.
- Meeting the patient's non physical needs.
- Planning for the patient's discharge.
- Evaluation of nursing care objectives.
- Locally specified questions.

Nineteen patients (50% of all older patients on the study wards at the time of audit) were included in the audit (10 from Oak ward and 9 from Elm ward).

3.2.1.4 *The Shortened Quality of Interaction Schedule (SQUIS)*

The quality of social interactions between nurses and patients was measured using the SQUIS tool (Dean et al 1993). This had been previously utilised in the evaluation of services for older people by the Health Advisory Service (Health Advisory Service 2000 1998) who recommended its use for this project. The rationale for using this tool was to compliment the more practical focus of Monitor 2000 by measuring the more psychological, emotional and attitudinal aspects of care delivery. Data were collected through non-participant observation of four patients on each of the study wards. Eight observation periods, each lasting fifteen minutes, were carried out over a 48 hour period on each ward. Observation periods were planned to capture activity at different times of the day and night. Four categories were used against which the quality of interactions were coded:

- Positive social interactions – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.
- Basic care interactions – basic physical care with task carried out adequately but without the elements of social or psychological support as above.
- Neutral interactions – brief indifferent interactions not meeting the definitions of other categories.
- Negative interactions – care provided which is disregarding of the resident's dignity and respect.

The activity being undertaken at the times interactions occurred were also coded against eight categories. These categories included sitting/lying, moving, unorganised activity (e.g. reading, knitting), personal care, eating, drinking, therapy, and clinical care.

3.2.1.5 *Patient focus group and interview*

As well as the data collected through patient interviews undertaken as part of the Monitor 2000 audit, a semi-structured focus group was held to obtain patient views on their experiences of rehabilitation care in greater depth. Four patients on Oak ward took part in the focus group, with one other patient on Oak ward who was unable to attend on the day being interviewed individually. The focus group and interview were audio taped, transcribed and checked for accuracy. No patients on Elm ward wanted to take part in the focus group.

3.2.1.6 Carer interviews

As well as the data collected through carer interviews undertaken as part of the Monitor 2000 audit, further in-depth interviews were held. Two carers from Oak ward responded to invitations to discuss their experiences of the provision of rehabilitation care in greater depth. These interviews were audio taped, transcribed and checked for accuracy. No carers from Elm ward responded to this request.

3.2.1.7 Observation

Participant and non-participant observation was used to obtain further information on the context and provision of rehabilitation care. Any contact I had with the study wards was used as an observation opportunity, with me also formally working two shifts on each ward. Data were recorded through the writing of field notes following contact with the study wards. These field notes were subsequently incorporated into an interim report which was distributed to participants for verification of accuracy.

3.2.1.8 Field notes

Field notes were kept by myself as a daily record of events. Entries were made regarding environments of care, formal meetings held, informal discussions with participants, observations made, further contextual information gained throughout formal data collection, my own perceptions of care provision and the study process.

3.2.2 The action phase

Data from the exploration phase were fed back to participants during eight ward meetings (4 on each ward) that were specifically arranged for this purpose. Following this, staff considered the areas of care they were interested in improving from which seven cycles of activity related to rehabilitation practice were identified. These were implemented during the action phase in collaboration with them. More information regarding how each action cycle was identified, and the data informing this identification, can be found in section 4.1.2. Four action cycles were identified and implemented on Oak ward and three on Elm ward. These were:

Oak ward

- To improve the standard of patient transfers to the rehabilitation wards.
- To meet the patients' needs for sleep, rest and activity more effectively.
- To improve the urinary continence care for patients.
- To improve the evidence based practice skills of nurses.

Elm ward

- To improve team working on the ward.
- To improve the general standard of care for patients, particularly those whom staff find it most difficult to care for.
- Tell it how it is: using a case study approach to identify current issues, problems and challenges surrounding the care for older people in this rehabilitation setting.

A variety of qualitative and quantitative methods were used to measure the process and outcomes of these action cycles. For each action cycle the definition of the problem, formal activities undertaken, learning activities incorporated with staff and data collection methods used are described below.

As well as the activities described under each action cycle, I also arranged regular monthly meetings with each individual ward to review progress and reflect on the process of implementation. These took place throughout the action phase on Oak ward however, due to difficulties getting staff together for meetings on Elm ward, progress reviews were undertaken on a one to one basis with the ward sister.

3.2.2.1 Oak ward

3.2.2.1.1 To improve the standard of patient transfers to the rehabilitation wards

Definition of the problem

Nurse to nurse liaison regarding patients being transferred to the rehabilitation wards, and the information given to patients and relatives before and after transfer, was poor. It was felt that this needed to be improved so that when patients arrived on the rehabilitation wards their immediate needs could be met in order that they would be ready, both physically and psychologically, to engage with the rehabilitation process.

Activities undertaken

- Seven meetings with the four ward sisters on both the acute and rehabilitation wards for older people to identify aspired standards of care and current issues when transferring patients, devise data collection methods, feed back data, develop action plans, assist with implementation and evaluate progress.
- Audit of the standard of patient transfers to the two rehabilitation wards over one month.
- Design of a new patient transfer form in collaboration with medical staff.

- Pilot of the patient transfer form over two months.
- Evaluation of the patient transfer form through a completion audit and staff feedback.
- Open informal discussions with patients on Oak ward asking them what information they would have liked / found useful on admission to the rehabilitation ward.
- Five meetings with the head of quality to work on information for patients and carers.
- Design of a patient and carer ward information booklet in collaboration with the head of quality.
- Patient evaluation of the patient and carer information booklet.

Learning activities undertaken with staff throughout the above included:

- assisting ward sisters to identify the core issues in relation to the transfer of patients that were currently impacting on the quality of patient care
- reflective discussions regarding current care provision and changes required to improve the standards of patient transfers to the rehabilitation wards
- assisting staff to identify the audit process, develop audit tools, carry out local audits and act on their results
- assisting staff to obtain patient views on care in relation to the provision of information, and the incorporation of these views into practice development initiatives
- assisting staff to identify and utilise learning resources within the organisation through collaborative working with the head of quality

Data collection methods used

- Audit of the standard of patient transfers (no. = 16 patients).
- Completion audit of the new patient transfer form (no. = 43 patient forms).
- Staff evaluation of the new patient transfer form, using a semi-structured interview guide, through three staff meetings facilitated by the two ward sisters on the acute wards and the ward sister on Oak ward (no. of staff = 20), and five individual staff interviews on Elm ward.
- Semi-structured informal interviews with eight patients and carers to evaluate the patient and carer information booklet.

3.2.2.1.2 To meet the patients' needs for sleep, rest and activity more effectively

Definition of the problem

Patient assessment related to sleep, rest and activity was poor preventing attention to individual needs, with this being exacerbated by ingrained ward routines. There was also a lack of opportunity for social interaction and activity on the ward. Routinised systems of work have been found to result in increased patient dependency (Miller 1985) which could adversely affect the ability of patients to rehabilitate physically. In contrast to this, activity programmes have been described as being able to meet the psychological and social needs of patients (Turner 1993), and thus have the potential to assist them in regaining optimal function in these aspects of rehabilitation care.

Activities undertaken

- Four meetings with the night nurses to feed back baseline data and identify and commence the implementation of an action plan for sleep, rest and activity for patients.
- Four meetings with the health care assistants on day duty to look at providing activities for patients.
- Visit by two health care assistants to a continuing care unit to gain information and ideas about an activity programme for patients.
- Open informal discussions with patients on Oak ward to ask them what activities they would like to be provided on the ward.
- Proposal for and the provision of games equipment by the League of Friends of the hospital.
- Collaborative working with the voluntary services manager regarding the provision of social activities for patients on the ward.
- Collaborative working with the ward physiotherapist regarding the provision of regular group exercise classes for patients.
- Development of a weekly activities programme for patients.

Learning activities undertaken with staff to support the above included:

- assisting staff to access existing evidence in relation to sleep, rest and activity assessment and interventions

- reflective discussions to identify the rationale underpinning current practice and how thinking may need to be changed in the light of presenting evidence
- assisting staff to identify and utilise learning resources outside of the organisation through a visit to another unit providing the care they aspired to
- assisting staff to obtain patient views on care in relation to the provision of daily activities and opportunities for social interaction, and the incorporation of these views into practice development initiatives

Data collection methods used

Apart from the activities described and the recording of field notes (see section 3.2.2.3), no other formal methods of data collection were used in this action cycle.

3.2.2.1.3 To improve the continence care for patients

Definition of the problem

Comprehensive assessment of the toileting and continence needs of patients, and thus the implementation of effective interventions to promote continence and manage incontinence, was lacking. The need to provide effective, integrated, evidence based continence care for patients is highlighted in the National Service Framework for Older People (Department of Health 2001b), and is one of the core standards in the Essence of Care Nurse Benchmarks (Department of Health 2001a). Continence promotion is also stated as an essential skill for the rehabilitation nurse (Royal College of Nursing 2000).

Activities undertaken

- Seven meetings of an 'Improving Continence Care' working group consisting of myself, one registered ward nurse, the urology nurse specialist, the ward geriatric consultant, the lead research and development nurse from the neighbouring primary care trust, and the clinical governance coordinator.
- Trust wide prevalence audit of adult patients with continence problems in collaboration with the clinical audit department.
- Audit of the knowledge and skill levels of nursing and midwifery staff on all adult wards in the trust regarding continence care in collaboration with the clinical audit department.

- Development of an evidence based urinary continence care pathway in collaboration with the neighbouring primary care trust.
- Provision and evaluation of three in-house continence care study days.
- Bid for a continuing professional development nurse in continence promotion in collaboration with the neighbouring primary care trust (unsuccessful).
- Three month pilot of the urinary continence care pathway on two of the care for older people wards.
- Evaluation of the urinary continence care pathway.
- Integration of work undertaken with the trust clinical practice group.

Learning activities undertaken with staff throughout this action cycle included:

- assisting the registered nurse leading on this action cycle to access, critique and synthesise existing evidence and identify best practice with regards to urinary continence care, and to implement interventions to address this
- reflective discussions with those in the continence care working group to explore the rationale underpinning current practice and how thinking may need to be changed in the light of presenting evidence
- the provision of three in-house study days

Data collection methods used

- Audit of continence prevalence (no. = 17 wards).
- Nursing staff knowledge and skills questionnaires (no. = 304).
- Questionnaires to evaluate the study days provided (no. = 84).
- Nursing staff focus group (no. = 5 staff) to evaluate the experience of nurses in using the urinary continence care pathway.
- Questionnaire to evaluate pathway information leaflets administered to six local user groups for older people (ageism group, NHS retirement fellowship, Forget Me Not dementia support team, service user samples from the primary care trust continence service, service user samples from the primary care trust day hospital, and service user samples from the acute trust urology clinic).
- Variance analysis of pathway documentation together with comparative semi-structured patient interviews to obtain the patient experience of continence care provision for those on a ward piloting the pathway and those on a ward not piloting the

pathway were planned. Due to difficulties in the action phase these were not completed (see section 4.2.2.3).

3.2.2.1.4 To improve the evidence based practice skills of nurses

Definition of the problem

Some registered nurses did not have the skills to access and utilise the evidence based literature, and could not therefore utilise current evidence to inform the above action cycles.

Activities undertaken

- Audit of the current level of registered nurse knowledge and skill in using computers, and accessing and critiquing the nursing literature.
- Liaison with the trust library regarding the provision of education and training in evidence based practice skills.

The main learning activity undertaken in this action cycle was assisting the registered nurse leading on this action cycle in questionnaire design to identify the educational needs of nurses in relation to evidence based practice skills.

Data collection methods used

- Registered nursing staff knowledge and skill questionnaires (no. = 9).

3.2.2.2 Elm Ward

3.2.2.2.1 To improve team working on the ward

Definition of the problem

The nursing staff were not working together as a unified team which was affecting the standard of care being provided to patients. Team functioning is considered to be a key role of the rehabilitation nurse, with team working skills being considered necessary for nurses to work within a philosophy of re-enablement (Royal College of Nursing 2000).

Activities undertaken

- Two interactive four hour workshops, run by an outside facilitator, were held with eleven nursing staff to identify, explore and problem solve current team working issues.

The learning activities undertaken with staff within this action cycle included:

- assisting staff to identify core issues related to poor team working that were affecting patient care
- reflective discussions related to current staff behaviour patterns and their affect on patient care
- problem solving activities related to improving team working on the ward

Data collection methods used

- Work undertaken by the staff in these meetings was typed up and verified for accuracy by the participants.

3.2.2.2.2 To improve the general standard of care for patients, particularly those whom staff find it most difficult to care for

Definition of the problem

Nursing staff on Elm ward were concerned with the standard of care they were currently providing, and with the discrepancies in the quality of care provided to different types of clients. The concept of the 'popular' patient receiving more nursing attention has long been documented (Stockwell 1972), however it is also suggested that the more popular patients in some care for older people settings may be those demonstrating behaviours that are the opposite of the empowering type (Nolan et al 1995) which staff in rehabilitation settings should be promoting.

Activities undertaken

- Working with nursing staff and patients on the ward one morning a week. Patients were identified whom staff found it particularly difficult to care for, with me then working with and caring for those patients to explore their health and social history which may have been influencing current behaviour, and identifying their care needs and current gaps in care provision.

- Organisation of reflective workshops on the afternoons of these days to feed back observations, explore patient case studies including the patient's health and social history, staff feelings towards the patient, the care they were providing and how it could be improved, and to develop comprehensive plans of care.

The main learning activity planned for this action cycle was reflective discussions related to patient scenarios.

Data collection methods used

- Participant observation was used to uncover discrepancies and gaps in care provision and identify patient scenarios to be explored in the reflection sessions. Observations were recorded in field note entries and it was planned to feed these back to staff in reflection sessions for verification of accuracy and discussion.

3.2.2.2.3 Tell it how it is: using a case study approach to identify current issues, problems and challenges surrounding the care for older people in this rehabilitation setting

Definition of the problem

Action cycles to improve care standards on Elm ward were not successful. It was decided to explore the reasons why. Service managers and nursing staff were invited to identify the problems and challenges surrounding care for older people in this rehabilitation setting.

Activities undertaken

- The current issues and challenges of caring for older people in this setting were identified through staff interviews and focus groups.
- Findings were fed back to ward nursing staff and managers for verification, and a ward action plan developed.
- The ward action plan was reviewed prior to the researcher withdrawing from the clinical area.

The learning activities undertaken with staff during this action cycle included:

- reflective discussions with staff following feedback of findings to enable them to explore and gain an understanding of how their issues and challenges were impacting on patient care

- problem solving activities to develop a ward action plan which addressed these issues and challenges

Data collection methods used

- Data were collected through five semi-structured interviews and two semi-structured focus groups (number of participants = 2 and 4) with ward nursing staff, and semi-structured interviews with two service managers. With the exception of one interview, where the participant declined to be taped, all interactions were audio taped, transcribed and checked for accuracy. Notes were taken of the remaining interview and checked for accuracy by the participant.

3.2.2.3 *Field notes*

Throughout the action phase I kept field notes as a daily record of events. Entries were made regarding progress of all action cycles including formal meetings held, informal discussions with participants, activities undertaken, observations made, further contextual information gained throughout formal data collection, incidents which helped or hindered progress, and outcomes achieved.

3.2.3 *The reflection phase*

The purpose of the reflection phase was to reflect on the process of the study and to measure change over time. Again a multi-method approach to data collection was used including:

- Monitor 2000
- Shortened Quality of Interaction Schedule (SQUIS)
- exit interviews
- field notes

3.2.3.1 *Monitor 2000*

Monitor 2000 was used to measure the quality of care being provided to patients at the end of the action phase of the study (details as in section 3.2.1.3).

3.2.3.2 *The Shortened Quality of Interaction Schedule (SQUIS)*

The quality of social interactions between nursing staff and patients at the end of the action phase was measured using the SQUIS tool (details as in section 3.2.1.4).

3.2.3.3 *Exit interviews*

The nursing staff and service managers for both wards, together with key trust staff who became involved in the study as it progressed, were all invited to take part in exit interviews to reflect on the process and outcomes of the study. From this, twenty semi-structured exit interviews were held with seven nursing staff from Oak ward, six nursing staff from Elm ward, the two service managers, four other trust managers and one consultant geriatrician. With one exception, where the participant declined to be taped, all interviews were audio taped, transcribed and checked for accuracy. Notes were taken of the remaining interview and checked for accuracy by the participant.

3.2.3.4 *Field notes*

Throughout the reflection phase field notes were kept by myself as a daily record of events. Entries were also made regarding summaries of exit interviews and informal discussions following these.

3.3 Data analysis

3.3.1 *Qualitative data*

Field notes, interviews and focus group data were thematically analysed using an approach which incorporated the principles of qualitative analysis outlined by Morse and Field (1996), the process of thematic analysis articulated by Burnard (1991), and methods of coding presented by Miles and Huberman (1994). Data analysis was continuous throughout the study, with different data sets relating to different action cycles and study phases. The following process was used for each data set:

- Repeated listening of audio tapes together with multiple readings of transcripts and field notes to enable immersion in and familiarity with the data to be gained.
- Reflection on each individual interview and focus group and the writing of individual summaries of them, and the construction of monthly summaries of field notes, to ensure a sense of the whole was maintained which could be referred back to during the coding process.
- Application of non pre-determined codes to interview, focus group and field note data.
- Grouping of similar codes under broader categories.
- Linking of categories through the identification of common emerging themes during which transcripts, field notes and summaries were revisited to ensure the themes were true to the data and had not been taken out of context of the whole.

- Memo writing throughout the previous three stages incorporating thoughts regarding codes, categories and themes, their relationships to each other, and data which arose that did not fit for which new categories needed to be considered.

3.3.2 Quantitative data

Monitor 2000, SQUIS, other structured audits and questionnaires were analysed using basic descriptive statistics. Audits which generated particularly large amounts of data (e.g. continence audits and questionnaires) were analysed using an SPSS software package for ease of management. During the study the trust purchased QUASAR software which, following training in its use, was utilised in the analysis of Monitor 2000 data in the reflection phase.

3.4 Ensuring quality of data

The quality of the study was addressed through its attention to the principles of credibility, transferability, dependability and confirmability outlined by Lincoln and Guba (1985). Credibility refers to the truth value of a study and as such reflects the extent to which the data, findings and interpretations are a true reflection of the experience of participants (Lincoln & Guba 1985). To address this findings, analysis and interpretations were continuously fed back to participants for verification, with all written reports and contents of presentations being checked by participants for accuracy prior to them being shared with a wider audience. Prolonged engagement with the study areas over three years facilitated the establishment of trust and rapport with participants which is considered necessary to enable them to be open and honest within the study process (Lincoln & Guba 1985). This was further enhanced through ensuring the confidentiality of data obtained (see section 3.5). Credibility of data was also achieved through the use of multiple methods of data collection and their integration to support and question emerging themes.

Transferability refers to the extent to which study findings are applicable to other contexts or subjects (Lincoln & Guba 1985). This action research report describes events which occurred within a specific and particular context. A rich description of the context in which the study took place, however, is incorporated into the report. It is considered that by doing this it allows others to identify if the context is similar to their own, and thus if the findings are applicable to their own practice situations (Meyer et al 2000). Findings from this study therefore have the potential to be generalised outside of this particular context through the recognition of relevance by individual practitioners.

Dependability refers to the extent to which research actions undertaken were logical and consistent (Lincoln & Guba 1985). Throughout this report methodological and analytical

decisions have been described allowing others to clearly follow and assess the appropriateness of the processes undertaken in reaching final conclusions.

Confirmability refers to the extent to which the findings of a study are determined by the participants and conditions of the inquiry, and not by the perspectives or biases of the researcher (Lincoln & Guba 1985). Constant referral back to raw data during analysis was made to ensure that findings were grounded in the data, together with verification of interpretations by participants as previously described. A review of my perceptions of the two study wards was also undertaken during analysis to ensure that I remained grounded in the data and was not unconsciously influenced by them (see section 4.2.1).

Waterman et al (2001), following a systematic review of action research, provide guidance for the assessment of such research in the form of 20 questions (see appendix 1). This had not been published at the time of commencement of this study and so could not be used as guidance for areas of consideration in setting up the research. I have, however, attempted to incorporate the essence of these questions into the writing of this report where possible. It can be seen that not all areas for consideration were addressed during the study thus highlighting limitations which existed within the process. These limitations are addressed later in the report (see section 6).

3.5 Ethical considerations

Ethical approval for the study was gained from the East London and the City Health Authority (ELCHA) Research Ethics Committee. Access to the study wards was negotiated with the trust project lead and the ward sisters, nursing staff and service managers working within those clinical areas, as was the study proposal and methodologies to be used. Although it was stated that participation was voluntary, it needs to be recognised that some staff may have felt pressured into participating due to the enthusiasm of other ward staff members. This was addressed through individual meetings with ward staff to provide verbal and written information about the study and explore any concerns they may have had. It was also stressed that they could decline to participate in formal data collection methods and activities at any time. Only after these meetings was written consent to participate gained. Ground rules were also set collaboratively between the researcher and ward staff at the beginning of the study which incorporated data management strategies, data access, individual responsibilities and issues of anonymity. No staff declined to participate in the study as a whole, however some did decline to be formally interviewed and not all participated in action cycle activities.

Patients and carers also took part in the study through voluntary participation in response to requests by the researcher. Written consent was gained following the provision of verbal and written information and the opportunity to ask questions. They were assured that declining to participate would not affect their care in any way.

An ethical dilemma of action research is that true informed consent is difficult to obtain as the course the research will take is not always known at the beginning of a study. Due to the participative and democratic approach taken in this study it was not known in advance what particular areas participants would want the research to cover or the data collection methods that would be used within it. I therefore revisited consent procedures with participants with any new methodology undertaken, as well as working throughout the study within the 'principles of procedure for action research' ethical framework outlined by Winter and Munn-Giddings (2001).

Due to the study taking place on two ward areas which were regularly accessed by a variety of individual practitioners, patients and visitors, it was not possible to individually inform all people passing through the wards that an action research study was taking place. To address this posters and information leaflets regarding the study, which also incorporated my name, photograph, contact details and planned observation schedules, were displayed in both study ward areas to inform all patients, carers and visiting professionals that the study was being undertaken.

Anonymity of the study wards within the trust could not be guaranteed as the staff in the organisation knew where the study was taking place. However, the confidentiality of raw data was maintained through the use of individual codes as opposed to staff names. All electronic data were stored on my individual computer with paper copies being stored in a locked filing cabinet accessible only by myself. Pseudonyms for the individual wards have been used in this report with collective titles being used for small, similar groups of staff to prevent individual identification. Any written reports or visual presentations were checked by staff to ensure confidentiality had been maintained and individuals could not be recognised.

4. FINDINGS

As with the methods section, for ease of explanation the study findings will be presented in relation to the previously described three study phases – the exploration phase, the action phase and the reflection phase. By presenting findings in this way it will also help links to be made more easily with the study objectives and how these were attempted to be met. The overall purpose of the findings section is to present the evidence upon which the final discussion is based thus enabling the reader to judge whether the conclusions arrived at are sound, relevant and true to the data.

Data gained in the exploration phase identified the social and environmental context within which rehabilitation care for older people was taking place, the quality of care that was being provided, where gaps in care existed, and the current issues and concerns of participants. These findings serve two main purposes in the context of this report. The first is to provide a description, in combination with sections 1.2 and 1.3, of the context within which the study was taking place. This will allow others to identify the relevance of this research to their own practice settings as well as providing the reader with an understanding of the baseline from which we were attempting to develop practice. The second purpose is to provide the data which influenced and informed the decisions by nursing staff to focus on certain areas of practice during the action phase of the study (the action cycles) thus giving the reader the opportunity to consider the justification for the work undertaken.

Action phase findings report on the activities undertaken within each individual action cycle, the evaluation of their effectiveness, and identification of any outcomes achieved. Staff reflections and evaluations of the action cycles were explored during exit interviews and for ease of comprehension, and to avoid fragmentation of data, these reflections and evaluations are included in this section. During analysis of the action phase data I was surprised by some of the findings that arose, and recognised that I had formed my own views of the two wards participating in the study and the success or otherwise of the activities undertaken. I therefore felt it necessary to consider and outline my current thoughts at this stage, and keep them in mind during further analysis, to ensure that findings were based on and were true to the data as opposed to being influenced by my own thoughts and feelings. A summary of this outline is provided at the beginning of the action phase section to provide the reader with the opportunity to judge if I was successful in this endeavour.

Reflection phase findings focus on two main areas, the first being a discussion of the repeat of structured baseline data collection methods to measure change over time. Second, building on the action phase findings which indicate the effectiveness of activities undertaken, findings in the reflection phase identify the factors that appeared to help and/or hinder developments from taking place. This section builds on the action phase findings by addressing and

evaluating in more detail the study process itself and its influence on the potential for development.

4.1 Exploration phase findings

Exploration phase findings are divided into two corresponding main sections:

- The context of care
- Action cycle data

In presentation of these findings all data collected during this phase have been integrated to prevent fragmentation, repetition, and to present a whole picture view. For percentage scores of Monitor 2000 and SQUIS results, please see appendices 2 and 3.

4.1.1 The context of care

Data collected in the exploration phase regarding the context in which rehabilitation care was being provided highlighted a number of key issues that impacted on the ability and motivation of staff to provide rehabilitation care. These concerned the care environments and facilities, support services and resources, focus of care provision, and staff support.

4.1.1.1 Inadequate care environments and facilities

Data gained in the exploration phase highlighted the inadequacy of the ward environments in relation to the provision of rehabilitation care. Neither of the study wards were specifically designed for rehabilitation being of the old 'Nightingale' style with their sizes, layouts and facilities presenting a challenging environment in which to provide rehabilitation care for older people. The 'Nightingale' layout meant that wards were cramped in space and afforded little privacy for patients. There were long distances for patients to walk to bathrooms and toilets which were small and not easily accessible to those with mobility and dexterity difficulties. Also, due to the age of the hospital building, they were in a poor state of repair. With the exception of a communal dining table on Oak ward there were no social activity areas or general living spaces on the wards as they did not have day rooms.

Staff felt that the ward environments impacted on the standard of rehabilitation care they could provide. This was supported by the observations of one of the lead research and development nurses from another trust who came to a meeting at the hospital. An excerpt from her field notes, which she copied to me, stated:

'The wards looked cramped, overcrowded, disorganised and unfit for their primary rehabilitation purpose... I wonder how patients can see the potential for recovery and progress in such environments – there is no prospect of improving to be able to go to

the day room, or dining room or garden. The patients were sitting around their beds; there was no space to facilitate their involvement in their self-care, socialisation, and group activities, own health promotion – these basic things are the key principles of rehabilitation.’ (Lead research and development nurse 2)

Patients and carers commented on the lack of stimulation the ward environment offered and that they had nothing to look at or distract them while they sat all day by their beds:

‘We’re right in that corner, we’ve got a blank wall in front of us.’ (Patient 5)

‘It would be nice if there were things on the wall for the patients to look at. Because patients are sitting and staring ... There’s nothing bright is there, nothing on the wall.’ (Carer 6)

As well as the impact of the environment on the ability of staff to provide rehabilitation care, there was also a concern for staff on Elm ward that the environment was ‘dingy’ and difficult to maintain:

‘(Nurse) said that the ward environment was awful and that they were fighting a losing battle to keep it tidy, clean and look presentable.’ (Field note 10/00)

This was accompanied on both wards by old furniture in poor condition, with staff and carers commenting on beds and bedside tables that were difficult to move:

‘So some of the furniture needs replacing ... I’m aware that the beds aren’t as good as they could be.’ (Carer 7)

As well as the considered inadequacy of the ward environments for care provision, the general facilities in the hospital for patients and staff were also poor. The staff canteen was shut at weekends and, one year into the project, this service was reduced even further with it only being open from 8am – 2pm on week days, with access to a poorly stocked food carousel and microwave then being the only meal provision for staff. For patients and relatives the League of Friends coffee shop was open until 1pm Monday to Thursday and 7pm on Fridays. Outside of these times there was no place for visitors to obtain food or a hot drink or take the patient they were visiting socially outside of the ward environment.

As services in the hospital decreased in preparation for future closure and a move to the main hospital site there was a lack of visible activity, and at times it looked deserted:

‘My first impressions of the hospital - it felt as if it had been ‘abandoned’. There was little activity outside of the individual wards and departments, and you could on some days walk the entire length of the hospital corridor without passing anybody.’ (Field note 01/00)

4.1.1.2 Lack of resources and support services

As well as the environments of care and hospital facilities being considered as inadequate, staff also commented on the lack of resources and support services available to assist them in care delivery. Nurses on both wards felt they were inadequately staffed to provide the care required by their patients. The staff on Elm ward specifically commented on the inadequate provision at night where they had three nurses for 29 patients. This was supported by SQUIS observations, one of which stated:

'We arrived on the ward at 21.30, but no interactions occurred with the patients being observed until 21.53. Are three nurses for 29 patients adequate at night? Patients may have to wait long periods for attention.' (Field note 01/01)

The staffing establishment was also queried by the staff on Elm ward, with temporary bank and agency nurses being used regularly to make up the numbers which they felt adversely affected continuity of care together with the support nursing staff could gain from their peers. Agency nurses did not work full shifts, with there being no agency cover between 12.30 - 15.00 and 20.30 – 21.15. This put more pressure on the reduced number of regular staff working during these times. Both wards felt that two registered nurses per shift was also inadequate to meet patient needs:

'(Nurse) felt that there needed to be more trained nurses on the ward to enable them to give a higher quality of care and keep up to speed on things such as documentation.' (Field note 01/01)

In addition to the above concerns regarding staffing levels, it was also expressed by patients and carers that there was not enough therapy provision. Staff on both wards stated that patients and carers were told they were being transferred for intensive rehabilitation, and therefore had expectations of daily physiotherapy and ward based occupational therapists which were not met:

'The word 'rehabilitation', they expect to come and see plenty of physios getting somebody up every half an hour and walking with them, and we know that's not going to happen.' (Nurse 8 Elm ward)

The lack of therapy provision was also highlighted in SQUIS observations where no therapy activity was coded on either ward during any of the observation periods.

As well as the stated inadequate staffing and therapy levels, lack of other service support could also be seen to add unnecessarily to the workload of nursing staff. There were no ward based administrative support staff (ward clerks) which resulted in nurses needing to leave patients to constantly answer the telephone and ward entry buzzer, and spend time faxing information to other departments and services. Also, outside the hours of 9am to 6pm, phone calls to external numbers had to be made via the main hospital switchboard which often took a long, and what was considered to be unacceptable, length of time to respond.

Domestic services at the beginning of the study were also considered to be inadequate by ward staff. There was only one regular domestic on each ward in the mornings, with an evening domestic only briefly visiting each ward to collect supper plates and provide a tea round. Therefore, once the morning domestic had gone home at 15.30, there was no further cleaning of bathrooms, toilets or general ward areas, the bins were not emptied, and patients were not provided with fresh drinking water until the following morning. Ward staff also stated that they often had to clear the supper plates themselves when the domestic arrived late:

'The cleanliness of the ward needs to be addressed as well ... we need to have some more help in keeping the ward clean.' (Nurse 8 Elm ward)

4.1.1.3 Lack of a rehabilitation care focus

As well as the environments, facilities, resources and support services being considered as inadequate to support rehabilitation care provision, the lack of a rehabilitation focus by staff towards care was also highlighted. Although designated as rehabilitation wards, the study areas were not providing this as described in the literature:

'The whole process of enabling and facilitating the restoration of a disabled person to regain optimal functioning (physically, socially and psychologically) to the level that they are able or motivated to achieve.' (Waters & Luker 1996 p.107)

From the baseline data collected gaps could be identified in the understanding by nursing staff of what rehabilitation was. The main focus of care was on meeting the physical needs of patients rather than the social, psychological and emotional aspects which accompany acute and chronic illness. Staff commented that many of the patients transferred to them were not suitable for rehabilitation because they did not have physical rehabilitation needs:

'(Nurse) said this is all very well, but at the moment they only have three patients for rehabilitation, and most of the patients they have at the moment are confused.' (Field note 04/00)

This lack of understanding could be attributed to the backgrounds of the staff on the wards which can be gained from the staff profiles carried out during the study. Only half of the staff on the rehabilitation wards for older people at this time were there through choice, with the other half not being originally employed for that speciality. Less than a third of the nursing staff on the wards had any previous experience of working in rehabilitation settings, and only two staff had any previous training or education in rehabilitation nursing. Staff stated that when the ward functions were originally changed to provide rehabilitation for older people they were not provided with any education or training in preparation to care for this client group.

As a possible result of this lack of knowledge, baseline data indicated that rehabilitation philosophies did not permeate the wards. Comments from staff that they did not have time to 'do' rehabilitation suggested that they saw it as a separate part of the job from nursing rather

than as a combined, integrated approach to care. An enabling culture was not evident, with routines and speed prevailing over a facilitative approach encompassing individualised rehabilitation goals and interventions. This was highlighted during SQUIS observations:

*'On visiting the ward at 08.00 I was struck by the fact that most of the patients were already up, washed and dressed, or in the process of being helped to do so. By 08.15, when breakfast started, nearly all were ready for the day. This seemed very quick and I wondered how much of a rehabilitation focus there was, or how much was just staff doing **for** patients for speed.'* (Field note 10/00)

During feedback sessions staff recognised this and talked about how they do things for patients rather than encouraging them to do things for themselves as it is quicker:

'They said they are not providing rehab, but they don't have the time.' (Field note 08/00)

Adherence to routines, and lack of control over their day and activities, was also highlighted by some patients:

'... they put you to bed, you're all nice and clean, tidy ... and when their shift starts ... 'are you clean?' I say 'yes', 'I've got to make sure', and over you go. Why do they do that?' (Patient 1)

Staff on Elm ward specifically expressed that it was hard to find time for rehabilitation due to the size, number of patients and number of staff on the ward, and that routines were necessary in an attempt to meet the fundamental care needs of patients.

Lack of an enabling culture was also highlighted through the Monitor 2000 results. Patients were not re-assessed on transfer to the rehabilitation wards, with previously undertaken assessments not identifying their abilities, needs or help required. The assessment forms used were not designed with a rehabilitation setting in mind which restricted the depth of assessment that could be achieved using this documentation. Recorded goals of care and planned interventions were non-specific. Goals did not identify what individual patients were aiming to achieve physically, socially or psychologically, with interventions not distinguishing between the activities the patient could, or was trying, to carry out, the assistance required, and those that needed input from ward staff or therapists. Evaluation records were again non-specific and did not identify patient progress towards individual goals and a move to more independent living.

Lack of an enabling culture was further highlighted in patient and carer interviews and focus groups. Neither patients nor carers felt they were involved in the assessment, care planning or care evaluation process, with only 50% of patients being aware of their probable future plans. Ability to participate in care was further hindered by a lack of information provided to them. Patients felt they were not always given explanations or information about their care,

treatment and progress, with relatives stating that they had to constantly push and chase people for this:

'It would just be nice if there was somebody that you could go to and say 'how's it going with my mum? Can you tell me what happened today' ... It would be nice if you didn't even have to ask, if someone just volunteered. That would be really nice.'
(Carer 6)

4.1.1.4 Poor staff support

As well as working in what was considered to be inadequate environments with insufficient service support, some staff also expressed that they did not feel valued, cared for or supported within the organisation with regards to the provision of care. They highlighted a lack of communication with them, and stated that they were not consulted about organisational changes that were inflicted upon them (e.g. ward moves) of which they were often given little information about or preparation for. They said there was no negotiation with them and that they were just 'told what to do':

'There's no communication ... even if you went to the ward and you said to the nurses 'this is happening' instead of just pulling these changes ... that's how we've felt it, that we've always been manipulated and downtrodden, because people have never given us the respect that we think we deserve.' (Nurse 8 Elm ward)

'The nurses asked for the patient to be sent in the afternoon when they had more staff (only had three nurses on an early shift for 29 patients). The patient was sent before lunch.' (Field note 01/01).

This expressed lack of value and consultation was supported by other information I obtained during this time. The new acting ward sister on Oak ward had unsuccessfully applied for permanent ward sister posts in the past but had regularly been given acting posts to fill gaps when required by the organisation. No support or development had been provided to help her gain the skills required to secure the elusive permanent post. Also, plans to open a 'winter pressures' ward and move staff from both study wards to manage it were not communicated until the last minute:

'I was informed of the winter pressure plans. The changes are due to take place in two weeks time. I asked if the staff on the wards had been informed and (service manager) said she hadn't told them yet.' (Field note 10/00)

Staff also felt that managers within the organisation did not listen to, and had little interest in, the issues that nursing staff faced on a daily basis, and that they did little to help to address these issues:

'(Nurse) said that people needed to listen to the nurses. (Nurse) said they don't make a fuss because they want an easy life, but they make a fuss because they care about the patients.' (Field note 10/00)

'(Nurse) said people are not given the resources or the support to do things. (Nurse) said the staff know what needs to be done but no-one will help them do it.' (Field note 10/00)

Even the risk management procedures within the organisation, which provided the mechanism for highlighting issues and concerns, were not found effective or supportive by staff:

'I asked if the staff fill in an incident form every time an inappropriate transfer occurs. (Nurse) said I used to do that but they just get returned with 'no action required' written on them.' (Field note 10/00)

The staff also felt that managers within the organisation were not visible within clinical areas to provide feedback and support unless a negative incident had occurred, which again indicated to staff a lack of interest in what was going on at ward level:

'(Nurse) said that the managers are not visible. They don't have anyone come round to see if they're doing a good job. (Nurse) said they used to be wary of the old matrons, but at least they made sure that people were doing their job properly. (Nurse) said that no managers come to see what goes on on the ward and there's no feedback.' (Field note 08/00)

The contexts of care in which the staff were working i.e. a hospital separate to the main site which was undergoing closure, had poor environments and facilities for staff and was in a poor state of repair, only added to their feelings of not being valued or cared for. These experiences also resulted in a view by some staff that, although they were frustrated about the standards of care they were able to provide, nothing would ever change:

'(Nurse) said that poor transfers had been happening for ages. There had been investigations in the past into inappropriate transfers but nothing ever happens to change it. It is constantly brought up at meetings, but again nothing changes.' (Field note 08/00)

They also influenced how staff viewed the action research project, with some being cynical about its ability to change things:

'(Nurse) said they have had research projects on the ward before. The results were presented to managers but nothing was done with them, and nothing changed. During one study the ward shut halfway through and the research was terminated.' (Field note 08/00)

Lack of support for staff was not restricted to the two study wards, or the service group to which they belonged. I also personally experienced an organisational culture of lack of

support when asked to check on a six bedded unit which had opened overnight to cope with a shortage of beds on the main wards, and make sure that it had the equipment and facilities required to provide adequate care. Numerous problems were identified, however although reported, no support from organisational managers was forthcoming:

'The whole situation was unsatisfactory and unsafe. The lack of support from managers was astounding. I cannot believe that a ward can open overnight and the managers responsible do not even visit it the next morning to make sure everything is OK. Also, after being told of issues arising, they do not help to solve problems or even seem in the slightest concerned about the safety of care provided. They really seemed not to care at all about the patients or the staff, which echoes much of the fieldwork I have done so far.' (Field note 01/01)

It also has to be acknowledged, however, that nursing staff did not always take responsibility for changing the situation they were in. They did not always report their concerns about care issues or staffing levels to managers, and often suggested that others needed to 'sort things out' for them. In a feedback session one service manager stated:

'This is interesting as nurses always tell me that everything is alright when obviously it isn't.' (Service manager 1)

This lack of responsibility is supported through field note entries:

'I encouraged them to fill in an 'unsafe staffing levels' form. They said they didn't have any. I encouraged them to find one. The fact that I had to persuade them to do this again questions how much responsibility they are willing to take.' (Field note 01/01)

'Neither of the nurses had had a coffee or lunch break as no relief for them was given, however they had not asked for it. By telling me they had not had a break they are taking on the victim role but are not prepared to fight their case.' (Field note 01/01)

In conversations with staff it also appeared that they did not have a good understanding of the challenges, issues and pressures faced by managers on a daily basis, or of their role within the organisation. A staff management split may therefore have been emerging here with each side appearing to exhibit a lack of understanding of the other's issues.

4.1.2 Action cycle data

Following the feedback of exploratory data to the staff on each study ward they identified areas of care they wanted to work on to improve the care for their older patients. This section outlines the specific data that informed the agreed action cycles.

4.1.2.1 Oak ward

The exploratory data identified that there was a good standard of physical care provided for patients on Oak ward, with this being supported by the participant observation undertaken. Nurses were knowledgeable about their patients who looked well cared for, with their hygiene needs being met to a high standard and attention being paid to their appearance. One carer stated:

'My mother always seems comfortable... she's beautifully clean, always.' (Carer 6)

The nutritional needs of patients were also met to a high standard with mealtimes, supervision of intake and the provision of alternative supplements being given a high priority. Documentation, however, failed to support the good standards of physical care, which could explain the low Monitor 2000 scores in comparison with observation, interview and focus group data.

The majority of patients and carers interviewed expressed that most of the nurses were caring, polite and did their best for the patients, with care on the ward being compared favourably to other in-patient hospital stays the patients had experienced. This positive approach of nurses was also supported by participant and non-participant observation, with SQUIS data identifying negative interactions being carried out by only two of the fifteen members of staff observed. Patients, carers and observation also highlighted the organised, calm, relaxed and welcoming atmosphere on the ward which was considered conducive to good care:

'And the ward, I've got to say this, it's very quiet, which I think is so important for elderly people.' (Carer 7)

On approaching some carers to join the focus groups they responded that they had no concerns about care on the ward, that the care was good, and they didn't feel the need to come to a focus group. This was reflected by one carer who did volunteer to be interviewed:

'Standards of care though are excellent...One of the things about (acting ward sister) is that she has got standards within the ward.' (Carer 6)

On observation the staff on the ward appeared to make a good team and work well together. They seemed willing to help each other and to communicate well:

'Regarding individual interviews as a method, some nurses expressed that they would be happy with just focus groups. They said that one of the ward aims was to be open and honest with each other, and they were happy to share their individual views in a group.' (Field note 07/00)

The acting ward sister, although sometimes clashing with staff due to a controlling and authoritative style at times, appeared knowledgeable, friendly, to care about the patients and staff, and be motivated and enthusiastic. This was supported by patients and carers:

'She is absolutely wonderful. She has this enthusiasm which is so contagious ... although they (visitors) may not say anything they will go away with certain impressions, and (acting ward sister) gives a lovely impression ... you feel really more relaxed going out and leaving mum in their hands.' (Carer 6)

The standard of physical care and quality of the team provided a sound foundation on which further improvements in practice could be built, with them identifying four areas of development they wanted to work on in relation to rehabilitation practice.

4.1.2.1.1 Action cycle 1 – To improve the standard of patient transfers to the rehabilitation wards

From the exploratory data collected it was identified that the transfer of patients to the rehabilitation wards needed to be improved. Staff on Oak ward stated that the information they were given about patients from transferring wards and the information on the 'nurse to nurse' forms accompanying the patients on transfer was inadequate, providing the receiving ward with little information about the patient's current condition and care needs. On some occasions no verbal communication from the transferring ward took place at all before the patient arrived. Staff also commented that decisions to transfer were not always appropriate, with them considering some patients as 'too sick to be here':

'(Nurse) said it is not that we don't want to nurse the patients, but they're not well enough to be here.' (FN 10/00)

Issues were also raised regarding patients being transferred before their fundamental needs had been met for that day, together with them arriving without all of their notes, named medication and property. Staff considered that current transfer practice compromised patient safety on arrival, as well as placing extra work on the staff of the receiving ward.

The psychological and emotional status of patients on transfer was inadequately addressed with the preparation and information given to patients and carers before and after transfer being considered inadequate. The Monitor 2000 audit showed that patients and their relatives did not always know why they were being transferred, what facilities would be provided to make their transfer worthwhile, and what their future plans were. In addition any fears, concerns or apprehensions regarding the transfer were not explored. Due to inaccurate information they also often had unrealistic expectations of the transfer as previously described (see section 4.1.1.2). Orientation to the ward on arrival was lacking with patients not being orientated to the ward layout or being informed of general ward routines, visiting hours or ward telephone numbers. Patients were also unaware of ward facilities such as daily newspapers, weekly large print newspapers, hospital radio, the library trolley and the availability of talking books.

4.1.2.1.2 Action cycle 2 - To meet the patients' needs for sleep, rest and activity more effectively

The baseline data identified a lack of attention to patients' needs for sleep, rest and activity. Assessments were not undertaken of their previous and current sleep and rest patterns, routines and difficulties. Difficulties experienced were not addressed in patient plans of care, with evaluation at night being non-specific (e.g. eyes closed for long periods).

The ward routines also demonstrated a lack of attention to individual needs for sleep, rest and activity. SQUIS observations highlighted a flurry of activity in the morning followed by long periods of inactivity with nothing going on. Fitting routines around shift patterns rather than patient needs was also observed:

'When we arrived on the ward at 19.00 the patients were already in bed or ready to get in and dozing in the chair... When we walked onto the ward at 21.30 the picture was a complete contrast to 19.00. It was a hive of activity. All the patients were now awake. One lady had got out of bed and was watching the television. This seemed a topsy turvey way of providing care – all patients settled and asleep at 19.00, but awake and lively at 21.30.' (Field note 10/00)

Patients and carers also commented that patients did not get offered a hot milky drink at night to help them settle.

There was a lack of provision for social interaction and activity on the ward, with no assessment being made of patients' hobbies, interests, former occupations or how they normally spent their day. SQUIS observations identified that patients 'just sit all day' with 89% of interactions observed being focused around fundamental and clinical care, with no social or individual diversional activity being coded during any observation period. Staff stated that they felt patients were bored, with this being backed up by patient interviews and focus groups where the experience of boredom and lack of activities available to pass the time were highlighted:

'It's a boring old day, for sure ... just sit there more or less and look at each other ... not much to do anywhere at all.' (Patient 3)

This was further supported by field note comments:

'As we got up to leave (patient) asked 'Are you coming back?' I replied 'yes later', to which she commented 'Oh good'. It seems a change from the normal routine, and fresh faces are welcomed. We may have been the only diversion the patients have had for a long time.' (Field note 10/00)

There was a television constantly on at the end of the ward, however only those patients in beds nearest to it could see and hear it. Patients commented that they would like to watch the television but did not ask to be moved nearer to it as they did not want to bother the staff:

'But then it's causing trouble for the nurses there ... I don't want to put any extra work on people.' (Patient 1)

The need for social interaction was also demonstrated through the process of patient interviews for the Monitor 2000 audit:

'Patient interviews lasted between 60 and 90 minutes with patients discussing previous life experiences and events as well as providing the information required for the audit... one patient expressed that he was glad of the company... This indicates that the patients wanted to talk to someone and were possibly bored and lonely.' (Field note 09/00)

The 'Nightingale' ward layout was also identified as a barrier to social interaction, with the bed-locker-chair arrangement making it difficult for patients to talk to each other:

'So if you want to speak to your neighbour, you can't do it.' (Patient 4)

There was a communal dining table on the ward, however patients were not encouraged to use it.

The staff stated that they used to have occupational therapists and volunteers providing a programme of activities for patients on the ward, but that it no longer happened. The lack of a hairdressing service was also highlighted by staff, patients and carers.

4.1.2.1.3 Action cycle 3 - To improve the continence care for patients

Getting their toileting needs met was a major concern for patients. Issues raised included being challenged when you ask for a bottle or bed pan, having to wait, and the fear of having an 'accident':

'If you ask for a bed pan, 'well are you sure you're going to use it?' Well no one can be sure of human nature... then the next day... you just say well I'm alright like this, 'no, no, no, you're likely to do it in the bed again.' (Patient 1)

Although nurses were observed regularly toileting patients identified as having problems with continence, an absence of comprehensive continence assessments, diagnosis and care management strategies meant that a focus on the promotion of continence and effective and appropriate management of incontinence did not prevail.

4.1.2.1.4 Action cycle 4 - To improve the evidence based practice skills of nurses

During the early stages of action cycle development it was identified that some staff lacked the skills needed to access and critique evidence based literature. This affected their ability to engage with practice development initiatives and implement evidence based rehabilitation care:

'(Nurse) said she would not know how to access the literature around this topic and did not know how to use the computers.' (Field note 01/01)

'(Nurse) brought a couple of articles with her but said she did not know what to do with them now.' (Field note 04/01)

This action cycle was therefore addressed further into the action phase of the study.

4.1.2.2 Elm ward

Elm ward had a much more difficult start to the study associated with the ward move during the exploration phase (see section 1.3.3). The ward had become much bigger due to an increase in bed numbers, and the client group had changed. The ward was designated as having 7 rehabilitation beds for young medical patients and 22 rehabilitation beds for older people, however immediately after the move a variety of other patients were transferred to them including patients from general surgery, orthopaedics, gynaecology, dermatology and patients with organic mental health problems. The patients at one time were being managed by seven different consultants who each carried out their ward rounds at different times, with nurses often not knowing when to expect them. The staff expressed that they did not have the knowledge and skills required to look after this mix of patients and that it was difficult to meet the specific needs of older people within it. The patient dependency had increased, and there was also a high proportion of confused older patients on the ward being indicated by the fact that only two patients were able to be interviewed at the time of the Monitor 2000 audit. Staff also commented on the large amount of nursing time required to dress the complex wounds of dermatology patients. Lack of preparation for the ward move, the patient mix, a changed nursing team and the challenging environment in which care was taking place resulted in a ward that was unable to work efficiently and provide a consistently good standard of care to patients.

The Monitor 2000 and SQUIS results indicated that the nursing approach to patients was polite, calm and efficient, and that the patients looked well cared for. They also indicated that the physical care provided to patients was of a good standard and that hygiene and nutritional needs were met. Participant observation, however, failed to support this. There were some periods where the fundamental needs of patients were not met, with nurses not always responding to their immediate needs or requests:

'One patient, who was wet, waited over an hour to be changed because the staff were having report.' (Field note 10/00)

Communication with patients was sometimes poor with little interaction during activities taking place. This was supported by SQUIS observations where, although ten positive social interactions were coded, eight of these were all by one individual:

'The patients' needs are mainly provided for but interactions are generally just enough to get the task done. Staff are not rude or unkind, but social interaction, banter and encouragement are not always forthcoming.' (Field note 01/01)

On observation the majority of staff appeared to be low in themselves with little enthusiasm. They also looked worn out, with some staff working long days to ensure the ward was covered. The observation that the staff had run out of energy to go the extra mile for their patients was validated by the staff during feedback sessions:

'I do not think that the staff do not care, I think they don't have the energy or motivation to express it.' (Field note 01/01)

When asked why they felt this was the staff expressed that the work was more stressful since they moved, with a bigger ward, different client groups, a different skill mix, and need for a wider range of skills.

The ward sister appeared to be as low as the rest of the staff and almost at a loss as to how to manage the new ward and team:

'She does not seem strong enough to pull them out of their low ebb ... she does not seem to be managing the ward or situation effectively, is letting things slip, and does not seem to be assertive enough to improve the situation.' (Field note 08/00)

One of the service managers informed me at this time that she was getting 'overrun' with complaints about the ward from patients, relatives and other health care professionals. Feedback from a patient experience inspection also raised concerns about staff attitudes and standards of patient care. My reflections at the end of one shift on the ward supported these concerns:

'I feel that standards are slipping. The ward looks messy and confusing. Nobody seems to know what others are doing. Patients do not receive responses when asking for help. Nurses do not seem to know enough about the patients to answer relatives queries, and I sometimes cringe when I hear their responses and see the relative being referred to many other nurses before their questions can be answered.' (Field note 08/00)

Due to the difficulties faced on the ward at this time, the action cycles negotiated focused on the key needs of staff to enable them to raise the general standard of care for patients rather than on specific aspects of rehabilitation care.

4.1.2.2.1 Action cycle 1 - To improve team working on the ward

From the participant observation undertaken it could be seen that the nursing staff were not working together as a team:

'There seem to be tensions within the ward team that were not there before the ward moved. I feel that the team at the moment is dysfunctional.' (Field note 08/00)

During a focus group staff verified this observation and commented that the nurses were pulling in different directions, not supporting each other, and that there was a lack of communication between them with information and feedback not being shared. There was felt to be a lack of respect for each other and a prevalence of unhelpful attitudes and gossip. Nurses in the team did not help each other out, and conflict within the team was avoided rather than addressed:

'I think the majority of people do care about the patients, but they don't care about each other.' (Nurse 8 Elm ward)

It was also felt that no one took responsibility for patient care. Staff felt this was affecting the care provided to patients as it resulted in omissions in care, care that was fragmented and uncoordinated, and a lack of clear lines of accountability. Staff again associated the current lack of teamwork with the work being more stressful since the ward move. Health care assistants also now felt less supported by registered nurses who, it was stated, were becoming more isolated from patient care.

4.1.2.2.2 Action cycle 2 - To improve the general standard of care for patients, particularly those whom staff find it most difficult to care for

Participant observation had identified times and scenarios where the fundamental needs of patients were not met and care could be described as superficial, with there being a lack of understanding and respect of how the patient may be feeling or why they may be behaving in a certain way. This seemed to be attributed to certain, but not all patients:

'I felt upset at the way these two patients were treated. I wanted to go and give the female patient a cuddle and tell her it was all right. I wanted to go and talk to the male patient and give him some tender loving care. For both these patients the caring was missing – why?' (Field note 01/01)

In feedback sessions staff acknowledged that they did not meet the needs of all patients either physically or psychologically, and that patients they found it 'difficult' to care for due to certain behaviour patterns were sometimes approached differently to others. They also expressed that they found it difficult caring for patients who were confused:

'(Nurse) said that patients wander, and it's difficult to keep an eye on them and stop them from leaving the ward.' (Field note 02/01)

The general standard of care being provided on the ward was of concern to staff, who articulated that it was below what they would like to be able to give.

4.1.2.2.3 Action cycle 3 - Tell it how it is: using a case study approach to identify current issues, problems and challenges surrounding the care for older people in this rehabilitation setting.

Attempts to improve the standards of patient care on Elm ward through the above action cycles were not successful (see section 4.2.3). Project initiatives were hindered by poor staffing levels on the ward together with a lack of staff commitment to and participation in activities. Actions implemented to improve practice were not sustained which led me to question how much impact the study could have on the ward:

'I don't feel the staff are engaged in the project, it seems to be passing the staff by. I don't feel I've achieved much here, and question if I ever will.' (Field note 06/01)

The staff did not seem able to overcome the destabilisation that resulted from the ward move, and concerns around care standards and staff performance grew amongst the ward staff, service managers and myself. Incidents were observed where patient needs were ignored, respect and dignity was not maintained, fundamental care was not provided, and patient safety was compromised:

'I was horrified at what I had seen this shift. Neglect on this scale had not been identified through Monitor 2000 or SQUIS and it was a shock to see it happening. There was no respect, dignity or caring exhibited, and the attitude of staff was very poor. Vulnerable patients were at the complete mercy of the staff and were treated very badly. This has raised some serious issues that need to be addressed.' (Field note 04/01)

It was felt that these issues needed to be addressed by the organisation and, due to their serious nature, were not within the study remit. However it was felt that one way I could help in this process was by presenting a full picture of the current issues and challenges surrounding the care for older people in this rehabilitation setting from which a developmental plan from both a clinical and managerial perspective could be devised. This was carried out in collaboration with the service managers and the ward staff.

4.2 Action phase findings

Action phase findings are divided into four corresponding sections:

- My perceptions of the study wards and outcomes
- Oak ward action phase findings
- Elm ward action phase findings
- Additional outcomes achieved not linked to individual action cycles

4.2.1 My perceptions of the study wards and outcomes

As stated previously, during the analysis of action phase data findings arose which, for me, were unexpected. This prompted me to consider my views of the two study wards and my perceived success of the development work undertaken before further analysis took place. A summary of this is presented here.

Throughout the exploration and action phases I formed a very positive view of Oak ward. The ward generally appeared calm, quiet and organised, and I felt that whenever I visited the ward I was welcomed and the staff were pleased to see me. I felt that the monthly meetings arranged with the staff to discuss the study proposal, methodologies, feedback and review study progress were generally well attended when staffing levels and workload allowed, with the staff always aware that they were taking place and organising their workload to enable them to be there. I also felt that patients received a good standard of physical care which reinforced my positive view even though some of the more psychological and social needs of patients were not being met. With the exception of the activities to address the patients' needs for sleep and rest I was of the opinion that the action cycles on Oak ward were successful with them being led by the staff and positive outcomes being achieved. I also felt that all staff were motivated, enthusiastic, engaged in and supportive of the study, with all of them participating to some degree in the development initiatives undertaken. This led to me associating any implementation difficulties with organisational issues such as shortness of staff and increased workloads. Some of my comments recorded in my field notes during this time supported this view:

'My current view of Oak ward is that the staff make a good team and work well together. They are enthusiastic and willing to think about their practice. The ward has a good atmosphere. Standards of basic care are good. The staff appear to want to change and are ready to go with the research. I feel very positive about the ward and want to work with them.' (Field note 08/00)

'The feedback and action planning sessions on Oak ward have all been very positive with lots of discussion. I feel I am building good relationships here and that developments will take place.' (Field note 01/01)

'Met with (nurse). She had worked really hard and was really enthusiastic. She always motivates me... I think that through the work we have been doing on continence we have developed an excellent relationship / partnership.' (Field note 10/01)

My view of Elm ward was, however, not as positive. I felt that the ward itself appeared disorganised, 'messy', and even chaotic at times, with high noise levels adding to an atmosphere of confusion. I did not feel welcomed by the ward and needed to work hard at building relationships with staff who appeared to not really want me there. Although meetings to discuss the research proposal and methodologies were attended by staff as planned,

feedback meetings were difficult to organise, and attempts to arrange any staff meetings to discuss project progress failed with staff appearing unaware that these were taking place and making no effort to attend. I was not impressed with the standards of care on the ward, nor the performance levels of some staff which were below my expectations. At more than one point I considered withdrawing from the ward as, due to the difficulties and constraints under which they were working, I was aware that the study was not a priority for them and that they did not necessarily have the capacity to engage with it, however the ward sister insisted that she wanted the study to continue. Following the abandonment of the first two action cycles (to improve team working on the ward and the general standard of care for patients) I felt that little could be achieved in continuing to work with the ward and staff. The 'tell it how it is' action cycle gave me a renewed sense of hope that some development may still have been possible, however following this I felt that, even though it enabled the staff to tell their story and a positive feedback meeting ensued, the commitment was not there to work on the action plan or take things any further. With the exception of a decision to change the care organisation system, and the creation of a social space on the ward, I felt that the study had had limited impact and little had been achieved. These perceptions were recorded in my field notes:

'My feelings about Elm ward are that the staff are not working together as a team. The staff seem low and down. They do not seem to have enthusiasm for anything at the moment and appear to be 'drudging' on. I also feel that standards are slipping. The ward looks messy and confusing. Nobody seems to know what others are doing. I feel that the team at the moment is dysfunctional, the ward confused, and that they are not ready for the research.' (Field note 08/00)

'I don't know where to go next with Elm. I don't feel as if the research is going to have any impact on there. I am spending a lot of energy on them but nothing is happening of any significance. Work we do is not sustained as no one is taking responsibility to sustain it. I am feeling that maybe I need to withdraw from the ward.' (Field note 05/01)

'Eventually we met (action planning discussion following 'tell it how it is' feedback). There were only three staff there. At the feedback session it was agreed that those who were not going to be present give their views to someone else who would be attending so they got some input into the action plan. Nobody had done this. Really disappointing after the enthusiastic feedback session we had.' (Field note 05/02)

What was emerging for me at this stage was, therefore, two individual case studies, one (Oak ward) which had been a success, and one (Elm ward) which could be considered a failure. By keeping this in mind as I re-analysed the data I became very aware that this may not have been the case and that my perceptions of success and failure may have been skewed. The following sections outline the activities undertaken during the individual action cycles for each ward, evaluation of their effectiveness, and the actual outcomes achieved which do not necessarily fit with my views outlined above. They highlight a lack of commitment of many

Oak ward staff to the study and the action cycles, and the lack of success of some development activities. Although some positive outputs were achieved these seem to be down to the participation of a few motivated individuals and groups of staff from other areas of the organisation. In contrast, Elm ward staff highlighted achievements that occurred following the 'tell it how it is' work that for me were surprising and many unplanned. A change in thinking, motivation and working practices had been achieved which was completely unexpected.

4.2.2 Oak ward action phase findings

4.2.2.1 To improve the standard of patient transfers to the rehabilitation wards

Although the transfer of patients to the rehabilitation wards was identified as a specific area in need of development by Oak ward, baseline data indicated that it was of equal concern for Elm ward. It was also identified that this action cycle could not progress without involvement from the two acute care for older people wards from whom the majority of patient transfers were received. The work undertaken on this action cycle was therefore a collaborative venture between the ward sisters and staff on the four care for older people wards, with myself securing regular time during the monthly ward sister meetings to help them to carry forward this action cycle. Over the period of this action cycle I met with the ward sisters a total of seven times.

Patient transfer audit

The first activity undertaken by ward staff was to carry out an audit of the standard of patient transfers to the two rehabilitation wards over one month. During ward sister meetings the standards they aspired to were discussed, and these were integrated into a patient transfer audit tool. During the month of the audit 24 patients were transferred to the rehabilitation wards with 16 of these having an audit form completed on transfer (67%). Findings indicated that patients and carers were informed of the reason they were being transferred 80% of the time. Patients were arriving with their medical notes, X-rays and drug charts the majority of the time (87%, 75% and 94% respectively), however the transfer of nursing documentation was poor with assessments and care plans only being present and up to date in 64% and 29% of cases respectively. Property lists were only completed in 31% of cases, with patients' named medication being sent only 58% of the time. With regards to information regarding the nursing care needs of patients on transfer, verbal information was received for only 55% of patients and, although the nurse to nurse transfer form was completed 69% of the time, it lacked information on the fundamental care needs of patients including their nutritional needs, presence of existing pressure sores and MRSA status. Information regarding the future plans for patients was also poor with only 40% of those transferred having an up to date discharge

checklist completed. All patients, however, did have their personal care needs met prior to transfer. Nursing staff on the receiving wards considered 21% of patients to be unfit for transfer with examples of 'unfit' including still requiring acute treatment and in the last stages of life.

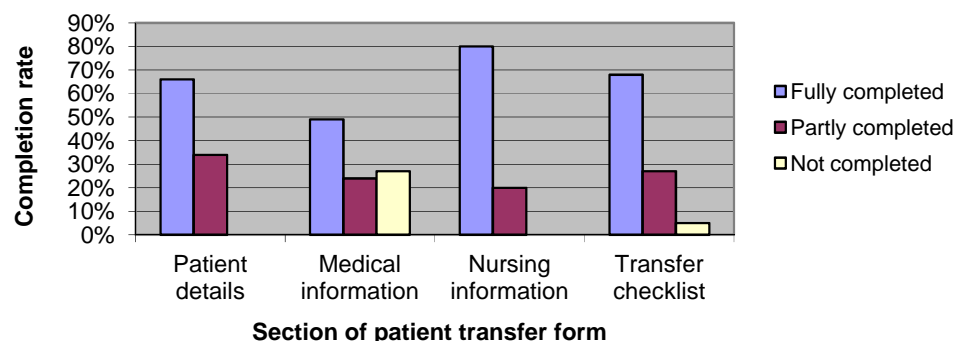
It can be seen that some of these results do not support the data collected during the exploration phase, especially with regards to the positive audit results obtained related to patients and carers being informed of reasons for transfer, patients arriving with their medical notes, and the fundamental care needs of patients being met prior to transfer. When questioned about this the ward sisters commented that they had fed back the original discussions regarding the standards of patient transfers to their staff which had raised their awareness of the issues and inspired them to pay more attention to getting aspects of it right. Changes in practice had already, therefore, started to take place before the audit commenced.

Patient transfer form

From discussions of the audit results the ward sisters identified that the patient care information provided to the receiving ward still needed to be improved. As well as improving the verbal information given they felt that the current 'nurse to nurse' form needed to be redesigned to provide more comprehensive multidisciplinary patient information, whilst including a transfer checklist to ensure that all aspired to standards were met. This was carried out in collaboration with the medical team who were already piloting their own medical transfer form. The new patient transfer form (see appendix 4) was piloted over two months with 41 forms being used. The form was evaluated through a completion audit and staff feedback.

The completion audit indicated that the majority of sections of the patient transfer form were fully or partly filled in (see figure 1). Difficulties experienced with completion of the 'medical information' section included patients being transferred at short notice with no doctor readily available to complete the form, and patients being transferred when a locum doctor was working on the ward who was not as familiar with their previous and ongoing medical needs.

Figure 1 Patient transfer form completion audit



Staff feedback on the form from both transferring and receiving wards was positive. All those questioned on the transferring wards said that the form was easy to fill in, and all but two nurses, who considered there to be too many things to fill in, said it took an acceptable amount of time to complete. All staff thought the form enabled them to provide all the information considered relevant for the patient being transferred, with no areas being considered as non-applicable. All those on the receiving wards said the information provided on the form was useful, that it covered everything they wanted to know about the patient when they arrived, and that there was no information provided that they considered unnecessary. All staff, from both the transferring and receiving wards, said that the form met its purpose and was much more comprehensive than the previous 'nurse to nurse' form. Other comments included that staff liked the transfer checklist, that the involvement of the medical team was positive, and that there had been vast improvements in the transfer of patients with which the form had helped.

Staff did raise some issues with regards to the form that required attention. It was queried that the medical information section and transfer checklists were not required when patients were transferred to nursing home care as existing nursing and medical discharge documentation is used. Space to record reasons for non-completion of these sections, and directions to other sources of information, was therefore added. An additional section for wound care was also considered necessary and was added to the 'nursing information' section on the form. It was also reported that some of the medical staff on the receiving wards were not getting to see the transfer form as it was filed in the nursing notes when the patient arrived. It was therefore agreed to attach the form to the inside cover of the patients medical notes to enable easy access by all staff.

Following the positive evaluation of the form, its use trust wide and integration into approved trust documentation was being considered by the trust clinical practice group at the end of the study. The acute care for older people wards continued to use the form for transfers to the rehabilitation wards.

During exit interviews staff on both study wards, together with the service managers, stated that the standard of transfers to the rehabilitation wards had improved. The process of developing the patient transfer form was identified as key in this outcome:

'The transfer form is making everybody much more aware that transferring elderly patients is not easy, it's not nice for the patient. It can be a very threatening situation to put someone in. I feel the work we've done with the transfer form will ease that pathway for the patients because the awareness has been raised and the involvement of other disciplines in that, and if you can make it smoother it's got to be better than making it bumpy for somebody who feels threatened anyway.' (Service manager 1)

It was also considered key in improving the transfer of information to nurses on the receiving wards:

'Because if you're the only trained nurse, as I was the other evening on the ward and I had three auxiliaries on with me, then you don't want things to go wrong for you. You want to be sure and you want to know where you're going. And it's very daunting when you get three (transfers) all in a row and you've got to sort them all out and worry if they are for resus (resuscitation), worry if their relatives are informed, all that sort of thing, simple things just get missed, you know. So it's a great help when it's thoroughly written down, you can see at a glance what has been done and what hasn't been done.' (Nurse 8 Oak ward)

Field notes recorded throughout this action cycle identified the enthusiasm of the ward sisters to develop this aspect of care. They were keen to work on the action cycle as they said it was interesting and something that they had wanted to improve for a long time. Meetings were lively and participative, and the ward sisters were self-motivated in working on agreed actions outside of arranged meetings:

'The deadlines and time scale came from them, not me ...they wanted to get on with it.' (Field note 10/01)

The ward sisters were open about the current low standards they were providing, and were able to discuss the difficulties they had in providing this aspect of care:

'There was no defensiveness about poor standards but a wish to get things right. It was also helpful in helping other wards to understand the different challenges each area faces.' (Field note 07/01)

This enthusiasm, motivation, openness and team working amongst the ward sisters allowed the action cycle to move forward and positive outcomes to be achieved.

Patient and carer information booklet

As a result of the baseline data which showed that orientation of patients and carers to the ward on transfer was poor, a separate strand in this action cycle – to design a ward patient and carer information booklet – was undertaken on Oak ward by one of the health care assistants and the ward sister. The first activity undertaken by the health care assistant was to ask the patients on the ward what information they would have found useful when they arrived. Results of these informal discussions showed that patients and carers wanted to know:

- what personal items they would need whilst on the ward
- what happens on the ward during the day
- who the staff are and what the different uniforms mean
- where the bathrooms and toilets are, and the general layout of the ward
- ward telephone numbers
- visiting times
- how they go about getting a bath on the ward

These requests were incorporated into a patient and carer information booklet, together with other information ward staff also felt needed to be included, with the help of the head of quality who had vast experience in producing patient information. Trust evidence based guidelines pertaining to the production of patient information were utilised in the design of this booklet.

The information booklet was evaluated through semi-structured informal interviews with eight patients and carers. Feedback was positive. All patients and carers stated that the information booklet was easy to read and understand. Half of the patients and carers interviewed commented that it answered all their questions and covered everything they wanted to know, with the others identifying extra information they would have liked including the name of the ward sister, the fact that it was a mixed sex ward, availability of the hairdressing service, and availability of the bilingual health advocacy service. Following feedback these omissions were added into the booklet. Other comments included that the booklet was well laid out and easy to hold and manipulate for those with dexterity difficulties. An information booklet was placed by the bedside of each patient on Oak ward and, following its distribution to the service managers, was disseminated trust wide as an example of good practice. The three other care for older people wards were in the process of developing their own information booklets using this one as a template at the end of the study.

Although development of the information booklet was successful and well evaluated by patients and carers, field note analysis in relation to this activity highlighted a lack of involvement by ward staff other than those leading on the work. Staff were invited to comment on the first draft of the booklet, copies of which were left on the ward, however no comments were received other than from the ward sister and health care assistant who had

undertaken the original work. During exit interviews staff stated that they had either not seen the draft copies, or had seen them but not looked through them. No explanation for why this may have been was offered.

4.2.2.2 *To meet the patients' needs for sleep, rest and activity more effectively*

Two main strands of activity were undertaken within this action cycle, the first led by a registered nurse on night duty, and the second by the health care assistants on day duty.

Addressing the patients' needs for sleep and rest

Following the feedback of baseline data results, an action plan to address patients' needs for sleep and rest was developed by the permanent night nurses on the ward. This action plan included:

- to learn more about the sleep and rest patterns of older people and causes of sleep disturbance
- to develop an evidence based sleep and rest assessment tool with which to identify patient needs
- to learn more about interventions to promote sleep and rest in older people and design evidence based core care plans incorporating these interventions
- to review current routines on the ward and identify how they help and hinder the promotion of sleep and rest for patients

Implementation of this action plan was unsuccessful. The night nurses were keen to improve the care provided to patients at night, and meet their needs for sleep and rest more effectively, however I experienced difficulties in supporting this work. Due to other activities being undertaken on regular day shifts I found it difficult to integrate night shift patterns into my working week and meet regularly with the night nurses, and was thus unable to provide ongoing help and support for them in undertaking this action cycle. Some actions were commenced including literature searches by myself and one of the night nurses, however this did not then progress to a comprehensive review on which other sections of the action plan could be based. I felt that lack of my support was key in hindering the progress of this action cycle:

'They were really enthusiastic to improve care and had made a real effort to go to the library and get some articles, and I had not been back to help with them. I had done a literature search and have not seen them since. I feel awful about this.' (Field note 01/02)

The difficulties I was having were discussed with the night staff and a way forward of a possible distance learning pack was discussed, however during this time two of the three nurses involved in the action cycle left the ward and it progressed no further.

Some outcomes were achieved, however, just through feedback of the baseline data results. Evaluations of care at night improved, with nurses evaluating against plans of care rather than providing standard non-specific statements. Nurses also commenced an extra drinks round on the late shift providing the opportunity for patients to have a hot, milky drink in the evening.

Improving opportunities for social interaction and activity for patients

Following the feedback of baseline data results, the health care assistants on the ward put themselves forward to look at how they could improve opportunities for social interaction and activity for patients. The first initiative carried out was to ask patients on the ward what they would normally do during the day at home, and what they would like to be provided on the ward to help them pass the time. Patient responses included:

- listening to a variety of music (including classical, swing, and jazz)
- reading books and magazines
- painting, drawing and crafts
- watching television and old films
- exercising to music
- crossword and jigsaw puzzles
- games
- bingo
- chats over a cup of tea
- a separate quiet room where you could go for a chat

This information was used, together with other baseline data results and ideas gained from a visit by two of the health care assistants to an activities coordinator in another trust, to review existing diversional facilities and organise an activity programme that patients could access. Radio headphones were tested with faulty ones being repaired or replaced, and discussions with the mobile library resulted in a greater uptake of books by patients together with the provision of assistive devices such as magnifying glasses and talking books. The activity programme included twice weekly afternoon games and music sessions, the provision of jigsaw puzzles, crossword and word search books for individual use, twice weekly exercise to music classes arranged by the physiotherapist, and offering patients the choice of eating lunch at the communal dining table. All activities equipment, including a CD player, was provided by

the hospital League of Friends. It was originally hoped that a separate room could be made available on the ward where activity sessions could take place and patients could go to chat, listen to music or watch television and videos in peace. This was not possible as the only room available was difficult to access and, due to its layout, did not provide a safe environment for patients. All activities were therefore to take place at the communal dining table.

The activity programme was slow to get off the ground. The games and CD player were on the ward for four months without being used. When asked why this was one health care assistant felt that the registered nurses on the ward were not fully supportive of the programme and therefore the health care assistants, although enthusiastic about it, felt unable to action the games sessions as they did not have the strength to make it work on their own:

'But I found that a lot of the staff nurses didn't want to get involved ... like 'just get on with it, it's your baby', or whatever, the lack of support I suppose is what I am looking for.' (Nurse 6 Oak ward)

This difficulty was discussed at a ward meeting following which one registered nurse volunteered to lead on the activity programme with the health care assistants to provide them with the support they needed. This resulted in games sessions being regularly implemented for two months. After this period of time interest in their continuing provision again waned and then ceased to continue. Staff were questioned about difficulties sustaining the games sessions in their exit interviews. The main contributing factors were stated as lack of staff and time to provide them. Staffing levels had decreased as the project progressed, with the ward employing a higher number of agency nurses. Due to agency nurse shift patterns there was a reduced number of staff available during the early afternoon which was considered by staff to be the best time for activity provision. The fact that activities had to be provided at the communal dining table on the ward rather than in a separate room was also stated as problematic as there was too much else going on around them leading to distractions and interruptions. Changes in the patient population was also stated as a contributing factor. Many of the patients were unable to fully engage in games sessions due to their high dependency levels, and there was an increase in those suffering from confusion. Other patients, staff stated, were just not interested in participating. This reduced staff motivation to continue the sessions and encourage patients to participate as they were having little success:

'... and then once they, the patients we did have doing the activities, they went, and then we got patients that were confused and so it was so hard to do anything with them and some of the patients they just didn't want to know... you know you'd say 'come on let's play bingo' or 'let's do a jigsaw puzzle' or something and it was 'oh no, no, no', they didn't want to know ... and that's what I think spoiled it as well because they didn't want to take part in them... I felt a little bit upset ... I felt like a failure because they didn't want to participate.' (Nurse 19 Oak ward)

Staff said that for games sessions to continue they needed regular help from others, such as volunteers or part time activity assistants, as due to the current staffing levels consistency of provision could not be guaranteed.

It was also stated, however, that even at times when more staff were available, with the exception of one registered nurse and one health care assistant no one was interested in supporting this action cycle. These two staff felt that even if group activities were not feasible one to one activities with patients could be achieved, however the jigsaw puzzles, crossword and word search books were never used.

Evaluation by staff of sessions that did take place was, however, positive. They said that patients enjoyed the sessions and it provided them with the opportunity to talk with others and have some fun. Relatives joining in the activities was also seen as positive. Staff also felt that it kept the minds of patients active as opposed to them sitting aimlessly by their beds:

'I noticed changes in some of them... it's stimulating their minds and they were doing things with their hands and thinking when we were doing bingo... and they were a lot brighter... I think it did help because it got them talking to each other more when some of them used to just sit by the bedside and that was it.' (Nurse 19 Oak ward)

Positive outcomes were also achieved through improving access to existing facilities:

'The health care assistants commented specifically on one patient who normally wanders all day. She had been given a book and book stand by the librarian and now spends her day settled and 'reading'. They also talked about (patient). He now goes down to the TV every evening after supper. They said he is much happier now.' (Field note 05/01)

The exercise to music sessions also had varying rates of success. The ward physiotherapist present at the beginning of the study was keen to provide chair based exercise classes to music on the ward, and these were commenced twice weekly. Once this physiotherapist left the ward, however, provision of these classes was inconsistent. For a year the ward was staffed with constantly changing locum physiotherapists whose motivation to provide such classes varied. As a result of these difficulties one of the health care assistants on the ward undertook a chair based exercise facilitators course, but again, due to the reasons outlined above regarding the provision of games sessions, implementation was hindered.

Offering patients the choice of eating at the communal dining table was also inconsistent. When asked why this was the case, staff again highlighted changes in the patient population, workload, and lack of interest by some staff as contributing factors:

'I was quite interested also in just letting patients walk to the table to have their lunches ... but sometimes the patients didn't want to mix ... and other times you knew they would like to, but by the time lunch came and everything was happening ... it never quite worked out really...it all depended on what it was like on the day, how

many staff were willing, the patients, everything had to come together.' (Nurse 3 Oak ward)

Baseline data findings were also discussed with the voluntary services department to identify if they could assist in the provision of social activities for patients. It was stated that volunteers were not available to visit the wards informally to talk to patients or assist with games provision, however they were willing to attempt other organised ward activities. This started with the pilot of an afternoon tea party which was very successful in engaging patients in social interaction and appeared to improve their feelings of well being:

'The registrar was so amazed at what was going on that she went to the consultant's office to get her to see what was happening. She told the consultant that 'her patients had woken up'. One lady who had been admitted because she was not eating or drinking ate three pieces of cake and then asked where the sandwiches were!' (Field note 06/01)

Following this success, two further tea parties in collaboration with a 'music in hospitals' group were arranged by voluntary services. This led to the provision of larger hospital wide events including Christmas parties, an Easter party and a Jubilee party, all with live music. It appeared that these were also successful in improving the psychological well being of patients:

'The patients seemed to love it (Jubilee party). One of them who we had interviewed as part of a focus group was singing and happy, whereas his mood is usually very low.' (Field note 06/02)

The voluntary services department also secured a hairdressing service for patients.

Although not as successful as staff would have liked, a positive outcome of this action cycle, however, was that the attempt to provide improved opportunities for social interaction and activity for patients resulted in the acknowledgement of its importance by both staff and managers in the trust:

'There is more to nursing than just washing and sitting them out and feeding them and giving their medicine. I think there's more. I think you have to make them happy while they are with us and think of the patients, what they will do when they are at home, how would they spend their day, what will they do in the hours that they are alone, so maybe, yeah, we have learnt something. We have to make it like home for them really because it is their home for quite a few weeks.' (Nurse 11 Oak ward)

'But also care around activities. I think that has been one of the most striking parts of the project, is the importance of rehabilitation and activities, which isn't perfect but is better now. So, I think that is probably the real key to it, and that people have bought into that, and I think people have bought into that at every level.' (Manager 3)

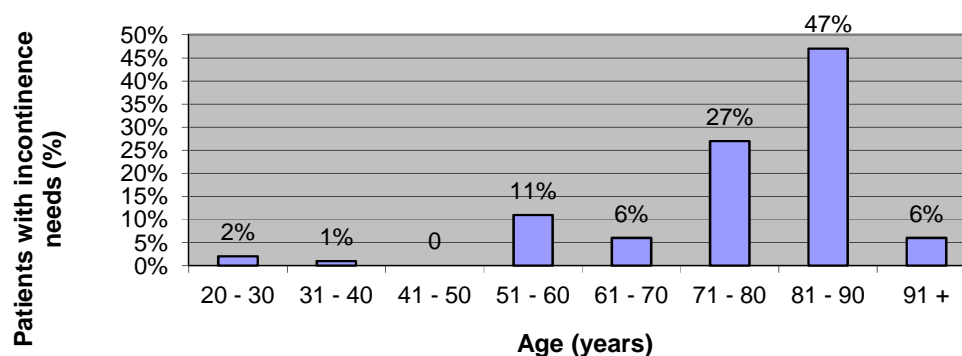
4.2.2.3 To improve the continence care for patients

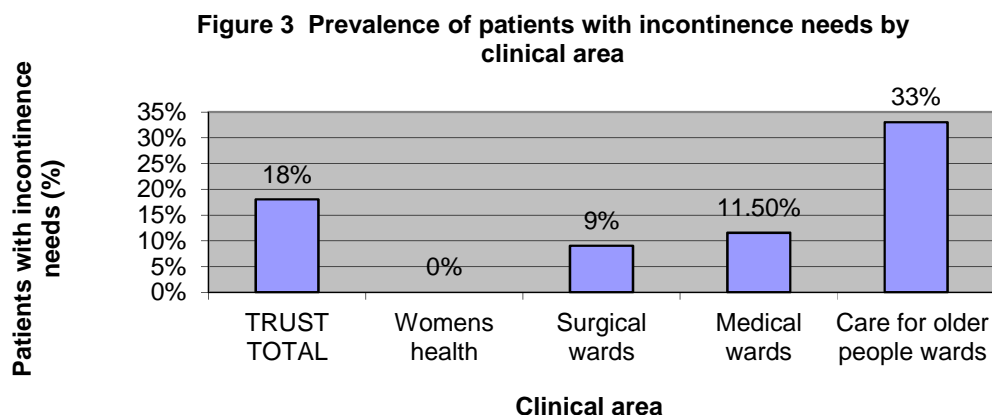
This action cycle was undertaken by one of the registered nurses on the ward who had a specific interest in the promotion and management of continence. Following a review and critique of the literature by the two of us it was acknowledged that this was a huge area of care requiring a vast range of knowledge and expertise which could not be provided by us alone. An 'Improving Continence Care' working group was therefore established (see section 3.2.2.1.3). It was also recognised that this was an area of care that needed to be incorporated into the whole patient journey and not just addressed once patients were transferred to the rehabilitation wards, therefore trust wide activity needed to take place. To facilitate this collaborative working with the trust clinical practice group and the clinical governance coordinator was undertaken.

Prevalence audit

A prevalence audit of patients with continence needs was undertaken to identify how big a care need this was within the trust, and where the highest concentration of need was located (see figures 2 and 3). It can be seen that patients between 70 – 90 years had the highest need for continence care, and thus the care for older people wards had the highest prevalence rate amongst the patients residing on their wards.

Figure 2 Prevalence of patients with incontinence needs by patient age



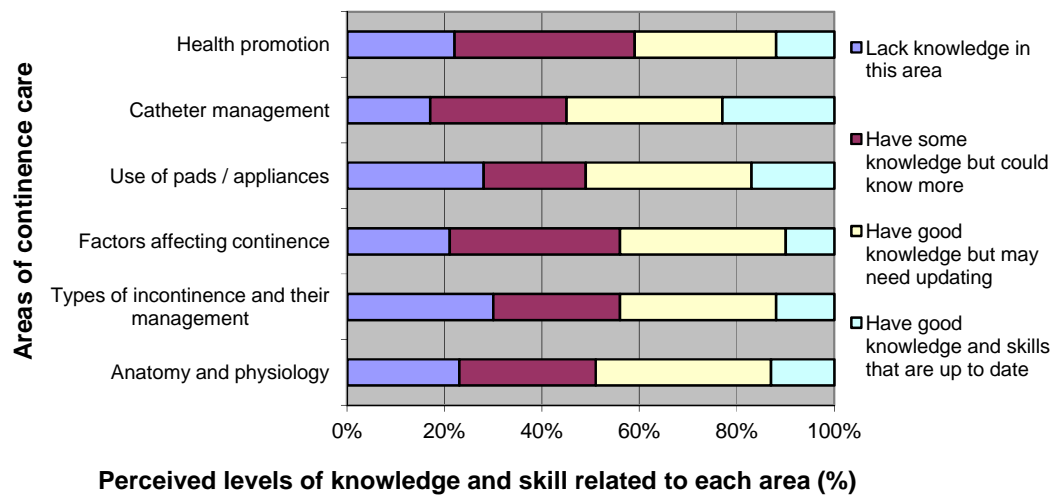


It does need to be recognised that this audit took place during the months of July and August, and that prevalence rates may change depending on the time of year which is associated with changes in patient populations. Nevertheless, the audit did identify that prevalence rates were high enough to justify attention being paid to this area of care. Also, as older patients are nursed in all adult clinical areas not just in designated care for older people wards, the need for a trust wide approach was strengthened.

Levels of staff knowledge and skills in continence care

Knowledge and skills questionnaires were administered to registered nurses, health care assistants and midwives to identify the quality of continence care being provided in the trust together with the training and educational needs of staff. The questionnaires were adapted, with permission, from others developed by the Northamptonshire Continence Service, with the clinical audit department in the trust assisting with questionnaire design and analysis. The questionnaire response rate was poor (25%) despite individual meetings with all ward sisters and charge nurses explaining the background and purpose to the questionnaire, and the sending of two reminder letters. The highest response rate was from the care for older people wards (64%). Results (see figure 4) indicated that gaps existed in the knowledge and skills of nurses and midwives with regards to all areas of continence care, with only 15% overall stating that they had good knowledge and skills, 33% stating they may need updating, 29% stating they could know more, and 24% stating that they lacked overall knowledge.

Figure 4: Nurse and midwife knowledge and skills in relation to areas of continence care



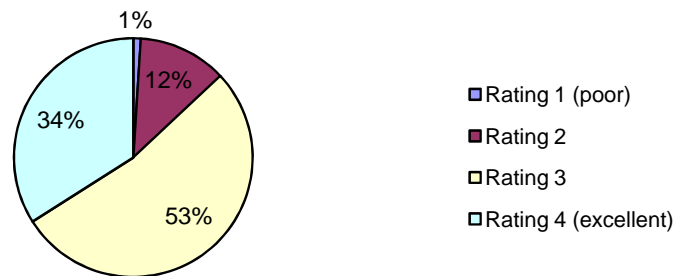
From the literature review carried out and the results of the knowledge and skills questionnaires, the working group felt that the best way forward to improve continence care was through the development of an evidence based urinary continence care pathway which would guide staff through the assessment and individual management strategies for their patients. Such a pathway had already been designed by the Northampshire Continence Service (Bayliss et al 2000a, 2000b, 2001) that had a strong evidence base and had been successfully implemented and evaluated, and which had also been adopted and was being piloted by the local primary care trust. With permission of the authors, the pathway was adapted and further developed by the working group to produce one that was more appropriate to the hospital setting in which we were providing care. Collaborative working with the primary care trust ensured that the pathway was transferable for use in the community thus facilitating continuity of care when patients were admitted or discharged.

Continence care study days

Following development of the urinary continence care pathway, an in-house study day on continence care, organised by myself, the urology nurse specialist and the registered nurse undertaking this action cycle, was held for staff across the trust on three separate occasions. Content was informed by the results of the knowledge and skills questionnaires to ensure identified gaps were addressed, and also included practical training in use of the pathway. Application to attend study days was through response to posters and flyers placed in all adult ward areas and e-mails to all nursing management teams. 52 applications were received within four days of advertising indicating the educational need for this in the trust. In total 97 registered nurses, health care assistants and midwives applied for the study days with 83

actually attending (86%). The study days were positively evaluated by participants when asked to rate them on a scale of 1 – 4 (with 1 being poor and 4 being excellent) (see figure 5).

Figure 5: Evaluation of continence care study days



Comments recorded by participants on the evaluation forms included:

'The topics were good and taught at an appropriate level. The demonstration enhanced learning and made it easier to understand.'

'I feel more confident in caring for a patient with incontinence. Before I didn't have such in depth information about incontinence.'

'I know so much more now than I did before I went into the study day. It was something new. We have had nothing like this before.'

Requests were also made for more training and education in continence care. The one criticism made by some participants was that there was a lot of information to digest, and that the training should have been spread over two days.

Although the study days went well, the process of organising them was very challenging due to a lack of organisational and administrative support. Although requested, no support was offered with writing confirmation letters, compiling delegate lists or photocopying large amounts of material. The lecture theatre provided for the first two study days was in the hospital in which the rehabilitation wards were located and was in a poor state. Chairs were missing and the available equipment was broken, with it being hard to find anyone who was willing to help to resolve these problems. The hospital catering that we paid for was of a poor standard with coffee arriving up to half an hour late each day and lunch being left piled up on a trolley with no plates or serviettes. This not only made the running of the study days much more difficult, but also highlighted again the lack of responsibility and care afforded to this particular hospital site:

'The lecture theatre was in a right mess. There was extraneous equipment everywhere, there was rubbish left, and the extra chairs had just been left in the corridor ... the OHP didn't work ... there was no video with the TV... Who is responsible for this place? No one seems to care about it.' (Field note 10/02)

The lack of care afforded to this site was highlighted further by the completely contrasting experience I had when the third study day was held on the main general hospital site:

'The difference having it at (general hospital) was astounding. Everything is set up ready, all the equipment works, coffee arrived dead on time and lunch was laid out really well. Much less stressful.' (Field note 11/02)

The continence care pathway

Once the study days were completed, the urinary continence care pathway was piloted on two of the care for older people wards over three months. Unfortunately it was not piloted on Oak ward as none of the staff attended the training sessions due to a stated shortage of staff at the time. It was therefore piloted on the two care for older people wards identified in the prevalence audit as having the highest number of patients with continence needs and whose staff had all attended the training sessions. The pilot was unsuccessful with only one patient being placed on the pathway during this time. This prevented any variance analysis or patient evaluation of care being undertaken. A staff focus group was held on one of the piloting wards (acute care for older people) to identify why the pathway was not used.

The staff on this ward were keen to pilot the pathway and had attended the continence care study days as they felt it was something they needed to learn more about. Implementing a change in practice, however, proved difficult. They stated that the timing of the pilot was the main reason it was unsuccessful. It coincided with winter pressures and the introduction of four hour wait targets in accident and emergency departments which resulted in an increased nursing workload on the ward. Patient dependency was higher and it was a time of rapid patient turnover. Patients were identified who could be commenced on the pathway, but this was not carried forward:

'There were people, so many good candidates, but we were under pressure.' (Nurse 1 piloting ward)

The rapid turnover of patients also meant that by the time staff had identified their appropriateness for the pathway, they had moved on. Although staff felt continence care was important to them, was of great importance to the patients, and that the pathway would be of benefit, other priorities took precedence:

'I think it is an important issue, but not quite as important as discharging and admitting patients.' (Nurse 2 piloting ward)

They also felt that a need to meet trust targets and priorities pushed this area of care into the background, with the paperwork involved in the pathway being considered daunting for some staff and putting them off using it as they felt it would be too time consuming:

'We had to meet targets that made it almost impossible to do any more paperwork than we were already doing.' (Nurse 2 piloting ward)

The other main issue that prevented implementation of the pathway was the lack of practical help. All the staff felt well prepared and informed to use the pathway following attendance at the study days and said they thought it was simple to understand, however they also said that more support was needed to help them put it into practice. Unfortunately this was at a time when I was withdrawing from the clinical areas and was not available to provide this support and, although contact details for seven staff experienced in use of the pathway was provided for the ward to help them with any difficulties, staff stated that they needed the continuous presence of one key person to give them 'a bit of a push' and provide them with on the spot help to start using it:

'...someone to come and work with us and say 'I've found a good candidate let's go for it'... somebody to say 'what's happening? Why aren't we doing it? Come on lets do one'.' (Nurse 1 piloting ward)

Staff felt that intensive help and support was particularly needed in the first month of the pilot to give it a 'kick start', with this support then being able to be withdrawn as staff became more familiar with use of the pathway. Staff also stated that, pathway aside, even though the study days improved their knowledge of continence care they had not changed their practice in any way, this further supporting the issue that formal education alone is not enough to enable staff to implement evidence based care:

'We all meant well, we all knew that we'd been on this study day we must at least make an attempt, but it never materialised.' (Nurse 1 piloting ward)

One patient was placed on the pathway, the reason being that she was on the ward longer than other patients due to her waiting for invasive treatment which allowed staff to follow the pathway through and bring it to completion. Staff caring for this patient stated that the pathway was easy to use and understand and that they experienced no difficulties in completing it. Although the amount of paperwork was originally off putting for staff, those who did use it said that it was actually quick to complete and wasn't as lengthy to undertake as they expected. Outcomes for the patient were positive, with incontinence episodes being reduced:

'When she went home she was only using 3 pads a day, and before that she wanted a pad every five minutes.' (Nurse 1 piloting ward)

Despite the difficulties encountered during the pilot period, the staff said that they would like to try again to implement the pathway. Key factors needing to be addressed to facilitate this process included implementation during autumn months, the pathway forming part of the

admission documentation so that it became part of everyday working practice, and the provision of an expert twice a week to support staff over the first month of implementation.

Even though the pathway was not implemented, evaluation of the patient information leaflets which accompanied the documentation was undertaken by the lead research and development nurse working in the primary care trust through the administration of questionnaires to local user groups for older people. Findings indicated that minor changes in terminology were required, however the style, size and layout of leaflets was considered appropriate and the content useful.

Changes in practice

Although the wards piloting the pathway felt that their practice had not changed, some improvements in the continence care for patients were identified on Oak ward. Improvement in the knowledge and skill levels of the registered nurse leading this action cycle were evident:

'As she read the scenarios (for the study days) she was telling me what type of incontinence the patient had, and what their treatment would need to be, as well as the core care plans that would be needed. She is now really knowledgeable about incontinence.' (Field note 10/02)

This improvement in knowledge led to the implementation of some changes in practice on the ward. It was identified by the registered nurse that more attention needed to be paid to the fluid intake of patients and the provision of alternatives to caffeinated drinks. This resulted in the ward domestic offering cold squash drinks as well as tea and coffee on drinks rounds, together with her circling the ward during hot weather to refill empty glasses. A water cooler was also purchased for the ward with the aim of encouraging patients to drink more through the provision of cold water as opposed to that which had become warm whilst sitting in jugs on lockers. Different, and what staff considered to be better, incontinence pads were now being used, with staff also commenting on how they had more individualised toileting regimes for patients as opposed to the previous two hourly ritual for all.

Again, although some successes were achieved, difficulties in implementing this action cycle on Oak ward were experienced. The nurse undertaking this action cycle received no volunteers in her requests for someone to help us with this large piece of work. As well as the staff not having the underlying knowledge to understand the changes she was trying to implement due to them not attending the study days, she also felt that lack of participation could be attributed to lack of interest in the topic together with a lack of willingness to learn and change. The need to constantly be there to facilitate change was also expressed:

'...but continence is such a, I don't know they just don't want to think about it, oh its got to be done, over and done with and that's it. It is quite difficult I think. It's not fun you see, continence. That's what they say, it's just like a chore, a task ... sometimes

they listen and sometimes they don't ... I mean obviously you talk to them say this is what I've learnt, this is what it says, so if we do that... I think it does filter through, you know you have to be there, and then it does filter through. It is hard.' (Nurse 3 Oak ward)

4.2.2.4 To improve the evidence based practice skills of nurses

This action cycle was led by one of the registered nurses on the ward who had an interest in information technology and in assisting staff to become familiar with the nursing literature. The main activity undertaken as part of this action cycle was an audit of the current knowledge and skill levels of nurses in using computers and in accessing and critiquing the nursing literature.

Knowledge and skills questionnaires

Nine questionnaires were distributed to registered nursing staff with seven being returned (78%). Results indicated that the computer and evidence based practice skills of nurses were poor. Although all those responding had used a computer before, only four had used one within the last six months, with the others not using a computer for three to five years. Only three staff had previously had any computer skills training, with that being in the use of the trust 'nursing system'. Only one member of staff had ever searched databases for literature, those used including Medline and CINAHL, with the same person being the only one who knew how to use the internet. Only one nurse said they knew how to carry out a literature search, with four stating they knew how to critique a research article. All respondents said they read a professional journal on a regular basis with these being the Nursing Times, Nursing Standard and Professional Nurse, and it was in these journals that staff said they accessed the latest research. When questioned about training needs, three respondents said they needed training in basic computer skills and all aspects of evidence based practice, with three others asking for input specifically on literature searching.

While the questionnaires were being analysed the trust started to provide free computer skills courses for all staff at a local college. This part of the action cycle was already, therefore, being provided for and no further action was taken. The literature searching and critiquing skills still, however, needed to be addressed. The trust librarian had offered to help with such training, if needed, at the beginning of the action cycle. The nurse leading on this action cycle therefore agreed to liaise with the library to look at how this could be provided. Progress was slow due to the nurse being moved to staff another ward, and then applying for another post within the care for older people unit. Review meetings, however, identified that they still wanted to follow this action cycle through. At the time of project completion no further progress had been made. From exit interview analysis, however, one member of staff on the

ward stated that they had gained some evidence based practice skills through undertaking literature reviews with myself as part of other action cycles:

'So that's one thing I learned a lot like looking into research ... because I hadn't been to a library for a while ... going through research, you know I mean reading the what do you call it, reading those evidence based things, what they did and just discussing with you really.' (Nurse 3 Oak ward)

4.2.3 Elm ward action phase findings

4.2.3.1 To improve team working on the ward

Teambuilding work was requested by the staff on Elm ward as they thought it was the main issue for them following the organisational changes they had undergone. It was agreed that the work should be led by an outside facilitator who was experienced in team development. Two team building workshops were held and attended by ten (out of thirteen) day staff and a representative of the night staff. The workshops were held on Saturday afternoons and, to allow all staff to attend, the trust professional development nurses managed the ward during this time together with bank and agency nurses whose use was authorised by the service manager following a request by ward staff. Ward staff who were not originally on duty on these days were also allowed to claim the time back at a later date.

Workshop 1 was the first time that staff on the ward had been able to get together as a team to discuss ongoing issues. Facilitated discussions resulted in staff talking openly for the first time about problems and difficulties they experienced in the team and how this affected their ability to work together. A way forward was agreed centred around respecting each other, working together to put the patient first, and improving communication. Evaluation of the day was positive, with all staff stating that they personally got something out of it. Informal feedback by staff following the workshop stated that the attitude of some staff was changing with them being more approachable, and also that staff were now able to challenge each other when difficulties occurred by referring to the 'way forward actions' that were negotiated and agreed by all.

The second workshop, however, raised some real team issues that up until then had remained hidden. Long standing feuds and unresolved issues between staff were exposed, together with them really opening up about how they personally felt trying to work in this team. This was an emotionally charged workshop which exposed the underlying conflicts affecting the ability of the staff to work together in any way. Evaluation of the process by the facilitator stated that this was one of the most challenging teams she had ever worked with and that the team was in chaos, however the workshops had enabled conflict to come to the surface and allowed people to start talking to each other. She felt that the next step was to help the staff to deal with the chaos and conflict in further workshops over the next year.

A third workshop was therefore planned to start addressing the issues raised in workshop 2, however as the date of the workshop drew near the staff on the ward stated that they did not feel they needed it, that things had improved on the ward, and that it should be cancelled. As commitment and participation was key in these sessions the facilitator felt the workshop should not go ahead unless staff really wanted to be there, and left the option open for them to contact her at any time if they wanted the workshops to continue. They did not take up this offer.

Exit interviews showed inconsistent evaluations of the effect of the teambuilding workshops on the ability of staff to work together. Some staff stated that they now worked better as a team, were more conscious of their attitudes and behaviour towards each other, and that there was more openness amongst staff on the ward:

'The meetings were brilliant. We understood how we had to work as a team for the benefit of the patient ... the sessions helped to bring the team together.' (Nurse 1 Elm ward)

Others stated that the effects varied. They felt teamwork was sometimes improved, but it depended on who you were working with on the day:

'... some of the work's improved, sort of teamwork and that, but again it depends which members are on, I mean when I'm on with particular members I know I can rely on them and everything goes alright, everyone sort of helps each other, but I know when I'm on with other people things aren't going to go smoothly, because they won't help, and sort of stick to what they see as their work.' (Nurse 19 Elm ward)

Some staff, however, felt that although the teambuilding workshops were useful they had little overall effect on the ability of the staff to work together:

'I think it opened peoples' eyes, but I don't think it really changed a lot. I think people realised peoples' attitudes, but nothing's really changed.' (Nurse 22 Elm ward)

The decision of the staff to cancel further teambuilding sessions because they were no longer needed can therefore be questioned.

4.2.3.2 *To improve the general standard of care for patients, particularly those whom staff find it most difficult to care for*

Although the idea for this action cycle was suggested by staff, and the actions within it were negotiated and planned, it was unsuccessful. The days when I would work on the ward with staff and patients, and hold reflective sessions in the afternoon, were decided by the staff to fit around times that best suited the ward priorities. The first four planned days were, however, cancelled through agreement with myself and the ward sister due to projected staff shortages. When the staff rota was examined it indicated that there was only going to be a maximum of

three regular staff on duty over the whole of the early and late shifts on those days, and they would therefore be unable to attend the reflective sessions.

Following this, further days were planned at times when staffing levels were more adequate, and I attempted to work on the ward for three separate shifts (one per week over three weeks) to identify case study scenarios which would be reflected upon with staff in the afternoons. Although I successfully worked on the ward on these three days, and prepared case study presentations, the reflective sessions did not take place. This was not entirely due to staffing level issues but also the inability of nurses to organise their day to enable people to attend. The sessions did not appear to be prioritised by staff and, even though I had been on the ward in the morning and the staff decided the best time for the feedback sessions to take place in the afternoons, they were not committed to making them happen:

'I left the ward at 12.30 to have lunch and prepare for the afternoon reflection session. I had told (nurse) that I would be back at 2pm for the reflection session. I went back to the ward at 2pm to find (nurse) and (nurse) sitting at the desk. They told me that they had not handed over yet. They said they would be quick, but they still had not finished at 2.45pm. (Nurse) then said that they still had to write all their evaluations and could not come.' (Field note 06/01)

After four cancelled days and three unsuccessful attempts to run reflection sessions, this action cycle was abandoned.

Staff in exit interviews commented on a lack of commitment and avoidance attached to this action cycle, together with a lack of commitment to the study overall, with them stating that some staff just 'wanted me to go away and leave them alone'. When asked what prevented the reflection sessions from happening one member of staff stated:

'It was people's attitude ... 'Oh well, if I don't make the time then she will go'.' (Nurse 6 Elm ward)

4.2.3.3 Tell it how it is: using a case study approach to identify current issues, problems and challenges surrounding the care for older people in this rehabilitation setting

Following the lack of success of previous action cycles, a case study approach to 'tell it how it is' was undertaken. Findings from the staff and manager interviews and focus groups further supported some of the issues raised in the exploration phase, as well as identifying other concerns. Seven main themes regarding the experience of staff working within this setting were identified. These were 'what it is like', 'difficulties dealing with the workload', 'working within a poor environment', 'poor rehabilitation care provision', 'poor organisation of care', 'challenges in working together as a service', and 'why are we here?'.

What it is like

Words used by staff to express what it was like working on the ward included difficult, stressful, hard, frustrating, sad, tiring and manic. They stated that the high workload put them under constant pressure and that they did not feel satisfied with the care they were able to provide, which led to low morale and lack of motivation:

'At the end of the day you think 'what did I do?' It's just work, work, work.' (Nurse 10 Elm ward)

This led to staff, at times, dreading coming to work:

'Sometimes you dread it, like 'Oh God, what am I going to face today.' (Nurse 21 Elm ward)

The service managers interviewed recognised the difficult circumstances under which the staff were working, and acknowledged that it was hard for them:

'The ward functions in difficult circumstances... the wards and staff are isolated over at (hospital). There is less room to share good examples of care and practice and to feed off others which means things become stagnant.' (Manager 2)

Staff stated that they didn't feel appreciated by either their colleagues or managers, and said there needed to be more recognition for the contribution they made.

Difficulties dealing with the workload

Both ward staff and service managers commented on the staffing establishment being low for the area, and that the skill mix needed to be addressed. Shortage of staff and reliance on temporary staff was a major concern with agency staff being difficult to secure, often being unreliable, and registered agency nurses not always performing to role. In addition, the ward frequently ran with only one registered nurse per shift. Staff felt this affected the quality of care they were able to provide to patients as there was a lack of continuity and the workload exceeded the number of staff available to provide it:

'No matter how much you want to give the care it is actually physically impossible.' (Nurse 19 Elm ward)

'You can't always put into practice what you know you should do.' (Nurse 13 Elm ward)

The amount of administrative and paper work needing to be completed by registered staff was also commented on, with this taking them further away from the bedside and clinical work. Constantly changing bed numbers was also considered problematic by staff. Recognition by service managers of the difficulties staff had in managing such a large ward resulted in bed numbers being reduced whenever patient activity allowed. Staff, however, experienced

problems when bed numbers were then increased at short notice due to increases in patient activity as they were unable to plan effectively for this and secure the increase in staff required.

Staff felt that the above issues resulted in reduced safety levels and patient care sometimes being neglected. It also meant that time to work on development activities, or even hold ward meetings, was not often available.

Working within a poor environment

Staff commented on the effect the working environment had on themselves and their patients. They considered that the ward lacked the facilities needed to care for 29 patients, the majority of whom were elderly. Apart from there being no day room, there was no hoist for use with the bath, toilets were difficult to access, and staff had difficulties obtaining soap, toothbrushes and toothpaste for patients:

'...goodness knows the last time I gave a patient a bath or shower.' (Nurse 1 Elm ward)

The ward décor was also in need of attention with staff commenting that the ward was not bright and cheerful, did not look attractive and was not decorated well, with the floor being in a poor state of repair:

'It's a depressing, dingy environment which doesn't help patients, doesn't help relatives and doesn't help us.' (Nurse 21 Elm ward)

Poor rehabilitation care provision

Staff felt they were not providing good rehabilitation care. One reason stated for this was that some staff did not understand the concept of rehabilitation. They said that a lack of knowledge of rehabilitation and a 'do for' approach rather than one of supervising and encouraging was the norm:

'We haven't got the proper knowledge of rehab to do it.' (Nurse 1 Elm ward)

Patient suitability for rehabilitation was also questioned, with patients being transferred who were physically unwell and a mix of client needs preventing a pure focus on rehabilitation care from taking place:

'If they're sending patients that can't even get out of bed, and need total nursing care, they're taking your time up, and how can you rehab people like that?' (Nurse 22 Elm ward)

'And so while you have got this mixture, you can't really run it as a proper rehabilitation ward, it can't be done, because you have got too much other things going on, too much other things that take your time to do.' (Nurse 21 Elm ward)

The unsuitability of the environment for the provision of rehabilitation care was again raised, together with the lack of activities provision and any social space resulting in patient boredom and lack of motivation to do things for themselves.

Ward staff and service managers acknowledged that, as well as formal training in rehabilitation, the staff also needed to rethink the way they worked and organised their day from routines that involved rushing and doing to those that spread the workload over a 24 hour period, and which would allow more time to be spent with individual patients. It was also expressed that the purpose and function of the ward needed to be redefined in light of the patient population it was currently serving.

Poor organisation of care

The need to rethink the way staff worked and organised their day was further highlighted by staff with regards to providing general, not just rehabilitation, care. Staff stated that although they were supposed to be working within a team nursing system, this was not currently effective. They said that within this system nobody appeared to be responsible for patient care and everybody was just 'mucking in'. Workload and patient care needs were not planned within the teams at the beginning of shifts, and there was a lack of clearly defined roles for registered nurses and health care assistants which led to tensions between them. This resulted in workload inequity, poor time management, a mad rush to get the work done, staff not knowing what was happening on the ward as a whole, aspects of patient care not being completed, and thus poor standards of overall care provision:

'You are just running around in a complete circle all the time.' (Nurse 22 Elm ward)

Ward staff felt that a system of patient allocation would be more effective so that responsibility for each patient could be clearly identified, workloads could be more fairly split, and planning for individual patient needs throughout the day could be undertaken.

Challenges in working together as a service

The views of staff regarding working together as a ward team mirrored those already outlined in section 4.1.2.2.1. Further comments were made however, by both staff and service managers, regarding how they worked together to provide a service for older people. Some ward staff expressed that they found service managers supportive, appreciative and approachable, and that they felt the service managers did know the challenges staff faced on the ward. They commented that there were things that even the managers could not change

as 'their hands were tied', and that they also had a high workload. They felt that managers faced some of the same challenges as ward staff around managing budgets and recruitment issues, as well as needing to meet other trust targets and government directives such as waits in accident and emergency departments:

'They face a lot of the same problems as we do ... they know we are short of staff and I'm sure they don't like it any better than we do. I'm sure they are as upset as us that they can't provide better care.' (Nurse 19 Elm ward)

Others, however, felt that service managers were not aware of what was going on. It was commented that the staff on the ward hardly saw them, that there was little communication with them, and that when they needed to talk to someone there was no one available. Service managers validated some of these comments expressing that, due to their workload commitments, they were unable to support the staff as much as they would like:

'But my main concern is that I don't see them enough, I don't spend enough time with them, and I'm always afraid that they might think that I'm not there for them ... I'm very conscious that they might think I am neglecting them.' (Service manager 1)

It was also expressed, however, by both ward staff and service managers, that staff did not make themselves visible to managers either. They did not always tell them what was going on, communicate what they wanted, or ask to meet with them:

'We are not doing enough at ward level to stand up for things and get ourselves sorted ... we don't say, we don't let the manager know. If the manager gets the full story probably the help could have come earlier.' (Nurse 1 Elm ward)

'They tell us what they think we want to hear.' (Service manager 2)

Why are we here?

Even though the above challenges were faced by nursing staff, they still continued to work on the ward. When asked what it was that got them to work in the mornings they stated that they found the work challenging yet interesting, with many opportunities for learning both about and from the patients:

'The knowledge there is good, you are learning all the time.' (Nurse 22 Elm ward)

Staff said they were committed to their patients and found it fulfilling when they saw patients get better knowing they had made some contribution to this. Despite ongoing problems within the ward team staff stated that they did come to work to cover for each other, especially when short staffed:

'When it's short we always try to help out, because we know how hard it is when you are short ... you have sympathy with the rest of the team.' (Nurse 4 Elm ward)

Action planning

The above findings were fed back to the ward staff and service managers. Response to findings was positive with both ward staff and service managers showing an interest in, and valuing, the openness and honesty of others and what they had said. This was confirmed during exit interviews where staff commented on how their individual concerns had been validated and a greater understanding of each other's challenges and issues had been gained:

'It highlighted what people were concerned about on the ward and it also highlighted that a lot of people were concerned about the same thing which is sort of nice because, you know, I'm sort of always worried about doing something because there's just my own personal fad or my own personal concern so it's nice to see other people had the same concerns and that, and I think also bringing everything out into the open was a help.' (Nurse 19 Elm ward)

'I think it identified the needs of some of the staff that perhaps I had not thought about.' (Service manager 1)

'I suppose it was reassuring to have my concerns ... if I wanted to spend more time with them and I couldn't ... some of the staff realised that as well.' (Service manager 1)

Following the feedback of findings an action plan was agreed with both ward staff and service managers. This included:

- Improving the way care was organised on the ward through:
 - implementing a system of patient allocation
 - clarifying the roles and responsibilities of staff
 - changing the way the patients' day was organised
- Starting to address the gaps in rehabilitation care on the ward through:
 - defining the ward purpose with ward staff and service managers
 - creating a social space on the ward and implementing activities for patients
 - improving staff knowledge and skills through attending a rehabilitation practice course (see section 4.2.4)
- Improving communication between ward staff and service managers

During exit interviews, ward staff and service managers commented on the progress they felt had been made on the ward following the 'tell it how it is' work. Firstly they commented on more openness amongst the staff on the ward, and how they were more focused in what they were doing both as individuals and as a ward team:

'Everyone is saying one thing ... so we now know what we are doing, it's more focused, and everyone is working toward one goal.' (Nurse 6 Elm ward)

'I know what I am doing. I know what I stand for ... I know my limit as well, I know my learning curve and I know what I need ... I know what my client, what my boss, what they expect of me.' (Nurse 1 Elm ward)

Most felt that this had led to an improvement in standards of care and, although data relating to complaints received was unavailable for analysis, a perceived reduction in the number of complaints together with an increase in positive feedback was reported by staff and managers:

'Care has improved ... patients in my view seem a lot happier.' (Manager 3)

'Even more cards telling us that we're doing good, more chocolates on the ward and more biscuits, more thank you cards ... that makes us happy.' (Nurse 1 Elm ward)

Implementation of the patient allocation system was seen as a contributory factor in improving care standards. Most staff felt that through this system better relationships had developed between patients and staff and that care had become more patient focused. It was also considered to be a more manageable system for staff, improving their knowledge of the patients and their care needs:

'You could see that patient focused care. It's not like you wash four patients and start doing something else... Now that you wash four patients you see that the dressing is soaked and you do it. You check your temperature, you do your kardex (patient notes), and it's not like you're guessing what happened to the patient ... it is manageable too.' (Nurse 6 Elm ward)

With the implementation of more patient focused care staff stated that patients were being given more choice about how their day was organised, with them being encouraged to do more things for themselves. Staff felt that this was the first step in engaging with a rehabilitation philosophy and that they were ready to embrace it further:

'The way we work is changing, not rushing patients in the morning ... encouraging patients to get up for breakfast and washes instead of having it in bed ... That's rehabilitation, you motivate people to do more for themselves ... we know what rehabilitation stands for now.' (Nurse 1 Elm ward)

As well as the ward staff highlighting a readiness to engage in rehabilitation, managers also exhibited this together with a greater commitment to developing the service:

'I think if we're going to have rehabilitation wards then we need to look at the environment, we need to look about therapy input and it needs a lot more finance, work, manpower hours put into it to develop that.' (Service manager 1)

Rehabilitation care had also been enhanced through a re-organisation of bed areas to create a partitioned social space with a small dining table, and the participation of staff and patients in

social activities including two afternoon tea parties on the ward and other main hospital events organised by the voluntary services department. Staff now realised the contribution this could make to patients' well being, as well as enjoying participating in the activities themselves:

'I couldn't believe it when people bring back old memories, people from different beds sit down and talk together for the first time.' (Nurse 1 Elm ward)

With these improvements in care standards came an increased commitment and motivation amongst staff to continue to improve and, although some staff were less enthusiastic about the improvements that had been made than others, they all stated that they now felt ready and keen to engage with change:

'And after the interviewing I said as well, I wouldn't use lack of time as an excuse anymore. The day I walked out of this place, I said, 'That is it, time or no time has nothing to do with the commitment' ... people have a more positive attitude now ... and before they didn't want to know.' (Nurse 6 Elm ward)

'I think it has made people more aware, I think, definitely, and it has made people want changes more.' (Nurse 21 Elm ward)

The roles and responsibilities of nursing staff had yet to be addressed, together with defining the purpose of the ward. Further discussions as to how communication between ward staff and managers could be addressed had also still to be held, however staff felt this would now improve as following further organisational change one service manager would be based continuously at this hospital and would no longer have their workload responsibility split between the two hospital sites.

4.2.4 Additional outcomes achieved not linked to individual action cycles

As well as the outcomes related to the individual ward action cycles, other outcomes related to exploration phase findings were also achieved during this time:

- Following the feedback of exploration phase findings to service managers, domestic service provision on both wards was increased. Both wards were provided with a comprehensive evening service, with an extra daytime domestic also being supplied to Elm ward.
- Funding from 'Nightingale Ward Improvement Monies' was used on both wards to install walk in showers and refurbish existing bathrooms and toilets, with all being easily accessible for those with disabilities, mobility and dexterity difficulties.
- A work based learning 'Rehabilitation Practice' course was commissioned and developed in collaboration with City University to meet the educational needs of both registered nursing staff and health care assistants.

4.3 Reflection phase findings

Findings in this phase are split into two sections. These are:

- The repeat of baseline data collection methods
- Reflections on the study process

4.3.1 Repeat of baseline data collection measures

The Monitor 2000 scores for all sections improved over the period of the study on Oak ward (see appendix 5). With regards to observational data SQUIS results indicated a reduction in negative interactions between nursing staff and patients, however there was also a small reduction in positive social interactions (see appendix 5). This reduction was not supported by the comments of the three carers interviewed who stated that they could not fault the staff or the actual care given to patients. Another positive finding during SQUIS observations at the end of the study was that patients were now being offered daily showers and were walked to washrooms in the mornings rather than being provided with bowls by their beds.

There was little change in the Monitor results on Elm ward with the exception of a major improvement in scores for discharge planning and, although the overall score for locally specified questions increased, there was a decrease in those specifically related to rehabilitation care (see appendix 6). SQUIS results indicated an absence of negative interactions between nursing staff and patients which was a positive finding, however their percentage of positive social interactions had also decreased (see appendix 6). The two carers interviewed, however, said that the ward was a friendly place and that the nurses were always smiling, did their best, and cared about the patients. They stated that information giving still needed to be improved as they had to seek it out, and that some of the nurses were not as knowledgeable about the patients as others. They did, however, feel that their concerns were responded to. Other comments made included that the ward was noisy preventing patients from getting any rest during the day, and that physiotherapy provision was less than they expected.

Documentation of patient care needs and plans of care remained poor on both wards. Patients were still not being re-assessed on transfer for general care or rehabilitation needs, with care plans and evaluations still lacking a rehabilitation focus. Particularly on Elm ward assessments and plans of care were just adopted from the transferring wards with no review or attention to current needs. It does, however, need to be questioned how documentation can be kept up to date with the staffing levels as low as they were on the wards. This is supported by the fact that 48% of SQUIS observations on Elm ward were of agency nurses and also by field note recordings made during the reflection phase:

'Went up to Elm ward and didn't recognise anyone. It was all agency nurses. Eventually found (nurse) who was the only member of regular staff on duty. Their

staffing levels are appalling. How can you improve practice when staffing levels and the skill mix are this poor.' (Field note 01/03)

Further analysis of Monitor 2000 and SQUIS results has not been undertaken as part of this section. During data collection throughout the study I continuously questioned the validity of these tools to measure change in care quality over time, and thus their ability to provide meaningful data for reflection. Concerns regarding these tools included:

- The baseline data collected on Elm ward using these tools was not supported by the participant observation which took place concurrently. This led to the researcher questioning the sensitivity of the tools in measuring current care quality.
- The Monitor 2000 tool relies on documentary evidence as a main measure of care quality. This means that if nursing documentation is poor, as was the case in this study, quality of nursing care will be reported as poor regardless of what is actually carried out in practice.
- The Monitor 2000 percentage scoring system does not always allow changes in practice to be recognised. An improvement in one aspect of care can be cancelled out by a deterioration in another that occurs in the same section. Lack of sensitivity of this tool in particular to this study is further demonstrated by the rise in scores on both wards regarding discharge planning which was not an identified action cycle.
- With regards to the SQUIS tool, it was not possible to observe exactly the same staff at the beginning and end of the study due to attrition and shift patterns, therefore a true comparison of before and after interactions could not be obtained. It also needs to be recognised that one staff member can skew the results by carrying out a large number of positive social or negative interactions. If this staff member is not present at both measurement times the validity of the results can be questioned.
- The presence of agency nurses on the ward during SQUIS observations also affects the validity of results as they are not permanent members of staff and would not have been involved in the study and practice development activities. The validity of the post results on Elm ward can therefore be questioned as 48% of interactions observed were by agency nurses.
- The type of activity being undertaken during observation periods also determines the results obtained. Asking patients what they want for breakfast, lunch or supper is generally a basic care task, therefore in observation periods occurring during mealtimes these made up the majority of interactions thus reducing the potential for more positive social recordings. Although the observation times were mirrored at the beginning and end of the study, different activities did take place preventing valid comparisons from being made.

Therefore, although the results from these tools were useful in helping staff to identify areas of practice they wanted to work on, their utility as before and after measures in this study can be questioned. Their validity as before and after measures in research studies in general also needs to be further explored.

4.3.2 Reflections on the study process

Analysis of exit interview data produced six main themes related to participants' experiences of being involved in the action research study. These were 'staff expectations of the study', 'difficulties changing practice', 'raised awareness', 'facilitating factors', 'collaboration versus delegation and authority', and 'keeping the change process going'.

4.3.2.1 Staff expectations of the study

Participants spoke of their expectations at the beginning of the study and whether these had been met. There was a perception by ward staff that I was going to go in and tell them what to do, and that there would be no negotiation of the changes needing to be implemented. The participative approach came as a surprise to them:

'I thought you were going to do lots of changes, things that we probably wouldn't like, have all these ideas and want us to do it, but we wouldn't get anything out of it.' (Nurse 11 Oak ward)

Some staff on Elm ward had high expectations of the study at the beginning that were not met, and which resulted in feelings of frustration and disappointment:

'I felt a bit disappointed because the expectation was that it was going to develop into a proper rehab ward and you would have rehab activities going on ... I was hoping that something big would come of this, I'm feeling a bit let down.' (Nurse 19 Elm ward)

On reflection, however, staff recognised that the change in focus of the study from one centred entirely on rehabilitation to one addressing the more pressing needs of the ward at the time was an appropriate move to make:

'Without staff motivation or the way we started it, you can't achieve anything... because I was thinking 'Oh we've forgot what rehab is, and why on earth are we talking about ourselves all the time' ... but no, we've sorted ourselves out, and we're very open, and you can do anything and you can achieve anything, so that's what I believe for us.' (Nurse 6 Elm ward)

This was supported by managers who said that their expectation was that in three years time they would have 'wonderful up and coming rehab areas'. On reflection they now realised this expectation was unrealistic, and that the realities of practice were very different:

'...so even though the project was focused on rehab, I think when you're working in an environment of healthcare you can't stick to that small focus because there's so many other things going on that you have to address, issues and make things better as you go along your way, and that's much more of an outcome than having a lovely philosophy for rehab.' (Service manager 1)

Staff commented on the process of implementing changes in practice. They were not familiar with the procedures involved and were surprised at how long it took:

'I thought it was going to happen a lot quicker, a lot, lot quicker ... I mean it's a lot to be done isn't it ... it's the little things, you might do a piece of work, then you got to go and write it, and then you've got to show it to everybody, it's a long haul process really and that's what shocked me.' (Nurse 3 Elm ward)

They were also surprised by the responsibility placed upon them in implementing change. They did not think that it would be down to them to implement changes, and expected more help from others outside of the ward teams:

'But I thought there would be more people involved... to help ... I wasn't expecting that (it was down to us to do it) ... do you know what I mean, not to actually overtake the whole ... as it was to do the whole thing.' (Nurse 6 Oak ward)

Staff also commented that they thought I would have more power to make things change and that I was going to do it for them. They were disappointed that this wasn't the case:

'I thought that your role was really supreme, I thought that you could override management and everything, 'we need this and we need that', and I thought you could just go off and do it, but obviously, and unfortunately, it is not the case.' (Nurse 21 Elm ward)

4.3.2.2 Difficulties changing practice

Staff expressed the difficulties they experienced in trying to implement changes in practice in general, as well as specifically in relation to rehabilitation care. Together with the issues already raised throughout the project such as staffing levels, time and lack of training, they also commented on the fact that the wards were not functioning as rehabilitation wards, lack of staff participation, and issues related to gaining trust within the study.

Not rehabilitation wards

Staff expressed the difficulties they had trying to improve rehabilitation care when they felt they were working in areas that were not actually rehabilitation wards. Only one participant viewed the wards as rehabilitation with the others saying that this was just a title, and that it did not reflect the care provision being provided. This was highlighted, as previously discussed, by

the client groups staff were looking after. Staff felt that they were only receiving a minority of patients who had rehabilitation needs with some patients being very confused, some bed bound, some extremely unwell, and some in the last stages of life. In addition, patients were being transferred who were just waiting for discharge or placement to be arranged. Although they considered some patients suitable for rehabilitation, the client mix made a focus on this difficult:

'We're classified as a rehab ward in inverted commas, but we're still dealing with the type of patients we always had, that might not have been for rehab.' (Nurse 6 Oak ward)

'We were told it was a rehab ward, but really they were just sending very ill patients and that was quite frustrating because we're concentrating on the ill ones, which we have to, the ones who are better, we could have worked on them a bit more ... but that was quite frustrating I thought... Rehab should mean rehab really, not a mixture.' (Nurse 3 Oak ward)

The way the wards were staffed also added to the view that these were not rehabilitation wards. As well as the nursing staff skill mix the numbers of physiotherapists, occupational therapists and speech and language therapists was considered inadequate for a rehabilitation setting, with difficulties accessing other key services, such as chiropody, also being expressed:

'But I still think whether it will be true rehab wards until we do get the resourcing right.' (Manager 6)

The re-naming of the wards rather than their development into rehabilitation areas was also recognised by managers:

'The wards were sort of labelled with this very quickly due to other changes in the trust ... the wards became rehabilitation wards, became without any process of becoming them.' (Service manager 1)

It was also stated that trying to achieve a particular type of care in an environment that cannot provide it made some staff feel that they were not achieving, and this adversely affected morale:

'And I suppose that is one of the difficult things for morale, particularly if you've got, you know, that it's not a rehabilitation ward ... what are you actually doing, you're just waiting for them to have a week or two more recuperation, then packing them off home ... 'That's all I'm doing, that is all that the physios are doing', just sort of maintenance, physio until they are ready to go home, until they get packages sorted out or until they've had just had a few more days, then you wouldn't have much morale, because you don't have much purpose in your job...' (Consultant 4)

'...because to try and improve rehabilitation care on a non-rehabilitation ward is very hard.' (Nurse 19 Elm ward)

Lack of participation by some staff

As well as a lack of commitment to and participation in early action cycles by the staff on Elm ward, this was also the case with many on Oak ward, with staff commitment being variable and participation falling on a few motivated individuals. Staff on both wards highlighted lack of participation of all team members in change activities as a factor which hindered development:

'Everybody has got to be of the same mind and as enthusiastic about things otherwise it doesn't work. One person can't do everything, it's got to be everybody in and doing it.' (Nurse 21 Elm ward)

'You can only make things happen by working together.' (Nurse 3 Oak ward)

The fact that some staff were not originally appointed for either care for older people or rehabilitation settings was considered one reason for their lack of participation, as they were not interested in the field in which they were practicing:

'I mean when the previous ward was closed and moved it was all a big shift from acute care to rehabilitation, and I just get the impression that some people don't actually want to be doing that... It may be that they don't want to be where they are at the moment. I think they want to be nursing, but I think they want to be in different fields of nursing.' (Nurse 19 Elm ward)

This was exacerbated by the presence of ingrained ways of working that people did not want altered:

'It's breaking that habit of custom and practice, the rituals, that is the most difficult thing.' (Nurse 3 Oak ward)

Lack of participation by some team members resulted in others who were keen to change losing motivation to keep trying, thus reducing the overall ability of the ward to improve practice:

'If you're part of a team and you've been there for a long time you're going to be more interested in your work, and you want everybody else to do the same, and if they don't we tend to lose heart too.' (Nurse 8 Oak ward)

Analysis of field notes also revealed this lack of participation of many staff in development activities, together with a lack of ownership of the change process. I felt that I constantly needed to push staff to ensure that interventions took place with this resulting in me often taking the lead in development activities and intervening when things did not go according to plan:

'I do not feel staff are participating in the research or owning any of it. They are not taking responsibility for development activities. It seems as if the registered staff feel that everything is down to me and I am organising everything ... They are not helping to make things work. They want things to happen but want someone else to do it all the time.' (Field note 06/01)

On Oak ward this led to me starting to work only with the few motivated individuals who were keen to participate at the expense of those who weren't.

Due to the difficulties described, and their knock on effects, it was felt that for improvements in practice to take place one person needed to take overall responsibility for making things happen within the team and lead on change activities. Staff and managers felt that the ward sisters should have taken on this role, but did not do so:

'But you need that push from leaders, from ward leaders ... it needs to be driven.'
(Service manager 1)

Field note entries supported this, with analysis of them indicating that although the ward sisters wanted practice to improve they were not willing to take responsibility for making this happen or provide the motivation or support necessary to engage the staff:

'On both wards I have to work hard to maintain staff motivation... I am constantly pushing them to progress. Responsibility for implementing or sustaining change is not taken on board. I think a lot of this is down to the leadership skills of the managers.'
(Field note 05/01)

Time taken to gain trust

Staff also commented on issues to do with the research study itself which may have affected the amount of change that was able to take place. The time it took to build up a relationship of trust with participants was considered to have reduced the time available for development activities. Staff were originally suspicious, and also threatened, by a stranger coming into their areas. It was expressed that people hope they are doing a good job and that someone coming in dispelling this hope, and identifying that there are things that need to be improved, can be very uncomfortable:

'There was a lot of fear around the project too and that certainly put the barriers up, and some of that fear was around that you would find things and then start to try and 'tell' people what to do or how to sort it out.' (Manager 3)

This fear seemed to be exacerbated by me professionally reporting to the director of nursing rather than the care for older people managers:

'It (direct access to the director of nursing) also causes fear I think in an organisation that works in such a hierarchical way.' (Manager 3)

Some of this fear and suspicion could be attributed to the lack of preparation some people received prior to commencement of the study. This resulted in a lack of clarity regarding the study purpose, working boundaries, and what I was really there to do:

'People don't know what you are ... we don't know your initiative, why you come.'
(Nurse 1 Elm ward)

'I think it needs to be recognised how such a post can be potentially threatening to a manager. There needs to be more ownership of the manager in establishing the post.'
(Service manager 2)

4.3.2.3 Raised awareness

Although staff experienced difficulties in changing practice, those that did get involved talked about what they had gained through participating in the study. Participants said that their awareness had been raised through the work undertaken, and that the project had 'opened peoples' eyes'. They were now more aware of what was happening on the wards and of what needed to be changed:

'The project has brought problems to light, which is good, because obviously they were there before but well disguised, so it's yes, it's made us more aware that there are things up there that need to change.' (Service manager 1)

This raised awareness gave participants the opportunity to think about the care they were giving, enabling them to start reflecting on their practice and examine what they did:

'Because it makes you think doesn't it? It makes you dig into the depths of your mind and pull out information that you didn't realise was there and think 'yeah, maybe'.'
(Service manager 1)

'Your research gave me the chance to step back and question myself whether I'm doing my job as I should be and whether I could have done it better, if not why?'
(Nurse 1 Elm ward)

Raised awareness and an increase in reflective practice allowed changes in thinking about rehabilitation to occur with respect to the function of the rehabilitation wards:

'Maybe we should have thought about different concepts for (hospital), because not everyone want, needs to be rehabilitated ... and maybe we're labelling patients too much and we're not thinking about streams, and I wish I'd thought of this three years ago. But maybe the project's made me aware.' (Service manager 1)

Finally, participants commented that they were more aware of the change process and action research, including how people go about it, its benefits, and the difficulties encountered:

'It's made me more aware of sort of the barriers that people do put up against change and how hard it is to change things, not just from the ward perspective but from things that are beyond our control.' (Nurse 19 Elm ward)

'A much better appreciation of action research ... I think you can read about it, but it's not until you are actually involved ... you can actually appreciate the benefits of it.' (Service manager 1)

4.3.2.4 Facilitating factors

Participants commented on the facilitating factors that enabled some change to take place and the above awareness to be achieved. These fell under the four themes of 'someone to get it going', 'a continuous presence', 'working together', and 'the power of achievement'.

Someone to get it going

The presence of a catalyst (a researcher) to get things moving was considered a facilitating factor by participants. They felt a catalyst was needed to get the ball rolling and help to make change happen. Some staff felt that they needed someone to help them to diagnose current problems and come up with possible ideas to address them:

'Because you never actually sit down and study what it is you are doing at the time, well apart from the odd ward meeting when you discuss issues and that, you don't have anybody actually analysing maybe things could be done differently, or maybe things could be improved ... because you could sort of write things down for us and look into issues that were a problem for us ... and help us to handle them better.' (Nurse 8 Oak ward)

Others felt that they knew what needed to be done but needed someone to help them get started:

'Or maybe the ideas were always with the nurses, maybe I don't know, but it's just that you don't know how to make it happen and you need somebody to come from outside to say 'oh you could do this, do that'.' (Nurse 3 Oak ward)

'There was an objective outsider in getting them started.' (Service manager 2)

Although myself being an outsider to the organisation impacted on the time it took to gain the trust of participants, once that trust was gained being considered an objective outsider was seen to enable staff to talk more openly:

'You see I think you are neutral ... I can talk to you, you stress on confidentiality ... and people are happy to say what they want... because we have got so many things to say.' (Nurse 1 Elm ward)

As well as a catalyst, it was identified that you also needed a motivated person on the ward who was willing to lead and take responsibility for changes. Motivation tended to be attributed to two factors. The first was because the individual saw a need for change and wanted something to happen:

'This had been, like something's been bothering me you know, incontinence ... something's got to be done ... everything was helter skelter.' (Nurse 3 Oak ward)

The second motivating factor was that the staff saw a benefit in the change for them personally, and also for the patients:

'I enjoyed it (games sessions), I did enjoy it, and it, I felt happy because of the patients enjoyed it as well ... as I said if it makes the patients happy it makes me happy.' (Nurse 19 Oak ward)

A continuous presence

One of the key facilitating factors identified was the constant presence of a researcher who could give time to staff. Staff commented that I regularly visited the wards and could be contacted at any time. This availability meant that someone was always there if they needed help, advice or support:

'You were there all the time weren't you, from the beginning, and you didn't push you were there just like popping up, just to remind us without saying anything ... We knew that we were supported, yes you were there ... we could ask you questions if we were in trouble ... it's just you being there ... we knew we could go to you for advice.' (Nurse 3 Oak ward)

'When you pass by the ward and we are in trouble, and you just passed by just to say hello even, but you've been very helpful at the situation ... at least you had time to give to us.' (Nurse 4 Elm ward)

'But you've given them something else a bit different, and perhaps just being there sometimes is enough.' (Service manager 1)

It was suggested that this presence provided leadership, encouragement and support for staff to try and improve practice, with them being motivated by someone taking an interest in how things were progressing:

'Still, they know you are there ... they know that you are there ... so they try their best.' (Nurse 4 Elm ward)

It also presented them with someone they could talk to and confide in who would listen to what they had to say, thereby giving them a voice and the confidence to speak out:

'Because we see you regularly on the ward then I can always call you and I know you'd listen to me, you see. And I can identify with you because you are a familiar face ... and it's been good because I've been able to air my views.' (Nurse 8 Oak ward)

'You listen to us, you let me speak, you want to hear from us ... you lend me your ears.' (Nurse 1 Elm ward)

'You provided strength for them to actually say 'I'd like to do it differently'.' (Service manager 1)

Staff identified that they felt valued by someone listening to them, showing an interest in them, supporting them and giving them a voice. This encouraged and motivated them to develop further:

'You feel more valued being involved in a project like this ... I really felt as if I was needed, because they were hearing the nurses' voices, the workers on the you know front line.' (Nurse 3 Oak ward)

'I feel good now in what I am doing, before I didn't take any pride in it, I just come and do it, but now I want to do it better.' (Nurse 1 Elm ward)

Working together

Working together with the staff was also considered a facilitating factor in the study process. Those that took part in the action cycles commented that they had focused on aspects of care that they wanted to work on and that were important and of benefit to them as well as their patients, not aspects chosen by others. This increased their motivation to participate, with actions having a purpose and being relevant to everyday practice:

'The research is closer to home, it's associated with what I do, I'm part of it I would think ... it's about patient care, but it is also a lot about nurses, we ourselves should benefit, we should get to see ourselves better too.' (Nurse 1 Elm ward)

Ward staff also talked about the advantages of a flexible approach in enabling them to get involved in development activities by making allowances for and fitting meetings around their work and time constraints, as well as using different approaches when others started to prove ineffective:

'The good thing about it, you are constantly coming back and finding time and that... You used different styles, I remember when it was becoming difficult ...then you devise another way (tell it how it is) and that helped ...Nothing stopped, it carried on, the research carried on, and it doesn't matter how it was done before, but it was continuous ... because you didn't stop, you devised another method.' (Nurse 6 Elm ward)

'Even if you've had to sit down with them at the desk while they are working, you know you've done that, and I think that's shown a lot about how you can't just expect staff to come up to meetings and give their views, it's not as easy as that ... you have to take it to them and really work with them.' (Manager 6)

This ward based approach was also highlighted as beneficial in the developments that took place. Participants felt that their knowledge and understanding was improved through the conversations and discussions that arose from the feedback of data, work on the action cycles, and informal prompting and coaching by myself when present on the ward. They classed this as knowledge that could not always be gained from textbooks, and which had more of an impact on changing practice than formal education alone:

'I mean I tried different methods with them, taking them all out to a classroom, but it is not always the answer because they're very keen on that day, maybe the next day, maybe the day after but give it a week, and they're back into their old style.' (Service manager 1)

'Before you started no one ever said 'why are we doing that or why are we doing this'', so it's in everyday work in what we do on the ward, we use it differently in what we do, and we like to talk about it all the time.' (Nurse 6 Elm ward)

This data was further supported by field note recordings which highlighted the impact of this approach on staff learning (see appendix 7 for illustrative section of field notes). It was also stated that by undertaking this approach it showed there was a lot of unacknowledged potential amongst the staff that just needed to be encouraged and developed:

'But to know the abilities of others and the potential there to build on, that has been quite beneficial ... it has shown us there is potential out there, if only you can invest time with people.' (Service manager 1)

The power of achievement

Finally, motivation for staff to persevere in change activities was facilitated through the achievements they made along the way. All those who participated were proud of the part they had played in helping change to happen and the recognition their work was receiving, and said they felt that they were making a difference:

'I feel very proud the way that had gone ... people say how the tea party was successful. People feel proud ... the way things are going now it's as if we've achieved something.' (Nurse 6 Elm ward)

'It's made me feel I've made a difference even if it is very, very small.' (Service manager 1)

This recognition was enhanced by the stated raised status and profile of care for older people services within the trust. It was stated that those at a more strategic level had been given the opportunity to see what was happening on the coal face and engage with the issues surrounding how older people were cared for within the organisation:

'I also hoped it would raise the profile of elders which it has done ... it's given quite senior people a view on how care of the elders should work.' (Manager 3)

4.3.2.5 Collaboration versus delegation and authority

Even though the approach used in the study was considered a key factor in helping staff to engage with change, there was disagreement about how delegatory I should have been and how much authority I, as a researcher, should have had in enabling improvements in practice to be made.

Some of the ward staff felt that I needed to be more 'pushy' and delegate activities to individuals rather than asking them to volunteer to take part in various action cycles. It was expressed that some staff were more likely to push themselves forward than others, resulting in lack of participation from the less assertive members of the ward teams. It was also highlighted on Oak ward that, even though some staff were not interested in participating in the action cycles at the beginning of the study, they did want to get involved when they saw achievements being made but did not then know how to do so, resulting in them feeling left out. This, however, was not the view of all members of ward staff, with some feeling that more delegation would have had a detrimental effect on the researcher-participant relationship, with staff not wanting to participate at all as they would have felt they were being told what to do. The difficulties of getting the balance right is illustrated in the following quote:

'I mean you showed us, but I think it's up to all individuals, we are all different, some of us will take the lead and just go, the others probably need a bit more push, but no ... unless you want to grab us by the hair and pull us across and say do this, I mean what could you do really apart from that?' (Nurse 3 Oak ward)

There was also disagreement over whether I should have had more power and authority within the service. Some ward staff, especially on Elm ward, felt that more change could have been achieved if I had possessed more 'managerial clout':

'If your word was law then that would be brilliant because there would be so much change ... I wanted you to have more say ... You need more force behind you to make it happen. You can see what's going on, what changes are needed, but no power to make it happen.' (Nurse 21 Elm ward)

This view, however, was refuted by all the managers interviewed. They felt that I was able to build up a rapport with staff, and that they were able to talk openly with me, because I was impartial and did not have managerial authority. It was suggested that although it is easier to

direct change rather than help people see it for themselves, such an approach would not have enabled me to 'see it how it is' which was key in the changes that took place:

'Managerial clout is not part of the role ... this role is about raising possibilities through encouragement, opening eyes, and facilitating ... in this role you have to form relationships with the staff, to be facilitative you have to get to know them as people ... People don't open up to managers, they tell you what you want to hear. This role should definitely not be managerial.' (Service manager 2)

4.3.2.6 Keeping the change process going

Participants commented on what they felt they needed, once the study completed and I withdrew from the clinical areas, to enable them to continue the change process. Even though some staff were now ready to engage with change and take some responsibility for it, all participants expressed that the ward staff needed someone, outside of the ward teams, to continue to come up with ideas, help get things going, keep things 'ticking along', monitor progress, and make sure things did not get abandoned:

'When you leave it might stop, so maybe we need someone like you, someone to go round and get it going and find out what's going on. Remind us this needs to be done, because people just fall back into their old habits. It's nice to have someone there to keep an eye and make sure things are done, keep things going.' (Nurse 11 Oak ward)

The continuous need for someone present to talk to who would provide leadership, help, advice, support and feedback, and thus keep motivation up, was also expressed:

'If you're not here who do we talk to? ... We need people to come in to help people to change, and we need these people around for a long time, so we don't go back to square one.' (Nurse 1 Elm ward)

It was also felt that this person needed to be in a position which sat outside of the routine clinical and managerial activities to allow them the time to concentrate on leading professional and practice enhancement without getting tied up in the everyday melee of things to do, a difficulty currently faced by ward sisters:

'A lot of people are very willing to get involved and devote some of their personal time and whatever to things that they think are worthwhile which are beyond that everyday work, but the amount of time to set it up and drive it is much more than to participate in it ... you need somebody to actually lead it.' (Consultant 4)

It was agreed that investment was needed in senior clinical positions that could undertake these types of roles, examples of which included lecturer practitioners, modern matrons, clinical nurse specialists and nurse consultants.

5. DISCUSSION

The previous sections of the report present a mixed story of success and non-achievement associated with a variety of organisational, contextual and individual factors. Further reflection on the study findings has resulted in a greater understanding of what may have prevented or enabled the change process within this study, and will now be explored in relation to two theoretical frameworks. These are the theory of learned helplessness (Seligman 1975) and the senses framework (Nolan et al 2006).

5.1 A suggested theory of learned helplessness

It can be seen that the contexts in which care was being provided at the beginning of the study and the challenges faced by staff had a major impact on the quality of rehabilitation care they were able to provide. Ward environments did not facilitate, and could be considered non-conducive, to rehabilitation care. Nurse staffing levels, skill mix and knowledge and understanding of the concept of rehabilitation, together with numbers and availability of therapists, were considered inadequate for rehabilitation provision. There were also questions regarding the suitability of patients transferred to the wards and their ability to undertake active rehabilitation. These contextual issues and challenges not only affected the quality of care provided, but also the ability of ward areas to provide some key aspects of rehabilitation care. This has real implications for the motivation of staff working in these areas. The labelling of wards as 'rehabilitation' brings with them certain expectations. When these expectations cannot be met a feeling of failure can ensue reducing morale and motivation to continue trying. This possibility is supported by the work of Finlayson (2002) who identified that the working environment was one of three key factors that affected nursing staff morale and motivation. Brown (2005) and Nolan et al (2002, 2006) confirm this further in their findings that student nurses who experienced care in what they term as 'impoverished environments' tended to believe that they were unable to make a difference to the care that older people received. Such 'impoverished environments' are described as those which have an inadequate physical environment with a lack of resources and equipment, inadequate care practices, lack of dynamic leadership, poor staffing levels, and staff who lack appropriate knowledge and skills accompanied by a lack of investment in staff training (Brown 2005). These characteristics can be identified with the participating wards in this study.

The work by Finlayson (2002) also identified that a second key factor affecting nursing staff morale and motivation was whether they felt valued in their workplace and organisation. Some ward staff and managers in this study said that the staff did not feel valued, with them attributing this to examples such as lack of consultation regarding organisational changes, not being listened to, lack of support, and lack of interest, appreciation and help by others regarding the issues that they faced. This supports further the findings of Finlayson (2002) who identified perceived worth, levels of support, being listened to and recognition of work undertaken as key issues impacting on staff feelings of being valued. The devaluing and

marginalisation of work with older people in general has also been highlighted by Nolan et al (2002), and this could be seen to be exacerbated in this study by the fact that half of the nurses on the study wards were not there by choice but as a result of organisational moves, indicating that 'anyone' can work in these settings. Not only does this devalue the speciality but it also results in staff working in these areas who do not want to be there, thus further reducing overall morale and motivation.

The above issues regarding the contexts of rehabilitation care and staff not feeling valued can therefore be associated with reduced morale and motivation of staff. However, I am also suggesting here that the situation staff were experiencing may have led to a state of learned helplessness (Seligman 1975). Learned helplessness occurs when a person learns that outcomes are not affected by their behaviour, and thus are beyond their control. When events outside of a person's control are experienced, an expectation of future uncontrollability can develop which can lead to deficits in motivation, cognition and emotions. An expectation of future uncontrollability can result in a reduced incentive to keep trying and a response of passivity and giving up (motivational effect). This also interferes with learning that a future action has influenced an outcome when it does become controllable, with individuals not perceiving that their behaviour had any effect (cognitive effect). These experiences can result in low mood and feelings of hopelessness (emotional effect) (Maier & Seligman 1976, Seligman 1972, Seligman 1975).

A state of learned helplessness could be associated with the majority of staff on the study wards who experienced a lack of control of contextual issues and a lack of voice within the organisation, which led to them feeling powerless to effect care provision. This was demonstrated most strikingly on Elm ward by staff not being consulted about, and lack of negotiation regarding, major organisational changes such as the ward relocation which imposed upon them adverse changes to the care environment together with the staff and patient groups. This was repeated again on both wards when winter pressure plans were again decided and imposed with no negotiation or consultation with staff on either of the study wards. Examples of when staff actions failed to influence outcomes were also evident. When staff were previously concerned about issues impacting on patient care, such as unsafe staffing levels or inappropriate patient transfers, they completed incident forms to highlight these with service managers, however they were rarely acted on and no feedback was given leading staff to feel that their actions had no effect on changing the situation. Valid requests for patients to be transferred at appropriate times and for staff to be told when patients would be arriving were also often ignored. Deficits in motivation, cognition and emotions resulting from future expectations of uncontrollability can also be identified. The motivational effects of learned helplessness would explain why staff stopped trying to change the situation they were in by ceasing to take the actions described above, and did not always try to help themselves by reporting concerns to managers, as they may have felt that even by doing so it would not have any effect on the situation. This may also explain their lack of motivation to take part in

development activities as they may have felt that it would not make any difference, and their wish for someone else to sort things out for them as they felt unable to do so themselves. The cognitive effects could also explain why certain individual action cycles were unsuccessful. Requests by Elm ward staff for personnel to manage the ward so that all ward staff could attend the team building workshops were met by the service manager and professional development nurses indicating that the staff request had resulted in a positive outcome, however this did not help to motivate the staff to sustain the implementation of this initiative or stop them from feeling that managers did not listen to or support them. The request for activity equipment made by the staff on Oak ward was successful, however this was subsequently not used with there being no motivation amongst the staff to do so. Also, although the increase in domestic services, refurbishment of bathrooms and toilets and development of a rehabilitation course resulted from a direct result of the information provided by ward staff in the exploration phase of the study, staff still attributed these successes to me as the researcher as opposed to the influence they themselves had in achieving these very positive outcomes. Finally, the emotional effects of learned helplessness were expressed through the stated low morale felt by staff on the study wards, however this was more marked on Elm ward than Oak ward.

Whilst applying this theory I had the constant concern that something did not fit. Although most of the staff on both wards had difficulty engaging with development initiatives in the study, and exhibited an expectation of future uncontrollability (and thus learned helplessness) through deficits in motivation and cognition, they were contrasting in other aspects such as ward organisation, atmosphere, staff behaviour and performance, and standards of care. Oak ward was not in the same place as Elm ward and did not outwardly appear to be as helpless in everyday aspects of the working day. Further exploration of learned helplessness theory and engagement with its reformulation goes some way to explaining this. Following the original work on learned helplessness the model was reformulated to refine its applicability to human situations. Abramson et al (1978) suggested that people's perceptions of the causes of their helplessness influences the generality and chronicity of their expectations of future helplessness, as well as their self-esteem. This is influenced by whether they attribute their helplessness to internal or external factors, stable or unstable factors, and global or specific factors. People can attribute their helplessness to an inadequacy within themselves to influence outcomes (internal) or to things outside of their personal selves (external). They can also attribute their helplessness to factors they consider as long lived and recurrent (stable) or short lived and non-recurrent (unstable). Finally, a prediction that helplessness will recur over a broad range of situations is attributable to global factors, whereas helplessness deficits occurring over only a narrow range of situations is attributable to specific factors. It is suggested that those who attribute their helplessness to internal, stable and global factors are more prone to general and chronic helplessness and, with the internal attribution, to suffer from deficits in self-esteem.

The attributions made by the staff in this study can be assumed through the data collected. It indicates that many of the staff on both Oak and Elm wards attributed much of their helplessness to external factors such as lack of staff and time, the type of patients transferred to them, and a lack of managerial and organisational consultation and support. However, particularly on Elm ward, staff may have also attributed their helplessness to internal factors such as not themselves having the skills or abilities required to care for their client group. Also, deficits in self-esteem associated with internal attributions was demonstrated through the staff reporting that they did not feel appreciated, recognised or valued for the contributions they made. From the comments made by staff it can also be seen that on both wards they attributed their helplessness to factors that were stable, with this being demonstrated by them repeatedly voicing that things had been tried before but that nothing changes or will ever change, resulting in them feeling that things were always going to be out of their control. The constant organisational changes with the absence of information and negotiation can also be considered as long lived and recurrent thus strengthening the stable attribution. With regards to Elm ward it can be considered that their helplessness occurred over a broad range of situations within the work environment affecting their ability to work together as a team, provide a reasonable standard of patient care and participate in practice development initiatives. This recognises a global attribution towards their helplessness deficits in the work environment. Oak ward, however, was different. Although a state of learned helplessness can be proposed through them perceiving that whatever they did they could not control future outcomes, and with them exhibiting deficits in motivation and cognition, this seemed to be related to more specific situations. The general standard of physical care on the ward was good, the ward was calm with a pleasant atmosphere, and the staff did seem to work together when planning and executing patient care. It seemed only to be in relation to the practice development initiatives in this study that most staff seemed unable to engage. This could be due to the fact that, as stated, research studies that had been carried out on the wards before were unsuccessful in implementing changes in practice and thus they felt that it would be no different this time. This supports a specific attribution, with helplessness not being transferred to other everyday work situations outside of this. It can therefore be suggested that the staff on Elm ward attributed their helplessness to both internal and external, stable and global factors which made them prone to a general and chronic helplessness with self-esteem deficits. It can also be suggested that the staff on Oak ward also attributed their helplessness to stable factors, but with more emphasis on external and specific ones reducing the generality of their helplessness and self-esteem deficits. It also needs to be recognised that a few individual staff on Oak ward were keen and able to engage in the study and practice development initiatives thus indicating that they were not in the same suggested state of learned helplessness as their colleagues. On further exploration of the Oak ward staff profile data it can be identified that those who did participate in the practice development initiatives had been on the ward for a shorter period of time than those who did not (means = 3 years and 13 years respectively). It can therefore be suggested that they had not been exposed to a

lack of controllability for as long a period of time and thus had not developed the degree of learned helplessness as other staff in that environment.

5.2 Movement out of learned helplessness states

It can therefore be suggested that the majority of staff on the study wards at the beginning of the study were in a state of learned helplessness which prevented them from engaging in development activities. However, there is also evidence to suggest that by the end of the study the staff on Elm ward had started to move out of this learned helplessness state and were ready to engage with, and able to implement, some changes in practice. This movement out of learned helplessness is evidenced by a reversal to some degree of the motivational, cognitive and emotional effects previously experienced. At the end of the study the staff on Elm ward indicated that they were now more enthusiastic about, committed, and motivated to engage with change. This, together with their wish to continue to do things better, demonstrates a reduction in the motivational effects of learned helplessness. A reduction in cognitive effects was indicated by the staff recognising their achievements and the part they played in these, and feeling that they were making a difference and could achieve more. Finally, a reduction in the emotional effects of learned helplessness was demonstrated through the pride that staff expressed in relation to the part they played in helping change to happen and the achievements made, together with the recognition of this by others and the stated raised profile of their work with older people within the trust.

It therefore appears that by the end of the study Elm ward had started to move out of the suggested learned helplessness state, however this was not as evident on Oak ward. Reasons for this now need to be explored to facilitate an understanding of the processes through which staff were enabled to progress.

5.2.1 *The potential positive role of chaos*

Study findings indicate that Elm ward was in chaos, with observations by myself and an outside facilitator highlighting the disorganisation and 'messiness' that appeared to exist. McDaniel et al (2003) comment on how managers in organisations tend to see chaos as undesirable and, through structures and processes, attempt to prevent its occurrence, even though in this instance it could be considered that the chaos on Elm ward actually resulted from the organisational changes that were imposed upon them at the beginning of the study. Wheatley (1992) however, through engaging with hypotheses and discoveries from the new sciences such as quantum physics, self-organising systems and chaos theory, explores new ways of looking at chaos within organisational theory and practice. Wheatley (1992) and others (Arndt & Bigelow 2000, Haigh 2002, Peirce 2000, Ray et al 1995) consider chaos to play an important role in the workings of organisations, with it being considered necessary for organisational growth and development. In support of this, the desire for equilibrium often

strived for in organisations is questioned by Wheatley (1992) with her suggesting that this indicates a state where energy and capacity for change and growth has been exhausted, and that a search for such a state is 'a sure path to institutional death' (p.76). With reference to these ideas it can be suggested that the chaos being experienced by Elm ward may possibly have been beneficial in providing the potential for change through the energy and creativity that disequilibrium, disturbance and chaos provide, and from which order can be achieved and deterioration avoided (Wheatley 1992).

Although chaos can therefore be suggested as providing the potential for change, the degree of chaos being experienced by Elm ward appeared to disable rather than enable them in this respect. It can also be suggested that the considered state of learned helplessness that they were in at the beginning of the study prevented them from being able to capitalise on this potential and engage in such activity. Furthermore it can be questioned whether, within this context, Elm ward were in any position to try and participate in any change at all at this time, and that attempts to do so were detrimental. Failure to achieve change in the early stages of the study, even with the support of a dedicated researcher, may have enhanced feelings of helplessness thus further reinforcing this state as the study progressed. However, the staff were able to engage with change towards the end of the study. What helped them to eventually start to move out of this suggested learned helplessness state, and what supported them through the chaos to enable them to do so, now warrants further exploration.

In exit interviews, staff highlighted the facilitating factors that they considered enabled some changes in practice to be achieved. Although helpful in their raw form, these factors currently lack any theoretical underpinning which reduces their utility outside of this particular practice context. Further exploration of these factors is now therefore considered in relation to a framework that has the potential to provide a theoretical understanding of how these factors enabled changes and movements out of learned helplessness states to be achieved.

5.2.2 *The Senses Framework*

The lack of an appropriate practice framework for nursing older people has been recognised in the literature and by formal nursing bodies such as the former English National Board for Nursing, Midwifery and Health Visiting (Nolan et al 2006). It is argued that the lack of such a framework may have contributed to the lack of care focus for this client group who do not easily fit the predominant functional restorative or curative models of care, and may also have exacerbated the difficulties experienced in securing high quality staff to work in this field of nursing (Nolan et al 2002, Nolan et al 2006). In 1997 Nolan expressed his concern with 'the lack of a therapeutic rationale for work in long term care settings with older people' (Nolan et al 2001 p.16). In response to this he identified six 'senses' which he believed might provide such a therapeutic rationale and direction for staff working with this client group, and improve the care that older people received. Over the last decade the senses have been theoretically and

empirically tested, validated and refined in relation to, and in collaboration with, older people, their carers, practitioners and student nurses, and across a range of settings (Brown et al 2008a, Brown et al 2008b, Davies et al 1999, Nolan et al 2002). This has culminated in the development of 'The Senses Framework' (Nolan et al 2006) which it is suggested provides a potential framework for practice. Within this framework it is suggested that if good therapeutic care for older people is to be achieved they need to experience six senses. These are a sense of:

- security – to feel safe
- belonging – to feel part of things
- continuity – to experience links and connection
- purpose – to have goal(s) to aspire to
- achievement – to make progress towards these goals
- significance – to feel that you matter as a person (Nolan et al 2006 p.8)

It is also suggested that the senses are best realised within the context of a relationship-centred approach to care which recognises that all those involved in the caring relationship (i.e. the older person, their family and the staff caring for them) need to experience the senses if high quality care is to be achieved (Nolan et al 2006), with it being acknowledged that unless staff are able to experience the senses for themselves they are unlikely to be able to create them for their patients (Brown et al 2008b). It is also recognised that although the relevance of the six senses to a range of settings has been demonstrated, the meaning of each sense and what contributes to their creation will vary depending upon the context in which they are being applied (Nolan et al 2006). With this in mind I will now apply the senses framework to this study in an attempt to better understand the context within which care was being provided and what may have helped the staff on Elm ward, and certain individuals on Oak ward, to move out of the suggested learned helplessness state, as well as supporting Elm ward through the chaos to enable them to do so.

In applying the senses framework to this study it can be identified from the data collected that the senses were not being experienced by the staff on Elm ward or Oak ward at the beginning of the study. Inadequate care environments, resources and staffing levels, together with a lack of education and training provided to enable the staff to care effectively for their client group, would all have affected the ability of staff to feel safe within the care context and thus experience a sense of security. This would also have been further affected by the lack of negotiation and preparation for impending changes. The constant changes that staff experienced within the care context would also have impacted on a sense of continuity, with changes to staff teams, ward names and identities exacerbating this. A sense of belonging was threatened again by changes to the staff teams, as well as the separation of the wards from the main hospital site, activity and support. A sense of purpose was not evident with staff

not seeing the wards as rehabilitation wards and not having a specific philosophy to work towards. This affected their sense of achievement through them being frustrated and unhappy with the standards of care they were able to provide. Finally, the staff did not experience a sense of significance with them not feeling valued, cared for or supported by the organisation, and with them being expected to work within poor environments and facilities.

It can be seen from the evaluation phase data, however, that the approach and development activity undertaken provided the opportunity for the staff on Elm ward to experience these senses within the context of this study. The general approach used in the study enabled staff to experience a sense of security and continuity. A sense of security for staff was enabled through the neutrality of my role and the confidentiality agreements that accompanied it, together with my constant presence and accessibility to ward staff. This provided them with someone whom they could trust, who they could turn to for help and advice, and who was there to support them through the study process. This continuous presence, together with the flexible approach used to enable the practice development work to continue even when work commitments challenged it, also provided a sense of continuity for staff. Aspects of the 'tell it how it is' work then appeared to facilitate the staff in experiencing the other senses. A sense of significance was enabled for staff through someone taking time with them and showing an interest in them by listening to their experience of what it was like to work in this context. This resulted in them feeling valued and that they 'mattered', with the sharing of these experiences with managers who listened and acted upon them giving them a voice within the organisation whilst also raising the profile and recognition of their work. The reciprocal sharing of staff and manager experiences validated their concerns and led to a greater understanding between these two groups, and thus a greater sense of belonging for staff. This would also have been enhanced by the team working amongst ward staff that was facilitated through them working together to implement the action plan, and the sense of identity that they started to develop. By focusing the action plan around areas the staff wanted to work on this ensured that development activities were relevant to everyday practice, and important and of benefit to both them and their patients, thus facilitating a sense of purpose amongst staff. Finally, a sense of achievement was enabled through them achieving positive changes in practice that they were proud of, and the recognition of their work by others in the organisation.

It can also be seen that, by meeting the senses through the approach used, the suggested ways of 'curing' learned helplessness were also addressed. Seligman (1972) identifies that the initial problem in reversing the effects of learned helplessness is one of getting going. It would seem that my presence and the 'tell it how it is' work seemed to be the catalyst that was needed to do this. Lennerloff (1988) reinforces that central to the theory of learned helplessness is that people learn helplessness in uncontrollable situations, therefore it can be assumed that by enabling individuals to regain some control of their situation some recovery from this could be achieved. This was achieved through helping staff to feel secure, giving them a voice and raised profile within the organisation, enabling them to control decisions over

what development activities they wanted to engage in and when these were to take place, and through the achievements they started to make with it being stated that achievement is one of the most important sources of a sense of control (Robertson 1986). Finally, Seligman (1975) found that breaking the helplessness pattern often required a long programme of continuous direction and reinforcement in helping individuals to learn that actions can affect outcomes, with my continuous presence and the accompanying advice, encouragement and support given helping to provide this.

It can be seen that by utilising an approach that enabled the staff to experience the senses, the staff on Elm ward were able to move through the chaos and start to move out of a state of suggested learned helplessness into one where they were able to engage with change and achieve some positive changes in practice. It also helps to further explain why Oak ward were not as able to do so. Although my general approach was also utilised with the staff on Oak ward to provide a sense of security and continuity, they did not get the opportunity to participate in any type of 'tell it how it is' work which seemed to be key in enabling the staff on Elm ward to experience the senses of belonging, purpose, achievement and significance. The reason why the staff on Oak ward were not given the opportunity to participate in such work can be traced back to my views of the two wards throughout the exploratory and action phases of the study (see section 4.2.1). The 'tell it how it is' work was undertaken with Elm ward due to the failure of the original planned action cycles and my less than positive view of the ward, with this resulting in a need for me to change my approach with them in an attempt to achieve something worthwhile by the end of the study. However, my very positive view of Oak ward, and my perception of the success of the action cycles being implemented there, resulted in me not considering there to be a need to further explore the staff experiences of working on the ward. On further reflection it has been demonstrated that this view was inaccurate, and it can be argued that this blinkered view prevented such activity from taking place which may have resulted in the staff on Oak ward experiencing the senses and thus having the potential to also move out of a learned helplessness state to one where they were able to achieve.

5.3 The senses framework – a potential framework for facilitating practice development and change

From the above discussion it can be suggested that the senses framework presents a potential theoretical approach to help staff move out of a state of learned helplessness into one where they are able to engage with change. However, I would suggest that it also presents a potential theoretical approach for the facilitation of practice development in general. The importance of effective facilitation in implementing change is widely acknowledged, with it being considered as one of the key variables for success in the practice development literature (Harvey et al 2002, Kitson et al 1998, McCormack et al 2006, Rycroft-Malone et al 2004). It has also been recognised, however, that facilitation within this context is complex and poorly defined (Simmons 2004). Loftus-Hills and Harvey (2000), in a review of the role of facilitators

in changing professional health care practice, did identify that the concept broadly encompassed notions of enablement, support and encouragement, however the approaches facilitators used to work in such ways were not made clear. The literature identifies a raft of qualities and skills which are considered as being required of people working in practice development roles (Kitson et al 1998, Loftus-Hills & Harvey 2000, McCormack & Garbett 2003) together with numerous tools and methodological interventions used within projects to achieve their aims (Loftus-Hills & Harvey 2000), however theoretical frameworks underpinning facilitation approaches are scarce. One exception is the model of critical companionship (Titchen 2000).

Critical companionship is described as:

'a helping relationship in which an experienced facilitator (often, but not necessarily, a colleague) accompanies another on an experiential learning journey, using methods of 'high challenge' and 'high support' in a trusting relationship.' (Titchen 2003 p.33)

The model consists of a series of knowledge domains and strategies that, when considered as a conceptual whole, provide a person-centred framework of facilitation which enables others to reflect on and critique their practice. The overall purpose of critical companionship is stated as being the enablement of others to practice in a person-centred and evidence based way, with the author claiming success in this endeavour through reference to her study findings (Titchen 2003). It can be seen from the study reported here that moves toward more person-centred practice were being made, thus suggesting that working with staff within the theoretical framework of the senses also has the potential to meet one of the same purposes of critical companionship. Similarities between the domains in the critical companionship model and the senses framework can also be identified, especially in regards to the relationship domain. This domain encompasses the processes of mutuality, reciprocity, particularity and graceful care. From the descriptions provided of what these processes involve (Titchen 2000, Titchen 2003, Titchen & McGinley 2003) it can be seen that the process of mutuality encompasses elements of the senses of security and belonging, with those of reciprocity, particularity and graceful care encompassing elements of a sense of significance. The process of temporality in the rationality-intuitive domain can also be seen to equate to elements of a sense of continuity.

The similarities between the philosophy, outcomes and some concepts of these two frameworks suggests that either may have been successful as an approach to facilitation in this study in enabling staff to move out of a state of learned helplessness into one where they were able to engage with change and effect practice development. I, however, found the critical companionship model conceptually and philosophically difficult to grasp, with its complexity being supported through recognition by the author that it can take up to five years to develop expertise in the critical companion role (Wright & Titchen 2003). This may therefore reduce its utility as a facilitation approach in a practice development context,

especially in situations where the practice developer themselves is relatively inexperienced. In comparison I found the senses framework to be conceptually clear and user friendly and, due to its similarities to parts of the critical companionship model, would now suggest that it presents itself as a potential framework for the facilitation of practice development. The senses framework has been extensively applied in different contexts and with a range of individuals, however its utility as a facilitation framework has not before been addressed. I would now propose that its utility in this context warrants further exploration.

6. LIMITATIONS OF THE STUDY

Based on a systematic review of action research, Waterman et al (2001) developed guidance on assessing action research reports in the form of 20 questions (see appendix 1). Although this guidance has not been tested in practice it can be seen as a tool for critical reflection, and will be used here as a basis for identifying the limitations of the study. Limitations of the study fall under the following questions:

- Was consideration given to the local context while implementing change?
- Was the relationship between researchers and participants adequately considered?
- Were data collected in a way that addressed the research issue?
- Were steps taken to promote rigour of the findings?

Was consideration given to the local context while implementing change?

The local context was unknown to me before access to the study wards was negotiated, with knowledge of the context only being gained through the qualitative data collected in the exploration phase of the study. Although the importance of the context has been recognised in final study findings, this contextual knowledge was not addressed, and could be considered as being ignored, in the early stages of the study thus preventing its impact on the action phase of the work from being explored.

Was the relationship between researchers and participants adequately considered?

The involvement of participants in the study has been addressed throughout the report, however from comments in exit interviews it can be questioned whether the staff on the study wards had a clear understanding of their role within the study. This could have been exacerbated by a collaborative and participative role being promoted but prevented in the early stages of the study by them not being involved in the setting up of the work or in structured data collection during the exploration phase. Also, a comprehensive reflexive commentary regarding my own individual values and beliefs and how they may have influenced participant relationships and the overall study has not been included in the report. Although the ability of the researcher to be aware of all the values, beliefs and influences that have the potential to impact on their research has been questioned (Cutcliffe 2003, Etherington 2004, Freshwater 2005, Waterman 1998), acknowledgement of those that were in my awareness would have enabled others to explore some of my motivations and actions in relation to the study process and judge the effect these may have had on findings and outcomes.

Were data collected in a way that addressed the research issue?

Some of the methods used to collect data in the exploratory phase of the study can be questioned. The structured data collection tools did not have a rehabilitation focus and so did not address the affective, cognitive, biographical, temporal and existential components of rehabilitation care considered essential in the literature (Nolan et al 1997). Their sensitivity in addressing the aims of the study can therefore be questioned, together with the relevance for staff and patients of the action cycles identified from them. They also appeared to have played a large part in directing the early stages of the study, with most action cycles being derived directly from them at the expense of the more contextual data that was collected. Greater attention to contextual issues at this stage as was achieved through the 'tell it how it is' work, although possibly resulting in a change in study focus, may have been more relevant to participants. Using a relationship-centred approach to data collection through which the experiences of staff, patients and carers in these settings could be explored in more depth may have further increased the relevance of the study for them.

The data focused on in the reflective phase of the study was based mostly on staff participant self-report of their experience of being involved in the study, the exit interviews for which were conducted by myself. It can be questioned whether, through the relationships I built with participants as the study progressed, they were open and honest about their experiences or whether they told me what they thought I might want to hear. However, not all the experiences reported were entirely positive thus reducing the possibility of this effect. The practice changes reported also arose from this data as opposed to other more focused data collection methods, and so again were reported by staff. Whether patients felt that positive changes in practice had been achieved is therefore unknown. Exploring staff reports with patients following exit interviews would have been useful in validating or questioning the views of staff.

Were steps taken to promote the rigour of findings?

Although the methodology chapter outlines how the quality of data was ensured throughout the study, as discussed above a reflexive account was not included in the study report. This prevents the identification of any personal influence I may have had on the study process and outcomes.

7. CONCLUSION

This report has outlined an action research study which set out to improve the care for older people on two rehabilitation wards in an acute NHS trust through a collaborative approach to change. It has raised some key issues in relation to the context of rehabilitation care for older people, together with what can help and hinder the development of practice in such settings. It has been suggested that staff working in 'impoverished' environments of care, who do not feel valued within their organisations, can experience states of learned helplessness which disable them from engaging with practice changes designed to improve the care provided for their patients. It has also been suggested that a facilitative approach which enables staff to experience the senses of security, belonging, continuity, significance, purpose and achievement can help them to move out of such a learned helplessness state into one where they are motivated to achieve and engage with change. As discussed, the senses are best realised within the context of a relationship-centred approach to care. Through this the following questions can be asked in relation to this study and rehabilitation practice:

- If we are not there for staff, how can we expect them to be there for patients?
- If we do not talk to, listen to and give staff a voice, how can we expect them to talk to, listen to and give a voice to patients?
- If we do not care for, value and respect our staff, how can we expect them to care for, value and respect patients?
- If we do not support and enable staff, how can we expect them to support and enable patients?
- If we demotivate staff, how can they be expected to motivate patients?
- If we do not work in partnership with staff, how can we expect them to work in partnership with patients?
- If we do not find ways for staff to learn new skills, how can they help patients to do so?

Working with staff in a way that realised their senses provided the potential for them to work in a way that enabled patients to also experience them, with a move towards this being demonstrated by some of the practice changes that took place towards the end of the study.

It has been highlighted in the literature that little research has been undertaken in nursing in relation to the nature of facilitation (Titchen 2003) and that further research, knowledge and clarification regarding successful facilitation processes and approaches is required in order for practice developers to be able to base their practice on sound evidence (Simmons 2004). It is hoped that this study goes some way to providing this through the comprehensive application of a theoretical framework – the senses framework – to study findings, the underlying philosophy and concepts of which helped to provide an understanding of what facilitated change in this practice setting. It is also proposed that this framework has the potential for wider application outside of this study, and that it presents a potential theoretical framework for

the facilitation of practice development. This warrants further exploration within similar contexts as well as other practice settings.

It is not unusual to find reluctance to change, however it is important to identify the underlying causes for this reluctance and ways of working which may be able to overcome it. This has been achieved in this study through the identification of learned helplessness states and a facilitation approach that helped to address them. Although this study was carried out within a specific context, it is suggested that the challenges faced by staff were not unique. The current NHS climate is one of hierarchical organisations tasked with meeting government targets within a culture of effectiveness and resource management which often results in rapid and continuous change. I would suggest that the helplessness experienced by the staff in this study is not uncommon and that the results of this study could be transferred to other organisations who are struggling with similar issues.

8. RECOMMENDATIONS

Recommendations for practice

The purpose of the two study wards needs to be defined. If they are to continue to function as rehabilitation wards, and do so effectively, the resources and environments of care need to be addressed.

The effects of continuous organisational changes on individual staff, teams and patient care need to be recognised. Further organisational changes need to be discussed with staff and adequate preparation for such provided.

The trust needs to work with its staff in ways that enable them to experience the senses of security, belonging, continuity, purpose, achievement and significance if they are to be able to engage with change agendas and effectively meet the needs of their patients.

The trust has decided not to continue the lead research and development nurse post. How staff are to be supported in further practice development, both on the study wards and in the trust as a whole, needs to be identified.

Organisations need to explore and identify the reasons why staff are unable to engage with change initiatives to enable the implementation of appropriate facilitative interventions.

Recommendations for teaching

Ways to promote and facilitate informal work based learning need to be identified, which can accompany more formalised teaching, to enable staff to reflect, learn from and develop practice on a day to day basis.

Recommendations for research

Learned helplessness theory provides an explanation of why staff in this study were unable to engage with change. Consideration of this theory in similar contexts may be helpful.

The senses framework as a theoretical framework for the facilitation of practice change warrants further exploration.

CASE STUDY

MY ACTION RESEARCH JOURNEY: A SELF-REFLECTIVE INQUIRY

INTRODUCTION

This case study is a self-reflective analysis of my experience of undertaking the previously reported action research study. The report provided a comprehensive and logical account of the study including details of data collection, analysis, findings and theoretical explanations related to what facilitated and hindered the development of practice on two rehabilitation wards for older people in an acute NHS trust. Following the writing of this report, however, I experienced discomfort in the thought that something was missing from the account and that it did not reflect the entire reality of the process. Further reflection on the data collected prompted me to consider that what was missing was my personal experience of undertaking the study which, in my mind, was more complex and chaotic than the report articulated. I therefore felt there may be further learning to be gained through exploration and reflection on this experience.

Undertaking the study was not easy for me. My memories were of a painful and emotional journey which remained hidden within my field notes at the back of my filing cabinet for two years after study completion. It was only after this passage of time, and involvement in a further study which provided a more positive research experience, that I was able to re-engage with them. Even after this, writing the case study was challenging, with it resurfacing the raw emotions that I had previously buried and tried to forget. The process, however, proved to be beneficial. Not only did it enable me to gain a more bearable understanding of my experience and find some meaning in my struggles, but it also further enhanced my knowledge of the study context itself. Together with this it has raised pertinent issues in relation to the support that would potentially be most helpful for me if undertaking this type of work in the future.

The case study presents itself as two journeys. The first is an account of my experience of undertaking the research, with the second illustrating further learning and development through reflection on and re-analysis of it. The case study should be read in association with the previous research report and refers to data included in the report which, to prevent repetition and allow more scope for further exploration, is not re-examined but referred to throughout to signpost the reader to more detailed information as required. It also needs to be recognised that this case study has been written retrospectively, with the conclusions made being based on theoretical application to study data which has not been confirmed with study participants.

METHODOLOGY

Purpose

The purpose of this case study is to share the learning gained from an analysis of my experience of being an action researcher. This will be achieved through:

- the presentation of a themed analysis of my research experience
- a discussion of this experience in relation to relevant theory
- identification of the usefulness of this approach in contributing to a greater understanding of a study context
- recognition of the researcher support needed to enable these processes to take place

Data used

The data used in this self-reflective inquiry were the three years of field notes I kept whilst undertaking the previously reported action research study. As well as forming a daily record of events, they also included a record of my thoughts and feelings throughout the study process. This equated to 303 pages of field notes typed in single spaced size 10 Arial font. These field notes were largely unstructured and did not follow any specific reflective framework. They were therefore present in a very raw form which, although unwieldy, also prevented pre-determined themes from influencing the subsequent analysis.

Data analysis

Field notes were thematically analysed using an approach which incorporated the principles of qualitative analysis outlined by Morse and Field (1996), the process of thematic analysis articulated by Burnard (1991), and methods of coding presented by Miles and Huberman (1994). The following steps of analysis were undertaken:

- multiple readings of field notes to enable immersion in and familiarity with them to be gained
- the construction of monthly summaries of field notes to ensure a sense of the whole was maintained which could be referred back to during further analysis
- extraction of those field notes from the whole that related specifically to my experience of undertaking the action research study
- application of non pre-determined codes to this extracted data
- grouping of similar codes under broader categories
- linking of categories through the identification of common emerging themes

Transferability

Although the research journey described was undertaken within a specific context, the learning gained from it can be utilised by others through the principles of theoretical generalisation (Sharp 1998). This case study provides rich contextual detail of my experience which is supported by extensive quotes from my field notes. This, together with the context in which the study took place being described in detail in the research report, will allow others to judge the relevance of findings to their own situation. The learning gained from this case study is potentially relevant to others who have undertaken action research journeys and encountered similar challenges, and as such has the potential to be transferred outside of this particular context

Ethical considerations

Ethical approval for the research study, which included the recording of field notes, was gained from the East London and the City (ELCHA) Research Ethics Committee.

FINDINGS

Field notes outlined the journey I made and highlighted the challenges and difficulties that I faced, as well as the strategies I employed in attempts to bring the study to a fruitful conclusion. Reflection and analysis identified three main themes. These are 'the novice researcher – impact on study process', 'working with continuing challenges', and 'surviving the study'.

The novice action researcher – impact on study process

When I commenced this journey I felt that I was well equipped and had the experience required to perform in the role of lead research and development nurse (see section 3.1.1.1). On reflection, however, I can identify that although a sound practice developer with some experience in qualitative research, as an action researcher I was a complete novice. My reading around action research was limited to methodological research texts and I was unaware of the complexity involved in carrying out an action research study. Field note recordings identify the impact this inexperience may have had on the study process and falls within five main sub themes. These are 'my need for structure', 'my need for recognisable progress', 'impact on collaboration', 'reinforcing helplessness' and 'reinforcing 'them and us'".

My need for structure

Field notes identify that I struggled with the methodological flexibility needed in undertaking action research, especially in the early stages of the study. My initial approach in the exploratory phase was very structured, with me having a map of data collection activities that I needed to complete within certain deadlines. Although this structured approach was not a problem in itself, my inability to deal with occurrences that impacted upon it was, with field note entries highlighting my difficulties in being able to deal with changing agendas that disrupted my plans. Having a logical plan gave me a feeling of safety and control in an unfamiliar situation, with disruption of this resulting in me feeling destabilised and insecure:

'I worked really hard in my head and on paper getting my focus clear and felt I had it 'sorted'. Finding things have changed has instilled a kind of dread in me, and I feel a sense of having to start again – I can't bear it.' (Field note 07/00)

I feel my need for structure influenced the path of the study in the early stages. Although formal meetings and discussions with staff highlighted and reported the contextual issues and struggles they were experiencing (see section 4.1.1), completing the structured audits (Monitor 2000 and SQUIS) took priority over further exploration of the issues that were a real concern for staff and patients and directed the course that the study then took. Although I was aware that a different focus was probably needed, I was unable to take the risk of digressing from my original proposal and venturing into the unknown:

'It is clear that there are a lot of underlying issues that have not been addressed. I feel they (staff) need someone to listen to them and take seriously the problems and issues they are dealing with. I think it may be more important for me to hold in-depth staff interviews to really get to the bottom of what their current issues are, but this would take me away from the study and its main focus of rehabilitation, and there is not time to do this now with the other action cycles going on.' (Field note 04/01)

My need for recognisable progress

My inexperience as an action researcher is also demonstrated through my focus on a constant need for measurable progress throughout the study. Many field note recordings relate to my struggles with what I considered to be a lack of acceptable progress throughout both the exploration and action phases which affected me on a personal level. One of my main frustrations was the lack of commitment and participation of some staff towards the study which prevented actions from moving forward. This seemed to have an unduly excessive effect on me:

'I was frustrated, angry and fed up. I am giving a lot of time and energy to the ward, supporting them through difficult times and fighting their corner for them, but am

getting nothing in return by way of commitment. I feel 'why bother' when I am getting nothing back.' (Field note 06/01)

On reflection I feel that the reasons for what could be considered as this 'over the top' reaction can be attributed to three main explanations. Firstly, it can be seen from field note entries that I took lack of progress to be a personal failure on my part. Even when I knew there were valid reasons for lack of staff participation, I still found this difficult to deal with:

'Although I constantly state that staff understandably do not have my study as a priority at the moment, I seem to be unable to deal with this issue.' (Field note 08/00)

This, together with comparisons with the progress being made by the other lead research and development nurses, led to me continuously questioning my ability to perform in the role:

'I don't feel that I am getting anywhere. What have I done or achieved? I'm one year into the project but haven't implemented anything yet. Other post holders are holding educational workshops, action learning sets, reflective practice sessions and examining trust wide agendas but I'm not doing any of that ... Have I let these teams down? I seem to have lost faith in my own ability at the moment.' (Field note 01/01)

Secondly, lack of commitment by some staff gave me the impression that the study, and by association myself, were not important to or valued by them:

'I keep giving to them, but get nothing in return in respect of moving the study forward. I can't keep going like this. I need to be valued as well, and need them to be a bit more reciprocal in this partnership / relationship.' (Field note 04/01)

These experiences led to reduced motivation on my part at regular times throughout the study, with me struggling to maintain the enthusiasm required to continuously work at engaging staff and move action cycles forward:

'I can't make people participate because the study is voluntary, but it feels like a continuous slog of trying to keep people interested and motivated which is exhausting at times.' (Field note 05/01)

Thirdly, I felt a great deal of pressure to deliver on the study. The high profile of the wider project and huge investment that had been made in it created a lot of pressure to deliver acceptable outcomes to the funders and directors of the project:

'We are continuously reminded that a lot of money has been invested in the project and (commissioners) wouldn't be happy if it wasn't used effectively.' (Field note 05/01)

Impact on collaboration

From field note entries it can be identified that as the study progressed I became frustrated with the collaborative approach and its apparent inability to effect change on the study wards:

'I'm starting to question if collaboration is all it's cracked up to be. It's not effecting change on the wards as people are copping out. Collaboration is all well and good but sometimes people need a good kick to sort them out and make sure they are performing.' (Field note 05/01)

However field note recordings of my methodological inflexibility and need for recognisable progress throw into question how consistently collaborative my approach really was. Although the ward staff decided what developments they wanted to work on once baseline data had been collected, analysed and fed back to them, they were not involved in identification of the original study focus regarding rehabilitation care. Although the justification for this focus has been made clear (see section 1.3), it can also be questioned that I may have influenced this decision through my need for safety at the beginning of the study by focusing on an area of care that I had experience in and felt comfortable with.

Although some collaborative working with staff was evident in the action phase of the study, especially in relation to action cycles that were being addressed by motivated and enthusiastic individuals, when progress was not being made or activities were not going to plan my need to intervene to 'make things work' came into play:

'I popped in to see how the tea party was going. As I walked in I encountered a very frustrated voluntary services manager. Nothing was set up and no nurses were helping ... I helped her to make the tea and find things she wanted in the kitchen ... I wanted to make things work for the patients and the project.' (Field note 06/01)

This need to intervene and take control may have led to a vicious cycle of non participation, with staff knowing that I would be there to make things happen even if they did not actively take part. It also gave the impression that the study was really mine, not a collaborative venture, with it therefore being my responsibility to make sure things moved forward. This was highlighted in a conversation towards the end of the study with the ward sister on Oak ward:

'She said that, although very positive at what we had achieved, I would get all the credit not the ward. This shows that they see this as my project not theirs. Was collaboration and equality truly there?' (Field note 07/02)

Reinforcing helplessness

It can now be questioned whether the approach I used at the beginning of the study may have actually reinforced the helplessness that I have suggested staff were experiencing (see section 5.1). As well as me intervening when study progress was not going to plan, field note

entries also identify frequent situations where I acted on behalf of the staff when they were unable to resolve critical incidents and clinical challenges:

'I asked the nurses what they normally do in this situation regarding getting staff. They said the bleep holder has said there was nothing she could do so that's it. They seemed apathetic in the belief that no one was going to help them and just carried on with the day... I went to see the bleep holder and explained the situation, and she sent one of the agency health care assistants from her ward to help.' (Field note 01/01)

At the time I viewed these as supportive actions which resolved problems for them. However, on reflection it can be seen that this took control away from them, may have made them feel more ineffective in their ability to affect action, and made them unintentionally dependent on me for resolution of issues.

Field note entries also highlight how my perceptions of the two wards during the early stages of the study may have reinforced feelings of helplessness, specifically on Elm ward (see section 4.2.1). On reflection I feel that these perceptions were again influenced by my need for progress and inadvertently resulted in me splitting the two wards into the 'good' and the 'bad', with me feeling very positive about Oak ward and very negative about Elm ward:

'I feel that I have built up good relationships with the staff on Oak ward. They are very responsive and enthusiastic about the work I want to do with them. They welcome me and have made my life easier by complying with my requests for meetings etc. However I am getting very frustrated with Elm ward. They are not complying with my requests for meetings and this is making my life difficult. It is wasting a lot of time which is putting the project behind. I am starting to wish that I had not selected this ward for the research.' (Field note 08/00)

Although I thought that I kept these perceptions in check when working with both wards, a comment made by the ward sister on Elm ward during her exit interview identifies that this was not the case:

'My perception at the beginning was you were trying to compare (Elm ward) and (Oak ward), 'Oh this ward is better than that'.' (Elm ward sister)

This may have resulted in them feeling failures in comparison to Oak ward thus reinforcing their feelings of helplessness. It is also interesting to note the language in the above quote, with a focus on 'compliance' again questioning how collaborative my approach really was at this stage. It can also be questioned whether, due to the context within which they were working, Elm ward were in a position to try and participate in any change at all at this time, and that continuing attempts to engage them in doing so may have been more detrimental than beneficial. Failure to achieve may have enhanced feelings of helplessness thus reinforcing this state throughout the study.

Reinforcing ‘them and us’

As well as the possibility of reinforcing helplessness amongst the staff on the study wards, field notes also indicate that my experiences and actions may also have inadvertently supported the tensions between managers and staff (see section 4.1.1.4). My frustration with the service managers responsible for the study wards was frequently alluded to within field note recordings, with much of this relating to the apparent lack of care and support afforded to staff:

‘I cannot believe that the service manager didn’t go to the ward when she was told they were severely short staffed. Does anyone care about them? ... Somebody needs to own the staff here. It feels like the hospital is shutting down around them and nobody could care less about them. They are on their own.’ (Field note 01/01)

Field notes also recorded my frustration with the apparent lack of action taken by service managers in addressing issues of staff performance and care standards:

‘There is now an issue about staff on Elm ward not performing at even the most fundamental level. I have great empathy for the staff, but they have a responsibility to provide a basic standard of care. This is now a management issue, but is not being addressed by the service managers. I am reporting my concerns but nothing is happening.’ (Field note 10/00)

As well as my frustration regarding the organisational management of the study wards, I also encountered a lack of support for myself and the study from one of the service managers with her actions leaving me feeling like an unwanted intruder in the service group. Arranged meetings were often cancelled, I was not informed of organisational changes which could potentially impact upon the study, and she exhibited a distinct lack of interest in the work I was trying to do:

‘I was told I was not allowed to attend the service group meetings as I was not in the team. It is interesting that I am seen as not someone who could contribute to the team but who is a complete outsider. I asked if (service manager) would like me to send her the steering group minutes, but the response was ‘I would never read them’. This to me exhibits a total lack of interest in what I am trying to do.’ (Field note 06/01)

These experiences of working with the service managers made me angry and disillusioned with them:

‘I am getting to the point where I feel ‘bugger them’. I am getting little support from those responsible for the area. I cannot change patient care without the full backing of the service group and cannot continue to go in everyday and observe poor care thinking that nobody cares enough to change it.’ (Field note 06/01)

A review of field note entries indicates how my above experiences of the service managers may have affected my ongoing relationships with them. I lost faith in them as managers and,

instead of continually trying to gain their involvement, I reduced the amount of interaction I had with them. It also needs to be considered whether the staff on the study wards also picked up on my loss of faith as they did on my perceptions of the two wards previously described. This may have reinforced their views on inaction and lack of support by managers and could have served to validate and heighten the tensions between them thus exacerbating the 'them and us' scenario.

Undertaking the 'tell it how it is' work on Elm ward (see section 4.2.3.3), however, caused me to re-assess my perception of the service managers, with it providing me with an insight into their worlds that I had not previously accessed. Both service managers expressed how threatening they found my role and how worried they were that I would be critical of the service and show it in a bad light. One service manager highlighted that she was jealous of the relationship I had with the staff and the time I had available to spend with them, as well as feeling guilty that she was not able to support them as much as she would like. The other service manager also highlighted that she was not involved in the setting up of the post and did not understand what I was there to do. She commented that it had taken nearly two years for her to feel comfortable with me and trust me:

'There were ownership issues. There was no discussion of the project with me. We were told you were coming and you arrived. This was threatening and had the potential to cause problems.' (Service manager 2)

The service managers being able to express their concerns and fears enabled us to start building better working relationships. More interest was shown in the study and regular meetings were achieved where reciprocal sharing of information took place. Action cycles were also supported by the service managers with some outcomes being achieved before the end of the study. I also began to understand the potential impact my role may continue to have on them, which prompted me to continually reflect upon my approach:

'It must be really difficult for (service manager) to know that people are telling me things they are not telling her, and that I have to keep them confidential. She must feel left out and curious.' (Field note 12/01)

Working with continuing challenges

Although improved working relationships with service managers and some positive practice outcomes were achieved, I still struggled personally throughout the study with field note entries highlighting frequent periods of demoralisation and despair:

'At the moment I feel totally disillusioned. I am faced with organisational issues and care standards that concern me. Seeing the care it is sometimes only possible to provide is upsetting, and seeing the way patients are sometimes cared for is sad. At the moment it seems a mountain to climb to change it – what impact can I have when

the problems are deep rooted and accepted into the culture, and too vast to be addressed by one small research project.' (Field note 05/01)

Further reflection on field note entries associates these periods of demoralisation with two main causes which form the first two sub themes of this section. These are 'working in an impoverished environment' and 'role conflict'. The third sub theme - 'inadequate support structures' - explores how the mechanisms put in place to support me were not enough to overcome this demoralisation.

Working in an impoverished environment

Although the study started to progress, and some improvements in patient care were achieved, care standards were still below what I personally considered as acceptable. Having worked in rehabilitation settings before, and knowing what standards could be achieved, I had expectations which can now be considered as being too high for the context in which the study was taking place. Having to realign these expectations was a struggle, and one which I never fully overcame:

'I invested a lot of personal hope and expectation in the study, and it's painful when that hope is dashed. I have a feeling of emptiness.' (Field note 10/02)

As well as my expectations not being met, I was also working in the same impoverished environment as the staff (see section 4.1.1.1) which affected me emotionally. I often felt as if I was working in a building that had been abandoned, with there being an absence of the 'bustle' and activity that I was used to when working within a hospital setting:

'I am also working in the environment and atmosphere of a hospital shutting down which is dreary and un-stimulating.' (Field note 03/02)

Not only was I experiencing the same working environment as the staff on the study wards, but being the key person they confided in and talked to (see section 4.3.2.4) took its toll on me over time. It was as if I became a magnet for the feelings of others within the organisation, which was emotionally wearing:

'I am someone they offload on regularly, and although a positive thing it can make me feel low constantly listening to negative issues.' (Field note 01/02)

Role conflict

As well as struggling with the emotional aspects of being this 'magnet', there were other role conflicts that continuously challenged me throughout the study. The first of these was the internal conflict between my role as a researcher versus my previous roles as a manager. The issue of service manager inaction regarding managing staff performance and care standards remained, and I struggled with my need to intervene and manage the situation whilst

recognising the detrimental effect this could have on the study. Being in a role that carried responsibility without accompanying authority was difficult:

'I desperately want to 'sort out' Elm ward but feel this is not possible in my remit as researcher. It would go against the philosophy of action research and also, I feel, ruin the researcher participant relationship I have built up with the staff. I do, however, find the lack of managerial clout I have in this role very frustrating, and morally I find standing back difficult to cope with.' (Field note 11/01)

The need to maintain relationships to ensure continued participation in the study also created role challenges. Many of these centred around decisions regarding whether general poor performance and inaction should be reported at the risk of destroying relationships I had built with staff. Not only may this have resulted in their withdrawal from the study, but would also have 'dropped people in it' who had willingly participated in good faith. I felt I had allegiances and a responsibility to these staff which posed the dilemma of 'to report or not to report':

'Morally I feel I need to take this further as I feel I cannot sit by and witness poor standards, but if I do I may lose the trust of the staff and thus their participation, and also drop (service manager) in it. I do not want to drop her in it as our relationship is now much better and I don't want to wreck it. Also I don't want to drop any of the other staff in it as they have participated in the project. But what is the emotional cost of this?' (Field note 04/02)

The greatest role conflict for me, however, was that between my role as a researcher and what I considered to be my identity as a nurse. I constantly questioned the ethics of my role in an impoverished context which was short of resources to provide even the most basic of care. My need to 'put on a pinny and muck in' was high throughout the project, and was something I did on occasions as, morally, I felt unable to just stand back and let it happen. Trying to keep on my 'restrictive' researcher hat at the expense of a pure nursing one led to uncomfortable internal conflicts:

'I feel that I am swanning around researching while the staff I am 'collaborating' with are working their butts off in very difficult circumstances. I am getting paid a lot of money to research when what they need are more pairs of hands to be able to deliver care. I feel a fraud. I want desperately to do some nursing and forget the research which at the moment seems like a mill stone around my neck.' (Field note 09/01)

At times these conflicts led me to question if a researcher was the right role for me:

'This role conflict between researcher and nurse is making me miserable to the point where I feel I want to leave. I am questioning if I am in the right job. Am I cut out to be a researcher? I miss nursing and looking after patients, and want to do this again to make my life worthwhile.' (Field note 05/02)

Inadequate support structures

Field notes highlight that the continuing challenges I faced left me feeling demotivated and exhausted. This affected the energy I was able to put into the study and impacted on my ability to function effectively in the role:

'I'm not working to my full capacity... I can't seem to motivate myself at all and know I'm getting further and further behind. I seem to have hit a brick wall. I just don't want to do it, but also feel guilty that I'm not... Has my emotional state disabled me in some way so I'm not functioning hardly at all. I know I'll feel better if I put in a good days work and achieve something, it's just motivating myself to do it.' (Field note 11/02)

Although a variety of structures were put in place to help and support the lead research and development nurses throughout the project (see section 3.1.1.3), from the story told above it can be seen that they were personally not enough for me to contain my anxieties regarding the challenges I was facing and maintain what I considered to be an effective level of functioning.

The weekly study days at the university did provide me with an opportunity to remove myself from the study site and take some time out to think. The structured support provided during them did not, however, always meet my needs. As lead research and development nurses we were given the flexibility to decide how we wanted to use those days on a week by week basis, however, being a novice action researcher I did not know what I needed to know and was therefore unable to identify what would be most helpful. This flexibility also became disabling for me during times of intense challenge, conflict and demoralisation, with my need being for someone to make a decision for me about what would be useful.

Individual supervision sessions did provide me with study direction and were extremely useful for discussing and reflecting on methodology and study progress. However, the high profile and pressure associated with the overall project and the high standing of the project director led to me being reluctant to lay bare what I considered as my inadequacies in undertaking the study. This resulted in me never being totally honest about how hard I was finding the process and what personal and emotional struggles I was trying to deal with. The supervisor's ability to support me through these difficulties was, therefore, greatly impeded.

The action learning set brought with it both benefits and costs, and is the support mechanism that I found the most complicated to review. As with the individual supervision sessions it provided an opportunity to explore methodological and progress issues and find some practical solutions to these. It also, however, served as the safe forum to which the lead research and development nurses brought their individual personal and emotional struggles for exploration. This allowed validation of my own feelings as well as an opportunity to 'share the anxiety', but also resulted in meetings that were often highly emotionally charged and exhausting. In the last year of the study I found the meetings to be emotionally unsustainable. Not only was I trying to deal with my own anxieties, but I also had to engage with those of others. I found it painful to keep revisiting raw issues, and often left the set feeling exposed

and upset. The commitment I made to my colleagues regarding the action learning set meant that I felt a pressure to attend, with failure to do so making me feel as if I had breached that commitment. The pressure to attend caused me great anxiety, especially at those times when I was feeling particularly fragile:

'Went to bed and couldn't sleep. Was dreading action learning set. I am still feeling a bit emotionally shot and very tired. Lay all night dreading going to the set, but knew I should. Got myself into a real state over it. I just could not face the intensity of the day both emotionally and in length, and did not want to be with the team in that setting. But also felt really guilty because I knew (researcher) needed the support of the team today.' (Field note 03/02)

Although the action learning set did serve a supportive function throughout the early stages of the study, the high anxiety levels associated with it towards the end resulted in me emotionally withdrawing during meetings and rescinding my allocated presentation times.

Surviving the study

Although I considered leaving the post on more than one occasion, I did see the study through to completion. Field notes revealed reasons that prevented me from leaving, together with the coping mechanism I adopted towards the end of the study. These fall under the two sub themes of 'why I stayed' and 'how I stayed'.

Why I stayed

Although field notes highlighted the struggles that I encountered throughout the study, they also identified the positive aspects which kept me going and motivated me. One of these was the support I was given in my work by others in the organisation who had similar remits to mine. These included the clinical governance coordinator, specialist nurses, professional development nurses, lead nurse for education, and the head of quality. I also felt valued by these and others taking an interest in the study and providing me with encouraging feedback:

'She (consultant) said I was doing some really good work and gave me some very positive feedback. This boosted my motivation.' (Field note 10/01)

However, the main positive aspect for me was the building of reciprocal relationships with those members of staff who were motivated to develop, with their enthusiasm making me more motivated to stay:

'I came out of this meeting very positive. Her (nurse) motivation and enthusiasm rubs off on me. It is people like this who are keeping me going at the moment.' (Field note 06/01)

Feelings of loyalty to these staff was also a factor in me seeing the study through. I felt committed to those staff who were working with me, and did not want to 'abandon' staff who had been let down by others in the past:

'They might frustrate me and need pushing up hill sometimes, but I have a professional commitment to them and still feel personally involved with them.' (Field note 02/02)

I also had feelings of loyalty towards my colleagues in the wider project, including the other lead research and development nurses, project director, project coordinator and funder:

'Everyone has put a lot of time, energy and money into this project. I feel I would be letting them down if I do not bring it to completion.' (Field note 05/02)

Finally, I had personal reasons for staying. Field notes reflect the high expectations I have of myself, and that by giving up I would have felt I had let myself down. I also did not want to be defeated by a situation in which I had personally invested so much time, effort, 'blood, sweat and tears':

'I'm not going to let the bugger beat me. I'm going to see it through to the end.' (Field note 03/02)

How I stayed

Field notes indicate, however, that in order to survive to the end of the study I found a way of working during the last ten months that saw me through to completion. Firstly, I stopped focusing on the continuation of the research and maintaining staff participation at all costs, and started to be true to my own feelings:

'Ward meeting on Elm ward ... I acknowledged that organisational issues still existed, but was firm about the fact there were still 29 patients needing care and that they had a duty and responsibility to provide it as best they could. I said they needed to do their bit or no one would ever invest in them... This is the first time I have 'laid down the law' on the ward. I knew that after this the staff could refuse to participate in the research any further, however I felt this was a risk I had to take as I could not be silent about poor standards any longer.' (Field note 02/02)

Following this I stopped taking total responsibility for success, and began to disown problems that arose through lack of participation:

'After a night's sleep I made the difficult decision not to go up to the ward to see if everything was OK. Decided they needed to take responsibility for what happened yesterday. I think that if after two years some nurses are still not willing to participate fully in the project me going back today is not going to change that... I refuse to own this one.' (Field note 03/02)

As well as disowning the problems that arose in the study, I also started to disengage with my identities as nurse and manager. Letting go of my manager side enabled me to start disowning contextual constraints over which I had no control, and was the least difficult of the two to detach from:

'I don't feel so frustrated. Is this because I have left my manager hat aside and have stopped owning the problems.' (Field note 08/02)

Letting go of a focus on my nursing identity was much more difficult. My need to nurse was still high so I started to avoid situations where dilemmas around this could be posed. It can also be seen that I started to lower my expectations of the staff to reduce my frustration with care standards:

'I think my expectations have been lowered throughout the project. I expect less of the staff. It doesn't take much to impress me now whereas before these things would be expectations and taken as given, not impressive.' (Field note 01/03)

As well as letting go of some responsibility and previous identities, I also started to withdraw emotionally from the study and the overall project. Firstly, I withdrew from project and study discussions and stopped talking about and revisiting the emotional struggles that I was experiencing. I avoided situations where informal discussions may have taken place (such as over lunch) and, as previously described, stopped presenting at action learning sets or participating in the emotional presentations of others. This enabled me to 'stand still and protect myself' from situations which for me had become emotionally unsustainable:

'I feel in a safer place and don't want to rock the boat. I don't want to talk about it anymore. I don't want those emotions to come out again. This is where I need to be.' (Field note 04/02)

Secondly, I stopped engaging with the problems of the staff, giving so much of myself to them and taking on their troubles:

'At the moment I am coping by avoiding the emotional side of the work. I am withdrawing from anything that takes a lot of energy such as disputes on the ward or listening to staff but just staying away and not engaging with it. I think my withdrawal from the wards is a self preservation mechanism. Being so emotionally fraught I cannot engage with their emotional baggage as well, it is too much.' (Field note 04/02)

Although this was necessary I found it an uncomfortable position to be in, and one that left me feeling guilty and uncaring:

'It worries me that I might have stopped caring. This hurts and doesn't sit comfortable with me. I feel guilty about this and don't like myself very much for it.' (Field note 04/02)

Through disengagement and detachment I found a way, albeit at times uncomfortable, to see the study through. It also, however, resulted in me losing whatever motivation and enthusiasm I had left, with the remaining journey being one of submission and dependence:

'Feeling tired. Haven't got the energy to fight any more. Just want to do as I am told and if something else has to go then so be it. I've lost my fight, my enthusiasm and my passion. Just want to plod on and live a simple, easy life. I cannot go on fighting and cajoling. I think that to protect my sanity I have withdrawn a lot from the project and the team. I haven't got the energy to be like a 'dog with a bone' anymore. Just seeing this through to the end now.' (Field note 10/02)

DISCUSSION

From my story it can be identified that I influenced the study process through many of the actions I undertook. Acknowledgement of the ways in which researchers may influence their research is receiving increasing attention in the reflexivity literature (see for example Choi 2006, Finlay 2002, Gewirtz & Cribb 2006, Guillemin & Gillam 2004), however it has also been recognised that this is accompanied by a lack of attention regarding how the researcher may be personally affected by the research they undertake (Dowling 2006). From my story it can be identified that undertaking the study had an enormous personal impact on me resulting in a great deal of stress and rollercoaster of emotions that I found difficult to bear. Some of the stress and anxiety I experienced could be attributed to taking on a new role and its accompanying uncertainties, and working within the same impoverished environment as the staff, however I do not feel that this alone would have caused the degree of distress I experienced. On further reading, reflection and analysis I now feel that there may be a psychodynamic explanation for why I was so personally affected by this experience and suggest that not only was I experiencing my own stress and anxiety, but also that of the staff I was working with. This will now be explored in more detail in relation to psychodynamic theory. In order to make sense of this theory within the context of my work I will start by discussing the stress and anxiety that may have been experienced by the staff in the study and how the working practices I observed support their presence. I will then look at how my experience equates to that of the staff and how this may have been a result of psychodynamic processes, together with how an understanding of these processes has increased my understanding of the study as a whole. I then move on to address the issue of containment and consider how my experience may have been different if psychodynamic support during the study had been available.

The stresses experienced by staff

It is recognised that those working in the helping professions have the potential to experience a great deal of anxiety in their work, with Obholzer (2000) commenting on staff observed in such settings as going about their work 'irradiated by distress' (p.ix). Some of this anxiety is considered as being specifically related to the nature of the work that such staff undertake (Halton 1994, Obholzer & Roberts 1994), with various authors over many years, and working with different client groups, highlighting many common anxieties that present themselves. The classic work by Menzies (reproduced in Menzies Lyth 1988) identified the sources of stress experienced by nurses in a general hospital. These included being in constant contact with people who are physically ill or injured and who may not recover fully, if at all, together with carrying out tasks which could be considered 'by ordinary standards, distasteful, disgusting and frightening' (p.46). These stresses were found to have the potential to arouse conflicting feelings in individuals. Pity and compassion can be accompanied by hatred and resentment of the patients who arouse these feelings together with envy of the care they receive. These latter feelings, which could be considered as unacceptable in a nurse, can then give rise to guilt and great anxiety. As well as pity, resentment and guilt, Skogstad (2000) also uncovered feelings of sadness, ability doubts and helplessness in nursing staff on a medical ward, with Mawson (1994) finding feelings of depression, despair, inadequacy and hostility amongst staff working with damaged children. Work in settings for older people has also identified some anxieties specifically related to caring for this client group. These include working with deterioration and death when you want to repair (Davenhill et al 2007, Holman et al 2006), and anxieties relating to your own physical and mental decay, loss of independence and death (Roberts 1994). These can be accompanied by discomfort and guilt at being young and healthy (Roberts 1994). It can therefore be assumed that, as well as the stress of working in an impoverished environment and that invoked by organisational changes, the staff on the study wards were experiencing stress and anxiety related to the nature of their work, with many of the feelings described above including anger, sadness, inadequacy, guilt and helplessness being observed or expressed by staff in the study. Together with these, they may also have experienced further stress and anxiety in relation to the nature of the rehabilitation work they were tasked to perform. Rehabilitation is associated with people improving and getting better, however the environment in which the staff on the study wards were working was considered non-conducive to rehabilitation practice and the achievement of these aims. In the classic paper by Main (1957) it is suggested that individuals enter the helping professions to satisfy a need for reparation, and that if this need is not satisfied then feelings of anger, frustration, guilt, depression, despair, failure and even hatred can ensue. This can be present in any work setting where patients fail to get better, however failure to enable improvement on a rehabilitation ward, where this is one of the major aims, could be assumed to give rise to and even exacerbate the intensity of these feelings. Again, most of these feelings could be seen as present in the staff on the study wards.

As well as anxiety amongst staff in the helping professions being related to the nature of the work they undertake, it is also suggested that such stress can be exacerbated by the psychological demands patients and relatives make upon professional carers (Menzies Lyth 1988). Patients and relatives can also experience difficult feelings including those of anxiety, fear, depression, despair, helplessness, envy and anger in relation to their illness and current state of need (Menzies Lyth 1988, Skogstad 2000). In order to free themselves of such feelings and defend themselves against them, and often as a way of communicating these feelings to those caring for them, patients and relatives attempt to relocate them into the staff themselves. This is accomplished through the psychodynamic mechanisms of denial, splitting and projection where individuals deny and disengage with difficult, painful and unwanted feelings which are then projected outwards into others who, through a process of counter-transference, then experience these feelings on behalf of the originator (Menzies 1988, Halton 1994). As well as the feelings described above, the nature of the rehabilitation study wards also had the potential to raise further anxieties in patients. Patients were told that they were being transferred to the study wards for rehabilitation. For those who felt they could and wanted to engage with this process, the lack of sufficient environments, resources and rehabilitation philosophy prevented this from being achieved. This could potentially have resulted in feelings of frustration, anger, dissatisfaction and disappointment within this patient group. It can also be seen from the research report that for many of the patients transferred to the study wards a focus on rehabilitation may have been inappropriate. Roberts (1994) has highlighted the distress that may be caused when a focus on independence is maintained with older people whose physical and mental strength may be declining. An expectation of improvement in the absence of ability could therefore result in feelings of failure, guilt, inadequacy, despair and helplessness which may have occurred with these patients. It can be suggested that, in order to communicate how they felt and also free themselves from these difficult feelings, patients on the study wards projected them into the staff who then experienced them for themselves. The potential projected helplessness experienced by patients could then have served to worsen the learned helplessness state that it is suggested staff were already experiencing.

Confirmation of the presence of anxiety through the identification of socially structured defence techniques

Many of the anxieties and feelings described above can be identified throughout the research report as being experienced by staff on the study wards. Further support of their presence can also be confirmed through some of the working practices that were observed. Menzies Lyth (1988) suggests that the amount of anxiety experienced by nurses cannot always be tolerated, and that when this anxiety becomes too much to bear they find ways to protect themselves from it. This is achieved through the use of socially structured defence techniques which are systems of working practices that develop, often unconsciously, between members of

organisations, and that are structured to avoid the anxieties inherent in their tasks. Menzies Lyth (1988) identified the social defence techniques at play in her study of a general hospital. She found that the nurse-patient relationship was the core source of anxiety for the nurse, and was able to identify working practices which severed and depersonalised this relationship in an attempt to protect nurses from this anxiety. These practices included seeing all patients as the same with the same care needs, and organising the workload into a series of tasks which each nurse would carry out for a large number of patients. This restricted the amount of physical and emotional contact nurses had with any one individual, thus potentially protecting them from experiencing their own feelings about individual patients whilst reducing exposure to patient projections. As well as the nurse-patient relationship, anxiety was also raised in relation to the burden of responsibility on nurses, again resulting in the employment of various defence techniques. The use of task lists together with ritualistic work practices and standardised procedures were used to keep decision making to a minimum, with decisions that were made being subjected to obsessive checking and re-checking before action was taken. Lack of definition of who was responsible for what and to whom due to obscure and unstable role boundaries, together with a delegation of responsibility to more senior members of the organisation, also reduced the burden of responsibility and its accompanying anxiety on nursing staff. Aspects of these socially structured defence techniques can be identified in the working practices of staff on the study wards which included inflexible routines, the allocation of tasks within teams, lack of an individualised approach to patient care, and lack of attention to the social, emotional and psychological needs of patients. Responsibility for patient care was difficult to locate, with staff also delegating any responsibility outwards in the expectation that others would sort out their problems for them. The presence of these working practices could therefore be seen to confirm that staff were experiencing an overwhelming degree of stress and anxiety which required the use of socially structured defence techniques in order for them to continue in their work.

A psychodynamic explanation of my own personal experience

As well as socially structured defence techniques being utilised by staff as a means of protection from anxiety, it is also recognised that, as do patients, nurses can also undertake projection as a means of defence (Moylan 1994, Obholzer & Roberts 1994). Through this unwanted, difficult, and what could be considered unacceptable feelings arising from the nature of the work and patient projections, many of which have been described above, are denied, split off and projected into others within the organisation. It can be seen from my story that I experienced an array of feelings throughout the course of the study. These included feelings of sadness, tiredness, demoralisation, demotivation, dissatisfaction, disappointment, frustration, failure, inadequacy, helplessness, hopelessness, emptiness, guilt and anger. Although some of these could be attributed to my taking on a new role and its accompanying uncertainties, and working within the same impoverished environment as the staff, I am also

now suggesting that, due to the many similarities between my feelings and those experienced by the staff on the study wards, some may also have been projected into me by the staff as a means of ridding themselves of such difficult, uncomfortable and unacceptable emotions. I am also suggesting that once these feelings were projected into me I, through a process of projective identification (de Board 1978, Halton 1994, Hinshelwood & Skogstad 2000), identified them as my own and acted them out. This could explain the overwhelming anger, frustration, tiredness and demoralisation that accompanied my research journey. The motivational, cognitive and emotional effects of learned helplessness that I have suggested the staff were experiencing (see section 5.1) can also be identified within my story, with me exhibiting reduced motivation to continue trying to effect change, failure to focus positively on the progress that was made, and feelings of low mood and hopelessness. It would therefore appear that staff may have been projecting their state of learned helplessness and that, through projective identification, I became helpless with them.

The stress and anxiety that I was experiencing in my role could, therefore, have been a result of the anxieties I was experiencing on behalf of the staff. It can be seen from my story that these anxieties became too much to bear and that I also resorted to psychodynamic defence mechanisms in order to protect myself from them. These took the form of reducing the intensity of relationships between myself, the ward staff and the other lead research and development nurses, together with the responsibility I took for study completion. I detached myself from the daily problems of the staff and avoided situations on the study wards that had the potential to be emotionally charged. I also started to withdraw and disengage emotionally from the wider project and my colleagues through avoiding social situations and reduced participation in weekly meetings and the action learning set. Together with this I started to disown study activities and thus stopped taking responsibility for trying to make the study successful. Even though these processes were used as a defence against the high anxiety levels I was exposed to, they did not entirely resolve the problem. Acting in these ways was uncomfortable for me and I experienced further feelings of guilt, pain and personal dislike. This process has also been recognised in the psychodynamic literature, with Menzies Lyth (1988) referring to the secondary anxiety which can be created as a result of the implementation of socially structured defence mechanisms. I would also suggest that I, myself, used the processes of denial, splitting and projection in an attempt to rid myself of some of the uncomfortable feelings I experienced, with many of these being aimed at the service managers of the study wards. By projecting feelings of anger, inadequacy and guilt I was attempting to see these traits as originating in the managers as opposed to myself, which then allowed me to locate much of the blame for what was going on with them (de Board 1978). The defence mechanism of splitting can also be seen as being further present in my journey. My story articulates how I felt safe and secure when I was able to work in a structured and logical manner, with the organised approach on Oak ward (see section 4.2.1) sitting comfortably with me. It also articulates my discomfort when my structured and logical

approach was disrupted, with this equating to the chaotic atmosphere that was often present on Elm ward. Trying to work with both wards simultaneously resulted in me splitting them into the 'good' and the 'bad' so that I did not have to deal with the conflict created by these opposing feelings. It is also interesting at this point to consider the pseudonyms I gave to the study wards, and how these reinforced my feelings about them, with Oak trees being regarded as solid and Elm trees often being associated with disease (Dutch Elm disease).

Enhanced understanding of the study context

As well as the application of psychodynamic theory helping to explain my personal experience of undertaking the study, it has also resulted in me reflecting further on what may have been going on within the study wards. It has been identified that although socially structured defence techniques can be used as a defence against anxiety to enable staff to continue in their work, they can also often work against the primary task that staff are there to undertake (Obholzer 1994a). Practice and behaviours that I considered to be poor can now be seen as resulting, at least to some extent, from the defence techniques utilised by the staff to protect themselves against anxiety, and which then negatively impacted on their work task of caring effectively for patients. The negative impact of such defence techniques could be seen as more pronounced on Elm ward where the ward relocation and accompanying changes served to exacerbate the other anxieties being experienced by staff. Further reflection has also helped me to gain a different perspective on the behaviour of the service managers in the study. I saw their detachment from the study wards to be uncaring and unsupportive, however this can now also be seen as a socially structured defence technique that served to distance and protect themselves from the anxieties inherent in the staff and patients together with, as was found by Obholzer (1994b), the consequences of the decisions and actions they had taken. The use of socially structured defence techniques by staff and managers can also be seen as a major contributing factor for their lack of participation and commitment towards development activities and change. It has been recognised that engaging with change requires some dismantling and restructuring of socially structured defence techniques, with this having the potential to result in the resurgence of anxieties that have been avoided through the use of such mechanisms (Mosse 1994).

Engaging with this case study has also enabled me to reflect further on the rehabilitation care for older people and identify similarities between the roles of rehabilitation staff and that of action researchers working in practice settings. Both bring with them expectations of progress and improvement, with rehabilitation staff expecting this in relation to their patients and action researchers in relation to their studies. Just as I had a need for recognisable progress in the study it can be assumed that staff also had this need in relation to their rehabilitation patients. The frustrations I experienced through lack of participation of staff in the study may also have been experienced by staff in relation to their patients, many of whom they considered as

lacking the capacity to undertake rehabilitation. This may have been due to the internalised restricted definition of rehabilitation adopted by the staff which had a physical focus as opposed to one which incorporated the existential, biographical and temporal dimensions from which both those with and without physical capacity for rehabilitation could benefit. My frustrations with collaboration and a resulting need to intervene could be associated with the staff who, due to a need for speed, did things for patients instead of enabling them to do things for themselves. I had my hopes painfully dashed in relation to what could be achieved in the study, and it could be that staff felt the same when they could not achieve rehabilitation practice in areas that did not facilitate it or with clients who they considered did not have the capacity for it. I found the action learning set emotionally unsustainable due to it requiring engagement with the emotions of others as well as my own. This could also have been the same for the staff who had to engage with the emotional struggles of patients as well as their own. The staff experiences of attempting to provide rehabilitation care for older people could therefore equate to my experience of undertaking the action research study, with there appearing to be parallels between the needs of those performing in such roles. This is an important aspect for consideration for those undertaking action research in rehabilitation settings and which, if it had been recognised earlier within this study, may have provided an opportunity to effectively explore and address the needs of all those involved in the process.

The process of containment

From the preceding discussion it can be seen that through the application of psychodynamic theory to study data a greater insight into the feelings and behaviours of the staff and myself can be gained. Feelings of inadequacy and helplessness could have been projected into staff from patients and carers which the staff then experienced as their own. In order to free themselves of these feelings staff then projected them into me and I identified with them, with this resulting in me feeling inadequate and helpless with the staff. I now suggest that recognition of these feelings as emanating from the work being undertaken would have enabled them to be worked with and learnt from, as opposed to them resulting in the use of socially structured defence techniques that led to ineffective practices which failed to meet the needs of the patients or the study. This will now be further explored in relation to the process of containment.

My availability as a receptacle for the feelings of the staff can be assumed through my continuous presence on the study wards and the relationships that I built with them. This, I feel, made me particularly susceptible to their projections. Psychodynamic consultancy capitalises on these processes, with consultants utilising and opening themselves up to counter-transference mechanisms as a means of containing, identifying, making bearable and helping individuals and groups understand and work through the unconscious anxieties and emotions inherent in their work (Halton 1994, Moylan 1994). This results in a reduced need

for the use of defence mechanisms which, as identified by Obholzer (1994a) and Menzies Lyth (1988), often serve to act against the work task and create secondary anxiety. My lack of knowledge and understanding of psychodynamic processes at the time of the study prevented me from working in this way with staff or even identifying that these processes were in play, with me then getting drawn into the emotional atmosphere with them. However, as the study progressed the staff, particularly on Elm ward, did begin to engage with change, form closer relationships with patients and take more responsibility for patient care (see section 4.2.3.3). This indicates that their anxieties had been contained to some extent within the study with an accompanying reduction in the use of socially structured defence techniques. The research report suggests that a facilitative approach based on the senses framework (Nolan et al 2006), which enabled staff to experience the senses of security, belonging, continuity, purpose, achievement and significance, enabled them to engage with change (see section 5.2.2). It could be tentatively suggested here that, in the absence of a known psychodynamic approach to the study, working within such a framework may have provided the containment that staff required to reduce the use of defence techniques and engage more fully with the work task.

Although staff anxieties seemed to be contained as the study progressed, it can be seen that mine were not. Towards the end of the study I became overwhelmed by them which, together with the defence mechanisms I employed, disabled me from working effectively. Bolton and Roberts (1994) identify the need for support systems to be in place for those consulting with organisations in order to contain their anxieties and enable them to make sense of their experiences. On further reflection of my experience I feel that the structures put in place to support me were effective in containing my anxiety in the early stages of the study, however as the study progressed my levels of anxiety increased and the support structures were no longer able to perform this function effectively. The action learning set could be seen as potentially providing the best opportunity for anxiety containment and exploration of psychodynamic processes, however I feel that the way the action learning set was structured may have mitigated against this. Holman et al (2006) refer to the need for facilitators of groups undertaking emotion work to provide a 'holding' environment. The action learning set took place at a different location each month, often in one of the participants' own homes, and did not always keep to time. The facilitator was the coordinator for the wider project who also provided individual supervision for half of the lead research and development nurses. This, I now feel, prevented a continuous safe and boundaried space from being provided which could contain anxiety and allow for effective exploration of feelings and emotions. Also, as my anxieties increased, the defence mechanisms that I employed can be seen to have further restricted the ability of other provided support structures to contain my anxieties. I denied my feelings and emotions in individual supervision sessions and distanced myself from the lead research and development nurses which further reduced opportunities to explore how I was feeling.

In light of my story, and the greater understanding I have gained through further reflection on it in relation to psychodynamic theory, I now consider that some form of psychodynamic supervision would have been beneficial to me during the study. This, I suggest, would have provided the opportunity for containment of my anxieties, the identification of their origins, and the psychodynamic space to enable me to work with and through them. As well as reducing my tendency to treat any lack of success as a personal failure and preventing my over-identification with staff feelings, this may also have negated the need for the defence mechanisms I employed thus promoting more effective and positive performance in my role. I feel that it would also have enabled me to use my own feelings and emotions as a tool for gaining a greater depth of understanding regarding the staff within the study context which may have led to more effective work earlier in the study process. Finally, through the enablement of the above, a much less painful and difficult personal research journey may have been experienced.

CONCLUSION

This case study has presented the story and reflective analysis of my experience of undertaking an action research study. Using the application of psychodynamic theory a greater understanding of this experience and the study context itself has been gained, and lessons learnt regarding the personal support that may be required for those undertaking such work. It can be suggested that researchers undertaking studies in settings whose tasks involve working in relation with others will be exposed to psychodynamic processes, and that the feelings of researchers may be a useful indicator of what is going on in the research field itself. Appropriate support mechanisms need to be in place to facilitate the recognition of these processes and enable researchers to understand and utilise them positively in their work. Action research is an approach which relies on the building of relationships and, as such, should include in the study design the structures to be employed to provide this type of support. Parallels between the aims of action research and rehabilitation have also been highlighted with it being considered that the journeys of practice staff and researchers in this field may be similar. Although researcher reflexivity is advocated in the literature, its main focus tends to be the impact of the researcher on the study process in relation to rigour. Less attention is paid to the impact of undertaking the study on the researcher. It is also recognised that a balance needs to be achieved between self-awareness and self-indulgent 'naval gazing' (Finlay 2002). I feel that this balance has been achieved in this case study, with the learning gained from it enriching my understanding not only of psychodynamic processes but also of how knowledge of these can enhance an understanding of the field of study. It has also enabled me to move on from what I considered to be a very negative experience to one where I have been able to achieve a great deal of personal growth and development, as well as enabling me to consider the support both the staff and I would need should I undertake such a study in the future. The learning from this case study will be of relevance to other action

researchers together with those who are engaged in similar practice development or change activities that bring them into relation with others.

CRITICAL REVIEW OF THE LITERATURE

THE EXPERIENCE OF UNDERTAKING ACTION RESEARCH: A REVIEW OF THE LITERATURE

BACKGROUND TO THE LITERATURE REVIEW

My personal motivation for undertaking this review

My motivation for undertaking this literature review comes from my own personal experience as an action researcher in a study which aimed to improve the care provided for older people on two rehabilitation wards in an NHS trust. This was my first attempt at undertaking action research, and I went into the study with a positive view of the potential of this approach which I had gained through reading methodological texts and reports of action research in health care journals. My actual experience was, however, very different from what I had expected. It was much more complex and messy than the neat spirals of activity that I predicted, and was riddled with challenges and disappointments at what I was able to achieve. Within this research environment I experienced many difficult and painful struggles over the three years of the study which had a profound personal impact on me. The disparity between my original expectations of action research and my reality of undertaking it was vast, and although further critique and reflection on my experience some years after study completion allowed me to explore it in more depth and gain significant learning from it, I was left wondering if my experience was unique or if others had had similar experiences. Accessing the general reflexivity literature and published reviews on action research, where I expected this information to be located, did not provide the answers I craved (see below), and I therefore felt the need to embark on a more extensive review of the literature as a means of satisfying my curiosity.

Lack of attention in the general reflexivity literature

The concept of reflexivity is receiving increasing attention in the literature, especially in relation to general qualitative, ethnographic and feminist research (see Choi 2006, Jootun et al 2009, Kingdon 2005, Lennie et al 2003, Mauthner & Doucet 2003). This increased attention seems to have accompanied a change in thinking from the necessity of distance and objectivity in research towards an increased recognition of the difficulties of neutral, value free stances within the above methodologies (Greenbank 2003, Wren 2004). The reflexivity literature identifies a greater acknowledgement of the inevitability of bias in any study (Freshwater 2005), together with a recognition of the reciprocity that exists between the researcher and that being researched (Lamb & Huttlinger 1989). Although advocated within the above

research methodologies, the literature identifies that the term is ambiguous, poorly described and difficult to define:

'Finding a definition of reflexivity that illustrates what the concept means, and knowing how to achieve it, are both elusive.' (Colbourne & Sque 2004 p. 297)

Despite this, there does seem to be some general agreement within the literature that reflexivity refers to the researcher's acknowledgement of the influence they have on the research process and outcomes, and that it involves accounting for themselves in the research (Cutcliffe 2003, Jootun et al 2009, Kingdon 2005).

The literature identifies numerous researcher influences which have the potential to impact upon the research being undertaken. The most frequently cited of these are the researcher's personal values and beliefs (Carolan 2003, Jootun et al 2009), together with their values and beliefs regarding the work culture (e.g. nursing) and research (Lamb & Huttlinger 1989). This has the potential to include the researcher's social, political, ethical and cultural positions and views (Choi 2006, Gewirtz & Cribb 2006, McCabe & Holmes 2009) as well as their theoretical and epistemological standpoints (Mauthner & Doucet 2003). The location of the researcher in relation to social categories such as gender, age, race, ethnicity, nationality, class, sexuality and educational background have also been discussed in relation to researcher influence (Choi 2006, Pillow 2003), together with their past experiences and current personal interests (Jootun et al 2009, Lamb & Huttlinger 1989, Pillow 2003). In light of the said recognition of the difficulties of neutral and value free research, researchers are being asked to adopt a reflexive approach that openly acknowledges these influences, and to engage in continuous critique and self-appraisal to identify how they may have shaped and impacted on their research (Dowling 2006, Guillemin & Gillam 2004, Northway 2000, Rolfe 2006).

The main reflexivity literature, therefore, seems to focus on the impact the researcher has upon the research itself. This may be the reason why those who have engaged in this literature have identified that, in the majority of cases, reflexivity is seen as a means of ensuring and enhancing the validity, credibility, trustworthiness and ultimate rigour of a research study (Carolan 2003, Cutcliffe 2003, Dowling 2006, Finlay 2002, Gewirtz & Cribb 2006, Guillemin & Gillam 2004, Jootun et al 2009, Kingdon 2005, Koch & Harrington 1998). This restrictive focus, however, is now coming under scrutiny. McCabe and Holmes (2009) critique what they call this 'traditional' view and suggest that it limits the potential of reflexivity to accomplish different ends such as further informing the research process and gaining new depth and understanding from it, with Guillemin and Gillam (2004) supporting a wider application of reflexivity in research with a focus on its potential use as a tool for ethical practice. These considerations, however, still focus on reflexivity as a means of informing the research process, and I would suggest that it would be unlikely that undertaking any type of research that lends itself to the in-depth continuous critique and self-appraisal described above would not also have a reciprocal impact on the researcher themselves. Lamb and

Huttlinger (1989) are among the few authors who acknowledge this, with Dowling (2006) registering the lack of attention in the literature to how the researcher is affected personally by the research they undertake. Although reflexivity is an activity advocated in the practice of action research, and many reports of such are written in a reflexive format, attention to the personal impact of undertaking such research is not prevalent.

Lack of attention in published reviews on action research

The published reviews on action research that I accessed also failed to provide insight into what it was like to undertake an action research study. Waterman et al (2001) undertook a systematic review of action research as part of the NHS Research and Development Health Technology Assessment (HTA) Programme. Although the facilitation of action research was not stated as a focus for this review, and was not a component on the data extraction sheet, one of the objectives was to analyse action research in relation to its strengths and limitations, with this section of the review including discussion on the perceived challenges and tensions of action research in relation to what are termed '8 pivotal factors'. Within these factors consideration is given to the often difficult and complex role of the action researcher, with findings indicating that such researchers need to possess a multitude of qualities and skills. It is considered that they need to possess personal, interpersonal, intellectual and educational qualities, and that they need to be persuasive, enthusiastic and likeable and possess the attributes of perseverance and tenacity. It is also suggested that they require knowledge, skills and expertise in facilitation, multiple research methodologies, research design and implementation, and project, group and human resource management. In addition it is highlighted that, due to the time it may take to progress a project and the possibility that original aims may not be met, researchers may also have to manage feelings of frustration. The complexity of this role is further acknowledged by suggestions that experienced supervisors, and possibly even a team with appropriate expertise, may be needed in order to provide support. It is also recommended that researchers include a reflexive account in their study reports, however this is, as in the general reflexivity literature, recommended in relation to enhancing the study rigour as opposed to exploring the impact of such work on the researchers themselves.

Whitelaw et al (2003) undertook a review of the nature of action research to provide evidence with which to underpin the development of an action research resource for the health promotion division of the Welsh assembly government. They state that the review was selective and, although aims are given, lack of attention to review methods such as time frames, inclusion and exclusion criteria, data extraction and analysis makes it difficult to establish the exact parameters within which the literature search took place. This prevents the reader from being able to ascertain whether facilitation of action research and the experience of action researchers was purposefully not included in the review, or whether literature

pertaining to this was not discovered. The review does quote a researcher as stating that action research in community settings was 'evolving and dynamic' requiring a 'blend of patience, passion and rigour' (p.1), with the reviewers commenting that it is difficult to pin down such interpersonal and emotional aspects of action research in the literature, however this comment was unsubstantiated with no further information on the nature of this difficulty being forthcoming. The review also comments on the action research 'tradition' allowing and encouraging researchers to reflect upon and report the difficulties and failures they encounter in the process of undertaking action research.

The specificity of these two reviews may have precluded a focus on the facilitation of action research and the experience of action researchers in undertaking it, however acknowledgement of the complexity, emotional aspects and recognition of failure that they state are associated with such roles would suggest that such a focus would not only be helpful but could almost be considered as essential when reviewing the potential of this research approach. This can be seen as being especially relevant in the work of Whitelaw et al (2003) given that the review aims to provide a base upon which a practically focused field oriented resource can be developed. During my time as an action researcher I engaged in discussions with other action researchers through study groups, action learning sets, conferences and informal meetings together with individually contacting those whose work I had engaged with. During these discussions it became clear that many of these had found the action research process difficult and challenging, with the majority of them expressing to some extent the impact the process had on them as individuals. None of them, however, had published this aspect of their work. There appears, therefore, to be a potential gap in the reflexivity and action research literature with regards to the experience of undertaking action research which needs to be further explored.

AIMS AND OBJECTIVES

Aim

To understand what it is like for researchers undertaking action research studies, and what this can add to the current body of knowledge on action research practice.

Objectives

- To explore the experiences of those undertaking action research.
- To identify the learning that can be gained from understanding these experiences.
- To integrate this learning within the wider body of knowledge on action research.

METHODS

Search strategy

The electronic databases of Medline, CINAHL, PsycINFO, International Bibliography of the Social Sciences, Social Policy and Practice, HMIC and the British Nursing Index were searched using action research combined with the individual terms, and derivatives, of 'facilitation', 'experience', 'story', 'journey', 'narrative', 'reflect', 'reflexive' and 'personal'. These databases were chosen to cover a range of action oriented work within the fields of health, social care, education and social science research, and to ensure inclusion of specialist action research journals. The search terms chosen were felt to encompass those that could be used to portray the experience of undertaking action research. Hand searching of the journals 'Action Research' and 'Educational Action Research' was also undertaken to identify action research papers that may have been missed in the electronic database search through not possessing the actual search terms used. The databases and journals were originally searched from 2005-2010 to obtain the most up to date information on the topic under review, however this search only identified a small number of potentially applicable papers (no. = 41). In light of this the search was backdated to include papers published from 2000-2004. This extended search identified an even smaller number of potentially applicable papers (no. = 17) and, following the above recognition in the literature that there is a lack of attention in relation to this topic area, it was felt there would be little to gain in backdating the search any further.

Papers were selected for inclusion in the final review if they met the following criteria:

- they focused on the process of undertaking action research
- they made some reference to the impact that undertaking the research had on the researcher(s)

They were excluded from the final review if:

- they were purely descriptions of the research process, challenges, outcomes and lessons learned
- they were purely personal critiques of the research process
- they did not make any reference to the personal impact that undertaking the research had on the researcher(s)

Search results

The search process was a lengthy and time consuming endeavour. The search terms used were also widely applicable to a range of other topics including theoretical and methodological papers on reflexivity, narratives and storytelling, process papers focused on factors that facilitated or hindered achievement of research aims, and studies that focused on interventions in relation to patient experiences, stories and narratives of living with specific

illnesses. Nearly 2500 abstracts were reviewed and it became apparent early on in the search process that papers on what it was like for a researcher undertaking action research were few and far between. This originally led to me selecting papers that may have included some aspect of researcher experience, but which on second and more detailed reading of abstracts did not meet the inclusion criteria. These papers were subsequently not retrieved.

From the search process, 58 papers which had the potential to meet the inclusion criteria were selected and retrieved for further appraisal. Due to a lack of specifically stated aims and objectives in these papers, all needed to be read in full before a decision could be made on their appropriateness for the review. Following this appraisal, 31 papers were subsequently rejected and 27 retained for inclusion in the final review.

Limitations of the search strategy

Although the search was successful in locating papers which could inform the critical review of the literature, limitations of the search strategy can be identified. Reviewing such a large number of abstracts had the potential for some relevant papers to be missed. Also, if a paper did not state its approach as action research in the title or abstract it would not have been identified. This is supported by the fact that the hand searching of two journals identified three papers that did not include action research in the search fields. Action research also has a long history in education, and the lack of inclusion of a dedicated education database could have further limited the number of papers available for review.

Paper characteristics

A data extraction sheet was compiled for each paper included in the final review from which comparisons were made (for individual details of these papers, please see appendix 8). Out of the 27 papers retained, 21 were published in research journals with the majority of these (no. = 18) being published in those with a specific focus on action research (Action Research (no. = 10), Educational Action Research (no. = 7), Systemic Practice and Action Research (no. = 1)). The other research journals included two with a nursing focus and one with an environmental focus. Of the other six papers, five were located in healthcare related journals and one in a reflective practice journal (see appendix 8 column 2).

Due to the majority of papers being published in research as opposed to professional journals, a wide variety of topic areas were addressed across an equally wide variety of contexts. The main context within which studies took place was that of the community (no. = 11), with others including educational settings (no. = 10), hospitals (no. = 2), and voluntary, charitable, manufacturing and trade union organisations (no. = 4). Variety within the type of community setting was also present with these including, for example, indigenous communities and post-industrialised areas, and across a range of geographical locations including the UK (no. = 11),

Canada (no. = 6), the USA (no. = 4), the Netherlands (no. = 1), Scandinavia (no. = 2), Israel (no. = 1), and the Middle East (no. = 2). Topic areas addressed across the 27 papers ranged from community health and regeneration, professional and role development, clinical practice and educational interventions to the study of self-organised groups, violence against women, governance structures, and the development of information systems (see appendix 8 column 4).

A variety of reporting formats were used to explore the researcher experience of undertaking action research. Some authors situated their experience and reflected upon it in relation to a specific theoretical perspective, whilst others reported their experience in the form of a reflective narrative. Other formats included thematic and metaphorical presentations of experiences. Whilst 22 papers were written by the researchers or research team themselves, five papers specifically focused on outside evaluations of the action research experience of others. As well as the variety of formats used to relate the experience of researchers, papers also varied in their focus with some concentrating on the whole research experience and others on specific aspects of it (e.g. confrontation dilemmas, cultural issues, engagement and partnerships). The depth of reflection undertaken and exhibited was also inconsistent ranging from what I considered to be superficial and specific to detailed accounts of the personal impact undertaking the research had upon researchers.

The type of action research approach utilised was stated in papers, however the labelling of approaches was not exclusive with overlaps between the types of approaches used being identified. Eleven papers just specified action research as their approach, with three of these being stated as insider methodologies. Community based action research was stated in five papers, with three of these including a participatory aspect. Participatory action research was also identified as a stand alone approach in three papers, and feminist participatory action research in two. Other approaches included cooperative inquiry (no. = 3), 1st person action research (no. = 2), and teacher action research (no. = 1). Across these papers both insider and outsider research approaches could be identified (see appendix 8 column 3).

Only 18 of the 27 papers reviewed included information on the data collection methods used to inform the researcher experiences that were presented, with those that did include this varying in the amount of detail provided. Methods of data collection included reflective diaries and personal journals (no. = 8 papers), discussions and conversations (no. = 2 papers), and focus groups and interviews (no. = 8 papers). Out of these 18 papers that provided data collection information, only twelve identified how data were analysed to inform the area under study. This was mainly through thematic analysis, however the amount of detail provided regarding how this was undertaken again varied. This lack of consistent attention to methods of data collection and analysis prevented a comprehensive assessment of the quality of papers from being ascertained (see appendix 8 column 5).

With a few exceptions, most papers reviewed lacked adequate information regarding the background of the researchers with regards to their research history, motivation for undertaking the study, and previous experience in the topic area. Only thirteen papers identified any research history of researchers, with only eight of these providing information specifically in relation to their background in undertaking action research. The lack of detail to the background of researchers prevented any comparisons being made between levels of expertise and their resulting experience of the research process (see appendix 8 column 6). This, together with a lack of in-depth information regarding the context in which the studies took place in many papers, often made it difficult to situate the researchers and their experience within the studies they undertook.

The papers retained for review therefore covered a wide variety of contexts, topics and type of action research approach. There were also inconsistencies amongst them with regards to reporting formats, details of data collection methods and information on researcher backgrounds. As a result, and because of the small number of papers available for appraisal, it was considered that any type of systematic comparison of papers would lack utility and validity. All of the papers did, however, have something to say about the experience of undertaking action research and it was felt that in light of this, together with the lack of any recognised existing body of knowledge in relation to the review topic, that they had something to contribute. In order to capture this it was recognised that a different approach to this review was required, with it being considered that a secondary analysis of the literature would be the most appropriate way forward in order to start to build the foundations of a knowledge base in this area.

Secondary analysis of the literature

A secondary analysis of the literature was therefore carried out to identify commonalities regarding the experience of undertaking action research. This analysis did not set out to provide a systematic meta-synthesis of the topic under study, however it did incorporate some aspects of this approach identified by Thomas and Harden (2008), together with the process of thematic analysis articulated by Braun and Clarke (2006) and methods of coding presented by Miles and Huberman (1994). The following process was employed:

- All papers were read in full to enable familiarisation with them and a feel for researcher experiences to be gained.
- Each paper was read a second time and a summary sheet constructed to enable the context and complexity of individual experience to be maintained throughout further analysis.

- Each paper was read a third time and codes loosely applied to the text. At this point, and throughout the remaining steps, reflective memos regarding ideas and thoughts about codes and their relationships were constructed to assist in analysis.
- As new codes arose, previous papers were re-examined to identify if they were present.
- Codes were grouped together under common categories and themes. Papers were revisited, together with summary sheets, to validate the presence of these themes and ensure they had not been taken out of context of the whole.

Recognition of the researcher perspective

It needs to be acknowledged that a secondary analysis of this kind is open to the same subjectivity as any other qualitative analysis, and will be influenced by the values, beliefs and experiences of the person undertaking it. Having personal experience in the review topic area through undertaking action research myself, there was a risk that I would only focus on experiences that resonated with me as opposed to those that were different. I therefore consciously attempted to keep an open mind to the data and looked for similarities to and differences from my experience, as well as focusing on both positive and less positive stories and aspects. In spite of this it needs to be recognised that this analysis is inevitably based on my perspective of the literature, and that a reviewer with different experiences and standpoints may have seen it differently.

FINDINGS

Due to the number of different topic areas investigated by researchers over a wide range of contexts there were resulting researcher experiences that were very specific to the individual studies undertaken. Despite this there were also many similarities regarding what it was like for researchers undertaking action research. Secondary analysis of the retained papers highlighted five common themes which were 'experiencing tensions and conflicts', 'experiencing the researcher role', 'the vulnerability of action researchers', 'positive experiences' and 'riding the rollercoaster of action research'.

Experiencing tensions and conflicts

Researchers spoke of the tensions and conflicts they experienced in undertaking action research in relation to the competing agendas of multiple stakeholders and with regards to balancing control and participation.

Competing agendas

One of the most common conflicts experienced by researchers was in meeting the different, and sometimes seemingly incompatible, agendas held by the various stakeholders within individual projects. Researchers commented on how the agendas and needs of different agency partners took precedence over and influenced the direction and methodology of projects at the expense of the participatory and collaborative processes integral to action research. These included those of academic institutions (Faubert 2009, Jacobs 2010), employers (Carlisle & Cropper 2009, Oyum 2007), organisations (Meyer et al 2003, Ravitch & Wirth 2007), and those who funded research (Faubert 2009, Jacobs 2010, Lavie-Ajayi et al 2007, Ponc et al 2010). This left researchers questioning whose needs they were really serving (Lavie-Ajayi et al 2007) and whose side they were on (Oyum 2007). An example of this is most graphically illustrated by Langan and Morton (2009) who, in their feminist participatory action research study to evaluate a violence against women initiative, experienced excessive demands by the commissioning organisation which did not match the original agreed approach. This left them feeling 'damned if we did, and damned if we didn't' (p.179) and resulted in them being sacked when they were unable to meet the demands placed upon them due to a reluctance to sacrifice their underpinning values and beliefs.

The different agendas of those undertaking the research and those participating in it were also often found to be in conflict. Researchers report difficulties in securing participation in their studies for a variety of practical and cultural reasons (Hostick & McClelland 2000, Kamali 2007, Nyhof-Young 2000, Oyum 2007). A number of potential participants in community based projects were cynical of research, with past experiences leaving them disillusioned, reluctant to participate, and sometimes even hostile towards researchers (Carlisle & Cropper 2009, Dickson & Green 2001, O'Neill & Williams 2004). Lack of a research culture in other organisational contexts resulted in participants feeling intimidated or seeing research as an extravagance (Meyer et al 2003), making it difficult for researchers to gain acceptance in such areas:

'It was seen as an extra when times are hard! Some said we could have bought some foot soldiers with the money.' (Meyer et al 2003 p.411)

Different motivations between those undertaking and participating in projects also led to competing foci within the studies (Dickson & Green 2001, Gewirtz et al 2009), with some researchers reporting that participants wanted a focus on action and change and were disinterested in and impatient with the research aspects of projects (Braithwaite et al 2007, Carlisle & Cropper 2009).

Working within this environment of conflicting agendas caused anxiety and discomfort for researchers. In a community based participatory action research study fostering empowerment and encouraging healthy living amongst older people in the Netherlands (Jacobs 2010) the researchers found that, when time pressures increased, they needed to

choose between an empowering approach versus being taken seriously in the academic world through the use of applied research methods and reverting back to traditional research roles. One researcher stated that they felt this conflict throughout the project, and that trying to find a way to meet both agendas led to them feeling that they had failed in both areas. A similar experience is identified by Ponc et al (2010) who, in one of their feminist participatory action research projects focused on women's health, felt forced through pressure from the academic institution and funders to exert power over their research partners as opposed to developing 'power with' relationships. They felt that this contravened their work ethic and describe their journeys within these environments as being 'riddled with discomfort' (p.333). Within such a context, Dickson (in Dickson & Green 2001) made concerted efforts to involve her participants in her participatory action research to guide Aboriginal women in undertaking a health assessment. However, the participants' distrust of research led to the avoidance of broaching the topic of research in the early stages of the project and a need by the researcher to constantly rationalise, defend, justify and persuade in relation to her study. This was a role she felt uncomfortable with, did not like, and which made her feel as if she was deceiving her participants. Lack of participation made some researchers feel angry, disappointed and resigned at times (Hostick & McClelland 2000, Oyum 2007) with Oyum (2007), in an organisational change study to develop work teams in steel plants, expressing the frustration and powerlessness they felt within what they considered to be an impossible change context. Kamali (2007), in relation to a participatory action research project aimed at improving communication between state development and rural extension workers in Iran, highlighted the emotional impact that trying to achieve genuine participation can create:

'The significant challenges involved in achieving authentic participation have made me feel overburdened, locked up, hopeless and depressed at times.' (p.116)

Balancing control and participation

Researchers discussed how they tried to address power inequalities within their studies and involve participants in the research process by attempting to relinquish some of the control that they held (Hostick & McClelland 2000). Getting a balance between participant participation and researcher control has been compared by Sense (2006) to 'trying to drive the bus from the rear passenger seat' (p.1) with Faubert (2009), in her community-university physical activity initiative, commenting on the need to balance 'initiating action' with 'facilitating and supporting partners' to do the work. Some researchers, even when trying to address these issues, still struggled with these aspects. Lavie-Ajayi et al (2007) state how handing over the reins to participants felt unsafe and was accompanied by a fear that things may go wrong, with Jacobs (2010) exploring how the unconscious wish of the researchers to regain control and protect themselves against anxiety resulted in them withdrawing to familiar ways of working. One of the researchers evaluating teacher action research projects struggled in attempts not to

influence participants and drive the projects, with this resulting in him experiencing feelings of guilt and emptiness (Judah & Richardson 2006). Others questioned whether taking a back seat was appropriate and the most helpful way of working (Dickson & Green 2001, Gewirtz et al 2009), with some participants becoming frustrated with this approach and wanting the researcher to be more directive. In order to try and get the balance right, Dickson (in Dickson & Green 2001) commented on how she found herself in an 'ongoing state of self-censorship' in relation to her role in the project (p.257).

As well as researchers expressing discomfort with exerting power over participants, there were times when the community exerted power over them. Both Kamali (2007) and Gone (2006) explore the challenges of attempting to undertake action research within traditional cultures, however the strength of community power is most graphically illustrated in the study undertaken by Karnieli (2000) where cultural and traditional community values were in conflict with the educational intervention being implemented. This resulted in researchers unwittingly being in the centre of political conflict, with their refusal to play ball resulting in them being seen as enemies and their work undermined. Gender and cultural differences also made them feel that they were seen as weak and able to be manipulated and pressured, with them finding themselves 'rushing about between unkept promises' (p.34) which resulted in feelings of helplessness. The challenges and difficulties within this study were so intense that the researchers were forced to withdraw earlier than necessary, with even this raising further conflict:

'The end of the intervention process roused a sigh of relief from some villagers and even a sense of victory. Others were disappointed and are angry with us to this day. Some even called it betrayal ... They pleaded with us to withstand the village struggles, but despite their disappointment that we could not, our supporters agreed that conditions did not allow us to remain.' (p.32)

Experiencing the researcher role

As well as experiencing a variety of tensions and conflicts in their work, researchers also experienced issues and challenges in relation to the researcher role. These included managing multiple roles and positions, the disruption of pre-existing relationships, and the experience of identity conflicts and isolation. These, for some researchers, resulted in difficult decisions regarding necessary role and lifestyle changes.

Managing multiple roles and positions

Researchers needed to manage the multiple roles they held within their studies, with some of these including researcher, facilitator, educator, developer, evaluator, professional, advocate, colleague and friend. Some researchers considered managing this to be one of their biggest

challenges (Ravitch & Wirth 2007), with the different roles often being seen as incompatible and complex (Nyhof-Young 2000). The position of the researcher within their studies also caused difficulties, especially in relation to those undertaking insider action research of some kind. Insider action researchers talk of the conflicts they experienced between being an insider in the community or organisation being studied whilst also having outside affiliations to a funding body, commissioner or university. Some researchers articulate the benefits of this position, with these being highlighted as being able to combine the knowledge and beliefs of multiple perspectives and gain a wider view of the topic under study which can give rise to deeper learning and a richer research account (Faubert 2009, Humphrey 2007). However, insider action researchers also talk of how working within these positions was not only challenging but uncomfortable and even threatening at times (Carlisle & Cropper 2009, Ravitch & Wirth 2007), with Carlisle and Cropper (2009) finding that such researchers often felt like 'spies', 'gossips', and 'traitors' within their communities.

The experience of being in this position is comprehensively articulated by Humphrey (2007) through her doctoral work on the rise of self-organised groups within trade unions in Britain and her position as an insider-outsider in relation to the self-organised groups, the union and the university. She explores this metaphorically in relation to an insider-outsider 'hyphen' incorporating three phases which she individually experienced in her study. The first phase relates to her recognising the existence of such a hyphen through awareness of the differences between the life worlds and values of the union and university which she considered as being mutually indifferent and even hostile. She then explores the second phase which relates to the practical, ethical and political conflicts experienced between her role within the union and its potential to impact upon the research process, with this being compared to treading a tightrope:

'So I tottered on the tightrope of the insider-outsider hyphen, torn between the views and values of academics and activists camped on either side of me, and overlooking some murky waters below.' (p.16)

The third phase relates to taking charge of this hyphen through appreciating the uniqueness of being both an insider and outsider and developing the ability to work across the different life worlds. Although a positive developmental experience, this process encompassed many internal struggles which impacted personally on the researcher, and which have been experienced by other insider action researchers in a variety of contexts.

The disruption of pre-existing relationships

Working across the insider-outsider 'hyphen' affected many researchers' pre-established relationships, with the effect of this being underestimated at the beginning of the research process (Moore 2007). In the study by Humphrey (2007) her relationship with the self-organised groups to which she belonged changed, with any research work undertaken outside

of the groups to which she was personally affiliated being seen as disloyal. She also became aware that her engagement with the university life-world had the potential to drive a wedge between herself and her 'comrades', with the need to maintain confidentiality also resulting in her having to reinforce her research boundaries and distance herself from curious friends. Moore (2007) had a similar experience when investigating the governance processes within his organisation. Setting himself apart as a researcher and questioning their processes weakened the pre-existing bonds of loyalty and devotion between him and the organisation and was even considered as mutinous, with this leading to him becoming estranged from his colleagues. Braithwaite et al (2007), in relation to their community regeneration work, discuss further the detrimental effects their research role had upon relationships within their community. As well as commenting on the loyalty they felt towards their community and the personal impact of needing to maintain boundaries, they also comment on the jealousy and resentment directed at them for having a rare, local, well paid job, the inner conflict this caused, and the outcome of them feeling that they were now something different. Needing to take time out to complete the academic aspects of research also made them feel uneasy about not spending enough time within the community, with this leading to them engaging in what they class as 'a period of damage limitation' (p.70) in an attempt to rebuild damaged relationships.

Identity conflicts and isolation

In respect to these experiences, Braithwaite et al (2007) comment on the personal and social identity conflicts they created together with how feeling excluded by peers can lead to feelings of alienation. These feelings are supported by Lewis (2004) who, in relation to the schoolyard environmental change project undertaken, felt isolated and cut off from colleagues who seemed disinterested in the innovation. Humphrey (2007) also refers to the isolation she experienced in her study with references being made to being 'shipwrecked on a desert island' and 'seeking refuge in the desert' (p.19). Humphrey (2007) also explored in more detail the identity issues she faced. She alludes to how being pushed and pulled along the insider-outsider continuum can result in losing a sense of self, and how discovering unexpected and sometimes unpalatable information led to her questioning her own beliefs. Although developing a different understanding of herself was considered to be positive overall, it also created feelings of guilt that she was no longer the person who started the research with the blessing of those close to her.

Resulting role and lifestyle changes

The detrimental affects the research role had on pre-existing relationships, identity and beliefs led to some researchers finding the insider-outsider role untenable, with this resulting in role and lifestyle changes. With Humphrey (2007) this led to her relinquishing her official roles in

the union and, further down the line, leaving the union altogether and commencing an academic career. This decision removed the role conflicts experienced and was accompanied by a sense of relief. Moore (2007) also found the disruption of relationships and insider-outsider conflicts irresolvable which led to him questioning and reassessing his position within the organisation. This resulted in him pursuing a career elsewhere which, even though considered a positive decision, was 'a huge wrench and a painful experience' (p.36) that created upheaval and trauma for both himself and his family.

The vulnerability of action researchers

The experiences of researchers explored above resulted in them encountering periods of uncertainty and personal vulnerability, and resulted in roles that were considered to be personally demanding.

Experiencing uncertainty

Feelings of isolation and identity conflicts have resulted in insider action researchers experiencing periods of personal uncertainty (Braithwaite et al 2007, Carlisle & Cropper 2009, Humphrey 2007, Moore 2007). Feelings of uncertainty, however, are not just limited to insider work, with them also being exposed by other action researchers. Dickson and Green (2001) comment on working with the uncertainty of action research in relation to not knowing the course or direction the research may take in the early stages and thus whether the original aims would be met. This resulted in the researcher stating that she often felt she was 'holding my breath, hoping that things would fall into place' (p.253). This uncertainty of direction was a cause of concern for Hostick and McClelland (2000) in their co-operative inquiry with mental health nurses and their clients, where unexpected situations arising in the group led to concerns regarding the potential for harm to those involved. Other researchers talk about working outside comfort zones and within unfamiliar territory. The teacher researchers in the study by Gewirtz et al (2009) report on their feelings of apprehension in working outside their comfort zone of teacher control accompanied by doubts regarding their knowledge and ability to undertake research, a concern expressed by others (Judah & Richardson 2006, Lavie-Ajayi et al 2007, Meyer et al 2003, Nyhof-Young 2000). They describe their anxiety of working with uncertainty and liken it to 'entering uncharted waters', and 'diving into the sea and not knowing what you are going to find' (p.577). Crow et al (2006) also reflect on their experience and anxiety in working outside of their comfort zones when researching within environments and accompanying cultures that are unfamiliar. They refer to their experience as being 'strangers in foreign lands' (p.301) which gave rise to feelings of unease, fear, lack of confidence and a sense of being lost, with this sense of vulnerability also being expressed by Moore (2007).

Experiencing personal vulnerability

As well as vulnerability in relation to uncertainty, researchers also felt vulnerable with regards to the potential impact of their work on their own personal futures. McGee (2008) found that teacher researchers focused on certain research topic areas suggested by those working for the sponsors instead of those they were personally interested in, as these representatives were responsible for individual teacher assessments which subsequently informed salary increases and job security. Langan and Morton (2009) also explore the vulnerable position they were in with regards to future work opportunities. They felt that their reputations and potential future employment was reliant on their performance being acceptable to those commissioning the research, with these commissioners being influential in the area of work the researchers were passionate about together with the future research possibilities within it. This resulted in the researchers having to make difficult decisions with regards to pursuing their values and beliefs or compromising these to meet the needs of commissioners. Carlisle and Cropper (2009) found that lay researchers faced a similar dilemma, with their need to keep alive future employment opportunities impacting on the data they felt able to collect. Some of these lay researchers also experienced additional cultural pressures with them, and by association their families, being judged by their actions and behaviours. In this situation, personal and family status and credibility was vulnerable to acceptable performance in the action research role. The extra vulnerability of such community based researchers, who need to continue to live and work in that community after research completion, is also highlighted by Braithwaite et al (2007) who talk of how research reports were moderated to make them more acceptable to the organisation.

The personal demands of action research

Due to many of the experiences described above, some researchers found the action research role to be personally demanding. Langan and Morton (2009) found that the time they spent on their research far exceeded that which had been negotiated in their contracts, with time issues being a common factor amongst other researchers. The teachers in the study by Gewirtz et al (2009) stated that they underestimated the time commitment required in teacher action research, and expressed the difficulties of finding space for project work and fitting it into existing busy professional and home lives. Balancing work and home lives is a common dilemma for other action researchers. Lewis (2004) describes the difficulty the researcher in their schoolyard environmental project had in disengaging from the endeavour outside of work hours, with them describing the project as being woven into their life. The lay researchers in the study by Carlisle and Cropper (2009), due to being members of the community they were researching in, also found it difficult to separate the research role from everyday life. They felt a responsibility to community members and a need to give something back to them in return

for their participation, with this often resulting in them engaging in community activity outside of their negotiated remit and work hours. Braithwaite et al (2007) also responded similarly to the dilemma of needing to be accepted into the community by participating in activities not directly related to the research itself, with this resulting in them stating that 'you never clock off' and 'feel like a doctor on call' (p.67). It also impinged on their personal lives with them needing to catch up on academic activities in their own time. These demands were found to be stressful for researchers. Kamali (2007) comments that, in their research context, achieving participation required high levels of commitment and even sacrifice on behalf of those facilitating the research, with the researcher in the paper by Lewis (2004) expressing the energy required to maintain their project and the exhaustion that accompanied this.

Positive experiences

In spite of the challenges and personal struggles experienced by researchers, the majority of papers were written from a positive standpoint with Lewis (2004) commenting on the balance between difficulties and rewards that seems to exist, and many papers indicating a variety of positive study outcomes achieved (Carlisle & Cropper 2009, Crow et al 2006, Gewirtz et al 2009, Kamali 2007, Karnieli 2000, Lewis 2004, Meyer et al 2003). Teacher researchers commented on how undertaking action research positively impacted on their work roles and performance as well as boosting their confidence academically (Gewirtz et al 2009). They also refer to the positive effect it had on their relationships with students, with the development of relationships and friendships with participants also being identified as a positive outcome by Kamali (2007) and Ravitch and Wirth (2007). The opportunity to help others develop skills and confidence is also highlighted as one of the rewarding aspects of undertaking action research (Braithwaite et al 2007, Meyer et al 2003). The main positive aspects highlighted in the papers reviewed, however, are in relation to the personal learning gained by researchers. Nevertheless, although considered a positive aspect, the personal impact of learning about oneself can also be difficult and uncomfortable.

Personal learning gained

Researchers talked of how they had gained a greater understanding of the action research process and what it involved, including its strengths and weaknesses and the issues and challenges that arise from it (Gewirtz et al 2009, Kamali 2007). They also highlight the research skills that they developed through this process (McGee 2008, Meyer et al 2003, Nyhof-Young 2000). This increased understanding and development is captured by Kamali (2007):

'One of the evolutionary outcomes of this humane process of inquiry has been the profound change I have experienced in my own perceptions of research and

development. For a long time I used to work 'for' people as a development worker, then I gradually learned to work 'with' people, now I have begun to learn with people.' (p.116)

Some researchers also came to recognise the potential negative impact their previous approaches and behaviours may have had on participants (Kamali 2007), with Gransden (2004) reflecting on how he judged others based on his own personal standards with this resulting in him noting the negative aspects in others as opposed to their potential. In relation to approaches and behaviours, researchers highlighted their raised awareness of the importance of collaboration and a greater understanding of this concept and its execution (Hostick & McClelland 2000, Ravitch & Wirth 2007). This enabled them to be more flexible, relinquish some control, work with chaos, and not take it personally when things did not go according to plan (Gransden 2004, Hostick & McClelland 2000), with Hostick and McClelland (2000) reinforcing this through a focus on what was achieved as opposed to what wasn't. As well as the practical learning gained, researchers also talk of how, through undertaking their work, they have learnt more about themselves in relation to their personal insight, self-awareness and world views (Humphrey 2007, Moore 2007, The European-American Collaborative Challenging Whiteness 2005), with Nyhof-Young (2000) commenting:

'After many pages of writing about the personal implications of my new theoretical understandings I recognised that: 'I have fenced in unexamined thinking, and the barbs of wire haven't stuck yet, because I wasn't anywhere near the fences. I don't think I even noticed the fences, ... now I'm beginning to.' (p.477)

Impact of personal learning on researchers

Although learning about selves was seen as an enlightening experience, for many researchers it was also often difficult, uncomfortable and painful (Gransden 2004, Moore 2007, Ravitch & Wirth 2007, The European-American Collaborative Challenging Whiteness 2005). The European-American Collaborative Challenging Whiteness (2005) liken exposing their personal weaknesses to 'undressing themselves', with them commenting that this is 'not flattering' (p.249). They also express feelings of embarrassment, fear and shame when recognising that they behave in ways that contradict their beliefs, with one researcher describing this experience as being 'devastating' to their self concept (p.256). Gransden (2004) also expresses the shame felt when reflecting on his own behaviour within his study, with him commenting that undertaking direct critical examination of self felt potentially too threatening and painful to bear. Nyhof-Young (2000) also notes that such a self examination can be unsettling resulting in potentially painful outcomes:

'I might uncover a wasps' nest of untested assumptions, biases and stereotypes with which I build my world ... Wasp's nests, if uncovered or trodden on can result in nasty stings.' (p. 477)

In support of this, acknowledging a lack of self-awareness was uncomfortable and disconcerting for Moore (2007) who also comments on how difficult it is to learn about oneself:

'Home truths are perhaps the hardest medicines to take. I found recognising the assumptions that I had hidden within me to be a tumultuous and painful process.'
(p.33)

Riding the rollercoaster of action research

Those undertaking action research reported ups and downs within their projects which resulted in a range of emotions being experienced. From this they also identified a variety of support mechanisms that they felt helped them to ride this bumpy road.

The emotional turmoil

From the above analysis it can be seen that action researchers experienced a range of emotions when undertaking action research in relation to a variety of project processes and challenges, including anxiety, anger, frustration, discomfort, disappointment, helplessness, guilt and fear. As well as this, researchers commented on their overall experience of undertaking action research with it being seen by some as exciting, exhilarating, stimulating, enlightening, fruitful and personally rewarding (Dickson & Green 2001, Gewirtz et al 2009, Kamali 2007, Ravitch & Wirth 2007). However, Kamali (2007) also comments that despite positive project impacts and experiences, undertaking such work is not easy and, together with others (Halonen 2008, Hostick & McClelland 2000, Lewis 2004, Meyer et al 2003, Oyum 2007, Ravitch & Wirth 2007), captures the rollercoaster ride that seems to accompany some action research:

'Most of the time I have been proud of myself, but sometimes I have become annoyed and felt in despair.' (Kamali 2007 p.116)

'Some days I think it's the most amazing thing and it's great and rewarding ... And then some days it's really, really difficult. I mean it's tiring, depressing.' (Lewis 2004 p.109)

'... the nurses (researchers) suggested ... that it was like trying to run the 100-metre hurdles only to find that a new hurdle had been erected every time you thought you were at the end.' (Meyer et al 2003 p.413)

This rollercoaster of emotions led to some researchers questioning their continued presence in their research, with Karnieli (2000) commenting:

'The more we advanced, the more strongly the question what are we doing in this emotional, cultural chaos rang in our ears.' (p.34)

Researchers did, however, see their projects through, even though this was often painful and laboured:

'From our respective home locations we cried, we walked, and we talked our way through it all, one day at a time.' (Langan & Morton 2009 p.181)

Successful support mechanisms

Unsurprisingly, in light of the above experiences and accompanying emotions, many researchers state a need for support for those undertaking action research (Carlisle & Cropper 2009, Faubert 2009, Hostick & McClelland 2000, The European-American Collaborative Challenging Whiteness 2005). Researchers found different avenues of support within their studies which were valuable for them. The presence of a research colleague or inquiry group within a study was found to be beneficial for some, with this providing readily available opportunities for reflection on experiences, caring support and compassionate challenge (Crow et al 2006, Oyum 2007, The European-American Collaborative Challenging Whiteness 2005), with Oyum (2007) also commenting that this reduced their potential of being 'seduced by the field' (p.52). Dickson (in Dickson & Green 2001) gained support from other project personnel and committees external to the individual study together with family and friends, with her stating that 'many minds and many hearts do make the path clearer' (p.253). Humphrey (2007) states that she used her journal as a friend and confidante, with it providing her with the opportunity to disclose thoughts and feelings without judgement being made on them. She also advocates constructing a safety net before setting off on the action research journey which could include networking with other action researchers, consultations with trusted colleagues, and relaxation and meditation to free up body and mind.

RELEVANCE OF THIS ANALYSIS

This secondary analysis of the literature has identified the challenges and dilemmas experienced when undertaking action research. Many of these are consistent with the findings of others (see for example Brown et al 2003, Busza 2004, Coghlan & Casey 2001, Miskovic & Hoop 2006, Reed 2005, Roth et al 2007, Spalding 2009, Varcoe 2006, Williamson & Prosser 2003), some of whom provide suggestions and examples of how these challenges and dilemmas can be managed throughout the research process. What such papers fail to acknowledge, however, and what this secondary analysis has to add, is the personal impact that experiencing and trying to manage these challenges and dilemmas can have upon the researcher. My analysis of the literature has explored this and identified the personal struggles and discomforts that can be experienced by researchers engaged in such work, and the personal emotional journey that accompanies them. I suggest, through the undertaking of this analysis, my own action research experience and the experiences of others I have worked

and consulted with, that such an emotional component is an integral part of this research approach and one that cannot be underestimated. With this in mind I feel that the importance of this analysis lies in the recognition of this emotional component, and indicates a need for an ethic of care for action researchers together with consideration of adequate and appropriate support for them throughout the process. It also indicates the need for more to be written on this aspect of action research practice to enable others involved in such work to recognise that this emotional component exists, and prompt them to consider the support they may require before setting off on their action research journeys.

Need for an ethic of care for action researchers

Protection of participants in research has long been the role of research ethics committees where a focus on preventing harm has pervaded. There has recently, however, been a call for a focus on care within the researcher-participant relationship to accompany this mandate. Costley and Gibbs (2006) highlight the need to care for participants not just in relation to doing them no harm but with regards to ensuring their general well being, and argue for care as an ethic in practitioner research. In support of this, Meyer et al (2006) identify a need to be caring in action research that is undertaken in health and social care environments. They argue the importance of researchers supporting participants within the emotional context of their work, and consider that being caring is as important as the critical aspects of action research. What is missing from these discussions, however, is the impact that undertaking research may have on the researcher, and the need for them also to be cared for within the course of their research. A need to care for researchers is starting to be addressed in the emerging literature on undertaking sensitive research. Dickson-Swift et al (2008), together with others who have been involved in work with sensitive topics (Hubbard et al 2001, Lalor et al 2006, Melrose 2002, Rager 2005), recognise that researchers undertaking sensitive research may be emotionally affected by the process, and consider that such work poses emotional dangers and risks not only to participants but also to the researchers themselves. They go on to critique the lack of consideration given to this by research ethics committees and methodological texts, thus recognising the lack of protection for researchers engaged in these emotional processes.

Although this recognition of the emotional dangers and risks that exist for researchers is articulated in relation to sensitive research, similarities between this type of research and action research can be ascertained. Dickson-Swift et al (2008) adopt part of a definition put forward by Renzetti and Lee (1993) to define sensitive research, which they classify as 'research which potentially poses a substantial threat to those who are or have been involved in it' (p 2). They discuss that research can be considered sensitive in relation to the sensitivity of the research topic being addressed, if it has the potential to exploit the research community, and if it might bring to light 'hidden' aspects of participants' worlds. Many of the papers

included in this analysis of the literature fall into these categories with examples being studies focused on violence against women (Langan & Morton 2009), sexual health (Lavie-Ajayi et al 2007), gender and race issues (Gewirtz et al 2009, Kamali 2007, Nyhof-Young 2000, The European-American Collaborative Challenging Whiteness 2005), self organised groups and governance processes (Humphrey 2007, Moore 2007), regeneration (Braithwaite et al 2007) and researching in traditional cultures (Gone 2006). The action research aims of contributing to social science and social change, together with its participatory approach, can also be considered as enhancing its sensitive nature. A focus on social change can be threatening to participants, and has the potential to affect the participant community in ways that are not always welcomed and which may disrupt their current functioning. The participatory nature of action research and its move to work with people as opposed to on them (Reason 1998) requires researchers to build relationships and rapport with participants, with Dickson-Swift et al (2008) commenting on the emotional component involved in doing so. This is especially complex in action research where researchers are required to work with the tensions created by the often conflicting perspectives of stakeholder participants. Action research, through its approach and topic areas explored, can therefore be considered as incorporating components of sensitive research thus exposing those undertaking it to the same emotional dangers and risks throughout the research process. A call for the need to care for and protect action researchers within this process is therefore required.

Support needed for action researchers

As well as calling for an ethic of care for action researchers, mechanisms through which this can be achieved need to be considered. Together with a need for ethics committees to acknowledge the emotional dangers and risks to researchers, other issues related to the preparation and support of action researchers throughout the research process need to be considered. Those involved in sensitive research critique the lack of preparation such researchers experience with regards to the emotional aspects of undertaking their work (Davison 2004, Dickson-Swift et al 2008), with Dickson-Swift et al (2008) presenting a safety protocol for researchers and Rager (2005) suggesting that such preparation should include information on and planning for researcher's own self-care. I would suggest that this is also the case in relation to action researchers, with the majority of the action research teaching and learning literature failing to acknowledge this need. This is supported by Taylor and Pettit (2007) who recognise neglect of the personal dimension in action research teaching. Many self-care strategies drawn upon by researchers throughout their action research journeys have been identified in the secondary analysis of the literature, with such strategies as peer support and debriefing, journal writing, relaxation techniques and networks of family, friends and colleagues also being utilised by others undertaking qualitative, ethnographic and sensitive research (Arber 2006, Darra 2008, Davison 2004, Dickson-Swift et al 2008, Johnson 2009, Melrose 2002, Rager 2005). Other self-care strategies have also been considered by some of

these authors including counselling and down time (Arber 2006, Johnson 2009, Rager 2005). Knowledge of the potential need for such strategies, and how to use them effectively, needs to be considered by action researchers prior to commencing their action research journeys. This will enable their 'safety net' (Humphrey 2007) to be constructed and time to be made available for such strategies to be regularly attended to throughout the research process.

The role of research supervisors in caring for researchers is also being attended to in the research literature, with Dickson-Swift et al (2008) outlining recommendations for supervisors on how to protect their supervisees from psychological and emotional harm. They talk of the need for supervisors to assess the emotional risks and dangers to researchers of undertaking their research studies and, together with Arber (2006), recommend that they explore self-care strategies with them. This can only happen if supervisors are aware of the emotional component of undertaking research, something that is considered a necessity by Darra (2008). As well as assessing the potential risks and helping researchers to prepare for them, continued emotional support throughout the process is also required. Davison (2004) comments on the reluctance of some researchers to raise the distress they are experiencing with their supervisors fearing that this will be seen as a weakness, or that by doing so their competence may be questioned. In light of this she argues for supervision that recognises the 'complex emotionality of the research process, as well as the challenges involved in managing that process' (p.390) so that supervisors can support the researcher in working with their distress throughout the process rather than denying or suppressing it. This way of working has resonance with psychodynamic theory where researchers themselves have used psychodynamic methods in areas such as clinical supervision for general hospital nurses (Ashburner et al 2004), reflective workgroups with staff exploring complex loss and grief in an NHS continuing care unit for older people (Holman et al 2006), and the creation of communicative space in an inter-organisational project (Newton & Goodman 2009). In these studies the psychodynamic approach was found to contain the emotions of participants and enable them to understand these emotions within the context of their work. It can be suggested that if supervisors worked in similar ways the emotions of their researchers could also be contained and worked through within the context of their studies.

As well as enabling emotions to be contained and worked through, working in this way can also enable further learning of the area under study to be achieved. Links between emotion and knowledge are being increasingly recognised in the research literature (Holland 2007). Within this literature the role that researcher emotions can play in making sense of the area under study is being explored, with it being recognised that these emotions can give further meaning to interpretations of data and provide greater insight and understanding of the research area under investigation (Dickinson-Swift et al 2008, Heen 2005, Hubbard et al 2001, Johnson 2009, McLaughlin 2003). Hubbard et al (2001) comment on how emotions are just as important as cognitive skills in making sense of participants' experiences, but also contend that recognising this is one of the greatest challenges facing researchers. Accompanying this

challenge, and not appearing to be as prevalent in the general research literature, is how researchers can actually go about making sense of the emotions they experience within the context of their studies, with papers advocating the importance of using emotions in this way not always providing guidance on how to do so. A psychodynamic approach to research supervision may provide the vehicle through which researchers can make sense of these emotions and use them to inform their understanding of the research area being investigated. Although the rationale for this type of supervision can be justified, I feel it also needs to be recognised that this may be a new way of working for research supervisors who may also require knowledge, skills and emotional support for working in this way. In light of this it also needs to be considered if the supervisor is always the best person to take on this role, and that it may be more appropriate for them to assist the researcher in finding an avenue for this type of support elsewhere.

Acknowledging a gap in the action research literature in relation to the emotional impact of undertaking action research

The existence of an emotional element for those undertaking research is recognised and being increasingly addressed in the literature on ethnography (Arber 2006, Coffey 1999, Pellatt 2003), feminist research (Blakely 2007), general qualitative research (Hubbard et al 2001, Rager 2005), and more recently in the literature on research into sensitive topics (Dickson-Swift et al 2008, Johnson 2009). However, although this secondary analysis of the literature has identified an emotional component to undertaking action research, acknowledgement of the importance of emotions within this paradigm is still to gain momentum in the general action research literature with a few notable exceptions (see Dadds 2003, Heen 2005, McLaughlin 2003). In light of the similarities between action research and sensitive research, and the fact that action researchers regularly use the above methodologies in their work, the importance of recognising, exploring and paying more attention in the literature to the potential emotional impact of undertaking action research can be identified in relation to the personal risks this may pose to researchers and the need for them to be adequately prepared for, cared for and supported in this aspect of their work so that their emotions can be worked with and learnt from.

Although the need to pay greater attention in the literature to this aspect of action research practice can be justified, reasons for why this attention may be lacking also need to be considered. Heen (2005), although arguing the importance of taking feelings into account in action research, also articulates her discomfort in writing about this. Firstly, she comments on her struggles in acknowledging the significance of her learning for a wider audience, and states that although she thinks her learning with regards to the use of feelings in action research may be important for others to know about, at other times she questions this and thinks that 'my 'discovery' is very banal, and that I am making a big fuss out of nothing and

making a fool of myself' (p. 265). Secondly, she questions the suitability of publishing personal reflections on feelings and wonders 'if I am violating the rules about what should be told in public', continuing to add that 'I may risk shame and rejection' (p. 272). This type of concern is also addressed in the reflexivity literature where it is discussed that researchers undertaking such work may face external criticisms of being self-indulgent (Finlay 2002) and that this, together with a wish to maintain personal privacy (Etherington 2004), can lead to researchers 'sanitising' their research accounts. Dadds (2003) has more to add as to why the personal and emotional experience of undertaking action research is not written about, and refers to the pain that may be experienced by researchers in revisiting the emotional context in which their studies took place.

As well as these personal aspects that may preclude researchers from writing about the emotional components of their work, Dickson-Swift et al (2008) also discuss how researchers often have to weigh up the consequences of portraying emotions in their published work against the objectivity that they feel is valued by others. They discuss that omission of such emotional aspects is often a consequence of the limitations imposed by publishers, research committees, funders and journal editors. This is supported by the secondary analysis where the majority of papers were found in journals dedicated to action research for which submission guidelines are less prescriptive, and word limits less restrictive, than other professional journals.

Filling this gap in the action research literature

Reasons why researchers may not include an emotional component in their published work can therefore be found in the literature. The value of this aspect of practice finding its way into the current body of knowledge on action research cannot, however, be ignored. It is important for those who are new to action research to be able to learn from others about what it is like to undertake this approach so that they can formulate realistic expectations of what it might be like for them. They need to recognise that an emotional component is likely to accompany their action research journey and ensure that they consider the support and supervision they may need to enable these emotions to be contained, worked with and learnt from.

Sommer (2009) states that action research needs to be written up in different ways to reach a variety of audiences. As well as substantive and applied articles to reach colleagues, practitioners and the public, he also suggests the need for reflective papers which contribute to the improvement of action research practice. I would suggest that papers which address the emotional component of action research studies attend to this latter stance and can contribute to the practice of action research. However, if action researchers are to do this not only do they need to recognise the importance of writing about this aspect of their work, but they also need to feel that it is a valuable exercise and one for which they and their research will not be judged as self-indulgent and lacking rigour. They will also need support to revisit their

emotional journeys and make sense of them in a way that will benefit themselves and others. I also suggest that researchers who have not previously engaged in writing up the personal and emotional aspect of their studies may need guidance on how to present such work.

The papers reviewed in the secondary analysis of the literature were not easy to find, and it was not always possible to identify the main purpose of the papers from the titles and abstracts presented. Lack of in-depth contextual detail and information on researcher backgrounds in some papers prevents others from identifying whether the findings are relevant for them, with lack of attention to the data collection and analysis methods precluding judgement on the quality of the work presented. The papers reviewed were also inconsistent with regards to the format in which they were written which prevented a systematic comparison from being undertaken. It could therefore be advocated that the development of a framework for reporting the experience of those undertaking action research would be helpful to enable such work to be easily accessible, enable readers to judge the relevance of individual papers for themselves, and allow comparisons of experiences to be undertaken. It could also be suggested that the themes identified in this secondary analysis of the literature could, together with attention to the issues discussed above, provide such a framework against which researchers could examine their own experiences. However, I would also express some caution in relation to these suggestions as, personally, I found the narrative papers more engaging to read, with these leaving a greater impression on me than the more structured works. With this in mind I wonder if promoting such a framework would reduce such writings to structured, decontextualised thematic analyses that actually end up devoid of the emotions that the researcher is trying to present. As this type of work hopefully gains greater momentum in the action research literature this paradox may need to be further explored.

CONCLUSION

This secondary analysis of the literature has identified the personal and emotional impact that undertaking action research can have on the researcher. In light of this it has also explored a need for an ethic of care for action researchers that includes adequate preparation and support throughout the research process. This has been discussed in relation to recognising the emotional component of action research, identifying and making time for self-care strategies, and adequate research supervision that is able to effectively contain the emotions of researchers whilst working with and learning from them. It has also been argued that more attention needs to be paid in the literature to the emotional aspects of action research so that those planning to undertake it can engage with its presence, importance and potential consequences, and ensure that their 'safety net' (Humphrey 2007) is in place. For this to happen emotions need to be recognised as a legitimate part of action research practice, and researchers need support to re-engage with their feelings and present them in a way that will

be useful for others. It is also important to ensure that written papers are easily accessible to those who need to engage with this emotional side of their work. Finding the papers for this analysis was a lengthy and time consuming process, with the majority of those retrieved being from speciality action research journals. Action research is increasingly being used by practitioners (for example in health and social care settings) whose main sources of reference are the professional journals to which they are aligned and which tend to produce more descriptive action research reports. More needs to be published in such journals regarding the emotional components of action research to reach the increasing number of practitioners who are undertaking such studies. Consideration has also been given to the utility of a reporting framework with regards to this aspect of action research practice which is something that may need further exploration as this body of knowledge develops. Although limitations of this secondary analysis of the literature can be seen in relation to the search strategy used, commonalities of researcher experience have been identified and important messages from these ascertained. Whether the themes identified in this analysis resonate with others warrants further exploration.

DISSEMINATION ARTEFACT AND PLAN

DISSEMINATION ARTEFACT

This dissemination artifact is the first of two papers which have been written for and submitted to the Journal of Clinical Nursing. For the second paper please see appendix 9.

TITLE

Advancing knowledge on practice change: linking learned helplessness and psychodynamic perspectives.

ABSTRACT

Aims and objectives

To identify what was hindering staff from engaging in practice development initiatives designed to improve the rehabilitation care for their older patients.

Background

Participation is a key feature of action research and practice development. It is also one of the biggest challenges for those undertaking such work. This part of a three year study explores why staff on a rehabilitation ward for older people were unable to engage with practice change initiatives.

Design

An action research approach was used.

Methods

Data were obtained from twelve staff profile questionnaires, participant and non-participant observation, in-depth interviews and focus groups with thirteen members of staff, and three years of researcher field notes. Data were analysed using descriptive statistics and thematic analysis.

Results

The environment within which staff were attempting to provide rehabilitation care was inadequate. Some staff did not feel valued, supported or appreciated within the organisation, but also did not always take responsibility for changing the situation they were in. A lack of knowledge and understanding of the concept of rehabilitation was expressed, together with low morale and lack of motivation amongst staff.

Conclusions

Analysis of data suggests that staff were in a state of learned helplessness whilst also using socially structured defence techniques to protect them from the anxiety inherent in their work. This was preventing them from engaging in practice change initiatives.

Relevance to clinical practice

This paper presents psycho-social perspectives on what prevented staff from engaging with practice development initiatives. Although carried out in the UK, its findings have wider relevance through the application of theoretical perspectives to this topic area that have not previously been considered in the practice change literature, and which are likely to be of interest to those involved in practice change internationally.

Key words:

Learned helplessness; psychodynamic theory; change

INTRODUCTION

The population is ageing, with the number of people aged over 85 years being set to double in number by 2020 (Department of Health 2006a). Older people are the main users of health services, however the standards and provision of care for older people has been the focus of a number of reports over many years which detail ongoing unacceptable variations in standards of care provided to this client group (Davies et al 1999, Health Advisory Service (2000) 1998, Healthcare Commission 2007, Robinson & Banks 2005, Standing Nursing Midwifery Advisory Committee (SNMAC) 2001). Changes in care practices are required to address these variations. The launch of the National Service Framework for Older People (Department of Health 2001b) started this process, with a review recommending further developments (Department of Health 2006a). This has been followed by a number of further campaigns and practice guidance (Bridges et al 2009, Department of Health 2006b, Nursing and Midwifery Council 2009, Royal College of Nursing 2009), however recent reports identify that variations

in care standards for this client group are still evident (Patterson et al 2011, Tadd et al 2011). This paper reports on selected findings from a three year action research study designed to improve the rehabilitation care for older people in an NHS trust. It focuses on one ward where attempts to improve care were unsuccessful and explores the reasons for this. Data for this study were originally analysed in 2003 for the study report, however they have recently been revisited and re-analysed as part of my PhD studies from which new psycho-social insights and interpretations have been gained in relation to practice change. What prevented staff in this study from engaging in practice change is discussed in relation to learned helplessness and psychodynamic theory. How staff were enabled to move into a position in which they were able to engage with change once these insights had been gained is explored in a subsequent paper.

BACKGROUND

This action research study set out to improve the care provided on a rehabilitation ward for older people in an acute NHS trust. Quality of care audits (Dean et al 1993, Fearon & Goldstone 1995), formal and informal meetings with staff, and participant and non-participant observation highlighted gaps in the standard of rehabilitation care on this ward, with staff stating that it was below what they wished to provide. Although dissatisfied with the standard of care they were providing, attempts to improve this through the collaborative design and implementation of development activities was unsuccessful. A lack of commitment to and participation by staff in these activities was identified as the key factor that prevented change from taking place. One of the key features of action research and practice development is the participation of stakeholders in the development process (McCormack et al 2006, Meyer 2000). However achieving such participation is also highlighted as being one of the main challenges of this type of work (Arieli et al 2009, Dewing & Traynor 2005, Reed 2005, Williamson & Prosser 2002). Lack of participation in change activities has been related to many factors including contextual and resource constraints, differing agendas and power imbalances between researchers and participants, lack of time and enthusiasm, and the threatening and challenging nature of change itself (Arieli et al 2009, Brown et al 2003, McCormack et al 2002, Meyer et al 2000, Ryecroft-Malone et al 2004, Williamson & Prosser 2002). Although lack of participation by staff in this study could have been analysed in relation to these aspects, it was felt that there was a need to find out from them what was stopping their engagement in practice change in this particular context so that issues could be addressed to enable improvements in practice to be achieved.

AIMS AND OBJECTIVES

This paper reports on one part of the overall research study, the aim of which was to identify what was hindering staff on one ward from engaging in practice development activities designed to improve the rehabilitation care for their older patients. The objectives of this part of the study were to:

- identify what it was like for staff to work in this setting by giving them the opportunity to 'tell it how it is'
- identify the issues and challenges surrounding nursing older people in this rehabilitation setting
- identify what staff felt stopped them from being able to improve the rehabilitation care of older people in this setting

METHODS

An action research approach was used within the study to effect practice development through a collaborative approach to change. Action research has been described as 'a period of inquiry, which describes, interprets and explains social situations while executing a change intervention aimed at improvement and involvement' (Waterman et al 2001 p.11). My role as an action researcher was to work with staff to facilitate and evaluate improvements in practice and monitor and reflect on the change process itself. The participants involved in this specific part of the research study were the nursing and care staff based on the study ward (who will be referred to as staff for the remainder of this paper), and the senior nurse and general manager for older people services (who will jointly be referred to as service managers).

A multi-method approach to data collection was used throughout the study which included formal meetings, discussions, in-depth interviews and focus groups with nursing staff and managers, structured staff profile questionnaires, quality of care audits, documentary analysis, structured patient and carer interviews, participant and non-participant observation, and the recording of field notes. Specific information from this overall data set fed into this particular part of the study. Contextual data were obtained from twelve structured staff profile questionnaires together with participant and non-participant observation and researcher field notes. Any contact with the study ward was used as an observation opportunity together with sixteen hours of purposeful participant observation and eight structured fifteen minute non-participant observation sessions over a 48 hour period. Detailed field notes related to this part of the study were extracted from those kept over a three year period. These contained contextual information, a daily record of events, details of meetings and discussions with participants, observations made, and my own thoughts and feelings throughout the study process. Staff views of 'how it is' were obtained from eleven members of staff through five in-depth interviews (Ritchie & Lewis 2003) and two focus groups (involving a total of six staff).

In-depth interviews were also held with two service managers. All interviews were audio taped, transcribed verbatim and checked for accuracy.

Descriptive statistics were used to analyse the staff profile questionnaires. Thematic analysis using an approach incorporating aspects of those suggested by Burnard (1991), Miles and Huberman (1994) and Morse and Field (1996) was used to identify the main themes arising from the other data collected. This included repeated reading of field notes and interview transcripts and repeated listening to audiotapes to allow familiarity with the data to be obtained, the application of codes, grouping of similar codes under broader categories, and the linking of categories through the identification of common emerging themes.

Ethical approval for the study was gained from the local Health Authority Research Ethics Committee.

FINDINGS

Staff expressed what it was like for them working on the ward as 'difficult', 'stressful', 'hard', 'frustrating', 'sad', 'tiring' and 'manic'. They stated that they did not feel satisfied with the care they were able to provide which led to low morale and lack of motivation:

'At the end of the day you think 'what did I do?' It's just work, work, work.' (Staff 2)

From the data collected three main themes were identified that highlighted the issues and challenges of most concern to ward staff and service managers which resulted in these feelings, and which they considered impacted on their ability to improve practice. These themes were 'an inadequate care environment', 'lack of a rehabilitation philosophy' and 'lack of support'.

An inadequate care environment

The ward in which the study took place was based in an old building, a few miles from the main hospital site, whose services and facilities had been decreasing in preparation for future closure. The staff working on the ward were separated from the main hospital site and activity. The decrease in facilities included a reduction in social spaces for staff, relatives and patients together with a reduced restaurant service. Other services and departments moving out of this hospital site resulted in a lack of visible activity, with it, at times, feeling deserted:

'My first impressions of the hospital - it felt as if it had been 'abandoned'. There was little activity outside of the individual wards and departments, and you could on some days walk the entire length of the hospital corridor without passing anybody.' (Field note)

As the project started the study ward was moved to another location within the same hospital with little notice to ward staff. With this move bed numbers were increased and the client

group changed, with seven of the beds being designated for general medical rehabilitation. Immediately after the move, however, a variety of other medical and surgical patients and patients with mental health conditions were transferred to the ward. Staff expressed that they did not have the knowledge and skills to look after this mix of clients. Staff numbers did not adequately reflect the increase in bed numbers and temporary staff were regularly used due to an average staff vacancy rate of 17% throughout the study. Ward staff considered that these staffing issues affected the continuity and quality of care they were able to offer with the workload often exceeding the amount of people available to provide it:

'No matter how much you want to give the care it is actually physically impossible.'
(Staff 5)

'You can't always put into practice what you know you should do.' (Staff 9)

The study ward was not specifically designed for rehabilitation with its size, layout and facilities presenting a challenging environment in which to provide care. It was cramped in space and afforded little privacy for patients. There were long distances for patients to walk to bathrooms and toilets which were small and not easily accessible to those with mobility and dexterity difficulties. There were no social activity areas or general living spaces on the ward as it did not have a day room. Due to the age of the hospital building the ward was also in a poor state of repair, with the staff stating that the décor was dreary and unstimulating. Staff felt that the ward environment adversely impacted on the standard of rehabilitation care they were able to provide:

'It's a depressing, dingy environment which doesn't help patients, doesn't help relatives and doesn't help us.' (Staff 7)

Lack of a rehabilitation philosophy

A rehabilitation philosophy did not permeate the ward. An enabling culture was not evident, with routines and speed prevailing over a facilitative, inclusive approach. This was accompanied by a focus on meeting the physical needs of patients at the expense of more social and psychological aspects, with little interaction being observed between staff and patients when care was being provided and levels of communication being just enough to enable care tasks to be performed:

*'On visiting the ward at 08.00 I was struck by the fact that most of the patients were already up, washed and dressed ... I wondered how much of a rehabilitation focus there was, or how much was just staff doing **for** patients for speed.'* (Field note)

Staff stated that they lacked knowledge and understanding of the concept of rehabilitation. This could be associated with the fact that, following previous organisational changes, the ward was re-named as 'rehabilitation' rather than being developed into a rehabilitation speciality over time, with no training needs analysis or staff development being provided in

relation to rehabilitation care. Lack of rehabilitation expertise can also be identified through the staff profile analysis which found that only two fifths of the ward staff had any previous experience in rehabilitation nursing and only two members of staff had ever received any training in rehabilitation care. Also, only one third of the staff on the ward were there through personal choice with the others being relocated to the ward as a result of organisational changes. It was felt by some that the ward was not really a rehabilitation ward other than by name and that this, together with the other issues raised above, affected staff motivation to work and develop in this area:

'The wards were sort of labelled with this very quickly due to other changes in the trust ... the wards became rehabilitation wards, became without any process of becoming them.' (Service manager 1)

'...it was all a big shift from acute care to rehabilitation, and I just get the impression that some people don't actually want to be doing that.' (Staff 5)

'... because to try and improve rehabilitation on a non-rehabilitation ward is very hard.' (Staff 5)

Lack of support

Staff commented that they did not feel supported in their work. They discussed this in relation to the reduced organisational support available to them as well as a lack of team support within the ward.

Reduced availability of organisational support

The service managers were based at the main general hospital site and so were not easily accessible to staff on the study ward. Although some ward staff expressed that they found managers understanding and approachable, their geographical distance left others feeling isolated with them expressing that they did not feel valued, cared for, supported, listened to or appreciated within the organisation. This was exacerbated by a lack of consultation about, and preparation for, a variety of organisational changes which had the potential to impact significantly on the ward, with staff stating that they were just 'told what to do'. This, together with the inadequate environment in which they were working, left some staff feeling that managers had little interest in them and the issues they faced on a daily basis. These feelings were further supported by the lack of perceived action being taken by managers when issues and concerns were highlighted through the trust risk management procedures which resulted in staff ceasing to use them, and also resulted in some being cynical about the action research study and its ability to change things:

'I asked if the staff fill in an incident form every time an inappropriate transfer occurs. (Staff) said they used to do that but they just get returned with 'no action required' written on them.' (Field note)

'(Staff) said they have had research projects on the ward before. The results were presented to managers but nothing was done with them and nothing changed. During one study the ward shut halfway through and the research was terminated.' (Field note)

It was also expressed, however, by both ward staff and service managers, that staff did not always take responsibility for changing the situation they were in. They did not always make themselves visible to managers, report their concerns, communicate what they wanted or ask to meet with them:

'We are not doing enough at ward level to stand up for things and get ourselves sorted ... we don't say, we don't let the manager know. If the manager gets the full story probably the help could have come earlier.' (Staff 1)

'I encouraged them to fill in an 'unsafe staffing levels' form. They said they didn't have any. I encouraged them to find one. The fact that I had to persuade them to do this again questions how much responsibility they are willing to take.' (Field note)

It was also identified that even when managers did respond to requests for help, staff often failed to capitalise on this and use it to its full advantage:

'Following a request by the ward, the managers arranged for the professional development nurses and some agency staff to cover so that all staff could attend the teambuilding sessions. This was really positive... The resource made available for the teambuilding sessions was made available even after the teambuilding work finished, but they never used it.' (Field note)

Lack of team support

As well as the reduced availability of organisational support, a lack of support within the ward team itself was also identified with the staff commenting that they were pulling in different directions and did not communicate well. Although they were supposed to be working in a team nursing system this was not effective, with staff stating that within this clear lines of accountability were lacking and that nobody appeared to be responsible for patient care. Workload and patient care needs were not planned at the beginning of shifts and there was a lack of clearly defined roles for staff. This resulted in staff not knowing what was happening on the ward as a whole and a task-centred approach to care:

'You are just running around in a complete circle all the time.' (Staff 2)

DISCUSSION

Staff on the study ward were unable to engage with practice development initiatives to improve the rehabilitation care provided for their older patients. Reflection on study data identified both cognitive and affective aspects that prevented them from doing so. Study findings were re-analysed in relation to learned helplessness and psychodynamic theory with it being suggested that these concepts co-existed within the study and that they provide explanations for why staff were unable to engage in practice change.

A suggested state of learned helplessness

With the above experiences in mind it is suggested that staff were in a state of learned helplessness (Seligman 1975) which was preventing them from engaging in development activities. Learned helplessness occurs when a person learns to believe that outcomes are not affected by their behaviour and are thus beyond their control. When events outside of a person's control are experienced an expectation of future uncontrollability can develop which can lead to deficits in motivation, cognition, and emotions. An expectation of future uncontrollability can result in a reduced incentive to keep trying and a response of giving up (motivational effect). This also interferes with learning that a future action has influenced an outcome when it does become controllable, with individuals not perceiving that their behaviour had any effect (cognitive effect). These experiences can result in low mood and feelings of hopelessness (emotional effect) (Maier & Seligman 1976, Seligman 1972, Seligman 1975). This can be associated with the staff on the study ward who may have believed that they did not have the capacity to change due to a lack of control of contextual issues and lack of a voice within the organisation, with them feeling powerless to effect care provision. This was demonstrated most strikingly by them not being consulted about major organisational changes, such as the ward relocation, which imposed upon them adverse changes to the care environment and patient group. The motivational effects of learned helplessness would explain why the staff did not always try to help themselves by reporting concerns to managers or by following procedures put in place to assist this as they may have felt that, even by doing so, it would not have any effect on their situation. The cognitive effects could explain why staff did not utilise the personnel resources offered to them. Requests for such personnel to manage the ward so that all ward staff could attend team building workshops and other activities were met by the service manager and professional development nurses indicating that the staff request had resulted in a positive outcome, however this did not help to motivate staff to make use of this resource or stop them from feeling that managers did not listen to or support them. Finally, the emotional effects of learned helplessness were demonstrated through the stated low morale felt by ward staff.

Impact of learned helplessness on staff ability to engage with change

Following the original work on learned helplessness, the model was reformulated to bring in a focus on individual attributes and their contribution to the theory. Abramson et al (1978) suggest that people's perceptions of the causes of their lack of control over events determines the generality and chronicity of their helplessness deficits, as well as their self-esteem. People can attribute their helplessness to an inadequacy within themselves (internal) or to things outside of their personal selves (external). They can also attribute their helplessness to factors they consider as being long lived and recurrent (stable) or short lived and non-recurrent (unstable). Finally, a prediction that helplessness will recur over a broad range of situations is attributable to global factors (global) whereas helplessness deficits occurring over a narrow range of situations is attributable to specific factors (specific). It is suggested that those who attribute their helplessness to internal, stable and global factors are more prone to general and chronic helplessness and, with the internal attribution, to suffer from deficits in self-esteem. It can be seen that the staff on the study ward attributed much of their lack of control to external factors such as lack of staff, organisational consultation, and support. However staff may also have attributed their helplessness to internal factors such as not themselves having the skills or abilities to care for their patients. Also, deficits in self-esteem associated with the internal attribution was demonstrated through the staff reporting that they did not feel valued or appreciated within the organisation. Attribution to stable factors was exhibited with staff commenting that although things had been tried before, nothing changes, together with recurrent organisational changes such as 'becoming' rehabilitation wards and the ward relocation resulting in them feeling that things were always going to be out of their control. A global attribution could also be implied through staff feeling out of control in relation to a number of factors such as the care environment, their own ability and skills, the client group they were caring for, and having a voice within the organisation. All of this suggests that the staff may have been in a long term state of helplessness which had the potential to transfer itself to other situations both within, and possibly even outside, the work situation. This could therefore explain why they were unable to engage in the practice development initiatives.

Psychodynamic theory

As well as it being suggested that the staff were in a state of learned helplessness, further reflection on study data also suggested that psychodynamic mechanisms co-existed with this state and further contributed to the explanation of why staff were unable to engage with practice change. It is recognised that those in the helping professions have the potential to experience a great deal of anxiety arising from the nature of the work they undertake (Halton 1994, Obholzer & Roberts 1994). This can include being in constant contact with people who are physically ill or injured (Menzies Lyth 1988) and, in relation to working with older people, working with deterioration and death when you want to repair (Davenhill et al 2007, Holman et

al 2006) together with anxieties related to your own physical and mental decay, loss of independence and death (Roberts 1994). These anxieties can give rise to feelings of pity, compassion, sadness, depression, despair, inadequacy and helplessness, together with conflicting feelings of hatred, hostility and resentment of the patients who arouse these feelings (Mawson 1994, Menzies Lyth 1988, Skogstad 2000). The classic paper by Main (1957) further supports this by suggesting that individuals enter the helping professions to satisfy a need for reparation and that if this is not met then similar feelings, together with failure, can result. As well as the anxieties created in relation to the work task, it has also been recognised that these can be exacerbated by the psychological demands that patients and carers make on staff (Menzies Lyth 1988). Patients and relatives can also experience difficult feelings including fear, depression, despair, helplessness, envy and anger in relation to their illness and current state of need (Menzies Lyth 1988, Skogstad 2000). In order to free themselves of such difficult and painful feelings, attempts are made to relocate them into staff through processes of denial, splitting and projection which results in the staff experiencing them on behalf of the patients (Halton 1994, Menzies Lyth 1998). Menzies Lyth (1998) suggests that the amount of anxiety experienced by nurses through the mechanisms described above can become intolerable, and that they find ways to protect themselves from it through the use of socially structured defence techniques. These are systems of working practices that develop, often unconsciously, between members of organisations and include severing and depersonalising the nurse-patient relationship and the use of ritualistic task orientated work practices. These restrict the amount of emotional contact nurses have with any one individual thus protecting them from experiencing their own feelings about individual patients as well as reducing their exposure to patient projections.

A psychodynamic explanation for the inability of staff to engage with change

In applying this theoretical perspective to the staff on the study ward, the potential for them to experience anxiety in their work can be identified and seen to be present through many of the above feelings being expressed by them in the study. Staff also had the potential to experience further anxiety specifically related to the rehabilitation context in which they were working. Rehabilitation is associated with progress and improvement, however due to the context within which they were working the staff were unable to achieve these goals. This may have exacerbated feelings of frustration, failure and inadequacy in staff, together with worsening the state of helplessness that it is suggested they were experiencing. These feelings again had the potential to be exacerbated by the projections of patients who were placed on the ward for rehabilitation but were not facilitated in this process due to a lack of rehabilitation care practices. In order to protect themselves against these anxieties it can be seen that staff employed socially structured defence techniques including the implementation of a routinised as opposed to an individualised approach, lack of interaction with patients, and a focus on the physical as opposed to psychological aspects of care.

The use of socially structured defence techniques by staff further contributes to an understanding of why staff did not engage with practice change. It is recognised that engaging with change requires some dismantling and restructuring of these defences which then has the potential to enable the resurgence of anxieties that have been avoided through the use of such mechanisms (Mosse 1994). This is especially pertinent in this study as the defence techniques being used actually mitigated against the work practices that would be necessary for the provision of good rehabilitation care, and would therefore have to be dismantled if improvements in care were to be achieved. By changing these practices staff would need to engage with the anxieties that they had potentially been avoiding which could be difficult and painful.

CONCLUSION

The staff on the study ward were unable to engage in change activities to improve the rehabilitation care for their older patients. By gaining a rich and in-depth picture of their experience of working on the ward it is possible to claim that this was firstly due to the staff being in a state of learned helplessness, and secondly that the anxiety related to the nature of their work required the use of socially structured defence techniques to protect them against it. These techniques mitigated against the practice required for effective rehabilitation care and were difficult to dismantle due to the potential resurgence of the anxieties staff were attempting to avoid. Learned helplessness and psychodynamic theories are not new, however they have not previously been considered together and do not feature in the current health care literature on practice change. It is now suggested here that, due to the current climate of health care delivery and nature of the work undertaken, the situations experienced by the staff in this study were not unique, and that learned helplessness states and the use of socially structured defence techniques are likely to be present in other health care contexts. Recognition of these processes is essential if progress towards practice change is to be achieved. Only through recognising their presence can ways of working with staff to move them out of these states into ones where they are able to engage with practice change be identified. How staff were enabled to do so in this study is explored in a subsequent paper.

RELEVANCE TO CLINICAL PRACTICE

The current health care climate in the UK is one of continuous change which is reflected on an international level as health care staff are required to review their practice in line with advancing technologies and research, an ageing population, increasing expectations, finite resources and a proliferation of policy initiatives in relation to these. What this study contributes at this time is a psycho-social perspective on what may hinder the engagement of staff with practice change. Whilst this study was carried out in the UK, it has wider relevance by applying new theoretical understandings that have the potential to further inform the

practice change literature, and which are likely to be of interest to those involved in practice change internationally. It also has relevance not only for those working in rehabilitation settings for older people, but for those working within any health care context which needs to engage with change processes.

DISSEMINATION PLAN

INTRODUCTION

This dissemination plan outlines how the findings from this thesis have been, and will continue to be, communicated to the wider practitioner and research community to further inform the development of their work. It recognises multiple stakeholders within practice, education and research to reach a wide audience with different interests, agendas and roles. The plan commences by outlining the papers that have already been submitted for publication and the presentations that have already taken place throughout the process of my doctoral studies in relation to the research report element of this thesis and further insights gained from the case study element. It is then followed by the publications and presentations that I intend to undertake following completion of this thesis in relation to the findings and further analysis of the case study, critical review of the literature and my key argument in relation to the emotional context of action research. For ease of reference, summary tables of completed and planned papers, conference presentations and local presentations are included (see tables 5, 6 and 7).

DISSEMINATION

Papers submitted for publication

Two papers focused on findings from the original research study have recently been submitted for publication, both of which add to the current body of knowledge on practice development and change by considering theoretical perspectives which have not previously been considered in such literature. The first paper (see table 5 no. 1) presents psychosocial perspectives on what prevented staff on one of the study wards from engaging with practice development initiatives, and is included as the previous dissemination artefact element of this thesis. The second paper (see table 5 no. 2) focuses on the facilitation approach incorporating the senses framework which enabled these staff to engage with practice change towards the end of the study, and is included as an appendix for further reference (see appendix 9). The intended audience for these papers are practitioners who are involved in facilitating practice development or similar change processes, as well as those participating in such work. In order to reach such an audience both papers have been submitted to the Journal of Clinical Nursing. The amount of time passed between completion of the study and submission of the papers can be questioned, and requires explanation. When the papers were first written, the NHS trust in which the study took place declined approval to publish. Reasons presented included that they felt the papers portrayed the trust in a negative light, and that they were not well balanced. As my doctoral studies progressed and I undertook further reflection on and analysis of the study context I acknowledged that these comments had some justification. In

light of the learning I gained through this reflection and analysis the papers were further developed to incorporate new perspectives, following which permission was gained from the trust to submit them for publication.

Presentations undertaken

A variety of local, national and international presentations were undertaken to disseminate the findings from the research study. Yearly presentations were made within the NHS trust outlining the progress and findings of the study at different points (see table 7 no.s 1-5). Presentations were made to the director of nursing and their senior management team, the trust research forum, and the chief nurse of the Royal College of Nursing and nursing staff from all levels in the trust during a Royal College of Nursing visit. After completion of the study the final report was presented to the trust management executive group. The content of all presentations were discussed and agreed with the staff on the study wards, some of whom participated in them. These presentations aimed to reach a variety of audiences in the trust including management teams, professional development nurses, practitioners and researchers so that they could be utilised to progress the development of practice within the trust.

Yearly presentations outlining the findings of the research study at different points were also made at national and international conferences (see table 6 no.s 1-3). These included the Royal College of Nursing older people conference, the British Society of Gerontology annual conference, and the Royal College of Nursing international nursing research conference. Again, these conference presentations aimed to reach a variety of audiences including practitioners, those involved in care for older people services and the research community. All presentations were discussed and agreed by the staff on the study wards, however they declined to participate in the conference presentations themselves.

Following completion of the research study, the recognition that something was missing from the report, and further analysis of my field notes, my experience of undertaking the study was presented at a practitioner research study day and an action research study group seminar (see table 7 no.s 6 and 7). Feedback from participants at these seminars contributed to my recognition that this was an important aspect of action research practice that warranted further exploration and from which significant learning could be gained.

Ongoing dissemination plan

This thesis has argued that the emotional context of action research needs to be recognised and legitimised as an important aspect of the action research process, and that more attention

needs to be paid to this aspect so that those involved can engage with its presence, importance and potential consequences and ensure that appropriate support mechanisms are in place. It has also been argued that this message needs to be easily accessible to those who need to engage with this emotional side of their work thus requiring presentation within both action research and professional media. This ongoing dissemination plan identifies how I intend to communicate this message to the local, national and international research, education and practitioner communities to inform practice in these areas. Presentations at a variety of levels are proposed, together with papers written for high impact journals and more professional journals, to enable engagement with a wide audience across a range of disciplines to be achieved.

Communicating findings with the research community

Three publications and a variety of presentations are planned to communicate the findings of my thesis to the research community. The first paper will be written for the Nursing Research journal (see table 5 no. 4) and will encompass an analysis of my personal experience of undertaking action research, how this relates to the experiences of others, and the importance of writing the researcher into the research account in this way. The key message from this paper will be that there is an emotional component associated with action research that needs to be recognised, acknowledged, understood, legitimised and worked with throughout the action research process. It is proposed that this paper will also be submitted for presentation at the Royal College of Nursing annual international nursing research conference (see table 6 no. 5). The second paper will focus on my overall development journey as an action researcher throughout my doctoral studies, what I have learnt from this process, and how this learning can be of benefit to others (see table 5 no. 5). It is proposed that this will be written for the Educational Action Research journal with its key message being that there is an emotional component associated with action research, and that those undertaking such work need to ensure that they secure support to help them contain, work with and learn from this. The third paper will be written for the Action Research journal (see table 5 no. 9) and will focus on the potential contribution of psychodynamic theory to the practice of action research. Its key message will be that a psychodynamic approach has the potential to help action researchers recognise and engage with the emotional component that may be inherent in their work to help further inform the field of study. Local presentations in relation to these areas are also planned for the City University MSc. research methods module and the City University led action research study group (see table 7 no.s 9 and 10).

Communicating findings with the education community

One publication, one conference presentation and local presentations are planned to communicate the findings of my thesis to the education community. The paper will be written

for the British Educational Research Journal (see table 5 no. 6) with the intended audience being those who teach research methodology and supervise research students. Its key message will be that there needs to be an ethic of care for action researchers which includes adequate preparation for the emotional component inherent within it together with appropriate support throughout to enable researchers to engage with this aspect of their work. It is proposed that this paper be submitted for presentation at the Nurse Education Today / Nurse Education in Practice conference (see table 6 no. 6) together with it also being presented to the Early Years, Adult Years and Health Sciences Research divisions of the School of Health Sciences at City University once these divisions are fully established (see table 7 no. 8).

Communicating findings with the practitioner community

Two publications and one conference presentation are planned to communicate the findings of my thesis to the wider practitioner community. The first paper will be written for a special issue on implementation science in the International Journal of Nursing Studies (see table 5 no. 3) and will be based on a review of the literature regarding the experience of undertaking action research. Its key message will be that there is a gap in the literature in relation to the experience of undertaking action research that needs to be filled to enable those embarking on such a research journey to understand what it may be like for them and ensure that they have appropriate support mechanisms in place. The second paper will be written for the International Practice Development Journal (see table 5 no. 7) and will focus on the similarities between practice development and action research, and how the key messages from a review of the literature on the experience of undertaking action research can be applied to the process of practice change. The key message will be that there is an emotional component associated with action research and that, due to the similarities between the contexts within which practice development and action research are carried out, it has a potential presence in practice development which needs to be further explored. It is proposed that this paper will also be submitted for presentation at the Collaborative Action Research / International Practice Development conference (CARN/IPDC) (see table 6 no. 4). The third paper will consist of an analysis of the key messages from my thesis regarding the emotional context of action research, and will be prepared for the Journal of Clinical Nursing (see table 5 no. 8). These key messages include that there is an emotional component to action research, that support structures need to be in place for all those involved in it to enable emotions to be contained, worked with and learnt from, that adequate preparation is required for those undertaking action research, that more needs to be written about the experience of the researcher in undertaking action research so that others can engage with this aspect of practice, and that these messages have the potential to be applied to those undertaking other forms of practice change.

CONCLUSION

The above dissemination plan has the potential to communicate the findings from this thesis to a wide multi-disciplinary local, national and international audience of researchers, educationalists and practitioners. By conveying its key messages it has the potential to inform their work and the development of practice in these areas. Sommer (2009) argues that action researchers should publish articles in a variety of journals to reach colleagues, practitioners, and to improve action research practice. The intended papers outlined above, accompanied by the proposed presentations, aim to address this argument in a comprehensive manner.

Table 5 Papers for publication

Paper no.	Title	Journal	Date submitted	Impact factor	
				ISI web of science: JCR	Scopus: SJR
1	Cooper, J., Meyer, J. and Holman, C. Advancing knowledge on practice change: linking learned helplessness and psychodynamic perspectives	Journal of Clinical Nursing	December 2011	1.228	0.064
2	Cooper, J., Meyer, J. and Holman, C. Advancing knowledge on practice change: linking facilitation to the senses framework	Journal of Clinical Nursing	February 2012	1.228	0.064
3	The experience of undertaking action research: a review of the literature	International Journal of Nursing Studies	To be submitted March 2012	2.103	0.088
4	The emotional context of action research	Nursing Research	To be submitted June 2012	1.785	0.089

Paper no.	Title	Journal	Date submitted	Impact factor	
				ISI web of science: JCR	Scopus: SJR
5	Discovering and engaging with the emotional context of action research: a personal journey	Educational Action Research	To be submitted September 2012	-	0.031
6	Teaching and supervising action research: the need for an ethic of care for researchers	British Educational Research Journal	To be submitted December 2012	1.140	0.042
7	The emotional component of action research: application to, and need for consideration in, practice development contexts	International Practice Development Journal	To be submitted 2013	-	-
8	The emotional context of action research: key messages for those teaching, supervising, undertaking and participating in action research and practice change	Journal of Clinical Nursing	To be submitted 2013	1.228	0.064
9	Enhancing engagement with the emotional context of action research: the contribution of psychodynamic theory	Action Research	To be submitted 2013	0.846	0.032

Table 6 Conference presentations

Presentation	Title	Presented at:	Date
1	Innovations within limitations: tap dancing in clogs	Royal College of Nursing older people conference – bridging the gap	2001
2	If all in the garden can't be rosy, will a bed of daffodils do?	British Society of Gerontology 31 st annual conference - Active ageing: myth or reality	2002
3	Action research and work based learning: modelling future practice	Royal College of Nursing international nursing research conference	2003
4	The emotional component of action research: application to, and need for consideration in, practice development contexts	Collaborative Action Research/International Practice Development conference (CARN/IPDC)	To submit for 2012 conference
5	The emotional context of action research	Royal College of Nursing international nursing research conference	To submit for 2013 conference
6	Teaching and supervising action research: the need for an ethic of care for researchers	Nurse Education Today / Nurse Education in Practice Conference	To submit for 2013 conference

Table 7 Local presentations

Presentation	Title	Presented to:	Date
1	Care for older people: the current context	Senior management team meeting: NHS trust	2001
2	Developing nurses for their rehabilitation role in caring for older people: an action research study	NHS trust research forum	2001
3	CELEC action research project: care for older people	NHS trust research forum	2002
4	CELEC action research project: care for older people	RCN chief nurse visit: NHS trust	2002
5	Final report - CELEC action research project: care for older people	NHS trust management executive group	2003
6	Changing practice in challenging environments: making the case for psychodynamic support	Practitioner research study day: City University	2008
7	I don't wanna talk about it: my experience of undertaking action research	Action research study group: City University	2008
8	Teaching and supervising action research: the need for an ethic of care for researchers	Adult Years, Early Years, Health Sciences Research divisions: City University	Planned throughout 2012
9	The emotional context of action research	MSc. research methods module: City University	For 2012 module
10	Enhancing engagement with the emotional context of action research: the contribution of psychodynamic theory	AR study group: City University	For autumn meeting 2012

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20 QUESTIONS FOR ASSESSING ACTION RESEARCH PROPOSALS AND PROJECTS

Taken from Waterman, H., Tillen, D., Dickson, R. and de Koning, K. (2001) *Action research: a systematic review and guidance for assessment Health Technology Assessment 5 (23)*

1. Is there a clear statement of the aims and objectives of each stage of the research?
2. Was the action research relevant to practitioners and/or users?
3. Were the phases of the project clearly outlined?
4. Were the participants and stakeholders clearly described and justified?
5. Was consideration given to the local context while implementing change?
6. Was the relationship between researchers and participants adequately considered?
7. Was the project managed appropriately?
8. Were ethical issues encountered and how were they dealt with?
9. Was the study adequately funded/supported?
10. Was the length and timetable of the project realistic?
11. Were data collected in a way that addressed the research issue?
12. Were steps taken to promote the rigour of the findings?
13. Were data analyses sufficiently rigorous?
14. Was the study design flexible and responsive?
15. Are there clear statements of the findings and outcomes of each phase of the study?
16. Do the researchers link the data that are presented to their own commentary and interpretation?
17. Is the connection with an existing body of knowledge made clear?
18. Is there discussion of the extent to which aims and objectives were achieved at each stage?
19. Are the findings of the study transferable?
20. Have the authors articulated the criteria upon which their own work is to be read/judged?

OAK WARD

MONITOR 2000 AND SQUIS BASELINE DATA RESULTS

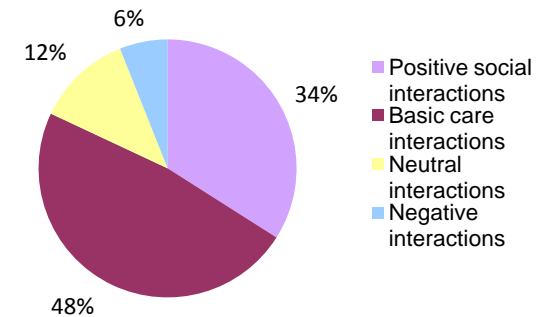
MONITOR 2000

SECTION	TITLE	SCORE OBTAINED	NUMBER OF APPLICABLE QUESTIONS	OVERALL %
A	ADMISSION, ASSESSMENT AND CARE PLANNING	294	675	44%
B	MEETING THE PATIENTS PHYSICAL NEEDS	250	405	62%
C	MEETING THE PATIENTS NON-PHYSICAL NEEDS	107	202	53%
D	PLANNING FOR THE PATIENTS DISCHARGE	41	92	45%
E	EVALUATION OF NURSING CARE OBJECTIVES	123	191	64%
H	LOCALLY SPECIFIED QUESTIONS	14	37	38%

SQUIS

Total no. of interactions = 86

Positive social interactions = 29 (34%)
 Basic care interactions = 42 (48%)
 Neutral interactions = 10 (12%)
 Negative interactions = 5 (6%)



ELM WARD

MONITOR 2000 AND SQUIS BASELINE DATA RESULTS

MONITOR 2000

SECTION	TITLE	SCORE OBTAINED	NUMBER OF APPLICABLE QUESTIONS	OVERALL %
A	ADMISSION, ASSESSMENT AND CARE PLANNING	234	581	40%
B	MEETING THE PATIENTS PHYSICAL NEEDS	216	338	64%
C	MEETING THE PATIENTS NON-PHYSICAL NEEDS	38	91	42%
D	PLANNING FOR THE PATIENTS DISCHARGE	16	78	21%
E	EVALUATION OF NURSING CARE OBJECTIVES	79	141	56%
H	LOCALLY SPECIFIED QUESTIONS	12	28	43%

SQUIS

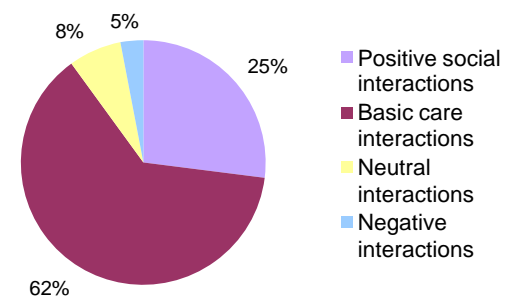
Total no. of interactions = 40

Positive social interactions = 10 (25%)

Basic care interactions = 25 (62%)

Neutral interactions = 3 (8%)

Negative interactions = 2 (5%)



APPENDIX 4

(HOSPITAL) NHS TRUST PATIENT TRANSFER FORM

Completed forms should be attached to the inside cover of the medical notes.

PATIENT DETAILS

Transfer from: _____ To: _____

Patient Name: _____ Hospital Number: _____

Age: _____ Date of Birth: _____

Consultant: 1) admitting consultant _____

2) referring consultant _____

3) receiving consultant _____

Further details if patient is being transferred outside of (Hospital) NHS Trust

Patient Address: _____

Next of Kin: _____ Relationship to Patient: _____

Address: _____

Telephone No. _____

MEDICAL INFORMATION

Date of Admission: _____ Diagnosis: _____

Past Medical History: _____

Medical problems during admission: _____

Results of relevant investigations:
(e.g. pathology / radiology) _____

Outstanding investigations:
(state if requested and dates if known) _____

Medication on transfer: _____

Mental Test Score: _____ Date: _____

Resuscitation status: _____ Date: _____

Reason: _____

Reason(s) for transfer: _____

Discharge plans: _____

Follow up plans: a) Specialty _____
b) Consultant(s) _____
c) Date(s) if known _____

Signed: _____ Print name: _____

Status: _____ Bleep no. _____ Date: _____

Medical Information section not completed Please see: TTA form Doctors Letter

NURSING INFORMATION

Assessment of patient

Walks	Independent	With aids	With help	Unable	Comments		
Transfers	Independent	With help	With hoist	Bed bound	Comments		
Toilet	Manages alone	Manages with help	Incontinent Urine/Faeces	Catheter	Comments		
Personal hygiene	Manages alone	Manages with help	Dependent		Comments		

Diet consistency (Circle all that apply)	Normal diet	Soft diet	Puree diet	Fluids only	Normal fluids	Thickened fluids	NBM PEG / NG
Special diet	Vegetarian	Halal	Kosher	Caribbean	Diabetic	Other (please state)	

Pressure areas

Intact Broken Waterlow score: _____

If broken:

Grade	Site	Treatment

Other wounds / ulcers

Wound type	Site	Treatment

Multiprofessional input

	Name	Contact number
Physiotherapist		
Occupational therapist		
Dietician		
Speech therapist		
Social worker		
Other		

Other relevant information: _____

Signed: _____ Print Name: _____ Date: _____

PATIENT PROPERTY

Valuables:

Money _____

Jewellery _____

Dentures _____

Hearing aids _____

Glasses _____

Keys _____

Disclaimer Form Signed Yes No Comment _____

Other property (Please list)

Signed: _____ Print Name: _____ Date: _____

TRANSFER CHECKLIST

	Yes	No	Sign	Comments
Patient Informed				
Relatives informed				
Ward informed by: _____				
Verbal handover to: _____				
Notes / X rays				
Prescription chart				
Medication				
Nursing admission / discharge sheet				
Observation charts				
Care plan				
Nursing progress notes				
Urinalysis recorded				
MRSA screening				
Personal care given				
Patient appropriately dressed for transfer				
ID band				
Patient fit for transfer purpose				

Transfer Checklist not applicable Reason _____

OAK WARD

MONITOR 2000 AND SQUIS REPEAT BASELINE DATA RESULTS

MONITOR 2000

SECTION	TITLE	SCORE OBTAINED	NUMBER OF APPLICABLE QUESTIONS	OVERALL %
A	ADMISSION, ASSESSMENT AND CARE PLANNING	297	630	47%
B	MEETING THE PATIENTS PHYSICAL NEEDS	321	423	76%
C	MEETING THE PATIENTS NON-PHYSICAL NEEDS	86	131	66%
D	PLANNING FOR THE PATIENTS DISCHARGE	72	87	83%
E	EVALUATION OF NURSING CARE OBJECTIVES	118	170	69%
H	LOCALLY SPECIFIED QUESTIONS	21	31	68%

SQUIS

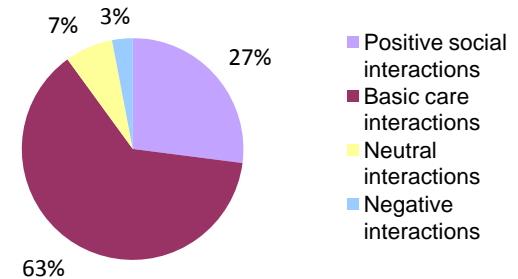
Total no. of interactions = 74

Positive social interactions = 20 (27%)

Basic care interactions = 47 (63%)

Neutral interactions = 5 (7%)

Negative interactions = 2 (3%)



ELM WARD

MONITOR 2000 AND SQUIS REPEAT BASELINE DATA RESULTS

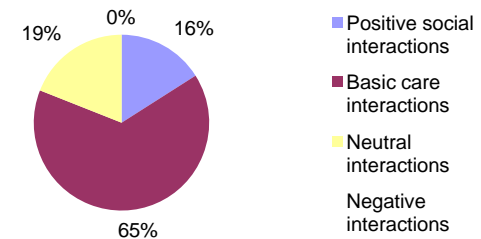
MONITOR 2000

SECTION	TITLE	SCORE OBTAINED	NUMBER OF APPLICABLE QUESTIONS	OVERALL %
A	ADMISSION, ASSESSMENT AND CARE PLANNING	253	575	44%
B	MEETING THE PATIENTS PHYSICAL NEEDS	217	345	63%
C	MEETING THE PATIENTS NON-PHYSICAL NEEDS	28	63	44%
D	PLANNING FOR THE PATIENTS DISCHARGE	45	63	71%
E	EVALUATION OF NURSING CARE OBJECTIVES	93	160	58%
H	LOCALLY SPECIFIED QUESTIONS	14	27	52%

SQUIS

Total number of interactions = 67

Positive social interactions = 11 (16%)
 Basic care interactions = 43 (65%)
 Neutral interactions = 13 (19%)
 Negative interactions = 0 (0%)



EXAMPLE OF WORK BASED LEARNING

Extract from field notes – 28/4/00

Ground rule discussion. Concerns were raised about patients telling the truth in interviews. It was said that patients could be nice to nurses one minute and then 'turn nasty' at another time. This led on to a discussion about why patients do not always behave as we would like. Issues around taking away patient control and independence, and the effect this may have on them was debated. We discussed how little choice we gave patients in hospital, and the nurses talked about how they do things for them instead of encouraging them to do it themselves as it is quicker. We discussed patients that expect nurses to look after them in hospital and do not want to help themselves – the sick role vs rehabilitation, and discussed how better assessment of patients, preparation for transfer to a rehabilitation unit and provision of information about the unit philosophy on arrival may help to address this issue.

Regarding giving patients more choice in hospital the nurses raised interesting dilemmas they often have to deal with when patients choose a course of action. These included patients refusing to have a wash, and not letting a nurse change them when they are wet. We looked at how our own personal standards are often forced upon our patients – just because we wash twice a day does not mean that everybody else has to! Regarding patients refusing care such as not allowing us to change them when they are wet we discussed the ethics of forcing care on others. We looked at weighing up the risks of providing vs not providing that care, and also at how we justify the decisions that we make. The nurses said that we often justify decisions by stating that that is what we always do. We talked about how examining our practice and looking at how we justify what we do can address some of the ethical dilemmas that we face. We also talked about how we approach patients, and that a more negotiating and persuading approach may help us to be able to give the care that is required.

Also regarding giving patients choice, the discussions moved on to the issue of routinised care. (Nurse) said that if we gave patients choices we would not be able to complete our work e.g. we would not get the observations done at 10.00 if we were still washing patients. I challenged (nurse) as to firstly why were all the patients on daily observations even when they were medically fit, and secondly why they had to be done at 10.00. She said the doctors wanted everybody on observations, and they have always been done at 10.00. This led us back to the discussion of justifying why we do what we do – because someone else tells us to and because we have always done it that way. This led to a discussion about how we could change this to meet the individual needs of the patient. (Nurse) said that attitudes and

routines are ingrained, and that we should be starting to think about looking at individualised vs routinised care. She said that when she was next on days she would try to do this, and inform the other staff what she was trying to do. The importance of identifying the patients normal routines on assessment was discussed so that we could provide 'tailor made care'.

This whole debate arose from one comment made when discussing ground rules. It was rich in depth and revelations. The nurses really started to think about and examine what they do and how and why they do it. They were not defensive to any challenges I made and really started to think about their practice and how it affects the patients. I was on the ward for two hours.

DETAILS OF LITERATURE REVIEW PAPERS

Authors	Journal of publication	Stated or inferred type of action research	Context of study	Methods of data collection and analysis re : researcher experience of undertaking the study	Background of researchers: i) previous research experience ii) experience of topic under study
Braithwaite, R Cockwill, S. O'Neill, M. Rebane, D. (2007)	Action Research	Insider community based participatory action research	Community regeneration in Wales. Understanding the nature of the underlying reasons for social exclusion, particularly in relation to the labour market (UK).	<p>Researchers recounted their experiences in verbal and written form to the team leader and academic advisor.</p> <p>All reflected on what lessons could be learned from the experiences. Similarities and differences summarised and related to theoretical literature, then reflected on again to ensure it was still true to the experiences.</p>	<p>i) 1 of the 2 researchers had previous community based action research experience.</p> <p>ii) Experience in topic area through being active members of the community in which the research took place.</p>

Authors	Journal of publication	Stated or inferred type of action research	Context of study	Methods of data collection and analysis re : researcher experience of undertaking the study	Background of researchers: i) previous research experience ii) experience of topic under study
Carlisle, S. Cropper, S. (2009)	Critical Public Health	Community based action research	Health promotion. Addressing local issues of health and well being in Wales with lay action researchers (UK).	External researchers informally interviewed lay researchers as individuals and in project groups on 20 occasions. Extensive notes taken and submitted to participants for validation. Multiple reading of notes and coding of data into key themes.	i) 1 out of the 6 researchers had experience of health services research as a research assistant. All were new to action research. ii) 3 had some familiarity with community development work. Experience in topic area through being members of the communities in which the research took place.
Crow, J. Smith, L. Keenan, I. (2006)	Educational Action Research	Action research	Collaboration between university health lecturers and a practice development and research nurse in an NHS hospital in England to develop an education package for hospital staff on dignity and respect (UK).	Reflective diaries and notes on reflective conversations. No details of analysis process except to state that diaries and conversations were analysed in terms of 'critical incidents'.	i) Previous experience in action research. ii) Experience in topic area (education and practice development).

Authors	Journal of publication	Stated or inferred type of action research	Context of study	Methods of data collection and analysis re : researcher experience of undertaking the study	Background of researchers: i) previous research experience ii) experience of topic under study
Dickson, G. Green, K.L. (2001)	Educational Action Research	Outsider participatory action research	Health promotion. Guiding older aboriginal women to assess their own health / conduct a health assessment (Canada).	No details of data collection or analysis.	i) 1 had experience of participatory action research. ii) Experienced in topic area (Aboriginal people and health issues).
Faubert, C. (2009)	Critical Public Health	1 st person insider action research	Community-institution (university) initiative in the context of strengthening the capacity of communities to provide more opportunities for children from underprivileged families to be physically active (Canada).	Recorded field notes and personal reflections in a journal every few days using the process of memoing. Supplemented by the recording of meetings and e mail conversations. Field notes and reflections summarised and imported in NVivo on a monthly basis.	i) Background in qualitative, intervention research. ii) States novice with no 'expert knowledge' or prior field experience in community mobilisation and capacity building.

Authors	Journal of publication	Stated or inferred type of action research	Context of study	Methods of data collection and analysis re : researcher experience of undertaking the study	Background of researchers: i) previous research experience ii) experience of topic under study
Gewirtz, S. Shapiro, J. Maguire, M. Mahony, P. Cribb, A. (2009)	Educational Action Research	Teacher action research	Teacher researchers investigating African Caribbean attainment (UK).	Semi-structured interviews with research facilitators and teacher researchers. Analysed using grounded techniques. Coding of transcripts, development of analytic frameworks through group discussion, comparison, interrogation and refinement of codes and themes.	i) No details. ii) Teaching experience but no details of experience of research topic (African Caribbean attainment).
Gone, J.P. (2006)	American Journal of Community Psychology	Community action research	Identifying the cultural grounds for innovative mental health service delivery for an American Indian reservation community (USA).	Interview with tribal elder. Record of discussion prepared from memory. No details of analysis.	i) No details. ii) Experience in topic area through ties with the community in which the research took place.

Authors	Journal of publication	Stated or inferred type of action research	Context of study	Methods of data collection and analysis re : researcher experience of undertaking the study	Background of researchers: i) previous research experience ii) experience of topic under study
Gransden, B. (2004)	Educational Action Research	1 st person action research	1 st person inquiry of a medical consultant into the role and process of peer teaching observation as part of a diploma in teacher education (UK).	Typed transcripts of handwritten teaching observations. Personal development journal. Personal review and critique of data and development of themes.	i) No details. ii) Experience in teaching. No details given of experience in peer observation.
Halonen, R. (2008)	Reflective Practice	Action research	Design and implementation of an information system to support the management of student mobility between universities (Finland).	Personal diary. No details of analysis.	i) Undertaken previous information system projects – no details of research methods / approaches. i) Experience in topic area (information system projects).
Hostick, T. McClelland, F. (2000)	Journal of Psychiatric and Mental Health Nursing	Cooperative inquiry	Cooperative inquiry into nurse patient relationships in community mental health care (UK).	States a form of autobiographical self-inquiry and dialogue with others. Reflective diaries. No details on analysis.	i) No details. ii) No details.

Authors	Journal of publication	Stated or inferred type of action research	Context of study	Methods of data collection and analysis re : researcher experience of undertaking the study	Background of researchers: i) previous research experience ii) experience of topic under study
Humphrey, C. (2007)	Action Research	Insider action research	The rise of self organised groups for women, black people, disabled people and lesbians and gay men within trade unions (UK).	No details of data collection or analysis, but uses some quotes from a personal journal.	i) No details. ii) Experience in topic area through being a member of the community in which the research took place.
Jacobs, G. (2010)	Action Research	Community based participatory action research	Health promotion. Intervention programme to encourage healthy living amongst older people in The Netherlands.	External researchers carried out semi structured interviews with all project researchers and health professionals and a focus group discussion with community members in the project team. E mails and other communications also used. Thematic analysis.	i) No details but states 'relatively inexperienced team'. ii) No details of experience in topic area.

Authors	Journal of publication	Stated or inferred type of action research	Context of study	Methods of data collection and analysis re : researcher experience of undertaking the study	Background of researchers: i) previous research experience ii) experience of topic under study
Judah, M.L. Richardson, G.H. (2006)	Action Research	Action research	State mandated action research in teacher professional development (Canada).	External researchers tape recorded and transcribed interviews with teacher researchers/facilitators. External researchers recorded thoughts in research journals. Reduced the data by looking for patterns, categories and themes.	i) No details. ii) Teaching and professional development experience.
Kamali, B. (2007)	Action Research	Participatory action research	Improving communication and gender awareness between state development workers and rural extension workers in rural Iran.	Use of focus groups, semi-structured dialogue, Venn diagrams, problem trees, force field analysis and action plans to learn and change.	i) Previous PhD research into this area. ii) Previous experience in topic area through PhD studies.
Karnieli, M. (2000)	Educational Action Research	Not stated (outsider action research inferred)	Application of an intervention plan to the educational system of a traditional Bedouin village in Northern Israel.	No details of data collection or analysis.	i) No details. ii) No details.

Authors	Journal of publication	Stated or inferred type of action research	Context of study	Methods of data collection and analysis re : researcher experience of undertaking the study	Background of researchers: i) previous research experience ii) experience of topic under study
Langan, D. Morton, M. (2009)	Action Research	Feminist participatory action research	Collaborative research with community organisations and the state to evaluate an initiative to expand service provision to women who had experienced intimate partner violence (Canada).	Participant observation and reflective process. Sociological analysis at 3 levels – macro, meso, and micro. Story articulated and rearticulated through solitary and collaborative writing.	i) Recent PhD sociologists. Previous experience as consultants on community based projects. No details of research methods/approaches. ii) No details of experience in topic area (intimate partner violence).
Lavie-Ajayi, M. Holmes, D. Jones, C. (2007)	Action Research	Cooperative inquiry	Exploration of safe expression of sexuality and young women's sexual health in a voluntary organisation (UK).	No details of data collection or analysis, but quotes and journal abstracts used.	i) 2 out of 3 had research experience. None had any experience of collaborative inquiry. ii) Previous experience in topic area through previous research or work roles.

Authors	Journal of publication	Stated or inferred type of action research	Context of study	Methods of data collection and analysis re : researcher experience of undertaking the study	Background of researchers: i) previous research experience ii) experience of topic under study
Lewis, M.E. (2004)	Environmental Education Research	Participatory action research	Environmental education project at a New York City alternative public high school (USA).	Narrative inquiry. Audio taped and transcribed interviews with researcher using an interview protocol. Development of narrative analysis methodology and a coding manual. Analysis techniques described in detail.	i) Research trained. ii) Experience as a teacher. Previous experience in topic area as a volunteer and through study.
McGee, A. (2008)	Educational Action Research	Action research	Improving professional development experiences of in service teacher educators in a Middle Eastern Gulf State.	Experiences of teachers captured through reflective journals, oral feedback, group and individual discussions of which notes were taken, oral progress reports, written reflections. No details of analysis.	i) No details. ii) Experienced teachers. Previously had professional development training.

Authors	Journal of publication	Stated or inferred type of action research	Context of study	Methods of data collection and analysis re : researcher experience of undertaking the study	Background of researchers: i) previous research experience ii) experience of topic under study
Meyer, J. Johnson, B. Procter, S. Bryar, R. Rozmovits, L. (2003)	Nursing Times Research	Action research	Development and evaluation of seven lead research and development nurses: care for older people in NHS trusts (UK).	Exit interviews with researchers and project leads, and project co-ordinator's field notes. No details of analysis.	i) Only 2 researchers had previously engaged in funded research. ii) Broad range of clinical experience in topic area (care for older people).
Moore, B. (2007)	Action research	Insider action research	Improving governance practice and performance in a charitable organisation (UK).	No details of data collection or analysis.	i) No details. ii) Experienced in topic area through being a member of the community in which the research took place.
Nyhof-Young, J. (2000)	Educational Action Research	Action research	Facilitation of a group of science teachers in addressing gender issues in science education (Canada).	Personal journal. No details of analysis.	i) New to action research. ii) Experience as science teacher but no details of experience in topic area (gender awareness).

Authors	Journal of publication	Stated or inferred type of action research	Context of study	Methods of data collection and analysis re : researcher experience of undertaking the study	Background of researchers: i) previous research experience ii) experience of topic under study
O'Neill, M. Williams, G. (2004)	Critical Public Health	Community based participatory action research	Health promotion. Tackling the determinants of ill health in post industrial areas of Wales (UK).	No details of data collection or analysis but extracts of field notes used.	i) No details. ii) No details.
Oyum, L. (2007)	Systemic Practice and Action Research	Action research	Introducing a team based work structure on shop floor level in nine smelting plants in Norway.	No details of data collection or analysis.	i) No details. ii) No details.
Ponic, P. Reid, C. Frisby, W. (2010)	Nursing Inquiry	Feminist participatory action research	Health promotion. Cultivating 'power with' relationships with community researchers, health and service organisations and policy makers in women's health projects (Canada).	No details of data collection or analysis, but field note excerpts used.	i) Experience in feminist participatory action research. ii) Experience in topic area (women's health).

Authors	Journal of publication	Stated or inferred type of action research	Context of study	Methods of data collection and analysis re : researcher experience of undertaking the study	Background of researchers: i) previous research experience ii) experience of topic under study
Ravitch, S.M. Wirth, K. (2007)	Action Research	Insider action research	Collaboratively constructed professional development programme for teachers in an urban elementary school in the USA.	Focused discussions with research supervisor over six months that were recorded and transcribed. No details of analysis process except to state that key themes emerged from the discussions.	i) No details. ii) Experience as a teacher, but no details of experience in topic area (professional development).
The European-American Collaborative Challenging Whiteness (2005)	Action Research	Cooperative inquiry	Cooperative inquiry into the impact of one's own white supremacist consciousness on oneself and others (USA).	No details of data collection or analysis but personal stories recounted.	i) Experience in cooperative inquiry and other traditional research activities. ii) Experience in topic area through long term study of it.

APPENDIX 9

PAPER WRITTEN FOR AND SUBMITTED TO THE JOURNAL OF CLINICAL NURSING

TITLE

Advancing knowledge on practice change: linking facilitation to the senses framework

ABSTRACT

Aims and objectives

To identify what helped staff to move out of a learned helplessness state and reduce the use of socially structured defence techniques to engage with practice change.

Background

Although the importance of facilitation in practice change is widely acknowledged, it is recognised that little nursing research has taken place in relation to its nature. Following the identification that learned helplessness states and the use of socially structured defence techniques were preventing staff on a rehabilitation ward for older people from engaging with practice development initiatives, some change was achieved. What facilitated and enabled this to take place needed to be explored.

Design

An action research approach was used.

Methods

Data were gained from thirteen in-depth interviews with staff and managers together with three years of researcher field notes. Data were analysed using thematic analysis.

Findings

The continuous presence, accessibility and neutrality of the researcher who worked together with staff on their issues of concern using a flexible ward based approach, combined with giving staff the opportunity to explore what it was like for them working in this area, were considered key in helping staff to engage with change.

Discussion

Further analysis of findings suggests that the senses framework presents a theoretical approach to facilitation that can help staff move out of learned helplessness states and reduce the need for the use of socially structured defence techniques.

Relevance to clinical practice

This study identifies a facilitation approach which enabled staff to engage with and achieve changes in practice. Although carried out in the UK, its findings have wider relevance through the application of a theoretical perspective for the facilitation of practice change that has not before been considered in this literature, and which is likely to be of interest to those involved in practice change internationally.

Key words:

Learned helplessness; psychodynamic theory; the senses framework; change facilitation

INTRODUCTION

The importance of effective facilitation in implementing change is widely acknowledged (Harvey et al 2002, Kitson et al 1998, McCormack et al 2006, Rycroft-Malone et al 2004), however it is also highlighted that little research has been undertaken in nursing in relation to the nature of facilitation (Titchen 2003). This paper reports on one part of a three year action research study which, following a diagnosis of learned helplessness and staff use of socially structured defence techniques, set out to explore the facilitating factors which enabled staff on a rehabilitation ward for older people start to move out of these positions into one where they were able to engage in change activities which benefited both themselves and their patients. Data for this study were originally analysed in 2003 for the study report, however they have recently been revisited and re-analysed as part of my PhD studies from which new insights and interpretations have been gained in relation to practice change. The factors that facilitated change on the study ward have been further analysed, and are presented in relation to a theoretical framework - the senses framework (Nolan et al 2006) - which it is suggested presents an approach to facilitation that enabled movement out of learned helplessness and the use of socially structured defence techniques to take place. Details of how learned helplessness and the use of socially structured defence techniques were diagnosed with staff on the study ward forms the focus of a previous paper (submitted for publication).

BACKGROUND

This study set out to improve the rehabilitation care provided for older people in an NHS trust. The staff on one ward were originally, however, unable to engage in practice development initiatives designed to improve the rehabilitation care for their older patients. To investigate why this was, eleven ward staff and two service managers were given the opportunity to 'tell it how it is' to identify, from their perspective, what was preventing them from engaging with change activities, with this data being supported by participant and non-participant observation and three years of researcher field notes. Findings suggested that staff were in a state of learned helplessness which occurs when a person learns to believe that outcomes are not affected by their behaviour and are thus beyond their control (Seligman 1975). This can lead to deficits in motivation, cognition and emotions which are illustrated by individuals giving up trying to influence outcomes, having difficulty recognising when their behaviour has had an effect, and feelings of low mood and hopelessness (Maier & Seligman 1976, Seligman 1972, Seligman 1975), all of which were exhibited by staff on the study ward. In addition, it was also suggested that staff were experiencing high levels of anxiety related to the nature of their work task and the psychological demands unconsciously placed upon them by their patients (Halton 1994, Menzies Lyth 1988, Obholzer & Roberts 1994). In order to protect themselves against this anxiety, staff utilised socially structured defence techniques (Menzies Lyth 1988) which split the nurse-patient relationship and prevented them from having to engage on an individual level. This was demonstrated through routinised care practices accompanied by the lack of an enabling and individualised approach that failed to meet the social and psychological needs of patients, and which worked against the practices required for good rehabilitation care. It was suggested that the use of these defence techniques prevented staff from engaging in practice change as, for them to improve rehabilitation practice, they would need to dismantle these defences which could result in the resurgence of intolerable anxieties (Mosse 1994).

Even though these processes were in play during the study, after the staff were given the opportunity to 'tell it how it is' an action plan was developed collaboratively between ward staff and service managers in a further attempt to improve the care provided for patients in this rehabilitation setting. A review of the action plan at the end of the study highlighted positive developments in place including:

- the introduction of a patient allocation system to establish clear lines of responsibility for care and facilitate more attention to individual patient needs
- ward layout alterations to create a partitioned social space with a communal dining table
- the introduction of social activities for patients

Some positive change by staff and service managers had therefore been achieved, with it appearing that staff were now starting to move from a learned helplessness state and the use of socially structured defence techniques into a position where they were able to participate in development activities. What facilitated and enabled this move to take place needed to be explored.

AIMS AND OBJECTIVES

The aims and objectives of this part of the study were to:

- reflect on the process of change
- identify what helped changes in practice to occur
- gain an understanding of ways in which staff could be facilitated to start to move out of a state of learned helplessness and the use of socially structured defence techniques to engage in change activity

METHODS

An action research approach was used within the study to effect practice development through a collaborative approach to change. Action research has been described as 'a period of inquiry, which describes, interprets and explains social situations while executing a change intervention aimed at improvement and involvement' (Waterman et al 2001 p.11). My role as an action researcher was to work with staff to facilitate and evaluate improvements in practice and monitor and reflect on the change process itself. The participants in this part of the study were the nursing and care staff based on the study ward (referred to collectively as 'staff' for the remainder of this paper), the service managers for the study ward and the senior nurse managers who also assisted in implementation of the action plan (referred to collectively as 'managers').

A multi-method approach to data collection was used throughout the action research study which included formal meetings, discussions, in-depth interviews and focus groups with staff and managers, structured staff profile questionnaires, quality of care audits, documentary analysis, structured patient and carer interviews, participant and non-participant observation, and the recording of field notes. Specific information from this overall data set fed into this particular part of the study. This included relevant detailed field notes extracted from those kept over a three year period which contained contextual information, a daily record of events, details of meetings and discussions with participants, observations made, and my own thoughts and feelings throughout the study process. In addition, thirteen in-depth interviews

(Ritchie & Lewis 2003) were held with seven staff and six managers to gain their reflections on the change process and what they felt helped changes in practice to occur. All interviews were audio taped, transcribed verbatim and checked for accuracy.

Thematic analysis, using an approach incorporating aspects of those suggested by Burnard (1991), Miles and Huberman (1994) and Morse and Field (1996) was used to identify the main themes arising from the data collected. This included repeated reading of field notes and interview transcripts and repeated listening to audiotapes to allow familiarity with the data to be gained, the application of codes, grouping of similar codes under broader categories, and the linking of categories through the identification of common emerging themes.

FINDINGS

Findings related to improvements in rehabilitation care arising from implementation of the action plan together with the facilitating factors that it was perceived enabled such changes and improvements to take place.

Improvements in rehabilitation care

Staff and managers commented that they felt standards of care had improved on the ward with the patient allocation system being seen as a contributory factor. Staff felt that through this system better relationships had developed between patients and staff and care had become more patient focused. It was also considered to be a more manageable system for staff which improved their knowledge of the patients and their care needs:

'You could see that patient focused care. It's not like you wash four patients and start doing something else. Now that you wash four patients you see that the dressing is soaked and you do it. You check your temperature, you do your kardex (patient notes), and it's not like you're guessing what happened to the patient.' (Staff 6)

With the implementation of more patient focused care staff stated that patients were being given more choice about how their day was organised, with them being encouraged to do more things for themselves. Staff felt that this was the first step in engaging with a rehabilitation philosophy and that they were ready to embrace it further:

'The way we work is changing, not rushing patients in the morning ... encouraging patients to get up for breakfast and washes instead of having it in bed ... That's rehabilitation, you motivate people to do more for themselves ... we know what rehabilitation stands for now.' (Staff 1)

This increased engagement with rehabilitation was also reflected in the involvement of staff and patients in social activities. Staff and managers now realised the contribution this could make to the social and psychological well being of patients, as well as enjoying participating in the activities themselves:

'The project itself has identified the need for social activities which has come along in leaps and bounds ... it improved patient care ... and it has made a big difference.'
(Manager 1)

Facilitating factors

The factors highlighted as facilitating changes to take place and improvements in patient care to be achieved fell into three main categories. These were 'giving staff the opportunity to 'tell it how it is'', 'the continuous presence of the action researcher', and 'the power of achievement'.

Giving staff the opportunity to 'tell it how it is'

Giving staff the opportunity to 'tell it how it is' was instrumental in encouraging and motivating staff to engage in positive change on the ward. Staff identified that this work gave them a voice and that they felt valued and cared for as a result of someone listening to and showing an interest in them and their work. This increased their motivation to act:

'You listen to us, you let me speak, you want to hear from us ... what is our role as staff? Before we didn't have any identity, we didn't have any recognition for what we were doing, we would be on the ward for the seven hours, and when we have done our hours we just go home. But now ... I feel good now in what I'm doing, before I didn't take any pride in it ... now I want to do it better.' (Staff 1)

It was also stated by both ward staff and managers that their awareness had been raised through this work and that this had 'opened people's eyes'. They were now more aware of what was happening on the ward, that problems existed, and what needed to be changed. It also validated the concerns of individual staff by them realising that others felt the same as they did, and that they were not alone:

'But it's opened people's eyes ... It highlighted what people were concerned about on the ward and it also highlighted that a lot of people were concerned about the same thing which is sort of nice because, you know, I'm sort of always worried about doing something because there's just my own personal fad or my own personal concern.'
(Staff 5)

Through hearing each other's views, having concerns validated, and joint working on change activities, staff highlighted that they were working better together and that they now understood the importance of teamwork. They felt there was more openness within the team and better communication, with everyone now working towards one goal. This facilitated the implementation of improvements in practice:

'I've learnt that unless you've got a team that is willing to back each other and you've all got the same idea and the same mind, I've learnt that it doesn't work!' (Staff 7)

By focusing change activity around the views and concerns of staff, it allowed areas to be worked on that were important and of benefit to them as well as their patients. Staff commented that the ward developments focused on aspects of care they identified as wanting to work on, not aspects chosen by others. This increased staff motivation to engage in change as activities had a purpose and were relevant to everyday practice:

'The research is closer to home, it's associated with what I do, I'm part of it I would think ... It's about patient care, but it is also a lot about nurses, we ourselves should benefit, we should get to see ourselves better too.' (Staff 3)

The continuous presence of the action researcher

The continuous presence of the action researcher and the way they worked with the staff on the study ward was also considered to be a major influential factor in facilitating change. The presence of the researcher was seen as a catalyst that 'got the ball rolling' through helping staff to diagnose problems, come up with possible solutions and get them started. Staff also felt able to talk openly to the researcher as they considered them to be neutral within the organisation and someone they could trust:

'Because people get so caught up in their day to day work that somebody like you comes in and changes an idea or has a look and you think 'oh that could change', and then it keeps people alert, it keeps people up and ready for change, and that is good, because other than that everything gets stale.' (Staff 7)

'You've been able to get our trust ... I can talk to you, you stress on confidentiality ... and people are happy to say what they want.' (Staff 1)

Staff commented that the researcher regularly visited the wards and could be easily contacted. This availability meant that someone was always there to give time to staff if they needed help, advice or support. It was suggested that this presence provided leadership, encouragement and confidence for staff to try and improve practice, with them also being motivated by someone taking an interest in how things were progressing:

'When you pass by the ward and we are in trouble, and you just passed by just to say hello even, but you've been very helpful at the situation ... at least you had the time to give us, to listen to us ...and you feel a bit better. When somebody sympathises with you it has a lot of effect on people.' (Staff 2)

Staff and managers also commented on the flexible ward based approach used by the researcher in working together with them. They felt able to get involved with and engage in change activities through the researcher making allowances for, and fitting around, their work and time constraints, and through capitalising on informal development opportunities as they arose:

'Even if you've had to sit down with them at the desk while they are working, you've done that, and I think that's shown a lot about how you can't just expect staff to come up to meetings ... you have to take it to them and really work with them.' (Manager 5)

Other benefits to this way of working were also highlighted. Staff felt that their knowledge and understanding was improved through formal and informal conversations and discussions that took place, work on change activities, and informal prompting and coaching by the researcher when present on the ward. They classed this as knowledge that could not always be gained from textbooks and which had more of an impact than formal education alone. It also resulted in staff starting to think more about the care they were giving, and prompted them to reflect on their practice and what they could do differently:

'It gave me the chance to step back and question myself whether I'm doing my job as I should be and whether I could have done it better.' (Staff 1)

'At the end of the meeting (staff) said that these meetings make you feel good as you talk about things and what you can do ... I think the benefit of the meeting is time for (staff) to think and discuss things.' (Field note)

Finally, it was stated that the constant presence of the researcher and this way of working had helped to identify that there was a lot of unacknowledged potential amongst staff that just needed to be encouraged and developed:

'But to know the abilities of others and the potential there to build on, that has been quite beneficial ... it has shown us there is potential out there, if only you can invest time with people... you've given them something else a bit different, and perhaps just being there sometimes is enough.' (Manager 1)

The power of achievement

Motivation for staff to improve practice was also continuously increased through the achievements they made along the way. All staff were proud of the part they had played in helping change to happen and care standards to improve, together with the recognition their work was receiving. This recognition was enhanced by the raised status and profile of care for older people services within the trust which resulted from the involvement of senior nurse managers in the process. With this came an increased commitment and motivation amongst staff to continue to improve, with all staff stating that they now felt ready and keen to engage with change:

'People feel proud ... the way things are going now it's as if we've achieved something.' (Staff 6)

'I also hoped it would raise the profile of elders which it has done ... it's given quite senior people a view on how care of the elders should work.' (Manager 3)

'I think it has made people more aware, I think, definitely, and it has made people want changes more.' (Staff 7)

DISCUSSION

It was originally suggested that staff on the study ward were in a state of learned helplessness (Seligman 1975) and were using socially structured defence techniques to contain anxiety (Menzies Lyth 1988) which prevented them from being able to engage in practice development activities. By the end of the study, however, staff were able to implement some changes in practice. It is suggested here that this was due to them starting to move out of that learned helplessness state and being able to contain their anxieties thus reducing the need for their defence techniques. Support for this will now be explored together with further analysis in relation to a theoretical framework of which the underlying concepts help to provide an understanding of what may have enabled this to take place.

Movement out of learned helplessness and the reduced use of socially structured defence techniques

Staff movement out of learned helplessness is demonstrated by a reversal to some degree of the motivational, cognitive and emotional deficits previously identified as being present. Staff indicated that they were now more enthusiastic, committed and motivated to engage with change. This, together with their wish to continue to do things better, demonstrates a reduction in the motivational deficits of learned helplessness. A reduction in cognitive deficits

was indicated by the staff recognising their achievements and the part they played in these, and feeling that they were making a difference and could achieve more. Furthermore, a reduction in the emotional effects of learned helplessness was demonstrated through the pride that staff expressed in their achievements together with the recognition of this by others and the stated raised profile of their work with older people in the trust. A reduction in the use of socially structured defence techniques amongst the staff can also be identified. Staff highlighted that they had developed better relationships with patients and that the care they were providing was more patient focused and less routinised. They also felt they were more knowledgeable about the patients and were now paying more attention to their social and psychological needs. Interviews highlighted the facilitating factors that staff considered enabled such changes to take place and, in relation to the above, movements out of learned helplessness and socially structured defence systems to take place. Although helpful in their raw form, these factors currently lack any theoretical underpinning. They will now, therefore, be analysed in relation to a framework that it is suggested has the potential to provide such a theoretical understanding.

The Senses Framework

In 1997 Nolan expressed his concern with 'the lack of a therapeutic rationale for work in long term care settings with older people' (Nolan et al 2001 p. 16). In response to this he identified six 'senses' which he believed might provide such a therapeutic rationale and direction for staff working with this client group, and improve the care that older people received. Theoretical and empirical testing of these senses has culminated in the development of 'The Senses Framework' (Nolan et al 2006) which it is suggested provides a potential framework for practice. Within this framework it is suggested that if good therapeutic care for older people is to be achieved they need to experience six senses. These are a sense of:

- security: to feel safe
- belonging: to feel part of things
- continuity: to experience links and connection
- purpose: to have goal(s) to aspire to
- achievement: to make progress towards these goals
- significance: to feel that you matter as a person (Nolan et al 2006 p. 8)

It is also suggested that the senses are best realised within the context of a relationship-centred approach to care which recognises that all those involved in the caring relationship need to experience the senses if high quality care is to be achieved (Nolan et al 2006), with it

being acknowledged that unless staff are able to experience the senses for themselves they are unlikely to be able to create them for their patients (Brown et al 2008).

It can be seen from the findings that the approach utilised within the study and the facilitating factors identified provided the opportunity for the staff to experience these senses within the context of this study. A sense of security for staff was enabled through the neutrality of the researcher role and the confidentiality agreements that accompanied it, together with their constant presence and accessibility to ward staff. This provided the staff with someone whom they could trust, who they could turn to for help and advice, and who was there to support them through the study process. This continuous presence, together with the flexible approach used to enable the practice development work to continue even when work commitments challenged it, also provided a sense of continuity for staff. Giving staff the opportunity to 'tell it how it is' then appeared to facilitate the staff in experiencing the other senses. A sense of significance was enabled for staff through someone taking time with them and showing an interest in them by listening to their experience of what it was like to work in this context. This resulted in them feeling valued and that they 'mattered', with the sharing of these experiences with managers who listened and acted upon them giving them a voice within the organisation whilst also raising the profile and recognition of their work. The reciprocal sharing of staff and manager experiences validated their concerns and led to a greater understanding between these two groups, which led to a greater sense of belonging for staff. This would also have been enhanced by the team working amongst ward staff that was facilitated through them working together to implement the action plan, and the sense of identity that they stated had started to develop. Focusing the action plan around areas the staff wanted to work on ensured that development activities were relevant to everyday practice and important and of benefit to both them and their patients, thus facilitating a sense of purpose amongst staff. Finally, a sense of achievement was enabled through them achieving positive changes in practice that they were proud of, and the recognition of their work by others in the organisation.

It can therefore be seen that by enabling staff to experience the senses they were able to engage with development activities which allowed changes in practice to be achieved. How this facilitation approach links with learned helplessness and psychodynamic theory is now further explored.

Reversing learned helplessness and containing anxiety

Seligman (1972) identifies that the initial problem in reversing the effects of learned helplessness is one of getting going. It would appear that the presence of the researcher and giving the staff the opportunity to 'tell it how it is' seemed to be the catalyst that was needed to

do this. Lennerloff (1988) reinforces that central to the theory of learned helplessness is that people learn helplessness in uncontrollable situations, therefore it can be assumed that by enabling individuals to regain some control of their situation some recovery from this should be achieved. This was enabled through helping staff to feel secure, giving them a voice and raised profile within the organisation, enabling them to control decisions over what development activities they wanted to engage in and when these were to take place, and through the achievements they started to make, with it being stated that achievement is one of the most important sources of a sense of control (Robertson 1986). Finally, Seligman (1975) found that breaking the helplessness pattern often required a long programme of continuous direction and reinforcement in helping individuals to learn that actions can affect outcomes, with the continuous presence of the researcher and the accompanying advice, encouragement and support given helping to provide this.

It is considered that for staff to reduce their need for socially structured defence techniques their anxieties need to be contained and made bearable (Obholzer 1994). It can be suggested that the continuous presence of a neutral researcher who staff could trust and talk to, together with them being interested in and listening to their concerns during the 'tell it how it is' work, resulted in them being potentially used as a container for staff anxieties. An enhanced sense of belonging and significance may also have provided the environment needed for staff anxieties to be effectively held on the ward. These would have provided the security staff needed to start to disengage from their defence techniques and engage with practice change that was previously threatening.

It can therefore be seen that the facilitation approach used within the study enabled some reversal of learned helplessness to take place and the anxieties of staff to be contained. This facilitation approach has been shown to meet the senses of security, belonging, continuity, purpose, achievement and significance for staff which then enabled them to engage with practice change. It can now also be suggested that a facilitation approach that incorporates the underpinning philosophy of the senses framework has the potential to positively impact on states of learned helplessness and reduce the need for the utilisation of socially structured defence techniques.

CONCLUSION

It is not unusual to find reluctance to change, however it is important to identify the underlying causes for this reluctance and ways of working which may be able to help overcome it. This paper has explored the facilitating factors that appear to have helped staff on a rehabilitation ward for older people move out of a state of learned helplessness and the use of socially structured defence techniques into a position where they were able to engage in change

activity to improve the care of their patients. Further exploration of these factors in relation to a theoretical framework has been undertaken which suggests that the senses framework presents a theoretical approach for the facilitation of practice change within such an environment. It has been recommended that further research, knowledge and clarification regarding successful facilitation processes is required in order for practice developers to be able to base their practice on sound evidence (Simmons 2004). This study adds to the body of knowledge on the facilitation of practice change by providing a practical example and theoretical perspective on such a process. The potential for the senses framework to be used as a facilitation approach outside of this study warrants further exploration.

RELEVANCE TO CLINICAL PRACTICE

The current health care climate in the UK is one of continuous change which it can be suggested is reflected on an international level as health care staff are required to review their practice in line with advancing technologies and research, an ageing population, increased expectations, finite resources and a proliferation of policy initiatives in relation to these. This study has provided a theoretical explanation of a facilitation approach which enabled staff in such a context to engage with and achieve changes in practice. Whilst this study was carried out in the UK, it has wider relevance through the application of a theoretical perspective for the facilitation of practice change that has not before been considered in the practice change literature, and which is likely to be of interest to those involved in practice change internationally. This work has relevance not only for those working in rehabilitation settings for older people, but for those working within any health care context which needs to engage with practice change.

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