



Title: An investigation into nurses' views and experiences of what creates a clinical learning environment within acute in-patient psychiatric wards

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**AN INVESTIGATION INTO NURSES' VIEWS AND EXPERIENCES OF WHAT CREATES
A CLINICAL LEARNING ENVIRONMENT WITHIN ACUTE IN-PATIENT PSYCHIATRIC
WARDS**

By

Cherrie Valerie Ravello

**A Thesis submitted to the University of Bedfordshire, in partial fulfilment of the
requirements for the degree of Doctorate in Systemic Practice.**

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Abstract: Although I was trained as a nurse, I became curious about the views of psychiatric nursing staff as to what they feel would create a clinical learning environment for them. This was as a result of having my dearly beloved father admitted to a medical ward, and being on the receiving side of care. This created a fear in me that surprised me. I was scared at how my father would be treated if I was not present to witness his care. As a nurse, strangely, I felt that I could not trust the nurses to provide safe clinical care for/with my father. I began to feel concerned about the competencies of nurses as I observed the care that was being offered to him. My observation and experience was that the ward environment generated an atmosphere that needed a form of nursing care that was collaborative and transparent where the hand-over between professionals communicated the needs of the patients in their care – from making sure that patients' bedding is comfortable, to checking whether they are trying to communicate something, to being sure that their medication has been properly given. This aroused my curiosity as to whether nursing staff themselves had views as to what is needed to have, or to create, an environment that sustained their original urge to take up nursing in the first place. I thus became curious to investigate the views and experiences of both qualified and non-qualified psychiatric nurses with the aim of improving the clinical learning environment within acute adult inpatient wards, as well as *secure* adult and male adolescent mental health inpatient wards, as these wards raise crucial issues to do with control, power, seclusion, rights and responsibilities, issues that are not easy for nurses to learn to deal with in their classroom training. For this study I interviewed sixteen staff members of wards within the National Health Service and the private sector.

The staff varied in their experiences and qualification, from qualified mental health nurses to non-qualified nurses. My findings show that: (1) Nurses often felt the ward organisation had hindered their learning through the way in which it worked to organise them. (2) Nurses would have liked to experience a different kind of learning. However they were not sure in what way or how they would like the learning experience to be. (3) The expert nurses were able to work in a competent manner despite the sense of the organisation organising their practices, as they were able to sense which of the limited number of organisational possibilities were open to them so that their choices allowed for their

practices to be learning experiences as well as providing sound clinical care. (4) Learning dialogues happen in contexts where nurses feel supported and where the episode of care in which they are engaged is also supported by a team approach and resourceful pulling together of skills and abilities. (5) There was a lack of space(s) for the nurses to use for reflection. (6) Nurses also expressed the need for supervision after an episode or critical event had taken place. (7) Throughout all the areas I inquired into, what was strongly echoed was that the psychiatric nurses all felt that they needed a voice within the organisation and its hierarchy of team structures within these wards. There was a felt sense that the nurses wanted and at times needed more expert nurses working in the teams. Overall, I was struck by the abilities which were brought to the forefront as the nurses shared their views and experiences of how they felt organised by the organisation. They were able to explore the factors that they felt would improve the quality of care that nurses provide and were able to share what they believe will help them in co-creating standards for how the clinical environment could become a learning environment for the nurses.

Contents

Chapter One: The frame/ locating myself in the research.....	1
The aim of the inquiry.....	3
Other aims that I would like to focus on.....	3
Previous studies.....	5
Principal research questions.....	8
Secondary research questions.....	8
Readers guide.....	9
Background.....	10
The “environment” in mental health inpatient wards, general environment.....	11
A clinical learning environment in mental health inpatient wards.....	12
Chapter Two: Making connections with the literature: Social constructionist and systemic ideas.....	17
Discourse analysis.....	19
Other tools of analysis that I have considered.....	22
Chapter Three: Method/ Methodology the natural history of my research inquiry.....	24
The topics that were covered during the semi –structured interview.....	27
Analysis.....	29
Ethics.....	30
Chapter Four: Psychiatry in the midst of complexity: Social Constructionism as a theoretical concept to inquiry into	

the practices of psychiatric nurses within inpatient wards – a reflexive approach.....	36
Orienting myself.....	36
Experiences from practice and its connection with theoretical concepts.....	38
Discussion.....	48
Conclusion.....	52
Summary.....	52
Chapter Five: Psychiatric Nursing as an Organisation of Practice: 'Sense making of learning within the clinical environment'	54
Situating the transcript materials.....	55
An organisation: What does this mean to psychiatric nurses?.....	63
An environment that is not conducive to learning.....	69
How can I learn when there is no learning to experience?.....	81
Mentoring the nurses, I have no voice, my words are not heard.....	84
Learning in the organisation, sense making, bringing together the fragments.....	87
Conclusion.....	95
Summary.....	96
Chapter Six: Psychiatric Nursing as an open, unfinished, still developing community of practices: Resourceful Communities	97
The inpatient psychiatric environment as a learning space.....	102
How does supervision influence learning in a community of practice?.....	115
Resourceful community: The dialogical and its usefulness to practice.....	121

Rules, culture, practices, what are they?.....	133
Conclusion/summary.....	137

Chapter Seven: Co-creating reflexive spaces in which to work: The influence of this on psychiatric nurses' views and experiences on how they were able at times to co-create reflexive spaces during their practice within inpatient psychiatric nursing.....141

Making sense of our social worlds.....	141
Reflexive space.....	147
A competent practitioner.....	150
The coming together of practices that create a reflexive space.....	154
What gets created when one is in that reflexive space.....	157
Having a creative way.....	159
Conclusion/Summary.....	160

Chapter Eight: Reflections on the managerial practices conducive to care in psychiatric nursing.....163

Stories of good practices.....	173
Stories of difference.....	183
Summary.....	188

Chapter Nine: The coming together of an inquiry: Suggesting learning improvements within the clinical environment in psychiatric inpatient wards.....	190
Summing up the findings.....	197
Summary.....	201
Appendices.....	202
1. Topic guide.....	202
2. Consent form.....	203
3. Participant information sheet.....	204
4. Research Information leaflet.....	211
5. Ethical approval.....	214
References.....	232

List of tables

4.1 Qualified and non-qualified psychiatric nurses.....	32
4.2 Experienced and less experienced senior qualified psychiatric nurses.....	33
4.3 Experienced and less-experienced non-qualified staff.....	34
4.4 Staff who were working in the various wards at the time of the interview.....	35

List of figures

8.1 CMM levels of context.....51

8.2 Spider plant.....59

8.3 CMM levels of context.....79

8.4 CMM levels of context.....94

8.5 CMM levels of context.....153

8.6 CMM levels of context.....156

8.7 Spider plant.....173

8.8 Spider plant.....178

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Chapter One

The frame/ locating myself in the research

This thesis addresses the views of psychiatric nursing staff as to what they feel would create a clinical learning environment for them within a number of inpatient psychiatric wards. When working on acute and secure mental health wards the expectation of all staff will be to work with the individual patients. However, without the opportunity to reflect on their work while doing it, their clinical learning is vague and of limited help in equipping them to work within these contexts safely and competently. Benner (1989) suggests the need to be present and to have an understanding of the lived experience of the illness which the nurse is presented with caring for, the ability to develop clinical knowledge and the ability to learn from patients derived from the opportunity to reflect in action. I became curious about clinical learning environments as a result of having my dearly beloved father admitted to a medical ward and, with being on the receiving side of care; this created a fear in me that surprised me. Although I was also a nurse myself, I was scared of how my father would be treated if I was not present to witness his care. This experience moved me to be curious about clinical environments that nurses are expected to work in. I as a nurse felt that I could not trust the nurses to provide safe clinical care for/ with my father. I began to feel concerned about the competences of nurses. As I observed the care that was being offered to my father, I began to ask myself what was happening in the inadequate nursing care I witnessed that left me feeling so uncertain. This aroused my curiosity about staff views as to what is needed to have, or to create, a clinical learning environment within nursing.

I chose to focus on the psychiatric aspects of care as I am also a psychiatric nurse. One of my many feelings and experiences is that within psychiatric care the patients are more vulnerable than in other areas of nursing care. Benner (1984) suggests that as nurses you take on the responsibilities not only for the physical aspects of the patient presenting with psychiatric ill health, but that you are also responsible for mediating between the patient and the other,

more normal culture. The nurse learns to understand the patients in their particularities, to appreciate the patients in their particular language and feelings behind their behaviours and words. The nurse learns to understand the private and idiosyncratic meanings that things might have for them. Psychiatric patients' capacity to consent might also be affected, as they are sometimes highly vulnerable due to impaired cognitive functioning, which makes their judgment of how clinical care is delivered to them more concerning. This does not take away the experiences of other vulnerable patients, for example older people with physical or mental illnesses, patients with learning or physical disabilities and children with physical or mental disabilities. However for the purpose of this research inquiry I have chosen to focus on patients who are having treatment for psychiatric ill health within an inpatient context.

I became curious to investigate the views and experiences of both qualified and non-qualified psychiatric nurses with the aim of improving the clinical learning environment within acute adult, secure adult and male adolescent mental health inpatient wards as the nature of these settings includes elements of control, power, seclusion, rights and responsibilities.

I am a student on a course which has a systemic social constructionist approach in which realities/meanings are socially created in interaction with others. Pearce (1994; 1995; 1989) Pearce and Walters, (1996), Pearce and Pearce (1998) and Gergen (1999) suggest that context creates meaning as we are in dialogue with each other where we bring a varied vision of our culture, race, gender and family as well as personal stories of our lived experiences. Consequently, I am interested in staff's views of what creates a clinical learning environment for them and how this is then demonstrated in how they provide high standards of care with their patients. I am also interested in what type of clinical environment creates a space for clinical care to feel safe for both the patients being cared for and the nurses providing the care. I am also interested in the stories that are co-created about the clinical environment. As a manager, consultant and psychotherapist I want to reflect on my own stories and the staff stories about clinical learning environments as these stories may emerge in these various contexts.

The aim of the inquiry is to address both qualified and non-qualified nurses' views and experiences as to what kinds of events, communications, and advice from their colleagues, specific teaching times and other informative experiences can/might work to create a clinical learning environment within acute mental health wards. Another aim has been to get staff views on what sort of clinical learning would best equip them to work in these various ward environments.

By a clinical learning environment I mean an environment in which nurses learn a practice *from experience* rather than simply learning to talk *about* nursing in written examinations. I will say more about the nature and need for such a context later in this thesis.

Other aims that I would like to focus on are: the therapeutic aspects of qualified and non-qualified psychiatric nurses' learning, both in the clinical and theoretical context. I would like to explore what resources they draw on to assist them in their learning and professional development. I also aim to explore nursing as a way of talking and a way of engaging. Another aim is to explore how qualified and non-qualified psychiatric nurses learn and relate to the ward environment and to patient care.

I am curious to explore what has been most useful to their learning and how the nurses might use this way of learning and relating to work with the junior nurses on the wards. I want also to explore with them how they relate to their patients in a way that promotes their patients' mental health and what has helped with this aspect of their learning. I am also curious to explore what they might want more or less of in their professional journey of learning and relating. All these aims are related to what I feel is needed and lacking, not only in current research findings, but also in current nursing education. Benner(1984;1989) suggests that nurses are equipped to carry out care from an expert position, they should not only be able to carry out medical orders, but they must be able to use their discretion in carrying out these orders, knowing when these orders are no longer needed for the safe and best care of the patients. Francis (2010) in his Mid Staffordshire NHS Foundation Trust report brought to the forefront the lack of care provided by nurses at this hospital. Some examples of this were: "Whenever you tried to ask the nurses or other senior person any questions, they were never

around or, as happened one day refused to come out of the office." "The appalling way she was treated there, the complete lack of interest in her well-being, will stay with me for the rest of my days." "Calls for help were regularly ignored and he was often left in his own excrement for hours." "Staff worked hard, from the tea lady to the team of doctors." These examples showed inconsistencies of care delivery over several years.

As this research inquiry develops, I hope that nursing teams will benefit by being able to develop a reflexive space to think about their practice and what aspects of their environment help with their learning and relating to their patients. I expect the benefits of the research inquiry will be that nursing staff will develop a greater understanding of their learning needs, and that this will contribute to a high standard of care delivery for patients. Another benefit could be its use in monitoring quality of care. On completion of this research inquiry, certain themes may emerge which may require further inquiry which I hope to work on in the future.

As the researcher, I have worked on a maternal mental health ward, acute mental health wards for adults and secure mental health wards for both adults and male adolescents, and also on an open inpatient ward for adolescents with psychiatric concerns.

On the secure wards for both adult and male adolescents, all patients are admitted on a detention order. This means Section 2 or 3 of the Mental Health Act 1983. Such patients often present with high levels of physical and verbal aggression towards the staff and fellow patients, and at times the level of harm is turned in on themselves, resulting in a number of suicidal attempts and at times actual suicide. The diagnoses vary with these patients from acute psychotic disorders, severe depression, borderline personality disorder, severe obsessive compulsive disorders and conduct disorder. Others are admitted with offences such as arson, actual bodily harm (ABH), and grievous bodily harm (GBH).

On the adult acute mental health wards, patients' diagnoses can vary from depression (low in mood with suicidal thoughts and plans) to psychotic episodes (abnormal thoughts/false beliefs about themselves or others). Such thoughts can pose a risk to themselves or others. Some behaviours presented can be very aggressive and threatening towards staff. They are admitted

as individuals and no other family member is admitted with the patient. This is important to ponder on as patients are people first, with families, friends and others involved in their lives. When individuals are separated from their family this separation can be distressing for all; the impact that this can have on being admitted to an acute psychiatric ward can be difficult and profound for all. The admission length of stay varies from one day to many months, where the goal is to discharge the patients into the community from which they were originally admitted.

In my most recent work, my responsibilities were that of working as a clinical nurse manager within a child and adolescent inpatient mental health unit. In this unit the clinical presentation of the adolescents is similar to that on the adult wards. They present with depression (low mood, unable to care for themselves) and psychosis (having abnormal thoughts/false beliefs about themselves or others). Such thoughts can pose a risk to themselves, other adolescents, members of the public, school staff and staff involved in their care on the ward.

The staff in this unit, and in the units from which I have drawn my data, vary in their experiences and qualification, from qualified mental health nurses to non-qualified nurses.

Previous Studies

Throughout my literature search I found no studies on staff views of what creates a clinical learning environment within these areas of care. This has stimulated my interest in inquiring into the views of staff about whether there is a need for these clinical environments to be different in the way in which learning takes place. There are huge differences in these acute psychiatric wards in comparison to rehabilitation or general medical nursing wards. Two such differences are that patients in the rehabilitation mental health wards who are physically unwell are better able to self care on these wards. This is partly due to the very nature of the environment on these wards being much less chaotic. This is also partly due to registered general nurses working on the medical wards not always having the required skills, knowledge and expertise needed to care for patients with psychiatric illnesses; therefore the mental health needs of the patients are better managed and supported on mental health wards. This also fits

with my own experience as a mental health nurse working on the general medical nursing wards supporting the nurses with patients who are experiencing acute mental health difficulties where there are other medical risks. I would however argue that the patients' mental health needs are better managed on a mental health ward and sometimes these patients are transferred to mental health wards where treatment is deemed to be better managed. The patients are visited by their children, partners or siblings. This period of acute admission could be distressing to the whole family; hence the clinical area is one which has to support the whole family at any given time.

In these clinical environments nurses need to have some knowledge of risk assessment in relation to child protection and child development issues, also knowledge on parental responsibility (Children Act 1989). These are extra responsibilities which are placed on the nurses who work in these wards.

There are a number of studies on student nurses' and newly qualified registered general nurses' learning within the clinical areas (Cooke and Matarasso 2005). However I have not seen any studies on psychiatric nurses' own views or on their experiences of what creates a clinical learning environment within adult and adolescent acute mental health settings. I am interested in how psychiatric nurses maintain their learning and relating to patients and colleagues within such a complex area of care.

Cooke and Matarasso (2005) claim that student nurses learn best when working with actual clinical cases as these provide a contextualised and realistic means for developing their reflective skills as mental health practitioners. Consequently, the clinical environment has to be equipped with clinical learning opportunities where nurses feel able to manage and teach students. Caramanica and Roy (2006) also suggest that it is important for nurses to have discussions with other nurses, and with academics, in order to create an environment that results in practice excellence. They suggest one way of doing this could be to engage in what they call a "Research Round program" which is learning sessions aimed at equipping registered nurses with the skills and abilities in critiquing the literature and determining its use to inform clinical practice. Arnold, Dean and Munday (2004) also suggest that, as student nurses work in

collaboration with clinical nursing staff who take on the dual role as educators and nurses, this is one way in which supportive learning environments could create an increased enthusiasm about psychiatric nursing. As these skills of collaborative ways of working are joined together, nursing quality of care would be better. While Slimmer, Wendt and Martinkus (1990) concluded that, as student nurses gain experience in a psychiatric clinical learning site, their views were that there was a decrease in the authoritative, restricted attitudes towards mental illness and an increase in the therapeutic milieu, as well as in the idea that community mental health nursing within psychiatric care could be the best way of providing care. This has heightened my hopes about clinical learning environments in psychiatric care, as these student nurses are the future nurses, and for me it would appear that learning has taken place within these areas of nursing care.

Benner (1984) and Kleffel (1991) have focused on general trained nurses and their clinical environment. This research highlights what constitutes a safe working clinical environment with respect to infection control and wound care. This, however, again brings to the forefront the huge gap in research inquiry into the clinical learning environment for psychiatric nurses. So, although Benner (1984) and Kleffel (1991) have suggested that we rethink the *environment* as a domain of nursing knowledge, and this has been to an extent researched in general nursing, much remains to be done within the field of psychiatric nursing.

As my interest was to gain staff views on what creates a learning environment within inpatient psychiatric wards, and to explore their views on the similarities and differences within these settings, my research questions were designed to capture this. These can be found on the page that follows. I will also be exploring these questions through a qualitative research paradigm and a systemic social constructionist paradigm. I was curious about the different type of clinical environment needed in these settings. Other curiosities that I had were: could clinical learning within all of these inpatient areas look and feel the same? How would the nurses share their views of what learning means to and for them within these settings? How can all the views of all the staff be embraced? If there is a need for each of the learning environments to be different, then what might be needed for this difference to be embraced?

I felt that it was very important to obtain staff views about what creates a clinical learning environment. This I believed would enable managers to provide the necessary support that staff may need to allow them to provide high standards of care to patients admitted to adult and adolescent acute mental health wards.

Principal research questions

- (1).** What accounts emerge about what constitutes a clinical learning environment and how do these stories contribute to clinical practice?
- (2).** What are the differences or similarities in nurses' views and experiences on what creates a clinical learning environment within acute adult, secure adult and male adolescent mental health inpatient wards?

Secondary research questions

- (1).** To identify areas of learning that might be applied to other areas of practice, so that patients' care remains of a high standard.
- (2).** To identify areas of training that nurses feel might be helpful to their learning.
- (3).** To explore what factors will improve the quality of care that nurses provide and what will help them in co-creating standards for how the clinical environment could become a learning environment for the nurses.
- (4).** To reflect on the implications for the patients in these clinical environments in relation to the different accounts held by staff about what constitutes a clinical learning environment.
- (5).** To inquire into what aspects of the clinical environment contribute to staff practices in the provision of high quality of care for patients and what aspects are detrimental.
- (6).** Qualified nurses' views in comparison to non-qualified nurses' views of what creates a clinical learning environment within these acute, secure, mental health inpatient wards.

(7). What accounts of the clinical learning environment emerge in the context of these mental health wards and how have these stories contributed to clinical practice in these areas of care?

Readers guide

This thesis is divided into eight further chapters. In Chapter One, I explore how I chose to frame/locate myself in the research inquiry. In Chapter Two, I draw on the literature that I used to make connections between theory and practice and practice and theory, thus co-creating a circular process of learning and connecting this learning into practice. I will then proceed to the method/methodology chapter which is Chapter Three, where I will share how I went about choosing the participants and interviewing them in a way that allowed them great freedom in expressing their views. In Chapter Four, I use social constructionism as a theoretical concept to inquire into the practices of psychiatric nurses within inpatients wards. In Chapter Five, I will share with the reader psychiatric nursing as an organisation of practice: 'sense making of learning within the clinical environment' where some nurses shared their views on their feelings of being organised by the organisation and the constraints and affordances that this presents for clinical learning to take place. In Chapter Six, I enter the space described by nurses as 'what would it look like and feel like for psychiatric nursing to be an open, unfinished, still developing community of practice?'. In Chapter Seven, I will share some stories told by nurses about their sense making of the caring aspects of inpatient psychiatric nursing and the influence of this on their views and their experiences, also their stories of how they were able at times to co-create reflexive spaces in which to work, which has in turn informed their practices. Chapter Eight explores reflections on the managerial practices conducive to care in psychiatric nursing. In each chapter I will be making connections to the literature that has helped me to illuminate my practice, and which then in turn illuminated my use of theory, which further enriched my practice. In moving back and forth between theory and practice in this way I aim to map out the harmonious relationship between the research inquiry and the approach which Bernstein (1983) describes as a hermeneutical one. Hermeneutical in the sense that each item of information becomes a building block of my understanding, which means that

I would be attempting to clarify my discovery in further blocks from the language and dialogue in the transcript material and my understanding and participation in the research inquiry. By doing so I would attempt to constantly move back and forth between these positions and the theoretical concepts in which I hope to share my understanding and that of the nurses.

In each chapter I will be sharing exemplars of practices from sixteen interview transcripts and reflections on my practice. Each chapter will have a summary of the findings and their relationship to each of my research questions. The last Chapter Nine will punctuate and connect all the chapters to the process of inquiry where my conclusion and a summary of my reflections and results will be situated. At the end of the thesis are appendices which contain the materials submitted to the ethics committee.

Background

There is a limited amount of research that suggests that the clinical learning environment for both qualified and non-qualified psychiatric nursing staff in inpatient wards is able to provide sound clinical care for their patients. This became evident when I explored the literature on clinical learning environments by searching for research papers/researchers' views on learning environments within inpatient psychiatric wards and then broadening the search for research done on learning environments. The sites I visited to conduct this search were AMED, BNI, PSYCINFO, MEDLINE, PUBMED, CINAHAL PLUS and PSYCNET. I became interested in Lave and Wenger's (1991) idea on "Situated learning and legitimate peripheral participation", as these concepts both work from within a wider context where there are more possibilities of how to go on in practice. As nurses work from the context of the medical model which focuses on treatment and results measurements, I was curious as to how the nurses will discuss what a clinical learning environment would mean to each of them. By the medical model I mean that the focus is on the physical and biological aspects of specific diseases and conditions. Foucault (1973) offers two views, which reinforce my view of the medical model, when he talked about the clinical gaze wherein this represents the non-holistic ways of caring. He spoke about this

gaze as implying an open field; it records and looks at illnesses in a whole. Yet, without the person at the centre of the whole, this dehumanises patients, treating them as objects to exert power over as only the illness is seen as important in finding a cure for. Foucault also talked about this gaze as one which goes straight to its object. This he said is silent, like a finger pointing, denouncing, and not taking into consideration the wider context that might influence how an illness might have started, therefore not able to find its holistic cure. These descriptions I would say form the medical model from within which most nurses work as they try to create an environment of care and learning. My research will clarify what constitutes a “clinical learning environment” and will also explore whether the clinical learning environment in which psychiatric nurses carry out their care has any therapeutic merit with respect to both the care and the recovery processes which patients who access the service become part of.

The “environment” in Mental Health inpatient wards

General environment

“Environment” as stated by the Collins English Dictionary (2006) means: surroundings, settings, conditions, situations, medium. It is a national requirement of Health and Safety legislation (1999) for employees to work in an environment that is safe. Employers have a duty of care under the law to ensure, so far as is reasonably practicable, employees’ health, safety and welfare at work; and they must consult workers or their safety representatives on matters relating to their health and safety at work. In general, an employer’s duties include making the workplace safe and without risks to health, and giving workers the information, instruction, training and supervision necessary for their health and safety.

Employees have legal duties which include taking reasonable care for their own health and safety and that of others who may be affected by what they do, or do not do. Also they must correctly use work items provided by their employer, including personal protective equipment, in accordance with training or instructions and not interfering with or misusing anything provided for their health, safety and welfare.

A clinical learning environment in mental health inpatient wards

The clinical learning environment could be described as a setting where safe clinical care is carried out. Where nursing staff have access to education in safety issues for both themselves and the patients entrusted into their care. Where nursing staff have access to clinical supervision and updated knowledge on the treatment of patients with varied diagnoses for whom they are expected to provide care. Where opportunities are available for nursing staff to gain knowledge of the policies and procedures by which the organisation and the wards function. Where the mix of skills, in terms of experienced and less experienced nursing staff, is at the centre of care provision, and where patients' care is of a high standard that can be measured by admission and readmission processes. Caramanica and Roy (2006) suggest that nurses should consider clinical expertise to assist them in their practice so that both experienced and inexperienced nurses could grow professionally and personally in their role as direct patient care providers. Caramanica and Roy (2006) further suggest that in creating an environment for practice excellence nurses should be encouraged to participate in discussions with academia, where research based skills and knowledge is linked with practice. Their participation in these discussion forums, where nurses are skilled to critique the literature and determine its relevance for clinical practice, would then support the environment in promoting practice excellence, which also connects to a community of practice, where patient care is of the highest standards.

Caramanica and Roy (2006) put forward the view that in creating an environment which has a high level of excellence nurses need to pay attention to how they create evidence based practices, where leaders pay attention to the voices of nurses as they facilitate the development of collaboration. The intended outcome must be to develop nursing students, as well as qualified nurses, to include nurse scholars who are working in the health care system, where the knowledge gained from these collaborations could be utilised and disseminated in a way that is transferable to practice as well as health care policy. Benner (1984) suggests that capturing descriptions of expert performance is a difficult task as experts operate from a deep understanding of the whole situation in which they find themselves. Benner (1984) also

suggests that psychiatric nurses use many ways to focus/channel the patients in their care which hold more potential for growth. She further elaborates this by saying that psychiatric nurses are guides and mediators, helping patients when they are confused to carve a path into a more shared world.

Benner (1984) talks about the importance of the nurses' approach when providing care for/with psychiatric patients. She talks about the need for clarity and clear therapeutic goal setting, being a mediator to support the patient, taking into account their cultural and psychological being. This heightens my curiosity for this inquiry as there is no mention of how the psychiatric nurses keep their own learning alive. However, the clinical learning environment will further be defined in co-creation with the nurses about their views and experiences of what makes for them learning, as we engage in dialogical conversations (Benner, 1984 and Shotter, 2008).

Arnold, Dean & Munday (2004) suggest that a collaborative approach to learning, in which clinical nursing staff provide clinical supervision for their on-campus lecturers, who in turn provide the theoretical concepts with which the nurses could then give names to their learning, is a possible way to create clinical learning environments. Arnold, Dean and Munday (2004) also suggest that nurses working in the mental health area fulfill a vital function in providing education and effective role modeling, and thus promote a positive learning experience to student nurses. They go on to suggest that nurses can enhance learning by facilitating a supportive environment which ensures that students are able to gain experience, knowledge and ideally adopt a positive view of mental health nursing.

There are thus multiple ways of describing what a clinical learning environment might be like, but what is important about them all is that they provide opportunities for staff to learn what cannot easily be taught in the classroom.

Staff may experience multiple realities in such an environment, where sharing of skills and learning from others might offer rich experiences in their learning within these environments. Through the telling of their stories, staff could co-construct their reality of what a clinical learning environment might mean to each of them. Pearce and Pearce (1998) suggest that

stories are the explanatory narratives that people use to make sense of their lives. We might say that people live in such a way as to call into being those stories that they love, need or want, and to prevent the realisation of those stories that they hate or fear. The co-creating of multiple realities is part of the relation between the person telling the story and the story told. For example, I would have my own views and stories of what has helped to develop my learning in varied contexts which I choose to draw on and share with others depending on the context that I might be invited into or find myself in.

As a manager, clinician and researcher, I understand this to mean that being in a number of contexts where learning of different types happens, different staff will tell different accounts of how they experience learning. As a manager, clinician and researcher I am concerned with how stories are co-created in these various contexts and how staff then feel able to share these alternative stories as they emerge. As a manager and researcher I am keenly interested in strengths, special abilities, and the aspirations of the staff and other members of the clinical team and their views of what might create a clinical learning environment. Woven into the events and descriptions that run counter to the “problem–saturated” stories were stories shared by nurses who participated in the research inquiry. These stories were in relationship to the complications nurses experienced when there were shortages of staff and where they were expected to work with staff who had minimal knowledge and experience in caring for the patients. I was interested in the possibilities of how both managers and nurses together can co-create alternative stories that reflect both the richness of their personal and professional ways of being expert in their own professional fields and how this can then be shared (Freeman et al, 1997).

These concepts I would say contribute to a community of practice as nurses grow and develop their practice together, where a shared way of working enhances the quality of care that is needed for everyone’s growth and development (Lave and Wenger, 1991).

In what follows, I propose to use the meaning of the term ‘environment’ as: “inpatient ward/wards (surroundings) where some mental health patients are sometimes admitted against their will, on a section of the Mental Health Act 1983”. While other such patients are

there on an informal basis with their agreement to stay and be treated for their mental health condition.

In these environments there are qualified mental health nurses with considerable experience in this field of care; there are also non-qualified mental health nurses, some of whom are less experienced, all working as part of a multi-disciplinary team. Most of the wards have a maximum of 22 patients at any given time. Nurses are at the forefront of providing care as they are usually the first professionals that patients come into contact with on the ward. The nurses spend longer periods of time providing direct contact with the patients. Patients present with various forms of acute mental health illnesses. The accumulated experiences of nurses, and the knowledge and skill they have developed as a result of working in these contexts, is not often gathered together or presented in a form that can be made use of by other less experienced nurses. Indeed, my own inner dialogue as I reflect on the knowledge and experiences I gather, will bring out how my own understanding can be affected by this material. I will then use these reflections in devising next steps in my research inquiry.

In talking about my own understanding I will be paying attention to being an 'insider researcher', which means how I position myself morally and ethically throughout the whole research inquiry process. Mullings (1999) argues that to acquire information that truly represents the real world, as researchers we must seek what she refers to as positional spaces, that is where both the researcher and the participants develop a level of trust and co-operation in the interview. Mullings's argument is that these positional spaces are often transitory and cannot be reduced to the familiar boundaries of insider/outsider privileges as they both hold advantages and disadvantages. Preston–Shoot (2009a & b) and McDermott (2009) suggest that as practitioners researching into our own practices we can identify ourselves as 'insider researcher' with a space that can both obscure elements of what is happening as well as enrich our perspective. They suggest that as 'insider researcher' practitioners must acknowledge the limits and the disadvantages of their position, they must adapt the capacity to step back from their practice and ensure that they remain within a theoretical framework. Floyd and Arthur (2012) suggest that, although undertaking insider research can be problematic, the researcher

should enter the setting with confidence as long as appropriate ethical boundaries are established at the onset and the researcher constantly re-visits this throughout the process. Floyd and Arthur (2012) also suggest that there is a belief that as an 'insider researcher' the access to participants is easier; however there are more rigorous procedures to follow which makes the process harder. I would agree. The process for me was made harder as I sought permission from the ethics committee to commence the research process, having a role within the organisation in which I was also researching. As an insider researcher I knew the participants and was very mindful of the need to explain how I was going to maintain their confidentiality and keep these materials and data in a safe and secure place. The themes which have emerged from these studies have come from nurses working in these various clinical environments and their views of their struggles to provide a safe and therapeutic clinical environment for the patients for whom they are meant to be providing care.

I now turn to my exploration of social constructionist and systemic literature which has helped me to gain some understanding of the importance of a learning environment and what might contribute to the co-creation of learning environments within inpatient psychiatric wards. I have drawn on theoretical concepts from various writers which have illuminated the complexities that psychiatric nurses encounter as well as the strengths and abilities they demonstrate in their daily delivery of care to their patients. I have also drawn on other writers from the nursing field to illuminate these complexities and help to make meaning or understand the theoretical concepts and practice that are needed for learning to take place. In the chapter that follows I will also aim to show the links and connections to theory and practice and practice and theory as a way of signposting the reader to join me on this journey of my research inquiry.

Chapter Two

Making connections with the literature

Social Constructionist and Systemic Ideas

I turn now from the concrete setting of my research proposal to the sources of the ideas informing it. Social constructionist theory suggests that we should pay attention to the social practices engaged in by people and especially to their interactions with each other. Social constructionism is an approach which assumes that people are in dialogue with each other or in a multilogue with many others, in a lived experience (Shotter, 1993; Shotter, 2005b). One approach to social constructionism (Shotter, 1995) emphasises especially the role of people's dialogically structured relations both to each other and to the rest of their surroundings.

The clinical environment is a place where learning is necessary for patients' care to be effective and where staff can learn new skills and develop existing skills in care giving. Within this process the knowledge and skills gained from it are jointly constructed in the interaction between staff, patients and the manager. This in turn is transferred to the patients' care and fed back into the system by a clinical audit, within which patients take part.

Burr (1995), in her account of social constructionism, suggests that knowledge is sustained by social processes occurring within people's daily interaction in the course of their social lives together. This implies that the ways in which we commonly understand the world, that is the categories and concepts we use, are historically and culturally specific. The interviews with nurses identified their concerns about the way in which their organisation understands and responds to their concerns for what it means to them to deliver high quality care. I believe that Burr's ideas of social constructionism have some relevance for nurses when working within a mental health environment and carrying out of their clinical tasks, as there are multiple stories of what mental health and recovery means to each person affected by mental health concerns. Also each professional brings with them multiple skills, knowledge and abilities from various backgrounds, which combine and join with each other. This is where our own history and background create dialogues and our interactions come into play.

I understand this to mean that the stories about how management acts within episodes of clinical learning are connected to the history of how the organisation responds to care delivery and training, and in particular, to the use of clinical training and its importance to practice. I am thus curious about the mental model that influences the way in which the organisation talks and how it suggests to the nurses how they might go on together to create “the difference that will make a difference” (Bateson, 2000).

Social constructionist thinkers are most interested in what happens in specific contexts and in the nature of detailed interactions among people. They focus on relationships, joint actions and co-constructed entities (Pearce, 1994). Gergen (1999) suggests that social constructionist theory offers a way of understanding this complexity through describing multiple realities.

My understanding of this in the context of a clinical learning environment is that the staff who engage in it are connecting to a variety of relationships which have an inter-relational aspect, where the knowledge and skills within the context are shared on various levels to include patients’ care delivery.

One tool for exploring how the stories that we have about our personal and professional lives connect with the utterance shaping them is Co-ordinated Management of Meaning (CMM). It can be used as a tool for exploring stories at different levels of context. CMM is a communication theory (a tool bag of theoretical concepts) devised by Cronen and Pearce (1995). It recognises communication as constructing and reconstructing the meaning that each of us gives to being human; the reciprocal relationship between action and meaning, shaping our lives. Pearce (1999; 2007) describes CMM as having two essential parts, one being coordinating actions and the other being making/managing meaning. Pearce (1999; 2007) describes coordinated as a sensitising concept. He goes on to state that our social worlds are not sufficiently stable but merely suggest directions along which to look, hence coordination does not tell us what are the necessary criteria from which to distinguish between coordinated and uncoordinated actions. With this concept at the forefront, coordination looks at the way people put their actions together, regardless of whether they are well coordinated or not. He further suggested that as human beings our actions in any given moment can be seen through

the lens of coordinating with our families, professions, religions, friendships. Pearce goes on to suggest that we could use coordination as a lens to look at some aspects of our social world, which might be used to liberate us from assumptions we might make about communication, which then helps us to find new ways of relating with each other. Also it gives us a way of finding openings for understanding and acting into the contingencies of our social worlds and it also provides a landmark for discerning the differences among several forms of communication, which we can use to call into being those forms of communication that better meet our needs. He goes on to describe Making/Management/Meaning as not being different as there could be no meaning without action and no action without meaning. We can however differentiate them as doing so sometimes helps us to see critical moments and make decisions about how to go on in these moments. He suggests that we begin to be curious about what specific meanings people make in any given situation, how they are making those meanings and how these meanings affect the social world that they are making.

This means that through the daily activities of learning in the clinical environment, how staff use theory and practice as they make connections within the various contexts of interaction or intervention allows for new ways of working to be co-created. I also understand this to mean that where staff knowledge and skills are recognised as a therapeutic intervention, this creates a way forward in the care delivery process as new stories are told of competences.

Discourse analysis

My reason for considering discourse analysis as a tool to explore my research project is because it draws out themes as they emerge in the text (Smith, 2008). Discourse analysis could be described as seeking to identify the stories lived and told that individuals draw on to make sense of their world and to explore their consequences and limitations (Burck, 2005). Discourse analysis has given me a structure and a lens to view the data. As I am obliged to shorten and leave something out, it helps me to make choices that are difficult, as all data cannot be captured in the writing up of the thesis.

My thinking was that discourse analysis has some similarities with systemic social constructionist research, as with both approaches/concepts we are connecting with our social worlds in a relational and dialogical way. They both invite us to connect to what is taking place in our social world and how we then share our understanding of this, hence my preference to use this alongside with CMM and Shotter's (2005a; 2008) dialogically structured concepts to guide me in the practical step by step exploration of making sense within my research inquiry. These concepts can help us to make sense of our surroundings.

Much of what we do in our daily lives with others we do by having conversations, very often by telephone calls, letters, email and instructions. In these communications language provides the categories and terms for understanding ourselves and others. Smith (2008) and Potter (1998) suggest that discourse analysis is treated as a relatively transparent medium; it is a predominantly directed pathway to what the researcher is most interested in, and some examples, events, cognitive structures, causal relations, or other utterances may be revealing of what speakers are trying to do in a particular situation. Potter (1996) and Silverman (2000) suggest that discourse analysis has many varieties and that the complexities are formidable. They suggest that discourse analysis can be seen as a contested disciplinary terrain where a range of different theoretical notions and analytic practices compete.

Shotter (1993) cited in Burck (2005) suggests that discourse analysis offers a way to scrutinise the orderly ways in which individuals account for and make sense of themselves and their social worlds. Davies and Harre (1997) and Wetherell (1998), cited in Burck (2005), suggest that identity is not seen as a fixed entity, but as reconstituted within and through discourses and descriptions. Burck (2005) suggests that discourse analysis seeks to identify the discourses and interpretive repertoires that individuals draw on to make sense of their world. She also suggests that discourse analysis is located in an aspect of a social constructionist paradigm.

The connections that I made here are in relation to how the nurses make sense of their views of the clinical learning environment and how I, as a researcher within the research inquiry, make sense of their views and my views of this environment.

One strand of discourse analysis, which has its origins in social psychology and sociology and is now commonly used in communication and other social science disciplines, is what I will use in this research inquiry report, namely discursive analysis. This form of discourse analysis aims to make visible the ways in which people's discourse is a central focus in their actions, in the ways it is used to explore events, settings, identities and the various discursive resources that are explored to build plausible descriptions. With this strand of discourse analysis, where talk and text will be analysed, it is the key to understanding interaction and social life. Here, we must pay further attention to analytic practices in the way evidence is used in the form of texts and recordings of interaction, in the way claims are formulated and supported (Potter, 1998 and Willig 2001).

Discourse analysis can be introduced by way of three fundamental principles: (1) Discourse is action-orientated, situated and constructed. (2) Within discourse in action, discourse analysis is concerned with actions and practices where discourse analysts assume a world in motion, a world where getting things done is the paramount concern. (3) Discourse analysis also treats discourse as situated in two principal ways, that is talk and texts are embedded in sequences of interactions; however actions do not hang in space, but are responses to other actions, and in turn, they set the environment for new actions, which also means that it is circular and systemic (Potter, 1998).

Treating discourses as constructed means analysing discourse as working with two levels of discourse construction. The first level is concerned with the way discourse is constructed out of words, idioms and rhetorical devices. The second level is concerned with the way discourse constructs and stabilises versions of the world. In some situations descriptions are often assembled as neutral and disinterested as to the particular actions they construct. An example would be that persons may construct a version of their feelings, or the settings they are in, or a history of that setting, as though for them no alternatives are possible; they are completely real for them as they stand.

Discourse analysis treats discourse as both constructed and constructive. Potter (1998) argues that rather than treating persons as acting in, and responding to, social settings on the basis of

various psychological entities, for example beliefs, feelings, intentions, both the setting and the psychological entities are treated as products of discourse. Potter (1998) suggests that discourse analytic questions can be broken up into a range of themes and, in practice, these themes often overlap. He suggests that the initial motivation for much discourse work is often the result of taking categories from a traditional perspective and then considering them in terms of the practices performed in talk or text intertwined activities.

The main sources of material used in discourse analytic studies are naturalistic materials: interviews, focus groups and texts. Naturalistic materials involve talk and interaction that would happen whether the researcher is involved or not. Interview or focus group material allows for a degree of standardisation across a sample of interviewees, with the same issues being addressed in each case. Such material allows for a degree of control of sampling of participants. Within interviews or focus groups, interviews can tend to be active and sometimes argumentative to facilitate analysis. There are advantages as well as disadvantages of focus groups. One disadvantage of focus groups is that it abstracts participants from their location in settings where they have particular stakes and interest in what is going on, and encourages them to theorise about those settings as if disinterested.

Other tools of analysis that I have considered. I will expand further on in the thesis as to why I did not use these

(1) Narrative analysis which focuses on how individuals present their accounts of themselves and how this is put together by human agents. The data results in story collections which have to be transcribed, selected and reduced. Narrative research is concerned with a particular kind of reflective and conscious ability (Oliver, 2003). Unlike an open-ended piece of discourse, a narrative has a finished structure which does not fit with my exploration of nurses' views and experiences of what creates clinical learning environments as the stories change depending on the nurse who is telling the story, thus there are unfinished stories of what creates learning within these wards (Smith, 2008).

(2) Conversational analysis (CA) which focuses on the study of talk-in-interaction in order to discover how we produce an orderly social world (Silverman, 2000).

(3) Interpretative Phenomenological Analysis (IPA) which is concerned with exploring in detail how participants are making sense of their personal and social world (Smith, 2008).

These methods of analysis did not fit with how I made sense of the data from my interviews with the nurses. Discourse analysis, I felt, fitted with social constructionist ways of exploring and meaning making.

In what follows in chapter 3 I discuss the method/methodology that I used for meaning making and sense making of the research process.

Chapter Three

Method/Methodology: the natural history of my research inquiry

The purpose of this study is to capture the lived experiences of those staff who have worked in the inpatient psychiatric settings in which I chose to do this research inquiry. Another purpose of the research inquiry is to capture the nurses' views and experiences as a way of bringing forth what skills, abilities and experiences might be useful in the creation of clinical learning environments. Also the research inquiry was not to produce facts but instead to explore possibilities within a range of different tasks, abilities, skills, that the nurses felt either already they had or were needed to be able to provide patients with competent care. I felt that a sample size of sixteen staff members was adequate to allow for these possibilities to be heard and noticed. From the sixteen staff that were selected, eight were currently working on the adult acute mental health wards, four were currently working on the secure adult mental health wards, and four were currently working on the secure ward for male adolescents.

I used a qualitative approach in order to obtain the views and experiences of nursing staff on what creates a clinical learning environment. I used this approach as a method to bring to the forefront dialogical ways in which my research inquiry aims to explore the nurses' views and their experiences. I felt that using quantitative methods would not have been instrumental in showing the dialogue in such an interactive manner. Also as my research inquiry is a practice based inquiry, looking at the structural properties of how they shared their views and experiences, it was more fitting to use a qualitative method of inquiry. I do not claim to have uncovered 'truth' about psychiatric nurses' views and experiences of what creates a clinical learning environment, but merely to have illuminated some local and contingent 'truisms' on the research inquiry issues.

The sixteen participants selected met the set inclusion criteria which were that I would not directly be involved in supervising the staff that were to be interviewed and they were all working on inpatient psychiatric wards. All eligible staff who showed their interest by way of a telephone call to me or by approaching me were invited to participate. The choice of the

sample size was discussed with the local ethics committee within the NHS and the private sector. We looked at the number of staff on each ward and we worked out an average of sixteen staff which was adequate for the purpose of my research inquiry which we agreed on. In deciding to use interview materials from sixteen participants a disadvantage of doing so was that not all possibilities were heard, which meant that my results are partial and limited, but at the same time suggestive for a number of possibilities for improvements. This disadvantage does not take away from the possibilities revealed in this study.

Another reflection was that there were two male nurses out of the sixteen nurses who were interviewed and having more male voices in the research inquiry might have meant a different outcome; however this might be for another research inquiry.

Each interview took approximately forty minutes and protected time was agreed between the participants, their managers, and I for such interviews to take place. The participants consented to take part in the study after being provided with a participants' information sheet. After having conversations with the ethics committee we agreed that participants who were receiving clinical supervision from me at the time of the inquiry would be excluded from the study. During the process of my research inquiry I was also part of the same organisation and system. My being inside the system and at times being outside of the system, was a point of reflection for me on how I understood and made sense of the conversations with the nurses, and how I then made sense of the transcripts in my analysis.

At times I was also taking the space between which allowed me to occupy the position of both insider and outsider. I felt that I had to remind myself of my duties and responsibilities as a clinical practitioner working in an organisation that I am also researching into, always mindful of the ethical and moral dilemmas that I could face as I shared the views and experiences of the nurses. I held at the forefront that I needed to be mindful of what were my own thoughts and feelings about how I understood what the nurses were expressing in comparison to what they actually expressed. Dwyer and Buckle's (2009) idea is that the insider researcher is one who has shared characteristics, with shared roles or experience within the situation in which the research inquiry is being carried out, whereas the outsider researcher is outside the commonly

shared experiences or roles of the participants. However, both the insider and outsider researcher cannot be separated from an inquiry as they both would remain always present in the research inquiry. However, as a part of my practice is to be able to self reflect I continued to do so throughout this research inquiry. One of the many biases to being an insider or outsider researcher is that being an insider enriches your experiences of what you are inquiring into, however the disadvantage to this is that you become too familiar with the subject that you are inquiring into, making your judgements questionable if your ability to be objective, reflexive and authentic is compromised. One of the many advantages of being an insider researcher is that your participants might be more willing to share their experiences with you because there is a shared assumption of understanding of a shared experience of role, of that 'you know what I mean' as you become one of them or they may say that you are one of us. I was always mindful of not letting my views or perceptions be clouded by my own personal stories and experiences of being a nurse myself with experience of working at some point during my career in all these in-patient wards. I did so by continuously reflecting on what my own understandings were and checking with the nurses where I felt that I needed further understanding of their own views and experiences.

The participants were recruited from two hospitals. There were at the time approximately 100 staff that fitted the inclusion criteria. They needed to be able to read, write and speak English. I was asked by the National Research Ethics Service, Hertfordshire Research Ethics Committee to write an information leaflet to the relevant wards, addressed to all psychiatric nurses who would be interested in taking part in the research inquiry, and I offered to meet individually with the interested participants that met the criteria (see appendix 4). I was approached by a number of staff on their receipt of my leaflet; all eligible staff were then given a participant information sheet (See appendix 3). The staff who agreed to take part was given a scheduled time for an interview to take place. After each interview it was transcribed with further curiosity to explore at other interviews, which was agreed with the nurses at the start of the process. All the nurses who took part in the research inquiry met with me for a semi structured second interview, where they were offered the opportunity to read the transcript of their individual previous interview. During this process some of the nurses requested that I read their

transcript back to them, which I did. Themes from one interview were used with other nurses in other interviews. This was done in a consecutive series until all sixteen participants, who met the above criteria for inclusion in the study, had been interviewed.

Informed consent was obtained. All participants who agreed to take part in the study were approached by me as the researcher and the study was explained to them individually. All the potential participants who expressed their interest were given an opportunity to read the participant information sheet and ask questions (see appendix 3). A consent form was given to be signed by participants on the day of the interview prior to the interview starting and as the researcher I also signed the consent form at the start of the interview (see appendix 2). The participants were informed that the intended results of the research inquiry would be reported and disseminated by internal report, conference presentation, to research participants and peer reviewed scientific journals. Confidentiality issues were discussed which meant that all the nurses were informed of how the data would be stored, who would have access to the data and how their identity would be kept anonymous. This was agreed to by all participants prior to the commencing of the research inquiry.

The topics that were covered during the semi –structured interview were

- 1.** Work environment, which means the type of unit and client group which is the Adult Acute Mental Health Wards, the Secure Wards for Adult Mental Health, and Male Adolescent Mental Health.
- 2.** Are there opportunities available for the nursing staff to access education and training?
- 3.** Are there opportunities available to the nursing staff to allow them to access clinical supervision?
- 4.** Clinical diagnoses of the patients.
- 5.** What opportunities are available to the nursing staff to be involved in the writing and use of policies and procedures?

6. The opportunities available to nursing staff to make decisions regarding the staffing levels in these clinical areas.

7. What are the views of the experienced (qualified) and less experienced (non-qualified) nursing staff within the clinical environment? (see appendix 1).

An interview schedule was drawn up to ensure that participants were asked the same basic questions in order to maintain consistency. Open ended and follow up questions were used in order to ensure that a detailed collection of data was obtained; these questions were developed until further data collection seemed saturated and no new themes emerged (see appendix 1).

As the researcher I introduced 'circular questions' in order to get a detailed response from nurses of their understanding of their views and experiences of what creates learning within the clinical environments. I used circular questions so as to explore the nurses' views and experiences with the expected outcome of making new discoveries. These questions were intended to bring out the patterns that connected for the nurses as well as how they thought others might see and make sense of what it means to work with shortages of staff. An example of a circular question would be (If I was to ask you what your colleagues would say that the clinical environment has contributed to your development and practice, what might they say?). As a researcher one of my tasks was to be exploratory, hence my connections with Tomm (1988) who suggests that the use of circular questions helps us to orient ourselves to our client's situation, the intent being predominantly exploratory. Tomm (1988) suggests that circular questions tend to be characterised by a general curiosity about possible connectedness of events that include the problem, instead of a specific need to know the exact origins of the problem. My sense making here was that I was forever curious about how possible it is to co-create a clinical learning environment within these inpatient wards and how the nurses can be a part of co-creating this.

I used tape recording and note taking simultaneously during the interview in order to ensure that all data during the interview were fully available. I then transcribed the data that I

collected immediately after each interview, which allowed me to be curious at each stage of the transcribing and interviewing process.

Analysis

As the researcher I used the method of discourse analysis and social constructionist theories as theoretical concepts by which to make meaning of the dialogues with the psychiatric nurses working in these various inpatient psychiatric wards. These concepts focus on identifiable themes and patterns of lived experience or observed behaviour, which followed the listed steps below:

(a) All interviews were transcribed word for word (verbatim) and then read again and again to gain a sense of meaning for them and to gain a mental impression of their overall structure (i.e., overall views of the transcript).

(b) Extracted significant themes and phrases pertaining to the experience under exploration.

(c) Created meaning from statements made.

(d) Organised meaning into cluster of themes.

(e) These themes were integrated into an exhaustive description of the explored topic.

(f) Exhaustive description of the explored phenomenon was formulated into statements identifying their fundamental structures.

(g) As the researcher I returned to each original source in a series of interviews asking the subjects about the findings in order to do a final validation. This was done by arrangement with staff once the original interview had been transcribed.

(h) The staff were informed that if they did not agree with the content, then this would be reviewed and adjusted/corrected as a way of ensuring validity of the information gathered (Burck, 2005).

All tapes and notes from the study were kept in a safe at all times and the principles of the Data Protection Act (1998, 2003) were followed. All tape recordings will be erased on completion of the Professional Doctorate in Systemic Practice. Only myself as the researcher and my research supervisor would have access to the data obtained during the study. I also as researcher used my personal computer to type the results of the study. Password acronyms were used in order to ensure that no one else had access to the typed information. The majority of data that I will use would be from interviews with nurses; however, some of the data would be from incidents that I recounted from my own experiences of being present as a participant in those events.

All information collected during this study has been kept strictly confidential. The identity of the participants is known only to me as the researcher. All tapes containing interviews, transcripts and notes do not have the participant's names; letters of the alphabet were used to identify the tapes for confidentiality reasons. No participant names are published in any of the final reports.

The interviews took place in one of the mental health unit interview rooms and as the researcher I conducted the data analysis. As the researcher I have control of the study and I have acted as the custodian for the data generated during the interview.

Ethics

As researcher during the research inquiry I had responsibilities for the overall management of staff in one of the wards and this could have raised ethical issues as the staff may not have felt free to express their views. No staff from that ward took part in the research inquiry. As researcher I took steps not to interview potential participants whom I was currently responsible for clinically supervising as I was aware of the ethical and moral responsibilities of being an insider researcher. As a nurse in my practices I always try to hold a reflexive stance while always being mindful of how the other nurses who took part in the research inquiry make sense of what I was doing and why I was doing it. On reflection it is important to say that my own experiences, and my own held views on what creates clinical learning environment within inpatient psychiatric wards, were sometimes a source of conflict for me as I had to pay

attention to the nurses' voice of what their views and experiences were of what creates learning within these contexts (Dwyer and Buckle, 2009; Floyd and Arthur, 2010).

I had several discussions with the local Research and Development Department for the NHS Trust who advised that the participants should be those who did not have direct clinical supervision with me as the researcher. Furthermore participants were made aware that participation was voluntary and that they could withdraw from participating in the study at anytime and their role within the units would not be affected in anyway. The staff were reassured about how I would keep the transcripts in a confidential manner so that their identity would be protected throughout and after the process of the research inquiry. All staff were reassured that their names would not be published in any work.

The audience for this thesis will be the examiners, the staff participants, the professionals interested in this area of research and other students commissioned to do research projects.

I would like to introduce the staff that took part in the research inquiry by way of tables which highlight the skills of those being interviewed. I will place these in four categories 1. Qualified and non-qualified psychiatric nurses. 2. Experienced and less experienced senior qualified psychiatric nurses. 3. Experienced and less-experienced non-qualified staff. 4. Staff who were working in the various wards at the time of the interview.

Table 4.1 Qualified and non-qualified psychiatric nurses

QUALIFIED PSYCHIATRIC NURSES	NON-QUALIFIED PSYCHIATRIC NURSES HEALTH CARE ASSISTANT (HCA)
NURSE 2	NURSE 1
NURSE 3	NURSE 14
NURSE 4	NURSE 16
NURSE 5	
NURSE 6	
NURSE 7	
NURSE 8	
NURSE 9	
NURSE 10	
NURSE 11	
NURSE 12	
NURSE 13	
NURSE 15	

Table 4.2 Experienced and less experienced senior qualified psychiatric nurses

EXPERIENCED SENIOR REGISTERED PSYCHIATRIC NURSES 15 – 25 YEARS	LESS-EXPERIENCED REGISTERED PSYCHIATRIC NURSES 5 -12 YEARS
NURSE 2	NURSE 3
NURSE 7	NURSE 4
NURSE 9	NURSE 5
NURSE 12	NURSE 6
	NURSE 8
	NURSE 10
	NURSE 11
	NURSE 13
	NURSE 15

Table 4.3 Experienced and less-experienced non-qualified staff

EXPERIENCED SENIOR NON – QUALIFIED PSYCHIATRIC NURSES (HCA) 20 -25 YEARS	LESS-EXPERIENCED SENIOR NON – QUALIFIED PSYCHIATRIC NURSES (HCA)3 -4 YEARS
NURSE 16	NURSE 14
	NURSE 1

Table 4.4 Staff who were working in the various wards at the time of the interview

FROM TWO ADULT ACUTE INPATIENT WARDS	SECURE ADULT MENTAL HEALTH WARDS	SECURE MALE ADOLESCENT MENTAL HEALTH INPATIENT WARD
NURSE 9	NURSE 4	NURSE 1
NURSE 10	NURSE 6	NURSE 2
NURSE 11	NURSE 7	NURSE 3
NURSE 12	NURSE 8	NURSE 5
NURSE 13		
NURSE 14		
NURSE 15		
NURSE 16		

In the chapter which follows I identify some of the many complexities psychiatric nurses encounter in their daily delivery of care to/with their patients. I will share exemplars from practice as connections are made to theoretical concepts to illuminate some of its meaning. I will number the exemplars in a sequential format.

Chapter Four

Psychiatry in the midst of complexity: Social Constructionism as a theoretical concept to inquire into the practices of psychiatric nurses within inpatient wards – a reflexive approach

In this chapter I would like to discuss how I developed an understanding of the complexities psychiatric nurses experience when working within acute and secure mental health inpatient wards. I will draw on social constructionist theoretical concepts and discourse analysis discussed in chapter two to illuminate theory and practice, and practice and theory connections. By this I mean that I will explore episodes of caring where nurses draw on concepts from writers and authors to show how caring is or could be guided by concepts which have informed their practice and in turn how their practice connects to these theoretical concepts which allows for the possibilities of new concepts; this then allows for knowledge to be developed and shared. An example of how this might make sense in practice is shared by Benner (1984) who argues that while medical orders provide guidelines for many nurses' activities, nurses must use discretion in carrying these out, therefore nurses in their practice must pay attention to literature and medical guidelines while at the same time providing sound clinical judgements. I will use exemplars from the transcripts with the psychiatric nurses where they shared their views and experience of the complexity in which they work and where we co-created meaning in our conversations with and about the clinical learning environment.

Orienting myself

In this section of the thesis, I aim to orient myself to my practice and learning in relation to my research inquiry into the clinical learning environment for psychiatric nurses as we together explore its complexities. I will reflect on some of my learning from being a participant of the (PDSP) programme. I will also aim to draw together my learning and reflections and to demonstrate how this has shown itself within my practice.

In many inpatient psychiatric wards, a number of serious untoward incidents occur on a regular basis, some of them a repetition of similar incidents either on the same ward or within the

other wards. When they occur, qualified nurses are expected to complete incident forms as well as “seven day reports.” Nurses are expected to take full clinical responsibility for their clinical area at the time of the incident. One of my aims is to explore how qualified nurses and non-qualified nurses learn and relate to the ward environment and to patient care. When working within a health framework, the National Institute for Health and Clinical Excellence (NICE) (2009) suggests that treatment and care should take into account patients’ individual needs and preferences, therefore nurses need to be working with this frame in mind, being continually mindful of each patient's needs.

This chapter will explore how psychiatric care is carried out within the midst of complexities. In my explorations, I will be drawing on concepts taken from the social constructionist movement as devised by Shotter (1993; 2010), Burr (1995), Cronen and Pearce (1995), Pearce (1994; 1995), Pearce and Walters (1996), Pearce and Pearce (1998), Pearce (2007) and Gergen (1999), who all suggest that when we interact, we interact in a dialogical way, that we are doing ‘witness’ as opposed to ‘aboutness’ communicating and relating with each other.

These concepts will invite us to bring our struggles with complexities to the forefront. Other theoretical concepts that I will make connections with will be Senge’s (1999) ideas on the use of mental models in organisations, which he describes as the vision of how we see our world. He goes on to suggest that all we ever have are assumptions, never truth, and that we always see the world through our mental models which are always incomplete. I will also draw on Benner’s (1984) ideas about the transitions involved in the development of the novice, first into a competent practitioner, and then into an expert, as well as Smith’s (2008) ideas on discourse analysis.

Also in this chapter I will aim to explore whether the clinical environment in which psychiatric nurses carry out their care has any therapeutic merit with respect to both the care and the recovery processes to which patients, who have accessed the service, are subjected. I will draw on the (NICE) (2009) publication as a point of reference as to what excellent care should look like.

While my role within these contexts varied, it was mostly as a manager that I became curious as to what influence my varied role would have on me as a clinical practitioner as well as a manager. One significant role which I held at the time was that of a family therapist, working with male adolescents and their families, and also with women who were diagnosed as having “severe borderline personality disorder”. During this period I worked in collaboration with psychiatric nurses as they carried out care, following the hospital care pathways (a patient's journey through the admission and discharge process) to ensure high quality care was delivered to meet the needs of the patients that they were caring for.

There are qualified psychiatric nurses with a lot of experience working in these wards; there are also a number of non-qualified psychiatric nurses, some of whom are less experienced. The patients present with various forms of acute mental health illnesses, the diagnoses for which can be found in ICD-10 classification of mental and behavioural disorders and the NICE Guidelines (2009).

In Chapter One I have mentioned the accumulated experiences of psychiatric nurses and the knowledge and skills that they have developed as a result of working in these in-patient psychiatric wards. I continue to place a huge emphasis on this as these experiences are not often gathered together by managers or indeed some senior nurses, or presented in a form that can be made use of by other less experienced nurses working in these complex psychiatric wards. Indeed my own inner dialogue and experience as a practitioner, as I reflect on the knowledge and experiences that I gather from my learning on the PDSP programme and also from my own practices, will bring out how my own understanding can be affected by this material. I will then use these reflections in devising the next steps in my research inquiry.

Experiences from practice and its connection with theoretical concepts

Below, I will aim to share some of my experiences that have brought to the forefront my hopes of inquiring into the complexities in psychiatric care as I continued to be immersed in the practices associated with it, while making connections to the literature and to my struggles, as I

continued to link theory to practice and practice to theory. By this I mean how the nurses worked within the medical model to provide care and how I made sense of their practice in relation to Benner's (1989;1984) sense of how an advanced practitioner provides care in relation to a novice practitioner. Relevant to this is also the written expectation of the guidelines which set out how nurses must practice, these guidelines are from the NMC (2008) and NICE (2009). Further urged on by Bernstein's (1983) ideas of the desperate need to learn to think and act more like the fox (the fox knows many things) rather than the hedgehog (where the hedgehog knows one big thing). Nurses like the fox had many ideas of how they would like the environment to be developed into learning environments and felt constraint by their managers, who seemed to have one grand idea of how more can be done for less. I want to ponder on those experiences and struggles where there are the glimmerings of togetherness among the nurses on the wards, and where the possibilities of a dialogical community exist in which participation could become mutual (Shotter, 2008).

Also as I continue to develop my reflections and self reflexivity on my practice as a manager, therapist, and as a nurse working with psychiatric nurses and having conversations with them about their practice and their reflections (Oliver, 2005), I will explore how my experiences of the complexities with which psychiatric nurses' practice influenced/informed my curiosity to inquire further into their learning and care giving. I will say that as a result of my research inquiry my practice has changed in that I feel more able to hear and to understand the need for experienced nurses to be on a particular shift as opposed to other shifts. For example, on a Sunday afternoon when patients are returning to the ward from a weekend on leave with their family, the ward sometimes feels an unsafe place to be, hence increasing the quality of nursing staff on Sundays has become the safest and more workable way of delivering best care to patients and their carer or parents. Benner (1984) talks about how one gets from the novice to the expert nurse; this I believe has helped to develop my practice since being on the PDSP programme.

This is demonstrated in the transcriptions of a number of episodes and exemplars portrayed below. I will refer to this first transcript as "**Lock Down**". It depicts an incident in a secure unit

where I was asked to help the nursing and therapy team to address behaviours that they were presented with. This transcription is in an episode in which nurses responded in a particular way which invited the patients to respond in a particular way. All numbers listed in the episodes / exemplars refer to psychiatric nurses' dialogue with me, with the exception of the name Cherrie which refers to myself within these dialogues.

(Episode /Exemplar Number 1) Lock Down:

Nurse 3: Patients do not want to get up and dress today, they informed the night staff that they will attack staff and damage property should staff try to get them up and that they were looking forward to a “**lockdown**” (a time when patients' behaviours are so dangerous that the police and other members of staff from the rest of the hospital have to attend the ward to support the current staff. This represents a time when the patients are in charge in a violent way).

Cherrie: Do we know why they feel this way?

Nurse 5: No we do not know, they were very unsettled yesterday, one patient in particular was disruptive, kicking at doors, making demands for nurses' time and verbally aggressive to the nursing team, while the others just looked on, then they all started you know.

Nurse 3: What should we do? It is time for the day's activities to start and we are running late for this.

Nurse 5: What should we do **Cherrie**, you are the Systemic Therapist?

Cherrie: I am not sure that I have the answer to this. How about we do nothing? We let them sleep for as long as they like and on awaking we think about the next step?

Nurse 5: OK. Let's do that and see what happens next.

What followed after was that the young patients, one by one, on finding themselves unopposed, gradually decided to go off to school.

In reflecting on what theoretical concepts informed my practice, and the influence this decision had on my practice, I will turn to Cronen and Pearce's (1995) Coordinated Management of Meaning (CMM) and their ideas on context creating meaning. For me the threat of aggression was in response to not being heard, which presented itself in terms of the patients being hugely aggressive. Thus, when **Nurse 3** said "*patients do not want to get up and dress today*" and when **Nurse 3** said "*what should we do? We are running late*" I was connecting with the idea that there should be no need for violence towards staff, as the staff were about to take a different position in their response to what would have otherwise been the expected response of the adolescents, which would have been to take control of the situation even if this meant with force as the care on offer was that of control and boundary setting in the form of secure services. I also, on later reflection, was able to think of Kendall and Wickham's (1999) idea of looking for contingencies instead of causes. They suggested that when we describe a historical event as contingent, what we want to say is that the event was not necessary, and that this way of seeing the event is one possible way out of a whole series of complex relations between events. So what else was happening within the ward environment was a curiosity that struck me.

Silverman (2000), Potter (1998) and Willig (2001) invite us to think about the utterances in the talk/text and to pay attention to how the utterance is constructed, in what context is the talk taking place and what function they fulfil. Also what is the text doing and how does it manage to do it? So, for example, when the nurse said that the patients were looking forward to a **lockdown**, in my sense making of Silverman, Potter and Willig, and on reflection, the questions that I had were: What did this nurse's words mean? What were they *doing* within this context? My sense was that this nurse wanted me to understand that the patients were in charge of the ward, and as nurses, they were powerless to intervene in any way and therefore they felt stuck in what seemed to be a frightening situation. When the nurse used the words 'the patients were very unsettled yesterday', 'kicking at doors', 'making demands for nurses' time', and 'verbally aggressive to the nursing team', my sense was that these words were doing the task of allowing me to have a visual sense of the patients being in charge of the ward. These words were showing me that the patients were not conforming to the rules of the ward or the

hospital. These words were creating a mental picture for me of the ward and what was taking place prior to the patients declaring that they wanted to have a lockdown. When the nurse used the words 'what should we do Cherrie?', 'you are the systemic therapist', on reflection these words were inviting me to take the position of being in control of the situation. Her words were saying that I should take the lead as they did not know what to do.

When I said "*how about we do nothing,*" on reflection I was also connecting with Shotter's (2008) ideas of aboutness-thinking versus withness-thinking, that is of how we as a team work with the situation at hand as something that needed a deeper sense of thoughtfulness. Also of relevance was Bernstein's (1983) idea of working as a community of practice as opposed to an organisation with rules. Another reflection I had also connected with Bernstein's (1983) idea of finding the resources within our own horizon and experiences that can allow us to understand what confronts us as different or unusual. He suggests that this way of being brings to the forefront such understandings which direct us to the dialogical conversations we can have about our own pre-understanding of what we are seeking to understand.

He goes on to suggest that to have a horizon is not to be limited to what is nearest but to see beyond it, where there are other possibilities. When **Nurse 5** said "*no we do not know,*" "*they were unsettled yesterday,*" both nurse 3 and 5 had been qualified for a period of 5 years. They had both worked in various settings; however these were short term or bank work. This secure inpatient adolescent ward was their first permanent post as a nurse since qualifying. With this knowledge at the forefront my sense making of how they responded to this situation was that their understanding of being able to create or to have a horizon of how best to go on was something that was not clear or understood by them. Within the frame of Bernstein's (1983) concepts of having a horizon, the nurses would not have had the necessary experiences to create the space to see beyond what their current practices held and to have a vision of what they would like their practice and learning to be so that they could be better equipped to provide innovative and safer care to patients. Having a mentor who is able to teach and lead the nurses can help them to be able to learn what it means to have horizons. A mentor taking the position of being an anchor point can also help newly qualified nurses when working with

such complexities who could otherwise find themselves adrift. On my reflection of this episode I was being the anchor point for the nurses, albeit after the event had taken place. On reflection I was also connecting to Benner's (1984) ideas of the beginner nurses who rely on detached and deliberate thoughts of as many variables as possible, while expert practitioners rely on meaningful engagement in the situation at hand. Here both nurses were beginner nurses relying on the way the organisation and the type of inpatient ward usually demands their care and attention and not having the expert knowledge and experience to engage in a meaningful way with these patients. The nurses felt that they had to follow the rules of the organisation and therefore engagement in a meaningful way was difficult. The ward had 15 patients all experiencing a high level of aggression and need. It could be argued that the nurses did not have the space to reflect or to pause, through lack of inner and outer resources, which disabled them in bringing forth new ideas of how to go on.

I will now turn to a second **transcript which I will name as "How do we relate with people?"** This points to my sharing of the stories and conversations that I have had with both qualified and non-qualified psychiatric nurses with regard to their views and experiences as to what kinds of events, communications, and advice from their colleagues have had a learning experience for them. It also explores the kind of specific teaching times and other informative experiences that can/might work to create a clinical learning environment within acute mental health wards.

(Episode /Exemplar Number 2) Nurse 5: Patient requested Yorkshire pudding, nurses refused the pudding as patient did not place an order previously. Patient gets aggressive towards nurses and fellow patients, smashing doors, windows and obtaining a glass weapon with the intention to hurt the nurses and other patients. The patient was secluded for a long period which initiated transfer to another placement.

Cherrie: How shall we reflect on what has happened?

Nurse 5: Well he did not order Yorkshire pudding at his initial ordering of a meal, these patients need boundaries.

Cherrie: Was there Yorkshire pudding that could have been served?

Nurse 5: Yes, but he did not order it.

Cherrie: So he did not order it? On reflection would you do something different?

Nurse 5: I am not sure, it is a secure ward and there are rules.

As my conversations with the nursing staff continued and as we explored together their sense making of this response “to not give the patient Yorkshire pudding,” words and phrases emerged like “emotions”, “feelings”, “hospital policies”, “the need for boundaries”. I was curious about the need from the nurses to control the patient, along with the sense of power over the patients, the use of the medical model and knowing what is best for the patients without the need to treat patients as the best source of knowledge of their own experiences all emerged. Potter (1998), Willig (2001), Silverman (2000) and Smith (2008) focus on the need to pay attention to the discourse and what the words are doing within the context. In this episode for example, when the nurse said ‘the patient did not place an order to have Yorkshire pudding, hence this was refused’, what were this nurse’s words doing? What did she want me to notice? My sense was that her words were doing discipline, control and rule following. What the nurse wanted me to understand was that when discipline, control and rules were not adhered to then there are consequences for all. Her words were painting a picture of the levels of aggression that the patients on this ward perform when they are faced with rules. What also struck me was how the mental models from which the nursing staff worked had such an influence on how the nursing staff cared for this patient.

When **Nurse 5** said

“yes, but he did not order it”, also when she said “it is a secure ward and there are rules”,

my reflections connected with Senge’s (1999) ideas and suggestions, that new ways of doing and understanding practice fail because they conflict with deeply held internal images of how things in the organisation should work. These images, he claims, limit us to familiar ways of perceiving and acting.

He goes on to suggest that our mental models inform not only how we do our sense making but how we then take action. One idea I had was that the nursing staff were following a set of mental models that, for them, fitted with working in secure services and that these mental models were actively shaping how they acted in this instance of providing care. Nurse 5 being a newly qualified nurse with some experience was rigid in her ability to follow a set of rules set by the ward and agreed with management for the purpose of boundary setting and consistency and by doing so she was not paying attention to the patient's need within the immediate context of his need to be fed with a food that he liked and enjoyed. Benner (1984), in tracing the development of the novice to competent practitioner, goes on to state that the most difficult problems to solve require a set of perceptual abilities, conceptual reasoning, and the ability to be engaged and attentive in care provision. **Nurse 5** was unable to think of the next best possible step and how she was going to address the needs of the patient in a satisfactory way; it would appear that she was stuck within a limited level of competences. **Nurse 5's** ideas of the adolescent as needing boundaries, was something that struck me; and my reflections connected with Shotter (2008) where he writes about difficulties of the will as best being described as difficulties of orientation or relational difficulties in which we need to explore how we can find a style or way of approach in relating to others and the othernesses we become a part of. It would appear that **Nurse 5** was struggling with her ability or lack of ability to relate to how the patient understood her reasons for not giving him the pudding when clearly there was pudding available. **Nurse 5's** ability to be relational and be orientated to the situation at hand was something that she either did not have or could not access at that point in her nursing development and practice. If the nurse had related to the needs of the patient at that given time, possibly through a respectful and caring dialogue, then as Shotter (2008) puts it, she would have been relating to the otherness which included the wider situation in which this episode of care was carried out.

To explore how qualified and non-qualified psychiatric nurses learn and relate to the ward environment and to patient care I will turn to this third transcript which I will call **“Sharing the stresses of the clinical environment” in acute adult inpatient wards**

(Episode/Exemplar Number 3) Nurse 13: Patient requested to go for a walk. I asked where he was going and how long he would be. Patient said that he would like to have fresh air and would be out for about 15 minutes. After 15 minutes patient did not return to the ward. We later found out that he had gone home and had killed himself while at home.

Cherrie: I am so sorry to hear this. Would you like to talk through how you decided to say yes to his request for a walk and fresh air?

Nurse 13: Yeah. Well I feel incompetent in my decision as at the time the ward was short staffed. He needed to have fresh air and I feel that my assessment could have been better prior to him having leave. I did not see this coming.

Nurse 13 was a newly qualified nurse in her first post as a registered mental health nurse, having such a huge responsibility placed solely on her was an expectation that on reflection was not in her repertoire of skills to draw from and therefore was beyond her level of competences.

One theoretical concept to which I made connection was that of the medical model and also that of a blame culture, answerable to policies and procedures which connect to the mental model of the way the organisation functions (Senge, 1999). This theory offers an anchor point, a framework from which to think about our practice to help us to challenge our thinking about what the medical model has to offer and what it cannot offer, one of these being holistic ways of working. Had the nurse used a holistic approach to this incident the outcome would have been a better one for all, as she would have paid attention to the details of the request from the patient, ensuring that she had conversations with her colleagues and a more in-depth conversation with the patient. For me this episode on reflection meant that I also needed to change my own orientation to one that would take into consideration the contexts within which we all work.

Bernstein's (1983) ideas of ways of understanding one's orientation with oneself so as to allow for a greater understanding of others, was a connection I also made with respect to this nurse; as for this nurse to have seen this episode she would have had to re-orient herself towards

other possible forms of assessment that might have had a different outcome for the patient. This would have shown itself in having a space where the nurse felt safe to ask questions from leaders and managers even if it was on another accessible ward. This episode suggests a change in the organisational ways of thinking, which will take us away from a blame, name and shame culture to one where we support each other. A culture where we explore our decision making processes without the need to apportion blame. This episode posed a question as to whether the nurse was or felt supported with her decision making process and whether without the shortage of staffing issues which she encountered the outcome could have been a different one. The pressures on the environment suggest a need for change, so that learning could take place. For this nurse having adequate staffing was an important factor in how she made her decision.

One of Shotter's (2008) ideas on spontaneously responsive listening and listening with intention was something that I also connected to, as the nurse shared her experience with me. I began to be curious about my listening when I asked her whether she wanted to *"talk through how she decided to say yes to the patient's request to go out for fresh air"*. I began to be curious about my response and wondered whether I was listening only for the opportunity to speak and was missing my capacity to notice her distress. Within this episode Shotter's (2008) ideas on witness thinking could inform our practices as using his theory as a concept guides us to pay attention to what is requested of us, of what is being said to us rather than being disengaged in a process where being engaged is part of this process. As in this episode, there was a sense from the nurse for the need to be cared for so that she felt able to care for the patient who was entrusted in her care.

Another connection that I made was to Bernstein's (1983) ideas of the need to nurture the type of dialogical communities in which pronesis (*transparency in our working, with a type of ethical and political 'know how', wisdom of practice*) can be practised, and where the views of all human beings are strongly realised. This idea can inform our practice by reminding us of the need to treat others as human beings with basic needs, the meeting of which is required to sustain health, and for us to be sensitive to these needs that all of us have and more so when

you have the responsibilities to ensure that you are caring for someone else, who might be vulnerable in many ways. This idea connected to this scenario where the patient was on the ward for treatment for depression with some suicidal thoughts, albeit he appeared to be in the recovery stage of his illness and was not showing signs or expression of suicidal intent.

On reflection, of the many issues and complexities that psychiatric nurses experience on a daily basis within these clinical areas, one thought I had was to inquire into these experiences using Discourse Analysis to identify themes and stories of influence that have had an impact on how nurses provide care within such a complex area of nursing so as to improve the clinical environment for nurses as well as patients (Potter, 1996a; Potter, 1998 and Smith, 2008). These themes will be further developed in the chapters which follow.

Discussion

As I made connections to transcripts of conversations with nurses from the ***LOCK DOWN episode***, the ideas of social constructionism as being dialogical and being in dialogue with another or multilogue with many others, in a lived experience, was something I connected with as the teams spend time to engage in such dialogue (Shotter, 1993). In these cases, the nurses could have engaged with the patients in a different way, if they had taken the opportunity to have conversations with their colleagues and with the patients. For the nurse who kept repeating that the patient did not order Yorkshire pudding, had the nurse responded in a more spontaneous and exploratory way with the patient the outcome would have been a different one.

One major learning which took place as a result of our talking together was that the nurses felt that they did not need to make a decision there and then; another was that it was good practice to allow for some thinking and talking time to take place within an episode prior to introducing an intervention, a slowing down of the need to respond which is not always possible in all episodes of care.

In making connections to the conversation on ***“How do we relate with people?”***, Burr (1995) suggests that knowledge is sustained by social processes through daily interaction between others in the course of social life. This implies that the ways in which we commonly understand the world, the categories and concepts we use, are historically and culturally specific. One learning from this way of talking was that the nurses felt that it was good practice to listen and respond in a way that connected to what the patients need at any given time, and to allow oneself to be free from “boxing the patients” within a preconceived way of providing care, and to work from within a wider framework of care provision. However, a sense of feeling trapped within the constraints of policies and procedures by the ward was shared by the nurses in that their ability to provide care felt limited. **Nurse 13** had tried out something new and “out of the box” which resulted in the patient committing suicide. Due to the nurse's fears of being disciplined for her actions she said that she should have done a better assessment, here taking full responsibility for her assessment she said “I feel that my assessment could have been better prior to him having leave. I did not see it coming”, implying that she did not follow the organisation's set rules of assessment to a level that she should have done and hence the outcome is a poor outcome. When Nurse 5 said “He did not order Yorkshire pudding” “It is a secure ward and there are rules” this nurse was rigorously following the rules of the organisation in a way that was disabling dialogue with the patient, resulting in a poor outcome. My sense was that should the nurses encounter such situations on the wards they would continue to feel organised by the rules, policies and procedures of the organisation which requires that the rules be followed rigorously. Within each episode a sense of learning could be achieved as the nurses feel able to share their experiences with other nurses, new ideas would emerge, thus widening the repertoire of skills and abilities for nurses on how to go on in difficult ward situations.

In making sense of the conversation ***“Sharing the stresses of the clinical environment,”*** one connection that I made was to CMM, (Coordinated Management of Meaning) which talks about a tool for exploring how the stories that we have about our personal and professional lives connect with the utterances shaping them. A major learning from this way of talking was that

the nurses felt that in this episode of communication making a judgment needed other voices; another was that access to these voices was something they would need to pay attention to.

This diagram which I call CMM levels of context demonstrates stories of influence in my sense making of what nurses said in this episode. The arrow pointing downwards is contextual forces of influence, which holds that one's moral sense of duties, rights, responsibilities and obligations helps to form the highest level of context that you work from. The arrow pointing upwards represents the implicative forces where the context would need to be powerful enough for changes to occur. These two concepts might have an influence on how stories in this episode might be understood. Pearce (2007) further suggests that these levels of context can have an influence on each other and though set out in a linear diagram it is worth holding at the forefront that one context can have an influence on the other which might then change what was initially seen as the highest context being replaced by another. Here the nurse felt a sense of the need to be able to share what she understood as the stresses of the clinical environment, where she related this to a patient in her care not being properly assessed by her prior to going out and the patient later committed suicide while being out. The nurse felt a need to be able to practise in a more supportive environment where learning can take place. The outcome of her experience was powerful enough to result in changes to how nurses are supported through learning from experience.

Contextual Force

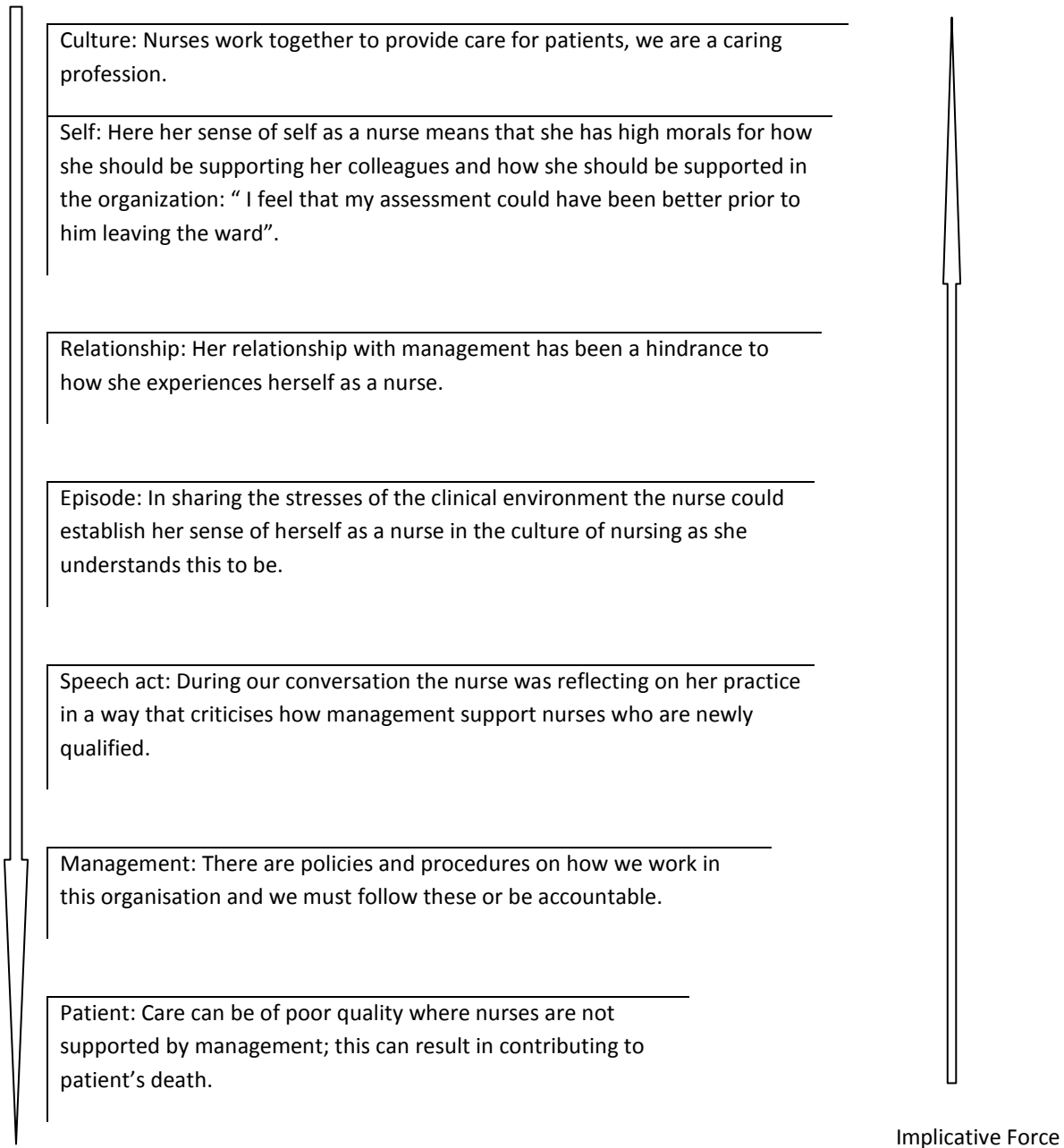


Figure 8.1 CMM levels of context

Adapted from Pearce (1994 p.347)

Conclusion

All these cases are related to what I feel is something that needs inquiring into as we provide care for patients within these clinical environments. During my many conversations with psychiatric nurses and my relationship with some of the literature my curiosity to inquire within their/our working environment emerged.

As I continued to be immersed in the literature and practices I had many thoughts of how these conversations might benefit the team, the organisations, the patients and my practice. This chapter has highlighted the need for a research inquiry into the clinical environment in which psychiatric nurses carry out care. My hope is that as these conversations take place the nurses will feel in some way that a space was co-created with them to explore some of the complexities that they face on a daily basis within the various inpatient psychiatric wards. My hope is also that the nurses will continue to share their episodes of interaction as we work towards a way forward where patient care will be of a high standard.

Summary: In summarising this chapter I reflected on the research questions and whether the questions connected to what the nurses had to say and how they shared their views and experiences. What was noticeable was that the nurses shared their views in a way which highlighted the complexities in the presentation of the patients as well as the system in which they work. The findings from these episodes for me were that there were some differences and similarities in nurses' views and experiences as they worked on the mental health inpatient wards. I was struck by the similarities of how the nurses felt organised by the organisation, shortages of nursing staff, the lack of feeling and being able to demonstrate competencies which was evident in their clinical decision making and the outcome of their decisions. The nurses were able to talk about the complexity of working within the clinical learning environment as they shared their stories about what for them could contribute to the clinical practice that they were engaged in. There were areas of learning which could be applied to other areas of inpatient psychiatric wards, in the ways in which episodes of care were managed.

The two nurses being newly qualified nurses were I would say figuring out what would be needed to create a clinical learning environment for them.

As a clinical learning environment would mean different things for different nurses depending on their experiences, some examples that I felt were implicit that needed to be drawn out were that: The environment needed to have more staff that were permanent staff. The wards needed to have experienced nurses on each shift so that the junior or less experienced nurses could seek out support when faced with challenging decisions that needed to be made with a patient's care. The wards needed to be smaller with fewer patients to care for at any given time, also nurses being able to have a mentor to support their learning and reflections. Learning in the clinical environment would need to be supported by management in order for effective resources to be accessed.

What I would say remains on-going work for the nurses is the ability to further reflect on the implications for the patients in these clinical environments in relation to the different accounts held by staff about what constitutes a clinical learning environment. Another is the ability to identify areas of training that they feel might be helpful to their learning and to develop the confidence to seek out those who can influence the system to act on these by possibly releasing time to learn. What I see as needing further development is the ability to inquire into what aspects of the clinical environment contribute to their practices in the provision of high quality of care for patients and what aspects are detrimental.

In the next chapter the themes that emerged from this chapter co-create the context for how to go on when working within such complexity of care and care giving. I become immersed in the conversations with psychiatric nurses on their views of how the organisation attempts to organise their practice and the constraints and affordances that this way of being within such complexities created.

Chapter Five

Psychiatric Nursing as an Organisation of Practice

'Sense making of learning within the clinical environment'

This chapter is set in the background of my work as a clinician and also as a manager, working alongside nurses in a variety of acute mental health inpatient wards. Working closely with psychiatric nurses in these environments I have gained a close professional contact with their roles and responsibilities. I have seen the difficulties experienced by nurses where they struggled to act in caring and reflexive ways within these 'organised' contexts. An example of this is when Nurse 13, during an interview with her said

'Like I have said they, sometimes people are stuck in their old conservative ways of doing things that it is very difficult for them to accommodate other things because that will entail change.'

The NICE guidelines (2009) suggest that treatment and care should take into account patients' individual needs and preferences. The Nursing and Midwifery Council (NMC 2008) in their code of professional conduct states that nurses should ensure that as professionals, they are personally accountable for actions and omissions in their practice and that they must always be able to justify their decisions.

My three main interests in writing this chapter are: (1) To explore how psychiatric nurses learn and relate to the ward environment; (2) how they are then able to transfer this care to patients where the needs of each patient are at the forefront of care delivery; and (3) how they are then able to work within the framework of above mentioned professional responsibilities in the ward environment when organised by the organisation (Benner,1984). I began to wonder about my own obligations as a nurse and my experiences of psychiatric nurses in my work context.

Situating the transcript materials

As part of this chapter I would like to share with you some exemplars and short stories from psychiatric nurses where patients present with a variety of psychiatric illnesses. These stories illustrate aspects of what nurses can learn on the wards and sometimes how what happens on the ward can impede learning. Some of the nurses are more experienced than others working in these areas of psychiatric care.

One of the many ideas which has informed my thinking is the story that, historically, nurses have experienced themselves as not having a voice. This connects with Benner's (1984) ideas of 'the novice to competent practitioner', in which Benner shared her views on nurses in their novice phase of their development where they relied on the instructions of doctors to guide their practice within the ward environment. During my inquiry with nurses they shared their feelings of being 'organised' by the organisation in such a way that at times it hindered their abilities to deliver care to and with the patients in ways that could create learning for other nurses. They described this as a constraint on their ability to learn within their clinical areas.

I will draw on this poem cited in Morgan (1989) to express many of the difficulties created for psychiatric nurses working in an 'organised' way by their organisation, where trying to fix one problem creates other problems.

There Was an Old Lady Who Swallowed a Fly:

There was an old lady who swallowed a fly

I don't know why she swallowed the fly

Perhaps she'll die!

There was an old lady who swallowed a spider who wiggled and jiggled and tickled inside her

She swallowed the spider to catch the fly

I don't know why she swallowed the fly

Perhaps she'll die!

There was an old lady who swallowed a bird

Now how absurd to swallow a bird
She swallowed the bird to swallow the spider who wiggled and jiggled and tickled inside
her
She swallowed the spider to swallow the fly
I don't know why she swallowed the fly
Perhaps she'll die!

This poem also highlights part of my conversation with two psychiatric nurses where they shared their frustration at feeling that management organised them in such a way that they were rarely ever able to finish one job properly before having to move on to another.

'It is like arranging furniture you know, which I think is not good'. Another nurse describes this practice as 'what seems to be a cure for one problem seems to cause another problem', 'the sense of being on a hamster wheel but the thing is ... it does not stop, because we, there is always somebody that keeps it going.' 'And it only stops when you leave the ward at the end of your shift and somebody else gets on that hamster wheel then.' ' Management then tries to help by bringing in Agency nurses, but these nurses do not know the ward and only cause us problems as we not only have to look after the patients, we have to watch what that agency nurse is doing when she is caring for the patients'.

As the nurses' work becomes organised by the structure of staffing constraints, as well as the power of the managers to organise their practice within the framework of policies and procedures, the nurses described their ways of working as becoming *mechanistic*. Morgan (1989) suggests that this way of working can dehumanise those involved as its very solutions shape the problems to be encountered, resulting in a very mechanistic way of being and relating.

In this chapter I will also explore how psychiatric care is carried out within an 'organised' way of working and the sense making that could be drawn out during and after this process. In my explorations, as I mentioned in chapter one, I will be drawing on concepts taken from the social constructionist movement as devised by Shotter (1993), Burr (1995), Cronen (1994) and Gergen (1999), who further elaborated on these concepts by inviting us to think about our sense making of how care is carried out and then how this gets created in conversations, an approach which I understand as working dialogically, also how one can work *from within* a system with the system exploring what Shotter (2008) calls "joint action" to bring these struggles to the forefront.

Other theoretical concepts that I will make use of are Senge's (1999) ideas of the mental models in organisation, Benner's (1984) ideas of the novice to competent practitioner and the competences which beginner/novice nurses need to have to be able to offer practice that is of expert quality, and Smith's (2008) ideas on discourse analysis as a method of engaging with the transcripts from the nurses. I will draw on other theoretical concepts that fit with nursing practices, including Caramanica and Roy's (2006) views on reflection on practice and the importance of creating an environment where reflection on practice is important for development.

Arnold, Dean, and Munday (2004) offer us the idea of nurses sharing their knowledge and skills in the clinical areas as being useful instruments of learning, teaching to student nurses, where having collaborative ways of working with education can create great possibilities for the development of expert nurses. Cooke and Matarasso (2005) also contributed to these nursing concepts by suggesting that nurses need to have time for reflective practices, which contributes to high standards of care giving. Holmes (2007) takes the view that as nurses we need to maintain reflective practices, which in turn enhance care delivery. Dassen, et al (2007) invite us to think of nursing in the midst of complexity in the sense of the level of violent and aggressive behaviours nurses encounter while providing care for/with their patients and the lack of reporting of some of these behaviours, either because they get used to them or it is too time consuming to report them as incidents.

Slimmer, Wendt, and Martinkus (1990) suggest that nurses should consider the clinical environment as a learning space for student nurses interested in training as psychiatric nurses as there is a decline in student nurses wishing to be trained in these areas of nursing due to negative undergraduate experiences within psychiatric mental health settings.

I will use metaphors to provide descriptive and illuminating ways in which nurses felt organised into a way of working, and also to explore what sense could be made of these feelings.

The metaphor of a 'spider plant' will be central to my vision for clinical learning environments, as where the spider plant sets down its roots, it creates more plants. This is a metaphor that I believe best describes nurses and their practices, when *their* roots are firmly grounded in the theory and practice of nursing. As we talked about how their current ways of working could be enhanced and how this might then become transferable into other areas of their practices, the spider plant was at the forefront of my thinking. Its shoots are pointers which connect with how learning could be created, co-created and shared, thus creating several clinical learning environments where care is of the highest quality.

To introduce the spider plant as a metaphor in making sense of the events I explore in this chapter, I will say something about its origin. The spider plant is called *Chlorophytum Comosum*; it is recognised by its long thin bladed green leaves which have white stripes down the middle. It got its name from the long curved leaves that come from a central point and give it the appearance of a spider. Its leaves reach up to 40 centimetres in length and about 15 millimetres in width. When mature, the plant will also produce small white flowers. The plant is popular for homes and offices due to its resilience and ease of care. It needs moderate light and water, and it is difficult to over water this plant. The plant is also well known for its ability to clean the air and absorb hazardous chemicals from the soil. This plant is easily multiplied (propagated) to create other plants; this can be accomplished by either splitting the central stem into two or cutting off a plantlet (miniature plant that grows at maturity) and planting it. After replanting the cutting or plantlet, it will grow roots and become a new independent plant (Dunder, 2009). Below I would like to show a visual image of the spider plant with its many possibilities for setting new growth.

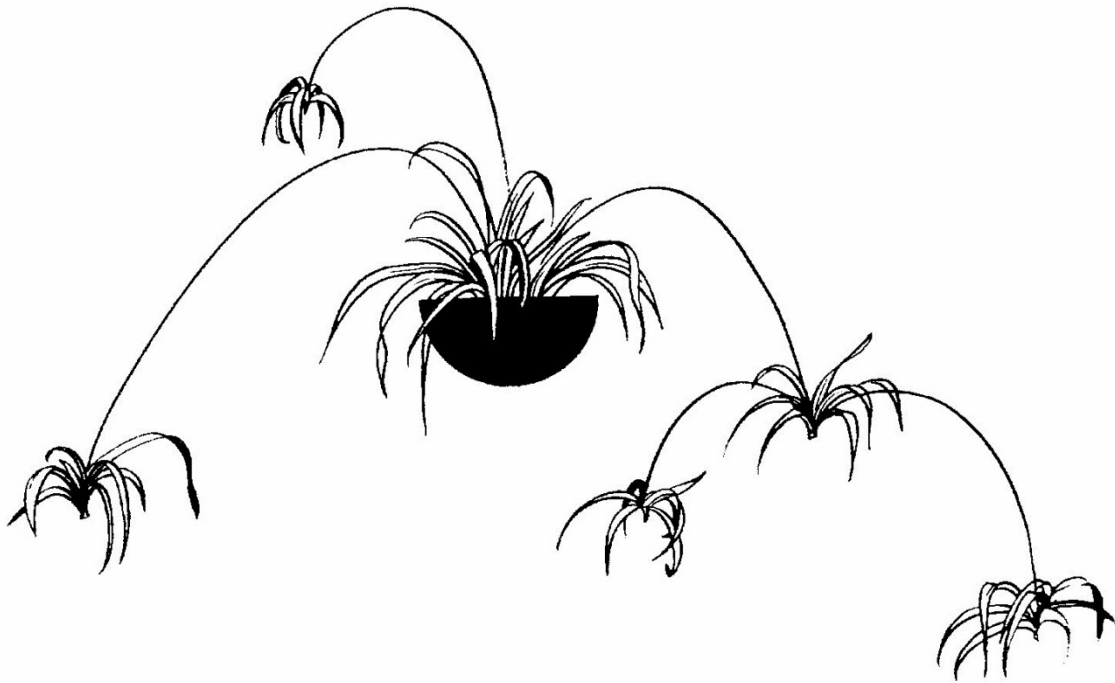


Figure 8.2 Spider plant

Adapted from Gareth Morgan (1997a. p.64)

Morgan (1997a) uses the spider plant as a metaphor to explore the various ways one might be able to understand how an organisation can embrace changes, having that visual sense of how the spider plant grows and changes and the condition under which these changes could develop. One connection to Morgan's (1997a) ideas of the spider plant metaphor was how the nurses can create or co-create a sturdiness that would wither away some of the organisational ways of working so that they become as the spider plant, which would enable them to work in many different and sometimes difficult conditions. The nurses in the various wards struggled with the concept of being sturdy, this was mostly due to the staffing levels on these wards, the lack of adequate experience for the responsibilities that they were given and the general lack of supervision, both of a formal and informal nature.

The metaphorical use of this plant brought to the forefront of my vision how psychiatric nurses working in inpatient wards would eventually grow, and be sturdy, and propagate in their practices as they moved around within the various fields of nursing from inpatient wards to community based work; and also, to bring to light how some of the blind spots which the nurses experienced could be avoided.

To point the reader to what Morgan (1997a) describes as something to be mindful of when working within “organised closed ways of working”, he suggests that powerful visions of the future can lead to blind spots, where ways of seeing also become ways of not seeing. This way of working resonates with psychiatric nurses as their work becomes organised by policies and procedures, where they become constrained in a way that at times prevents them from acting in other ways, thus preventing them in their thinking and acting, closing down possibilities of changes that will invite them to act in different ways. This becomes so when they have to work under pressure, where their creativity and productivity is measured by a culture of outside authorities, and where their own values of what constitutes caring become a constraint as they are unable to create a learning environment within the constraints of the organisation.

Here is an example which illuminates this way of thinking:

Nurse 13. ‘They will try as much as possible to discourage you by saying that it is not necessary and that you do not need further education and professional development as long as you can manage people on the ward.’

In this chapter I will show how psychiatric nurses working in acute inpatient wards struggle with some of the confinements/constraints of creating a learning environment. I will focus on some of the themes that emerge during the interviews that exemplify the ‘organised’ way of working. I will draw on the themes which highlight the possibilities which are available for psychiatric nurses to develop their abilities that might help to create a learning environment. It is also through my own experience of working in various contexts of the psychiatric inpatient ward environment that I have developed an interest in the way care was/ is carried out, the ability to

make decisions and how the decisions are made and then implemented, the chaos surrounding care plans in that they are sometimes incomplete. Care plans are tools used to guide the professional to provide the appropriate and safe care for patients, which are then used as tools for helping to create the care pathways for patients; it remains of crucial importance, therefore, that care plans are in place for the patients. For the nurses working within inpatient settings there appears to be a lack of space for reflection on their clinical practices. I will share transcripts from nurses on the level of aggression they have experienced from the patients, and how they felt that this was managed within the confinements of an organised way of working. I am also curious about how junior nurses learn within these environments and how senior nurses continue to develop new skills within the situational imprisonment that they appear to be working within, where the constraints are imposed by the way that the organisation 'organises' them, where there are pathways which are not yet visible.

I am curious about what appears to be, as Senge (1999) suggests, the unofficial favoured ways of practice which become traps that confine the nurses within 'organised' socially constructed practices, which they themselves have not participated in constructing. This I believe prevents them from exploring other ways of practising, where shared illusions and poor practices become the norms that interfere / hinder their abilities to think critically. Where these other ways of practising, within the organisation, 'organise' the nurses in ways that invite an assumed agreement, which then inhibit them from expressing their concerns about a practice.

During this chapter I will demonstrate how I have worked with transcript materials to co-create new understanding of transformation. Here psychiatric nurses seek to create new information about themselves and their environment. From the excerpts of transcripts the nurses shared how the organisation's way of 'organising' them in the environment of care hinders/ constrains their ability to learn, teach others, also what possibilities there are to create what they would like as a way of learning within their care environment.

In this chapter I will write in small self contained fragments where each one is aimed at arousing in the reader a sense of a particular situation in all its concrete details, a character of a particular concept, moments when a particular concept illuminates a particular situation and

other fragments which seem to me to arouse a special awareness in the reader to notice aspects of their own situations which are usually not responded to (Shotter, 2005b). They are written with the idea that after each one the reader will take time out from reading the text on the page and begin to do some imaginary work on their own to explore experiences of their own, which seem in some way to resonate with the character of the fragment that they have just read (Shotter, 2009).

Some of the fragments that I will be writing about have come from the interviews that I had with the psychiatric nurses and also from my reflections and integrations of these voices of request for change. I will also show how I have used these voices in a way that has invited / co-created a special type of learning in my current clinical place of work, where an organised way of working was very much at the forefront. In my thinking about theoretical concepts that I can draw on to help bring forth the themes that I was curious about, I connected with the concept of discourse analysis, which Smith (2008) points to as discursive analysis. This he suggests could be used as a tool to draw out the themes as they emerged in the text. I will also draw on Burck's (2005) ideas of discourse analysis being used as a tool which seeks to identify the stories lived and told that individuals draw on to make sense of their world and which they use to make sense of exploring their consequences and limitations.

Here are some of the themes that I will be making connection with in this chapter, which have been as a result of reading and rereading the transcripts: 'Feeling Subdued', 'Lack of involvement', 'being told what to do, there is no learning to experience' 'I have no voice, my words are not heard', 'feelings of failure', 'lack of time to reflect on one's practice and the busy ward environment'.

1. An 'organisation': What does this mean to psychiatric nurses?

Here I will share how nurses described their experiences on the ward, where they experienced a number of concerns, some of which are the lack of staffing, lack of training, lack of experienced nurses on duty on any given shift, experiences of violence towards nurses on the ward, lack of space and time for breaks and reflections, and the administration of the wrong medication to the patient as they continue to work in what they see as "within an organisation's way of working".

Nurse 6 is a newly qualified registered mental health nurse with approximately seven years experience of working on the secure ward. This is her first job after qualifying as a nurse and within the last two years she was promoted to a team leader post, which means that she has responsibilities for leading a team of nurses in delivering care for patients on a daily basis. This is an excerpt of our interview conversation which reflects how she and other nurses felt:

(Episode/Exemplar number 4)

"... obviously there is the staffing issues that you are always having to battle with being under staffed on the ward which is very tiring and people such as agency nurses, who are not at all committed to the job and are just there for the money" "... I think that we have had a very supportive team on the ward yes, (laughs), we had, but it has been a bit harder at present because there had always been good support. But at the moment there has not been such good level of support, but the team has still been there, so that has helped really. There are some very good managers that you could go to for support but I would not say that all of them are approachable

Cherrie: Right ... would you say that having more/better managers that are approachable would you say that this would then be better?

Nurse 6: Yes, more approachable, who do not do a "them" and "us situation" I very much feel that there is a them and us

Cherrie: What do you mean? Is there a separation between yourselves and the managers, a separation between the junior nurses and the managers?

Nurse 6: Yes, yes, definitely

Cherrie: ... what effects do you think that has on having the clinical environment as a learning environment, not having supportive managers around?

Nurse 6: I think that this is very de-motivating to people, so I think that there is a lot of people at present who is not working as well as they could because they have lost their motivation, they are not feeling so supported on the ward. I have noticed myself that there has been more sickness within the ward, so there is people changing shifts, there is not as much commitment to the ward at the moment, so it is like a stone and it puts out a ripple, so it has a knock on effect throughout and it is also disruptive to the patients.

Cherrie: So if you had a voice to speak with management what would you say to them?

Nurse 6: ... I would want to say well the things that I have been wanting to say to them for a long time, (laughs), that they really need to up the number of staff to support the nurses to make it a more positive environment. Also if they could at some point get rid of agency nurses and build a better team then we could be supporting each other on the wards

Here the nurse is saying many things and using many words which, on reflection, aroused a curiosity in me as to what her words meant, for example when the nurse uses words like 'battling with being understaffed', these words are doing the action of describing the shortages of staff on the wards. Her words invite me to understand the context in which nurses are providing care and how the nurses actually do this care. Also her words bring to my consciousness what is needed to provide better care to the patients on these wards. Nurse 6's words also were doing the task of allowing me to notice that she was not showing lack of support for the organisation or blaming the organisation for the current state of staff shortages when she said 'but the team has still been there so that has been helpful'; her words 'there used to be better care and learning taking place on the wards' meant that it is possible for this to happen again. Her words set the scene from her experiences of what helps and what is not so helpful, examples being 'agency nurses who are all not committed to the job and are just there for the money', 'staff being tired', 'staff being de-motivated', 'staff losing their motivation', these words are doing the task of informing me of what needs to happen in order

for the clinical environment to become a learning environment: there is the need for staff to be supported, to become interested in providing care and to feel motivated in their own caring abilities. The nurse, in expressing the quality of her experiences on the ward, remarked here that not all the managers were approachable, that lots of things needed to be said that were not said, that when obvious deficiencies are not addressed people become de-motivated, and in the end this extends out into the feelings and attitudes even of the patients. This nurse is very clearly aware that gradually, in an atmosphere of unapproachable managers, divisions occur and supportive collaborations disappear. Her words build a picture of how the clinical environment could become a learning space when agency nurses, whom she sees and experiences as not being interested in caring for patients, were no longer given employment on the wards and staff were able to build better teams where they can support each other in care delivery, (Silverman, 2000; Potter, 1998 and Willig, 2001).

Nurse 8 is a registered mental health nurse with twelve years experience of working in both secure and acute mental health wards and she is currently working as a nurse manager on a secure ward. She says something similar to nurse 6, but she adds some important details:

(Episode/Exemplar number 5)

“I suppose in the last eight months, it has been around more senior management decisions around resourcing, there is a system of managing staff on each shift, which is patients per day rates (PPDS) which means each ward has assigned a figure in the month and that is like an average which means the manager has to manage and make sure that we meet an average in the month and what this means is that we do not have as much resources as before. The number of staff is determined by the occupancy of the ward, so it just means that there are more tasks to do for less staff. The (PPDS) has impacted negatively and also the Well learning is squeezed out, because that is something that cannot be measured, so staff will prioritise the things that have got deadlines and reports that need to be done and be followed up on and really people then to work more in crisis mode to just get through each shift em, in terms of quality of documentation it you know it suffers, that is when they get supervision; I mean team leaders are also struggling to have supervision with the junior staff because of the time and the other commitments on the ward so that bit will also suffer, lots

of it is with the level of frustration within the staff, I mean some people also talk about looking for other opportunities as their expectations are not being met.”

While Nurse 6 talks about managers being unapproachable so that important things are unsaid, Nurse 8 remarks that even if needs for supervision and learning time were expressed the need would still go unmet as such needs are not measurable. Indeed if they were measurable, they would probably affect the overall budget index (PPDS) negatively. So here, paradoxically, in my understanding of nursing, we have a budgetary index leading to reduced quality of nursing care rather than to an increase in it.

Below I will list a number of different accounts of what an organisation is. First I will turn to Cole (1988). He claims that an organisation can best be described as ‘the framework of the management processes’. Organisation could be described as having two parts, one to describe the process of organising and the other being to describe the social entity formed by a group of people (Cole, 1988). Argyris (1960) cited in Cole, (1988) suggests that organisations are intricate human strategies designed to achieve certain objectives.

In a systems approach, organisations can be described as open systems which respond to external and internal influences when attempting to develop and ultimately achieve their set objectives. Some key areas of the systems approach focus on the relationship between formal and informal ways of organising the relationships to include the external environment, boundaries and the organisation’s culture (Cole, 1988).

In making connections to the above ideas of organisation within the context of psychiatric nursing the idea of the need for nursing to be a learning organisation was a story shared in the interviews with nurses. Their sense of this was that the organisation should be one in which the management team should be responsible for identifying and solving problems, thus allowing the organisation to improve and increase its capability.

During my interview with Nurse 8 she described the intensity of the organisational environment to health care issues both for the nurses and patients:

Nurse 8: “I am on a different ward now because I was experiencing burn-out. I was most concerned with the levels of assaults on staff and there is nothing that has happened in terms of remedial work to look at how we as staff or how to prevent the frequency of incidents and assaults on staff taking place”

From my experience as a nurse working in the various types of inpatient wards I would say that ‘burn-out’ in nurses occurs when they have to go into stressful situations everyday that they have no control over. When they have limited experience for the level of need that is required by the patients and when the support level is lacking and sometimes not always available to them. This also results in nurses not being able to sustain their motivation and results in poor care outcomes.

In reflecting on the words of the nurse and what these words were doing, for example, when the nurse uses words like ‘I was experiencing burnt-out’, ‘she was concerned with the level of assaults on staff’, ‘no remedial work done with staff on how to prevent the frequency of incidents or incident and assaults on staff’, these words were creating a vision whereby the atmosphere on the ward is so extreme that the nurses are not able to carry out their basic everyday task of caring for patients and within this context learning is not possible. The nurse’s words of ‘staff working in crisis mode’ paints a picture of chaos and lack of caring leadership which has a very top down feel to it. Her words were inviting me to feel the frustrations of the nurses who were working on the wards. Her words were also helping me to create a mental picture of her struggles as a manager and nurse, where she had explored a lot of thinking of how creating clinical learning environments might be possible. Her words invited me to look for opening possibilities in which learning can take place, (Silverman 2000; Potter 1998 and Willig 2001).

Nurse 8 during our interview shared aspects of the environment that she felt could help to create learning, although she was also identifying that much learning is needed for the environment to continue to develop its learning capacity and managers to be held responsible for this process:

(Episode/Exemplar number 6)

“ ... my views would be, maybe an objective measurement of people's training needs, that is supported by adequate resources, which would be time to engage in learning, whether it be discussion or time to look at research articles, it would be about more senior staff having protected time to engage in micro teaching or formal teaching with more junior staff to develop them, and even the most basic thing around supervision, because teaching can take place in supervision, and also an environment where students from different disciplines are able to come for placements, and also where there is more structure where there is research being encouraged and research taking place. ... I think initially it is more around staff motivation, looking at staff motivation and ... looking at things that incentivises the teams, because the work is quite difficult and although it is a secure ward, there are different secure wards where the acuity of the patients is different from say similar secure wards in any NHS trust, and certainly the low secure wards would probably be classed as medium secure wards in some of the hospitals that I am aware of, also it would be probably look at the advocacy of care for patients so that we are delivering evidence based care, and the aim would be to improving our practice. You would probably see high levels of engagement by patients in therapeutic interventions that are offered, the patients would be able to give feedback, like in the volumes of complaints sometimes is indicative of things not being as they should be and the volumes of complaint would be reduced, and I think that the patient length of stay could be impacted by well trained staff. I think that you might see, well it may not necessarily impact on how long the patients stay, but more about their quality of life, more about re-equipping them with life skills and how they progress in their care pathway. Because sometimes you might have patients, who for instance may stay on one-to-one observations, but there is no actual objective reason for someone to stay on one -to -one observation for a long period of time, and it just means that their abilities to engage in other more meaningful therapeutic activities are delayed, their risk is exaggerated but not measured”.

In making connections to Potter (1998), Silverman (2000), Smith (2008) and Willig's (2001) ideas on discourse analysis, Nurse 8's words were doing the task of inviting me to see the changes that she was able to think about as possibilities. Her words were creating a mental picture of a new environment which demonstrated that she was capable of co-creating a clinical

environment with spaces for learning. Her words invited me into her thought processes of what is possible on the wards, what had previously been 'burn-out', and de-motivated environments, were now turning into possibilities of clinical learning environments. As I reflected on this nurse's abilities to have a sensing of what was needed to change on the wards for these possibilities to become actualities, her words were creating several images of the clinical environment and the struggles therein for nurses.

Nurse 8 sets out her views and experiences of what it means for her to work in the clinical environments and what she experiences as needing to change for the clinical environment to be a better place for care delivery to be of a higher quality than currently. She focuses on staff motivation, and the importance of sustaining it. As a senior nurse, though, her judgement of the needs of the nurses to have supervision and teaching was not a request that she felt able to ask for within the organisation in which she worked. She wishes that there could be an objective measurement, which would seem difficult to arrive at from her description of the hospital ways of organising care. So although she has a clear idea of how care could be improved, her frontline knowledge seemed to be going to waste as there appeared to be no openings for this to be shared or indeed wanted. This nurse in our second meeting to read the transcript, once it was read back to her wept and said that not much had changed and that she was thinking about her options of leaving the organisation and setting up her own health care unit.

2. 'An Environment that is not conducive to learning'

I share these exemplars from the position of having what Bernstein (1983) calls 'background knowledge', my knowledge of nursing in the inpatient ward environments was something which enabled me to have some understanding of what was said. I gained understanding through the laborious struggle of tracking and returning to the transcripts in such a way that one might call living with the transcripts. These transcript extracts below I see as building blocks of my understanding, which I discovered through the reading and rereading of the parts and

the whole. Also by continuously tracking through the most local of local details so as to bring forth a global view, in such a way as to bring to the forefront the struggles faced by psychiatric nurses working in such complex environments. Here I am connecting to what Senge (1999) suggests that we should pay attention to. He suggests that the reason why new ways of doing and understanding practices fail is because they conflict with deeply held internal images of how things in the organisation work. These images he claims limit us to familiar ways of perceiving and acting. He further suggests that our mental models inform not only how we do our sense-making, but how we then take action.

As I reflected on what it would mean to have an organisation that is conducive to learning I made connections to the possibilities of having a particular skill mix in terms of experienced and less experienced nursing staff that matches the patient's needs, as it is crucial to have this skill mix at the centre of care provision and where patients' care is of a high standard and where care could be measured by admission and readmission processes. Caramanica and Roy (2004) suggest that it is of great importance to have someone with a clinical leadership position on each unit, where their expert knowledge will serve to assist clinical staff at the bedside so that the experienced as well as the inexperienced nurse could grow professionally and personally in their role as direct patient care providers.

Benner (1989) invites us to think of the nursing environment as one which has the primacy of care at the forefront. Benner invites us to ponder on the ability to be present in oneself, to be confident in our knowledge and competences when we are providing care for/with the patients, in a way that acknowledges your shared humanity. This she said is that which forms the basis of much of our nursing as a caring practice. Arnold, Dean and Munday (2004) suggest that we as nurses should not only focus our learning on practice but we should also have at the forefront thinking and problem solving skills which form the basis for theoretical frameworks for practices. My understanding of these suggestions is that nurses must extend their knowledge to be able to engage with themselves, the patients and their organisation at a macro-level which can be gained through the process of reflective practice and dialogue. This could be achieved by nurses having a human resource capacity for providing care, which will

have in itself the ability to find other possibilities which already exist but had not been noticed or drawn upon before. For example extending their current resources by doing group work with patients where less nursing input in terms of numbers is needed. Another example could be inviting patients to find their own resources which they could draw on, so that not every intervention is carried out by nurses; this will also help with the recovery of patients, which is what caring is about.

I will use exemplars from five psychiatric nurses who shared with me their views and experiences of the meaning of an organisation to them. I will make connections between practice and theory.

Here are two exemplars (Numbers 7 & 8) where nurses shared their views of the inpatient ward environment.

(Episode Number 7) Nurse 12 has been qualified for eighteen years and has worked in several acute mental health wards. She has a vast amount of experience in nursing care and has experienced many management changes during her nursing career. She was acting as the nurse ward manager at the time of the interview:

“But standards drop then, because you cannot cut corners with patient’s safety. So you cut other corners and then that always impacts on the standards that you provide and then your quality of I suppose life is affected really, because you go to the toilet late as you leave it to the last possible minute. You are shoving food in as you are on the go, you are doing your care notes and you are eating your lunch at the same time because you do not take breaks; all things like this that is not conducive to a learning environment. You know that you should do something and there is many times where I think, oh the doctors have said something and what I used to do was ask what does that mean, or I will look it up, but now that goes down, that slides down the list of priorities, because you can function without knowing it, but it is dissatisfying when you have not increased your knowledge. And it is difficult because it almost sounds an unrealistic thing to say that this is what needs to happen. Because it is almost a fantasy world, where this is how the ideal should be, but the reality is that it is quite disheartening because on the one hand you are trying to improve the standards with the

inpatient questioner survey thing, you are trying to do things with the productive wards to improve things because you know that the standards have been dropping, but realistically how do you create more time, you know, if you are moving faster and faster how do you create time for learning?

Staffing is another issue which hinders learning on the wards, so all these things will impact as well and you have to fit in finding staff because that is a priority because you then cannot leave the next shift short of numbers because that is when incidents happen. So it is all these things, and because of that you find people, for me when you have got these jobs it is alright for people to say well you need to prioritise and that you cannot do everything, but there are so many things that have got to be done, what you do is move faster and faster and of course you have to start cutting corners, but you have to be able to cut corners that are safe”

In my reflections on this exemplar I began to think about my own practice and expectation of myself as well as from nurses. I began to look at my practices and saw the environment in a very different way. I noticed that I had repositioned myself and continued to think what it would be like for me to work as a nurse on a shift within this environment as I had noticed that as a manager, management within an organisation had also re-positioned me to think strategically. I began to revisit what I stood for that had in the first instance ignited a passion within me to inquire into psychiatric nurses’ views of what creates a clinical learning environment. I saw the clinical environment as connected to my practice as opposed to disconnected and as a playfield for inquiry. I began to question and be curious with myself as to how I can practise differently and saw the clinical environment as a way to do witness practices as opposed to aboutness practice (Shotter, 2005a). Where instead of thinking that you already know what is needed for the patients, you begin to get into dialogue with the patients as to what they see their needs as being and how together with the patients we (patients and nurses) work together to meet their needs. Also where we begin to create a forum to ask questions about the usefulness of the inpatient questioner, which is a set of questions set by the organisation to measure how the patients feel their quality of care on the ward has been and what can help make their admission to the wards a good experience for them and together

with the management team and the patients create a joint way forward. Where we begin to look at possibilities of slowing down acting into situations and encouraging patients to take the lead in how their recovery process can begin. In connecting to the above example where the nurse is saying that standards drop and staff cut corners, working with Shotters' idea of witness as opposed to aboutness engagements, more fruitful work would be possible as this would open up dialogue on how to go on. The need for creating reflexive spaces or arenas where nurses could come together even if in limited numbers to reflect on their practices is an important finding which needs to be filtered back into the hospitals so that standards of learning and care giving could be improved. The need for supervision both formal and informal would be a way of introducing theory in a way that gives meaning to the care provided by the nurses. As I reflected on Silverman, (2000) Potter, (1998) and Willig, (2001) idea on sense making of words and what these words are doing; these words highlighted for me the many possibilities of working with the nurses in a more connected way, where practice and theory could be woven together so as to be engaged in why it is important to have reflexive spaces. I believe that this has the possibilities for changing practices and creating learning.

I also on reflection made connections to Benner's (1984) ideas of the novice to competent practitioner, where she states that the most difficult problems to solve require a set of abilities namely perceptual abilities, conceptual reasoning and the ability to be engaged and attentive in care provision. One reflection that I made to Benner's ideas was that as I did the back and forth tracking of the interview transcripts, what I noticed was that there were many abilities that this nurse was able to draw on and that despite the lack of resources she and her colleagues were able to provide care that was safe enough as they noticed what was important to pay attention to as they did caring within this inpatient psychiatric ward. I would describe this nurse as a competent practitioner, someone who could see what the situation calls for and act within it, noticing what is needed to make it better and striving to do so as she described the difficult working and learning clinical environment when she said:

“but there are so many things that have got to be done, what you do is move faster and faster and of course you have to start cutting corners, but you have to be able to cut corners that are safe”.

Another reflection I had when thinking about the above exemplar was that of the competent practitioner where this nurse had many stories of what is a learning environment, some of these may connect to her past experience of being a nurse in other less chaotic wards or of her own experience of what learning means when providing and receiving care. These stories were interwoven and did not always seem to connect. One story is that of her privileging the chaotic nature of an inpatient ward which brings with it its own difficulties in relation to how one can learn, the other being there is a lot to learn when the ward is chaotic as the nurse needs to provide care on a number of levels within the context that the care is needed, these skills being that of a competent practitioner. Benner's idea of the competent nurse being able to assess what the care needs are that as a nurse you must be able to prioritise, as the nurse is equipped with the experience and skills to do so, however for this nurse and other nurses who took part in the research inquiry the clinical environment did not seem to enable these skills to grow and develop which could result in "burn-out". The nurse in the exemplar was drawing on her years of experience; she was drawing on her level of competency to manage the care of the patients on the ward despite the managerial and environmental constraints. In comparison a novice nurse needs to work from a manual of how things/care can be done, which by its nature impacted on time, care and learning as they have not yet developed the skills and abilities to assess the patient in a holistic way within the time limited resources. There were a number of nurses who took part in the research inquiry who did not have as many years of experience and would fit with working from a novice stand point. My sense making of this is that the novice nurse should always work with the guidance, support and mentorship of a competent nurse, observing and practising these skills until she/he feels that she/he can "master" these skills, thus improving her competences and providing high quality care within a time limited, resource limited context where there is a high level of demands and expectation on the nurses providing care. I believe that management can do something different by having dialogue with the nurses about their skills, abilities and needs in order to provide care that is of the highest standards, rather than having policies and procedures that do not involve feedback from practising nurses within these wards. Away days are useful where managers can join the nursing team in helping to plan what is needed within the environment to co-create learning spaces.

I was curious about this nurse's understanding and sense making of what she thinks that she might need when working in such a fragile environment and had at the forefront of my thinking the usefulness of receiving clinical supervision. I asked the nurse whether there was anything that was useful to her learning and her practice within the clinical environment; her response was:

“it sounds really disheartening, and negative but if you ask anybody they will probably say nothing, because it feels, well morale is very, very low, people are exhausted, somebody the other day turned around and said that they cannot do another shift as they were exhausted, because when I checked I have done twenty one shifts straight, because people when they get a day off somebody called them to work. It is like the other day, twenty to seven on their day off somebody called them to work because we could not cover the shift”

The nurse went on to say that she did not always have access to supervision and that she could not tell me the last time that she had supervision in its formal sense; however she was able to talk with another senior colleague about some of these issues of how she was experiencing working within the clinical environment. These experiences of being able to talk with another senior colleague she said has shaped her actions in her practice as she used these conversations as a place for her to reflect on what she was actually doing in her job.

Bishop (1994; 1998) and DOH (1993) cited in Jones (2001) suggest that the introduction of clinical supervision could be helpful as it may recognise the need to protect professional practice. They suggest that work discussions that take place in clinical supervision offer a sustained environment for nurses to develop competencies. UKCC (1996) put forth a view that clinical supervision is considered to be an effective means of providing learning, enhancing nursing work and generally helping nurses to identify networks of support and recognise strengths and achievements. Jones (2001; 2003) suggests that clinical supervision is concerned with assisting the effectiveness of nursing practice by allowing time and space to think. This, he suggests, might help nurses to consider areas of strengths and bring to attention any oversight but most importantly to recognise the complexity of nursing work.

Bishop (1994; 1998) also suggests that the emergence of clinical supervision is a major issue on the nursing agenda and it is an exciting development that offers the profession an opportunity to maximise its enormous potential both educationally and politically. Bishop (1994, 1998) also argues that clinical supervision should have goals such as: safeguarding standards of practice, developing the individual both professionally and personally, and promoting excellence in health care. Norman (1997) cited in Bishop (1998) states that one of the vital frameworks of clinical supervision is having a supervision model which gives nurses the opportunity to audit the quality of their practice through reflection. It enables nurses to identify and to overcome shortcomings in practice, it encourages practice that is research based, with the result that standards are maintained and the potential harm to the patient is minimised which helps with risk management in having a tool by which outcomes could be measured.

Holmes (2007) suggests that too often nurses are left to 'pick up the slack' where the organisation organises the way that they work and that supervision could be a forum in which nurses could claim some space for reflection. Being mindful of working on these wards at some point in my nursing career, in order for nurses to reach a point in their practice where reflection is something they believe could enhance their practice, my belief is that nurses would need to be able to have spaces to pause and think about what is needed both for themselves and the patients. For this to be possible, the wards would need to be smaller in their capacity to care for patients and a reduction of patients on each of the wards would provide this space that is much needed. This nurse was left to "pick up the slack" in moving towards Holmes's idea of how supervision could be helpful, the nurse would need to ensure that she is having supervision by first finding out who her supervisor is within the organisational structure and taking responsibility and accountability to request time for supervision from her manager. I believe that my research inquiry findings would be useful to the nurses and senior management in these wards as it is crucial that spaces are created for nurses to reflect and learn so as to ensure safe care for patients and better working conditions for nurses.

Adams (1996) suggests that clinical supervision can be a useful tool for developing and maintaining three interdependent skills which are crucial to the development of effective and

competent nursing practice. He suggests that this is mainly (1) to integrate theory into practice through (2) the use of reflection and cultivating self-awareness. He also suggests (3) that the main purpose of clinical supervision is to increase the quality of client care.

The metaphor of the spider plant came to mind as this metaphor creates a visual picture of the growth and practices of the nurses as they work within the framework of an organisational way of practice. I began to think of the creative learning that can be possible, which could then be planted throughout the organisation in different wards, so that learning takes place which would result in higher standards of care delivery. Morgan's (1997a) ideas on the constraints and possibility of metaphor were of interest to me as I pondered on the use of the spider plant as a metaphor for processes that create more possibilities than constraints.

Here a nurse shares her experience which brings to the forefront some of the concerns that she has experienced during her work on the inpatient wards.

(Episode/Exemplar Number 8) Nurse 15 is a newly qualified psychiatric nurse with 6 years nursing experience in acute mental health inpatient ward and this is her second job as a psychiatric nurse working in an inpatient ward. Due to her level of competence and her passion for nursing she was recently promoted to ward sister, which is a senior nurse position, with responsibilities for leading a team of nurses and being in charge of the wards while on duty:

“Patients come in when they are acutely unwell and when they are behaving unwell, that is when they come to us. The majority of them are suffering with relapse episode and drugs induced psychoses, they come into A&E that is the first stage of when we see them. Some of them present with depression, bi-polar affective disorder, schizoid affected disorder, self harmers, suicidal. The clinical environment is conducive I would say, but sometimes it gets busy depending on the time the patients get in, that is all I can say, because sometimes the patients come in when the ward is already unsettled and other things are going on. So when the patients come in and there are visitors around it becomes very difficult to juggle people around, you can imagine if a patient is coming in who does not want to be in hospital in the

first place, it just becomes so busy it makes the environment very disturbing for some patients, not all of them, but on other good days there is no problem at all”

In reflecting on Nurse 15 sharing her views of the clinical environment being conducive for learning and providing care, I became curious as we had pre-booked an area off the ward to have the interview. However, due to her wishes to be on the ward and her concerns for the level of staffing available, we decided to move the interview to an office on the ward. The story of the ward being conducive seemed to change as we began to talk more about the environment. My sense was that Nurse 15 was trying to share multiple stories about the ward and the possibilities therein for both the patients and the staff. As here she was reinforcing that the clinical area was conducive to providing care, however should the ward become busy then the ability to have a conducive ward becomes compromised as chaos then emerges. I was curious as to what would afford such opportunities for different stories to come to the forefront. One sense that I had was that the nurse was struggling to express how she really felt as she had started a new role and felt loyal to this position in a way that was constraining what she wanted to express and in doing so was giving a paradoxical messages about the clinical environment. On reflection there was a sense that the nurse was not sure what she wanted to say in relation to the clinical environment and whether it provided learning to nurses.

I began to make connections to a number of theoretical concepts which seemed to have informed this way of practising, which allowed for the different stories to be told, this being Co-ordinated Management of Meaning (CMM) (Cronen and Pearce, 1980), around stories lived and stories told, and also around the ideas of context creating meaning. One story that I became conscious of was that my lived and told story was that I am also a manager and that the safety for the staff and the patients is a story that is shared by my colleagues about what I stand for and represent.

The CMM diagram below shows my exploration of the different levels of context that might have informed the nurse’s response during our conversation.

Contextual Force

Culture: As senior nurses working in an acute ward you **should** be able to cope and manage whatever the situation calls for on the ward to provide care for patients, we are a caring profession. Care of the patients are high on the agenda for the nurse, she sees herself as a good nurse who puts patients care first.

Self: Here her sense of self as a senior nurse means that she has high morals for how she **should be** loyal to the organisation and **not complain** about the nature of the ward 'The clinical environment is conducive I would say, but sometimes it gets busy depending on the time the patients get in, ..., because sometimes the patients come in when the ward is already unsettled and other things are going on'.

Relationship: Her relationship with management was one to be thought about, as here the nurse was having this conversation with a manager of the organisation, where she might have felt that she **must show** that she was able to manage difficult situations competently ...

Episode: Being in a new role and having the position of being a senior nurse within the clinical environment the nurse could establish her sense of herself as a nurse in the culture of nursing as she understands this to be.

Speech act: During our conversation the nurse was unsure of how to share her concerns about the environment as she was talking with a manager and was unsure of how management would support nurses who are in new roles.

Management: There are policies and procedures on how we work in this organisation. How would she be judged by what she had to say about the environment, as her position had changed where she was now a small part of the management structure? There was a sense that she **must** follow these policies and procedures or be accountable.

Implicative Force

Figure 8.3 CMM levels of context

Adapted from Pearce (1994, p. 347)

I wondered what influence this might have had on how we talked together in the interview as I occupied an insider/outsider and in-between researcher.

When Nurse 15 said 'you can imagine if a patient is coming in who does not want to be in hospital in the first place it just becomes so busy, you know, it makes the environment very disturbing for some patient',

I began to think here of two stories, one that said this is a great environment, and the other that said this environment is fragile and could become very unsettled with minimal change taking place at any given time.

Here Nurse 15 was sharing the importance of having space in what might become a volatile environment when limited by space. Listening to her comments, I began to reflect on the idea of the importance of having a space that is protected from the busy nature of an acute psychiatric ward where reflections and learning are more likely to happen. Cooke and Matarasso (2005) suggest that it is very important to have a space for reflective practice in nursing as this has been shown to improve both the patient and the nurses' role satisfaction. Cooke and Matarasso (2005) also suggested that these reflections should be from real clinical situations for there to be meaningful learning. Holmes (2007) further explored this concept by inviting us to think about the importance of receiving supervision as it helps in the process of reflection on practices and creates changes in views and approach to care giving. Slimmer, Wendt and Martinkus (1990) invite us to consider the clinical area as a learning environment for student nurses. They further talked about the importance of these environments as student nurses depend on their experience of being on these wards to assist with discarding some of the negative prejudices as a result of lack of sufficient contact with mentally ill clients, which causes difficulties in the understanding of the role of the psychiatric nurses when working within such complexities, which in turn lessens the amount of nurses with the expertise to work in such challenging areas of care provision, which then creates shortages of psychiatric nurses, thus adding to the difficulties of not having spaces to reflect on one's practices.

Here nurses talked about 'How can I learn when there is no learning to experience'

I will now turn to an exemplar from my interviews with one of the nurses who illuminates another concern:

(Episode /Exemplar Number 9) Cherrie: And have you noticed any changes in the nurses after an untoward incident or do you get a repeat of those untoward incidents? Or do you find that once these incidents have happened people learn from it, and they move on and provide care in a different way, or what happens when.....?

Nurse 8: Well I could only generalise because there is no systematic way with how we are managing untoward incidents. I think that it is different with every incident, but where people's registrations may be compromised there seems to be more support and more emphasis on we must do things differently, but sometimes the volume of incidents that is coming at you is just too rapid for you to step back and do more of the reflective work and then share any outcomes that have been identified or themes.

Cherrie: Have you got any ideas of how it might be dealt with?

Nurse 8: How it might be dealt with? Well I had hoped that the clinical managers and the security lead person would be more involved in helping to review incidents as sort of people who are detached from the wards, so once the incident forms are being completed and taken for logging that they will be able to pull out and using their levels of experiences as well be able to churn out any set themes that might even be logged and the training packages be tailored to meet those issues because some things do come around in cycles on different wards and really I do find my own time as a ward manager quite stretched. I do not have enough time to sit and go through these incidents and pull those bits out.

Cherrie: Are there certain types of incidents that happen on the ward on a daily basis?

Nurse 8: When I was on ward (B), I am on Ward (C) now because I was experiencing burnout. I was most concerned with the levels of assaults on staff and really there is nothing that has happened in terms of remedial work to look at how do we support staff or how to prevent the frequency of incidents and assaults on staff taking place and really I think, psychologically, people do feel devalued because you are expected to go in day in day out to go into an

environment with the potential with you getting assaulted very high. Once you have been assaulted the sickness leave is not that great for this hospital. But there would be that expectation for you to turn up as people cannot afford to be off sick for too long a time.

Cherrie: So do they turn up not well?

Nurse 8: Yeah, yeah, and the cycle just continues.

One reflection that I had here was that learning occurs when the event stops, and one begins to turn that past experience into one that is a learning event, as this nurse recognised that there was a need for learning from past incidents. However her idea that the clinical management and the security leads should take responsibility for creating learning, as she was too busy to explore the incidents that occurred on the ward that she manages, was something that made me curious. I began to think about the organisation's structures and what might have informed this nurse in her thinking that only senior management can or are responsible for creating learning in the clinical areas.

Benner (1984) suggests that nurses must be able to manage as well as prevent crises. My sense was that this nurse felt that she needed guidance from someone with authority in a senior position to help her with her thinking and learning processes when she is faced with difficult decisions in her practice. Benner (1984) argues that since the nurse spends a major part of her duty at the patient's bedside, and since the nurse is responsible for assessing, planning and implementing care for/with the patient, then it is her responsibility to manage rapid changes in the patient's situation. Thus I was curious as to the mental model of the organisation which appeared to have organised the nurse into thinking that this responsibility did not sit with her; rather it sits with senior clinicians. I was also curious about the way in which the organisation treats the nurses in that there seem to be no measures in place for nurses to have time and space for supervision or to reflect on their practice. The hospital seems to be working in such a way that no one is responsible for nurses, care and the general well being of all until a major incident occurs and then nurses will be judged as accountable practitioners responsible for the

care and well being of the patients in their care as well as other nurses for whom they are meant to be providing leadership. Senge (1999) suggests that managers must learn to reflect on their current mental models and until prevailing assumptions are brought into the open, there would be no reason to expect mental models to change. To connect with Senge's suggestion the nurses will need to be vocal in expressing their concerns with the clinical environment so that changes can occur as mental models are explored and challenged.

Benner (1984) also argues that the expert nurse must function with an eye to the future. On reflection I was curious as to whether the organisation organised the nurse so that she did not feel that she had the expertise to offer. I was curious as to whether the nurse may have had other times where she experienced incidents happening, where she knew the patient's background, risk, history, and also she may have nursed other patients who became unwell and aggressive where she was able to manage the incidents as she would have been able to anticipate the next possible incident, thus being able to draw on her own experiences to help her in her decision making when faced with such incidents. I was curious also as to the many possibilities whereby the nurse could draw on these experiences to help create learning within the inpatient wards.

UKCC (1992) cited in Bishop (1998) suggests that there is a demand on qualified nurses to be innovative, to develop new skills, to be answerable for their actions and to constantly update their knowledge. The UKCC (1992) guidelines on professional accountability state that nurses must 'act in a manner so as to promote and safeguard the interests and well-being of patients and clients, maintain and improve professional knowledge and competence'.

When Nurse (8) spoke about her feelings of being 'burned out' I was curious as to the possibilities that this could have provided for future exploration which on reflection I did not explore. I became curious about what was happening for me with my practice that closed down the exploration of what 'burn out' meant to this nurse. Shotter's (2005a) ideas of *witnness* and *aboutness* thinking is a theoretical concept that I reflected on, as at that moment in the conversation I was doing aboutness thinking and thus did not connect with the nurse's story of what burnt out meant to her in terms of her learning and her ability to create learning spaces

within the inpatient wards. I also connected with Shotter's (2008) ideas about "difficulties of the will" as best being described as "difficulties of orientation or relational difficulties" in which we need to explore how we can find a style or approach in relating to others and the othernesses we become a part of. In losing my focus on the nurse's lived experiences I neglected to explore conditions that had led to her feelings of "burnout". I also took her away from her own feelings and invited her to enter what Shotter calls aboutness talk rather than witness talk.

On reflection I noticed that I myself had turned to problem solving talk rather than exploring other possibilities. This I think was informed by me being a manager and getting into the process of fixing, by putting round pegs into round holes and square pegs into square holes. For me being an insider and an outsider of the organisation where I was researching, I had that lived familiarity with the nurses which could have had an impact on my ability to lose focus with the nurses' feelings of "burnout". Being able to constantly reflect on my position as a researcher has helped me to understand the taken for granted assumptions that can limit my ability to stay curious and probe deeper for the nurses' understanding of what my research questions meant for them and how they understood and shared their own views and experiences of what creates learning within these various inpatient wards. Asselin (2003) suggests that when we do research in our own setting, then we as researchers must continually guard against role confusion.

'Mentoring the nurses, I have no voice, my words are not heard'

To explore how psychiatric nurses learn and relate to the ward environment and to patient care when they feel organised by the organisation's ways of working which they experience as mechanical in its ways of relating, I will use exemplars from two psychiatric nurses where they shared their views and experiences.

(Episode /Exemplar Number 10) NURSE 15: When the ward is very busy the junior nurse is just left to pick it up and get along, you know, by themselves, but at times when it is not

like that we do sometimes say if I have got a student and the ward is busy and everything is chaotic, sometimes you forget to bring them along and say, because you want to get the patient safe and because you want to do things you are on autopilot you just do the things that you would do normally, you know, and then you think oh I should have got the student to come and tag along with me, you are so hyped up so at the same time to have somebody there when so many things are happening, so to then say come and do this with me because they will not know what to do so sometimes you just say to them that this is a learning opportunity, I will say just observe, I am not going to ask you to do anything, just observe from where ever you are and we will talk about it later on, you know, it is easier that way because for you to bring them on board, one they are anxious, they do not know what they are doing, but there is quite a lot of learning opportunities for junior nurses and for us as well, when the ward is you know, when you are faced with situations like that, yeah.

On reflection I became curious as to Nurse 15's voice when she spoke about the 'ward is busy', and how learning could take place when 'everything is chaotic'. The nurse was, however, able to point out that there was learning and teaching that was possible which could be described as not in the traditional sense of learning within a classroom or quiet ward setting. The nurse went on to describe the clinical environment by saying 'you are so hyped up so at the same time to have somebody there when so many things are happening, I will say just observe, I am not going to ask you to do anything just observe from wherever you are and we will talk about it later on'. She pointed out that despite the busy ward environment there was learning that is possible, 'but there is quite a lot of learning opportunities for junior nurses and for us as well, when the ward is, you know, when you are faced with situations like that, yeah'.

I was curious about the ability of the nurse to teach a way of practice, which was by observation and not direct input as the situation described by the nurse called forth learning in a way that was by observing. Bernstein (1983) put forward an idea which brought to the forefront a type of dialogical community in which everyone is free to participate in a dialogue whereby they continue to nurture a type of dialogical community/ co- created communities in which practices could be developed and enhanced. As a mental health nurse my experience is that observation is a key part of how one can learn through observing how your mentor manages difficult

situations either through dialogue with patients or with both dialogue and a physical intervention that might be needed. In the episodes which follow a nurse shared an experience of how staff attitudes can cause other staff to feel subdued. She was also able to think of possibilities that would make a difference that matters to nurses.

(Episode/Exemplar Number 11) NURSE 14 is a non-qualified psychiatric nurse, another term for her role is as a health care assistant (HCA). She started her career in nursing three years ago and was also studying to become a qualified nurse. She has worked in acute mental health wards for three years:

“What I have come to realise that has hindered me and has actually affected my learning in the environment in my current work on the ward is, number one, is staff shortage, as most of the time we do not have enough staff on the ward and as a result of not having enough staff we tend to, it is like, we are doing more than we should be doing or you are doing what you are not meant to be doing on that particular day. I found that to be actually something that hindered my learning and also staff attitude can subdue your own, say maybe what you have learnt and you want to practise, let’s say personality or attitude of some staff... (pauses)..yeah, (Laughs) in my opinion, I find some staff their attitude to be not very helpful on the ward as in, up to the extent that, I keep telling myself that I do not think that I will work on the ward for a very long time either; I will do something else. It is not that I do not want to be part of a team, but where I can be kind of autonomous, you tend to be subdued on the ward most of the time, maybe all the skills that you have acquired at other places, the skills that you have learnt and you know that you are good in this area , so some staff they, when I say they tend to hinder your progress or your, maybe I may not be using the right terminology, but they tend to subdue you that you cannot really bring out the best in you and you become complacent and you tend to say well whatever. What would be different, you know, is an environment where everybody, you know, where you are not afraid of contributing of the little that you know or an environment which is conducive for where you can open up to your team members and just be free and be yourself and not be what other people want you to be”

Here this nurse was able to reflect on what she sees as possibilities for learning within the clinical environment that were not readily available to her, as she shared her experiences of not being mentored in a way that she would like to have been mentored so that the environment becomes a learning place for her. Bernstein (1983) suggests that we should find the resources within our own horizon, that we should look for the experiences that enable us to understand our surroundings; this he suggests is what brings to the forefront our understanding of how we form learning practices. Another Bernstein (1983) idea which I connected with here was that we should have continuous dialogue with each other. This he suggests provides the context and the building blocks for learning where we can track between the most local of local details and the most global of global ways of relating in such a way that we can bring learning into view. Here this nurse was not able to have these conversations within the clinical environment which as she puts it has made her question whether working in the clinical ward environment was something she felt that she wanted to do. Her level of knowledge and experience did not fit with the task she seemed to be expected to achieve or complete. However, within her own sensing and observation she was able to say in the interview what her views were of what was needed for a clinical learning environment to be created:

“What would be different, you know, is an environment where everybody, you know, where you are not afraid of contributing of the little that you know or an environment which is conducive for where you can open up to your team members and just be free and be yourself and not be what other people want you to be”.

‘Learning in the organisation, sense making, bringing together the fragments’

Having reflected on exemplars from two psychiatric nurses who shared their views and experiences of their learning within the clinical environment, I will now use these exemplars in constructing a connecting whole from which I can draw out themes which will illuminate the sense making of learning in the clinical environment. I will pay attention to the ideas of social constructionist and discourse analysis during this journey as a way of drawing out the rules and rituals, themes, threads of sameness or differences as I share these stories from the nurses,

which highlight the complexities which these experiences bring to the forefront, the views and experiences of working from within the rules of an organisation of practice. I will also share with the reader how these experiences have changed my own practice as well as that of some of the psychiatric nurses whom I manage. Here I would also like to point the reader to what I would call 'living practices', my experience of reading back the transcripts also about the nurses' responses to hearing their stories/views read back to them and what happens when one reads them from the 'I' position (Shotter, 2009).

My reflections highlighted for me the various needs to orientate myself to the clinical inpatient areas and to look further into my own learning as well as that of the nurses who shared their views and experiences with me. One reflection that I had was that of Nurse 13, who is a qualified psychiatric nurse with five years experience of working in acute inpatient wards. This is her first job since qualifying. In the example below she said:

"patients who need more time, you know, when a patient comes on to the ward they are very unwell, you try to orientate them to the ward but there is more than just orientating them to the ward'. I think that there is more that should be done after that"

My curiosity was how can we have dialogues within the clinical areas to invite others in a way of practice that will improve the quality of care that we provide for the patients admitted on to our inpatient wards? On reflection I thought of dialogical learning, where new meanings and understanding are viewed as emerging through dialogue with each other as a reminder to us that knowledge is always provisional and new information is understood as a way to repeat revision of judgement in creative ways. My thoughts were to explore with the nurses glimmers of hopeful learning experiences as the views of almost all the nurses echo the sense that the clinical environment had become a very difficult place to create learning arenas which makes learning difficult if not impossible for them. The transcript which follows brings to the fore some of the glimmers of hopeful learning which can be fostered and developed within the inpatient wards settings.

(Episode /Exemplar Number 12) Nurse (13)

“I feel that in terms of experience I feel that I have gained quite a lot from my nursing on the wards”

I was struck by this as I began to ponder on the meaning making around the inpatient wards having something to offer the nurse that was useful in helping her to develop her caring skills. **Nurse (13)** also shared with me her experience of having an incident to manage in a safe and therapeutic way, this being her first experience when she required such depth of competence.

“It was my first time to come across this, that kind of situation, and I was standing in charge for one of the senior nurses and I remember that it was the way that I had reacted in that situation, because we were ok, in that we found the patient before anything had really happened and we managed to resuscitate the patient, take her to ICU and she came back to the ward after two days, and it was when the incident reoccurred about two months later with another patient then, and it was the reflections that we had done on the first incident, about how you can manage people with such mental health issues, which helped really and how you can put in place interventions that could kind of...”

Here it appeared that the nurse was surprised by her own level of competence as she was faced with such complexity in her practice and her own ability to manage this situation as a competent practitioner. The nurse went on to share how she was able to perform this task as a competent practitioner.

“I engaged everybody in what we were about to do and I first of all when you start the shift I plan what it is that we are going to do and I ask the various nurses how we might deal with the various situations and allocate and delegate duties accordingly communication as well so that I get feedback from them of what to do and how to make decisions”

The nurse shared how her ability to communicate informed how she was able to show her competence. On my reading back the transcript to her the nurse appeared to be surprised and shared that despite the feelings around their stories of the organisation organising the nurses, there was learning that could be had that proved to be useful. She said that she was pleased to

have had the opportunity to hear her words read back to her and that her views had taken on a different focus.

To turn my curiosity to **Nurse (12)**, she shared her views and experiences on her learning:

“She said that she can see from her previous experiences of learning and teaching that it does not necessarily have to be a calm environment’ she went on to say that ‘whatever sort of environment, whatever the patients are like and however many difficulties the patients have, that the clinical environment can still be a learning experience”

Her passion for her work highlighted her sense of providing the best care for the patient despite the struggles she was sometimes faced with. She went on to share her concerns for how she experienced her colleagues and her lack of understanding as to why nursing has changed from her qualifying to now. She questions her own learning as she made connections to how nurses practise today and what might be the ‘cause’ factor in how learning and sense making is experienced.

‘It does surprise me sometimes, I do not know if there is this gap between my ways of learning and their ways of learning or it can’t be the teaching because my teaching was appalling from when I was at school, so it can’t be that, it is the willingness to take things on board’

Nurse (12) shared her frustration with how the environment for care has become very different to how she had experienced it in the past. Also that management styles had changed and there is an expectation that you should not question these changes, however learning was always possible. She also shared her views on how reflection on one’s practice learning might be able to take place as this is a way of learning.

“I think that a lot of it is attitudes and I think that they think that they are qualified and that is it, even with third year students sometimes you get this ‘ I know it all’ so I don’t need to keep questioning people and asking questions’. ‘That is what surprises me sometimes how few

questions are asked. They either do things without thinking or what they are told without questioning or they do not actually question or look at how they are working’.

‘I do not know how much is about; they are not bothered about learning anymore or whether... I don’t feel that the environment works against people that they are actually scared to ask questions. I think that we try to foster an environment of learning, because I remember going to ward where some people were too scared to ask questions because they were made to feel stupid or they were belittled or that sort of thing or people got irritable with them, it is not like that here you know, I am always saying to them ask questions, keep asking, ask questions, pester people, ask people why are they doing that, question what’s done”

I experienced **Nurse (12)** as a professional with very high standards, who was struggling to understand why the organisation was functioning in such ways. She was reflecting in and on her practice and trying to make sense as to why the other nurses were not able to learn and practise in the environment that they were presented with.

‘I think that it is staff attitudes a lot of times, people’s receptiveness to learning which I think sometimes that it is that’s what matters, which is sadly lacking. I think that I am being polite here; I mean sometimes it is badly lacking. I think sometimes it just dismays me when I see an incident starting to happen that could be avoided if handled differently, that nursing skills come in to effect, that people actually think about their nursing skills and how to handle a situation, what options that they have got, how can they defuse this situation, how to listen properly to the patient, things like that.

Here I connected with Andersen’s (1990) ideas of reflecting and dialogues. My thoughts were what possibilities would have emerged with the nurse had she had the opportunity to reflect with her peers? I was curious as to what could have been co-created if the nurse had the opportunity to reflect with her peers in the form of a reflecting team where dialogue was privileged, where reflections were shared with her and her colleagues.

Nurse (12) shared her dismay about the lack of motivation from senior nurses and how this lack of motivation then filters down to the junior nurses, thus creating environments where learning becomes lacking:

“I actually find that the more senior or the most experienced nurse will not ask or question something to gain a better understanding or understand more. The newer qualified nurses, I am talking about two or three years’ experience, they do not even question practices and that filters down to junior nurses then, and I think that if rotation nurses and students don’t see qualified nurses asking questions then they would not ask questions, because you then create an environment where people don’t then ask questions and don’t question the practice on the wards”.

On my reading back the interview transcript to this nurse she seemed tearful and informed me that not much had changed since we held the interview. She said that on hearing her words read back to her that she would be making every effort to do things differently so that learning takes place despite the fact that the organisation organises how they work as nurses. She stated that the patient’s care is what matters most to her.

On making connections to the theoretical concept of CMM my reflections were how this nurse was able to share her views in such a way that brought to the forefront the difficulties that she was struggling with. The themes about practice that she brought out were that the organisation was trying to create a ward where nurses did not feel able to ask questions that would develop and enhance their and other nurses’ learning in the clinical areas. Also that nurses seemed to be unable to utilise their nursing skills when the occasion calls for such skills in managing incidents on the ward. Another theme was that nurses were being made to feel stupid or belittled when they asked a question in the clinical wards, which makes learning difficult as nurses developed feelings of being devalued. I connected to the ideas that CMM holds which suggest that there is no formal logic that determines how stories about one’s own life, a particular relationship, a practice and various elements of cultural patterns may be woven together. CMM suggests that the connections among stories are always made in situated activity with others (Cronen, 1994). It offers a particular way of exploring how different stories are fitted together in everyday life. It contends that there are hierarchical relationships among

stories. That is, one story may serve as the context for the development and extension of others, and in that sense it could be organised in a hierarchical order. It denies that there are any natural hierarchical orders to stories and that the hierarchical arrangements may change in the course of experience (Cronen, 1994). In connecting Cronen's idea of CMM to the above examples the patterns that emerged in the nurses being made to feel devalued, de-motivated have come from a wider connection to how management addresses issues of work ethics and the stories which get created within an organisation about how care should be delivered or performed, which in the examples then fosters poor practice. Moreover, nurses are struggling to find positive ways of learning and developing new practices of care both for themselves and ultimately for patients. The idea of the use of the Morgan's spider plant metaphor could offer the nurses along with management the possibility to be creative in how as a hospital they can create pockets of learning which can be shared throughout the inpatient wards, through the possibilities of rotation where nurses on the wards are working with nurses from other wards to share good practice. This can be by sharing how they use reflective spaces on their wards and introducing these on the wards that they currently rotating to.

In the diagram below I use CMM levels of context as a visual way of sharing my exploration of the nurse's story of, "I have no voice my voice is not heard"

Contextual Force

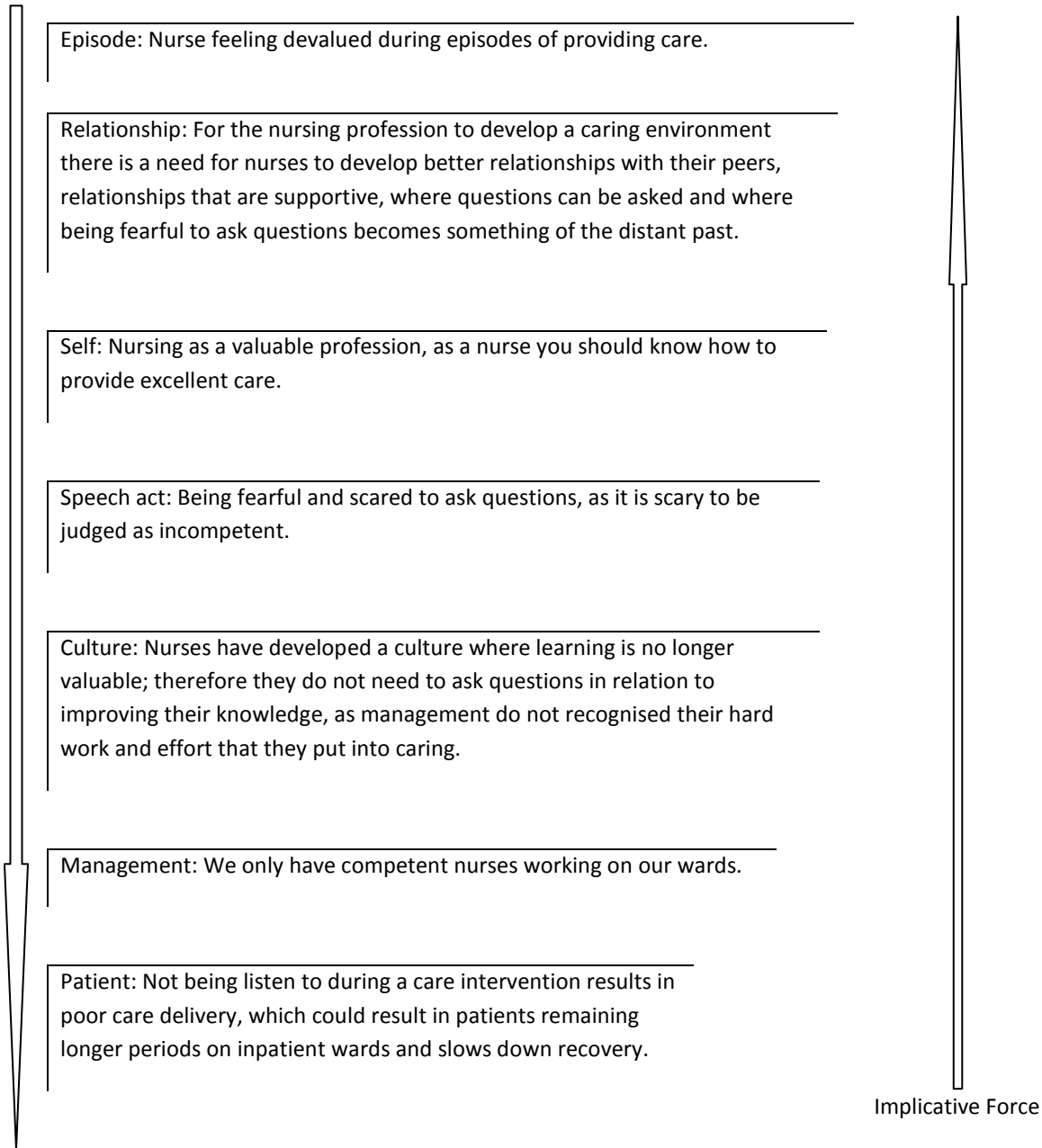


Figure 8.4 CMM levels of context

Adapted from Pearce (1994, p. 347)

Conclusions: During the period of working with psychiatric nurses in various inpatient wards, and with having interviews with the nurses as I attempted to put their views at the forefront, I was able to draw out some findings that expressed their views and experiences of their working in inpatient psychiatric wards, and the difficulties with how they felt organised by the organisation which placed constraints on their practices. However, these are only fragments from a larger number of themes which can be drawn out from my interviews with nurses who felt organised by the organisation in which they carried out care. However, some of the nurses felt that despite this way of working they were still able to learn and share their experiences of how learning was still able to take place. With a rich tapestry of experiences and views this work, of course, still remains unfinished. The findings that were drawn from the experiences of the nurses are listed below. These findings will be further explored during this thesis as connections will be made to these and other experiences and views from the psychiatric nurses working in inpatient wards.

- a. In the course of my research interviews, nurses discovered that learning had happened in the ward environment even though they had not yet realised it.
- b. Nurses felt that they did not experience learning that could be applied to their practice as they felt that the organisation had hindered this learning through the way in which the organisation organised them.
- c. Nurses would have liked to experience a different kind of learning, 'a something'. However they were not sure in what way or how they would like the learning experience to be.
- d. Nurses were able to practise caring in a different way despite being in an organisation which they feel or experience as organising their practice which can have constraints.
- e. The expert nurses were able to work in a competent manner despite the sense of the organisation organising their practices, as they were able to sense which of the limited number of organisational possibilities were open to them so that their choices allowed for their practices to be learning experiences as well as to provide sound clinical care.

Summary: In summarising the views of the nurses and how they felt organised by the organization, they were able to explore the factors that they felt will improve the quality of care that nurses provide, three such factors being, if they were able to have reflexive spaces, able to have more experienced nursing staff on duty and able to have the opportunity to have clinical supervision. With these factors at the forefront they would be better able to share what they believe will help them in co-creating standards for how the clinical environment could become a learning environment for the nurses. Noticeable were the differences and similarities in nurses' views and experiences shared on what creates a clinical learning environment within these mental health inpatients wards. I was also struck by how, despite the lack of reflective spaces that the nurses encountered, they were able to identify areas of learning that they felt were needed, so that patients' care remains of a high standard. They were also reflective on the need to explore factors which they feel will improve the quality of care that nurses provide and what will help them in co-creating standards for how the clinical environment could become a learning environment for the nurses. Despite the struggles and constraints that the nurses encountered in their daily practice, they were able to identify that they wanted to experience something different in their learning and practice. This was evident in their shared views as to their need for training and development as they were able to identify areas of training that they felt might be helpful to their learning.

In the chapter that follows I reflect on how nurses viewed their abilities to learn within inpatient psychiatric wards, also how I was invited to take different positions within these contexts and my reflections on these as I developed as a person, a practitioner, as a manager and as a researcher working within a health context.

Chapter Six

Psychiatric nursing as an open, unfinished, still developing community of practices: resourceful communities

The Department of Health paper on Equality and Excellence: Liberating the NHS (2010) suggests that the government will empower health professionals, where doctors and nurses must be able to use their professional judgment about what is right for patients. The government proposes to support this process by giving front line staff more control. The paper suggests that health care will run from the bottom up, where ownership and decision-making will be in the hands of the professionals and the patients. The government described this as a process that they hope will drive up standards and deliver better value for money and also create a healthier nation. My sense is that this is an individualistic approach to the health care proposed; by contrast I will explore a more relational approach to care. In this chapter I will describe how nurses might begin to put patients' care at the heart of everything we do, offering patients more choice and control over their health needs. In exploring a relational approach to care/caring I will propose to have at the forefront a key concept: **What is a community of practices?** In beginning to understand what a community of practice within inpatient psychiatric wards would look like, feel like and be experienced as, I will turn my attention to the Nursing and Midwifery Council Code on Standards of Conduct, Performance and Ethics (2008). This code outlines how nurses should conduct themselves both in their work place and in the world as a whole. The code states that as a nurse the people in your care must be able to trust you with their health and wellbeing. The code also states that nurses should make the care of people their first concern, treating people in their care as individuals, always respecting their dignity. The code continues that as a nurse you must work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community, where you must provide a high standard of practice and care at all times. The code further describes how nurses must conduct themselves by stating that as professionals they are personally accountable for their actions and omissions in their practice and that they must always be able to justify their decisions. Where they fail to comply with this code, their fitness

to practise will be called into question and registration as a nurse could be endangered. Where many nurses or professionals fail to comply with these rules or codes of conduct which are meant to guide their practice, the patients' care will be of a low and unacceptable standard. Kline and Preston-Shoot (2012) suggest that where these failures take place service users or patients have been seriously let down. This sometimes happens due to individual practitioners as well as managers' poor practice and more often as a result of a complex web of organisational dynamics. They also suggest that in order to ensure safe, competent practices, qualifying education and post-registration training should enable professionals to develop and retain the resilience, attitudes and capability to manage within the environments of caring.

This code has informed my practice as a clinical nurse manager and has helped to guide the support and supervision that I offer nurses in the clinical areas of practice. As my clinical and managerial practice developed and I continued to see the development of the nurses and other professionals within the team, I began to think more and more about a community of practice, where we can share the space to be accountable to the patients in our care as well as our fellow colleagues in the care professions; for example within the inpatient psychiatric wards the nursing teams sometimes use an approach to care as 'team nursing' or 'primary nursing'. Within 'team nursing' when a nurse is off duty the care of the patients should be handed over to another team member so as to continue with the care provided for the patient. However, the constraints that this imposes on the patient is that everyone in the team thinks that someone else in the team is continuing the care of the patient when in fact no one is following up the patient's care. While in 'named nursing' the patient is delegated a named nurse to provide their care, when this nurse is off duty the responsibility is hers to hand over the care of the patient to another nurse ensuring a better shared sense of accountability for the patient's care.

I see a community of practice as being one in which the team is enthusiastic and committed to develop their own skills and help with the development of others in the team, thus providing the best integrated care, where organised opportunities to learn as well as opportunities for engagement in practices can take place; where the community has a crucial role in involving

participation as a way of learning, a way of both being absorbing and absorbed in the culture of practices, where all in the team make the culture of learning theirs. A community of practice might best be created by observing how each other talks, works and how people generally conduct their lives, also by comparing how people who are not part of a community of practices relate to their surroundings (Lave and Wenger, 1991).

A community of practices is also a place where there is joint working, where patients' care is at the centre of what you do as a nurse; where collaborative ways of working are practised by the team/community, where relational and dialogical ways of working become the centre of care within these wards. It is also where the handing over of care is held in a general place, attended by all the team members, where there is a shift by shift handover and also in between hand-over to each other during the course of a twenty-four hour care practice. In a community of practice my expectation would be that the team would gather together with the same cause, purpose, meeting without rank or hierarchy, a place where people feel that they want to be there, knowing what part to play when in this community and feeling a sense of disorientation when practices are different from the community that they are a part of, where possibilities are shared as opposed to actualities. This is in comparison to a formal meeting where people have got set responsibilities with hierarchy or rank named to their purpose.

In this chapter I offer some episodes of practice shared by six psychiatric nurses about their practice within inpatient psychiatric wards; where they shared their experiences of working within the framework of a community of practice that has made a difference to the care giving process. What the psychiatric nurses who participated in this inquiry highlighted was that there is a much awaited need for a community of practice, as within this sphere of nursing the complexity seems to be overwhelming. I will contrast this with some episodes where care did not fit with shared open, unfinished community of practice stories.

Some theoretical concepts that I will draw on to illuminate these episodes of practices are from the work of Shotter (2005a) on witness thinking as opposed to aboutness - thinking, where Shotter offers a view that witness thinking becomes available to us as a result of our spontaneous responsiveness as living, developing and embodied beings to events unfolding,

occurring around us. He suggests that as living beings, when we allow the 'otherness' of others to enter us and make us other in a dialogical sense, which takes into account the unique individuals or unique circumstances that one finds oneself in on a daily basis as practitioners, then we begin to share in the witness thinking. Shotter suggests that this way of being in the world arises directly and immediately in one's living encounter with another's expressions which, as it unfolds, a bodily sense of the many possibilities for responsive action in relation to one's orientation in the present interaction emerges. This I believe connects to how as living human beings we are connecting and making sense of what it means to us to be in a community of practice. Shotter offers a view on aboutness thinking which suggests that this is more about pictures and perspective, frameworks and positions, repetitions and regularities and that this represents a monologic thinking, where monologue is finalised and therefore deaf to the other's response, which I understand as closing down possibilities for dialogues.

Bernstein, (1983) offers an idea of 'horizons'. He suggests that to have a horizon is not to be limited to what is nearest, but to be able to move beyond it. He suggests that we seek a fusion whereby our own horizon is enlarged and enriched, which we can move and which moves us as horizons change for us as we are moving, thus our horizons are always in motion. My connection with Bernstein's ideas is that, as a community of practice is co-created, this opens up many horizons for those within that community and possibilities for others to join that community or co-create other communities as horizons shift or move.

Senge (1999) offers us the possibility to reconnect with why organisations get into difficult ways of practising and communities of practices could get into practices that hinder growth and development, which can result in poor ways of practising. He invites us to think about our mental models as well as the organisation, community mental models. One way in which Senge invites us to ponder these ways of being is to point us to how we understand and see our mental models as they are always incomplete and chronically non-systemic. He invites us to see the inevitable biases in our ways of thinking and reflecting, he reminds us of the importance of slowing down our own thinking processes so that we can become more aware of how we form our mental models and how this can then influence our actions. Senge invites us to be mindful

of generalisations as these can lead to further generalisations. My connections to Senge in relation to a community of practice raise for me a curiosity to have some understanding of how a community of practitioners defines itself by its members and its practices.

Benner (1984) offers us the description of a therapeutic community in relation to its psychiatric patients, which I believe relates to the psychiatric nurses working within this community of care. Benner states that a therapeutic community provides a microcosm of social systems, networks of relationships, an arena for working out the issues of trust, conflict and co-operation. She sees the community as a basic therapeutic tool, which must be built, monitored and maintained. I understand this to mean a community where dialogue is at the forefront of the practitioners' practices. I will also draw on Lave and Wenger's (1991) ideas on community of practice where they described it as a base for learning and development. They argue that in learning and knowledge there is no activity that is not situated. They think of learning and knowledge as a comprehensive understanding, involving the whole person, where activities and the world mutually constitute each other, which seems to fit with what a community of practice might be based on.

I will be interweaving practices and theoretical concepts to illuminate this complex way of working and relating with each other as well as providing care to the patients. I will draw on social constructionist theory as a theoretical tool to guide me through the exploring of a community of practice within inpatient psychiatric wards. I will also draw on Seikkula's and Arnkil's (2006) and Shotter's (2007; 2008) work of what it is to be dialogical. Seikkula and Arnkil draw our attention to healing elements in dialogue, where they invite us to pay attention to the ways in which we address or manage our shared experiences. They share a view that as professionals, we in a dialogue must be present ourselves as an entire human and living person and not only as a neutral professional applying some method. Shotter draws our attention to the importance of how in our moment by moment actions when in dialogue the practitioners become co-researchers and the researchers become co-practitioners as each comes to an understanding of what they have been grabbed by in the unfolding processes of the dialogue. I will also draw on Benner's (1984) ideas of the novice to expert practitioner, of nursing practices

developing to different levels of competencies. Benner offers the idea that recognition, reward and retention of the experienced nurse who is in direct clinical practice and who can show in documentation with adequate description their practice are the first steps in improving the quality of patients' care.

I will use these concepts along with Bernstein's (1983) ways of being in the world as theoretical concepts to guide myself and the reader into what it is like to be a nurse on a psychiatric inpatient ward. Another theoretical concept that I will draw on is discourse analysis (Smith, 2008) which invites us to consider when reading our transcribed text that discourse and conversation should be the focus of our study, as in conversations our meanings are created and negotiated. Another concept that I will use is that of Coordinated Management of Meaning (CMM), where Pearce (2007) draws our attention to what it is like to make social worlds together; he invites us to think about coordinating our actions and making/managing our meaning. He goes on to state that there is no meaning without action and no action without meaning. Pearce invites us to think of CMM as a dynamic dance as this invites us to think of what we say and do as we take turns in unfinished, ongoing patterns of communication. I will use these concepts as tools in exploring the ideas of co-creating a space in which psychiatric nurses can reflect on their practice and in so doing create a community of practice.

The inpatient psychiatric environment as a learning space

Here I explore exemplars from psychiatric nurses as they share their account of what it means for them when the word "environment" within an inpatient ward is used. This is a big word and has many meanings depending on the context. During my reflections I will draw on theoretical concepts from Oliver (2005) in her writing on reflexive inquiry, where Oliver shares her ideas about practice, suggesting that as we practise reflexivity we make choices about how we will think and act. Oliver goes on to suggest that we become responsible and accountable for our choices, our actions and our contributions to a relational system, which I understand as a community of practice embracing these ideas of having a reflexive space in which to be. I will

also draw on Little-John's (1989) writing on reflexivity, where he suggests that reflexivity is the ability to turn something around on its head and hold an overall view on the phenomena that one is grappling with. Pearce (1994) offers a view that reflexivity has a connection to conversations and relationships. He sees reflexivity being the process by which one thing affects another which then in turn, affects the first. Pearce also talks about conversations as being forms of actions that affect relationships and that those relationships in turn affect conversations. My aim will be to use some of these ideas to illuminate retrospective accounts and connections to a community of practice and how these accounts have shaped and are shaping my practice. You as readers might ask what is the purpose of my reflections? My response would be that my purpose to share my reflections within this research inquiry is to turn something from/within an interview/dialogue into something that is useful for/to others.

(EPISODE/EXEMPLAR NUMBER 13)

Nurse 15: Well I will take it from ... because we have a variety of service users coming in ... I think that we should have an environment that is friendly in the sense that the team work collaboratively, there is a lot of team work and nurses are well trained in dealing with very acutely ill people.

Cherrie: When you said well trained what do you mean?

Nurse 15: People who have information at the tip of their fingers really, because, you cannot think and say, what do I need to do here, sometimes you have to react very swiftly, because of the emergency or the nature of the people that you are caring for.

Cherrie: So for you a learning environment would be where you have got team work, collaborative work and well trained nurses?

Nurse 15: And very clear good communication skills, of course you would be looking at highly competent nurses because you do not want somebody who is totally ... and they do not know what to do.

On reflection I became curious as the nurse shared her views of what could be described as a developing community of practice. She described *an environment that is friendly in the sense that the team work collaboratively, where there is a lot of team work and nurses are well trained in dealing with very acutely ill people*. One connection I had was to Benner's (1989) ideas of the privileged position in which nurses are embedded, as nurses provide care for/with people in the midst of health, pain, loss, fear, disfigurement, death, grieving, challenges, growth, birth and last but not least transition. As nurses are at the frontline of care delivery the need for dialogue in the care pathway is a necessary process on how care is then delivered. I was struck by the nurse's view of the need for expert nursing as she went on to state that she wanted nurses to have information at their fingertips, as the wait between thinking and acting is crucial to responding in an acute situation. I connected to Benner's (1984) ideas of novice to expert practitioner. In this idea Benner shares with us her sense of the expert level practitioner as being a nurse who has developed a certain level of commitment and involvement which is necessary to be able to provide care at an expert level. She argued that a nurse who practises from a 'distanced observer' position is less likely to notice subtle changes in the patients with whom she is entrusted to provide care for/with. This I would say is noticeable in my current work context, where drawing on this research has brought to the forefront the need for expert nurses to work alongside non-expert nurses so that a mentoring process is in place.

In my development as a nurse manager I have witnessed myself developing and changing my practice whereby I am able to invite nurses into a reflexive space by co-creating an environment in which reflections become part of our everyday practice and where every voice within the team is invited to share their views and experiences of what learning means to/for them. This space also allows for discussion on what being in a community of practice looks and feels like for them and other professionals in the team. As I reflected on the nurse's views on what she would like to experience in her clinical ward and in particular her own ability to be reflexive during our interview when she said that she wanted competent nurses, who had at their finger tips the information that is needed in an emergency situation, Oliver's (2005) ideas on reflexive inquiry were influential. I was able to think about my own sense of influence in the system that I was also a part of, being continuously mindful to pay attention to what was said to me and

what were my own experiences. I was able to reflect on my abilities to take up the space in-between or the middle ground, being continuously mindful that neither of these positions are static and being able to notice the boundaries within the research paradigm so as to have a defined role within the context of researcher and nurse as suggested by, Mullings (1999), Mercer (2007), Asselin (2003) and Preston-Shoot (2009a & b). Having read this nurse's views, in particular when the nurse said *'sometimes you have to react very swiftly, because of the emergency or the nature of the people that you are caring for'*, my curiosity remains on how can one be reflexive in a situation that needs emergency care? My experiences help me to think that in an emergency the level of knowledge and skills that is acquired during one's journey as a nurse, will be present to inform you of the next steps that are needed when faced with an emergency situation on the wards. However if our journey is limited due to lack of experience then as a nurse you would be guided by your senior nurse or nurse leader as the situation presents itself.

What then struck me was my own experience where a patient needed a special type of emergency care while experiencing difficult turmoil, where the patient began to behave in a manner which was placing her and others in a dangerous clinical space. This resulted in the patient needing to be restrained. The nurses responded with quick thinking and the intervention that was necessary. On reflection the nurses praised each other on the level of competent expert care delivery that was needed and in fact was delivered. Oliver (2005) invites us to think about when we practise reflexivity that we make choices about how we will think and act. She goes on to say that we become responsible and accountable for our choices, our actions and our contributions to a relational system. This is what I believe the nurse was making reference to, in the quest to describe what and how she expects nurses to practise. This is also what I believe contributes to a community of practice where in working together and sharing good practice clinical learning environments develop.

What follows is a transcript of the nurse as she continued to share her views on what a highly competent nurse is expected to do when in the practice area, which will demonstrate what might need to happen that will allow learning to take place.

(EPISODE/EXEMPLAR NUMBER 14)

Cherrie: Yeah, so what will a highly competent nurse do in comparison to a nurse who is not highly competent? What would you expect from a highly competent nurse?

Nurse 15: They can predict certain situations, know when to come in and set certain interventions, so that they can alleviate certain risk to the other patients or to the patients themselves, and people who ..., I am looking after, say if you have to give a patient medication to calm them down because they suddenly 'kick off'. I need somebody who knows the medication and knows what has been prescribed and if it is needed, usually it needs mixing, you know, someone who knows the ratios as well.

Cherrie: So a highly qualified nurse will know all of these things? And then that would make the environment a learning environment?

Nurse 15: Yes, it will, it does, also the other thing is if we could have kind of reflections, during or at the start of the shifts, and supervision as well.

Cherrie: So what would those reflections be?

Nurse 15: To reflect on certain things like intervention that have been going on during the course of the shift to see how best certain things could have been done, so in future people are more aware of how things are done and how to do it, when to react.

As I reflected on my question to this nurse what struck me was my own need for distinction between what a highly competent nurse and a nurse that was less competent do within the clinical environment. My thoughts were having highly competent nurses working within high complex areas of care would mean that care will at most be of a higher standard. However, this does not create further development of nurses to move within this area of care, hence in the transition stage of development which takes into consideration retirement and nurses leaving to work in other areas, this would mean that this complex environment of care will not be able to provide ongoing high standards of care. Morgan's (1997b), ideas of how one can become trapped in favoured ways of thinking was something I began to ponder. Morgan goes on to

invite us to think about the idea of powerful visions of the future which can lead to blind spots, where ways of seeing become ways of not seeing. He invites us to think about how forces helped people and their organisations to create the shared systems of meaning which allow them to negotiate their world in an orderly way. These he said can then become constraints which prevent them from acting in other ways. He warns us that favoured ways of thinking and acting can become traps that confine individuals within their socially constructed worlds, which then prevent the emergence of other worlds. Therefore in creating communities of practice, the community members must be able to challenge views, values and beliefs of each other so that growth and changes can develop. Thus a community of practice is never completed, but remains an ongoing, never ending way of being in the world. In connecting what this nurse said, should we ever reach this level of perfection and this nurse were to have always only competent nurses on the wards, then there is a risk that new learning would not enter the ward as the nurses would view themselves as expert, not needing to venture outside of this community, which will weaken growth and development within the wards, therefore a balance needs to be reached where nurses would rotate so that learning could be shared.

When the nurse shared her desire to have some form of reflections on different aspects of the shift, this was another point of interest for me. In my recent practice we have co-created spaces for reflections and debriefs where nurses and other disciplines come together to discuss good practices and practices that are not so good. We have learned as a team to respect each other's views and value this process of reflection as learning spaces, where all are welcome to contribute. Senge (1999) offers us a view which is that team learning involves "mastering" the practices of dialogue and discussion. He goes on to share with us that through team dialogue there is the free and creative exploration of complex and subtle issues where there is a deep listening to one another while suspending one's own views.

Another curiosity I had on reading the transcripts was that of the co-creation of a community of practice and what that might mean for psychiatric nurses. Here I share part of the transcript from a nurse which was echoed in the other 15 transcripts as to what a community of practice might look like. This transcript highlighted for me the kind of activities which nurses are

engaged with on a daily basis and the need to think of a community of practice as never completed and always unfolding to be able to work in the complexities of psychiatric inpatient wards. As I explored and talked with nurses from three different types of inpatient wards what struck me was that within these various locations the need for working as a community, working collaboratively, having time to reflect, nurses having clinical supervision, working with nurses who had a high level of experience versus nurses who were less experienced and feeling organised by the organisation were central themes for the nurses.

(EPISODE/EXEMPLAR NUMBER 15a)

Cherrie: What aspect of the clinical environment has improved your practice in care delivery?
I guess that you have answered some of this already.

Nurse 8: Yeah, yes, I think it is when we have had attendances to conferences; it has been a huge drive for us to meet the medium secure unit regulation set out by the Department of Health, where they had to look at and adhere to the requirements for physical security, relational security and procedural securities which has also impacted on us needing to review policies and how they are implemented in the services and that has had a huge impact because it is a national directive and a national drive and it has impacted on the way we worked because we also have to be demonstrating this, for instance with relational security, that certain therapies are offered to patients and they are attending certain groups and how many therapy hours are offered every week and that is information that we have to pass on to commissioners. So it is about an expectation that is set nationally and how do we deliver on that locally and then we have had peer reviews where we have had other personnel from other hospitals come in and inspected our adherence to the set standards.

Cherrie: So how has this improved your practice in your area?

Nurse 8: How? Well firstly it has been about awareness of the national guidelines and requirements. It has improved my practice by directing me in the areas of personal development so having to go out and read the document and review some of the policies and look at how we are actually implementing the policies and where our policies are lacking. It has also made me look at certain practices where for instance where we are sometimes using

the seclusion room, more frequently early on to look at de-escalation first, verbal de-escalation and try to engage the patient and using restraining and rapid tranquilisation as a last resort. I think that, that has been quite effective.

Cherrie: So you have noticed a change in the patients' presentation, with this type of way of managing their care?

Nurse 8: Yeah, I have noticed, and the staff reaction to incidents that take place on the ward. It is changing.

Cherrie: Ok, so the junior nurses, do they actually change from this way of working?

Nurse 8: Yeah they do and the more senior staff do role modeling, it becomes more apparent, because the whole hospital is subjected to these guidelines but there are some discrepancies on departments on how they are actually implemented and how they responded to emergency situations.

Cherrie: Right it sounds really interesting and really dynamic.

Nurse 8: Yeah, yeah.

On reflection I connected to Morgan (1997b) who suggests that we pay attention to organisations as organisms and he invites us to think about the livingness of organisations as occurring within a wider environment on which they depend on others and othernesses to satisfy their various needs. In connection to the nurse's experiences where she talked about the various influences from management in relation to how the patients are now cared for, due to the outside influences, for example the Department of Health, there have been changes as the nurses are taking more responsibilities to be role models to junior nurses and are better able to manage the level of incidents on the wards. The organisation needed outside influences to help to change some of its practices, which allowed for better working conditions for nurses, even though they might have felt organised by these systems that were in place. This has also had a positive impact on patients' care as there now seems to be a variety of therapies that

would need to be available and offered to patients, which could enhance care delivery. With the idea of a community of practice at the forefront of our minds, Morgan invites us to think of human needs as valuable resources that can contribute in rich and varied ways to an organisation's activities if given a chance. This nurse seemed to be very pleased with the changes that were taking place which allowed for better care to be offered to patients. However, we need to be mindful that care is delivered as nurses see the patients as people first, treating them with the dignity and respect that they are entitled to rather than offering the alternative care as a measure to meet the tick box culture that management demands of them that is needed to keep the hospital in business. Morgan's ideas connect to the need for providing competent care within nursing environments as required by the Nursing and Midwifery Council Code of Professional Conduct (NMC) (2008) which asks that nurses make the care of people their first concern, treating them as individuals and respecting their dignity. When Nurse 8 said

“It has also made me look at certain practices where for instance where we are sometimes using the seclusion room, more frequently early on to look at de-escalation first, verbal de-escalation and try to engage the patient and using restraining and rapid tranquilisation as a last resort. I think that, that has been quite effective”.

Nurse 8 was showing a deep sense for the respect for patients' dignity and how as a result of having professional development which seemed to be guided by national guidelines she was able to practise in a more humane way.

As a community of practice the NMC code of conduct (2008) suggests that as nurses we should work with others to protect and promote the health and wellbeing of those in our care, their families and carers and the wider community. The Department of Health White Paper (2012) suggest that people are people first and ask that we give people choices in how care is delivered to and with them.

When I reflected on this conversation with the nurse what struck me was the meta level that nurses are expected to work from, as Nurse 8 talked about the various regulations set out by the Department of Health where the hospital had to take into consideration the various aspects of security and the expectation that this is set nationally, though the nurse found this process to be a useful one as it has made her look at her practice. There was a sense of fear which governed how the nurse practises rather than from a position of curiosity and the desire to provide best care. I was struck too by the various influences on how and what kinds of care the patient received. This nurse spoke about reviewing policies as a result of set national directives, what struck me with this was that the policies were not reviewed as a result of what the patient's needs might be, however it was set so that the national directives were met, which fitted with how management had exerted their control on the system, not necessarily for the good of the patients, but to ensure that they were functioning for their own benefit. She went on to talk about the huge impact on the nurses that had arisen due to these imposed ways of working. Therapies for example did not appear to match the needs of the patient in so much as therapy had to meet the national directives and the commissioners' requirements. The nurse spoke about the need to have these practices in place so that the care commissioners could feel satisfied that the patients had what they think equates to good care. My experience as a manager guided my curiosity in the direction of the imposition of management as well as other agencies in how care should be provided without direct input from the nurses or the patient. Where managers are told to work within a budget, where lowering cost is the guiding principle on which care delivery is based. I connected this curiosity with Shotter's (2008) invitation to us to ponder our dialogue, to think about joint action and how we communicate within our daily interactions with others, how in our meetings with each other our activities become spontaneously and responsively intertwined, where something happens where we come to embody different ways of perceiving, thinking, talking, acting and valuing. I would also like to add the dimension of caring to Shotter's invitation.

This nurse appeared to foreground the importance of what the organisation, the commissioners, as well as the national directive needed as this appeared to be a 'tick their boxes exercise'. I was curious as to how I would invite nurses in my current practice area to

have different lenses to view care so that other important voices also get heard. This I believe has highlighted the need for commissioners to visit wards/departments and be participants in how care is delivered and to witness what counts as care and learning for nurses. Further reflections which I had when revisiting the transcripts of conversation with this nurse were her views on the word expectation, peer review and adherence to the set standards by these outside/inside forces. My curiosity led me to think about Senge's (2005) ideas of seeing from the whole as well as seeing from within an organisation, where he invites us to think of the whole as an empowering awareness where the 'seer' and the 'seen' requires a fundamental shift in the way they view the world, in this case the way the nurse views what is requested from her and the team. Senge (2005) suggests that we shift from viewing situations from a view of looking out at the world to one where we begin to look from within or inside what is being observed. In making sense of this, another way I could have understood this nurse's view was one of not being organised by the organisation, but one who uses the organisation, the national directives and the commissioners as pointers to look within what is needed within these psychiatric wards. This also connects to Senge's views that learning to see begins when we stop projecting our habitual assumptions and begin to see reality freshly. He goes on to say that a key to seeing from the whole is to be able to develop the capacity not only to suspend our assumptions but to redirect our awareness to that which lies behind what we see. To add another dimension to this I would say that attention needs to be addressed to that which lies within what we see, with this view at the forefront of my reflections and which I for my learning will pay attention to when in conversations with nurses, as I seek to explore the larger context in which and with whom they work. Here I would like to focus on how this nurse felt that she was learning within the constraints of the organisation's ways of working, for within these constraints there were also opportunities. When the nurse said 'staff reaction to incidents on the ward is changing', her own practice has been improved, she is becoming more aware of where she needed to focus her attention, which for her was about de-escalation as a first treatment line for agitation and potential violence rather than the use of physical restraint and rapid tranquilisation, which she now sees as a last resort within the treatment line. She spoke of the opportunity to further her professional development by being able to read and review

policies. The nurse also spoke about the opportunity she has had to look at the policies and make changes where the care of the patient would be of a better standard. She was also able to identify that not all the wards follow the policies and that there were in fact some discrepancies in some departments in the way that they responded to emergency situations. In the transcript below we continued our dialogue as to the nurse's views on what creates clinical learning environments.

(EPISODE/EXEMPLAR NUMBER 15b)

Cherrie: Ok, what are your views of what creates a clinical learning environment for nurses?

Nurse 8: My views would be, maybe an objective measurement of people's training needs, that is supported by adequate resources, which would be time to engage in learning, whether it be discussion or time to look at research articles, it would be about more senior staff having protected time to engage in micro teaching or formal teaching with more junior staff to develop them, and even the most basic thing around supervision, because teaching can take place in supervision, and also an environment where students from different disciplines are able to come for placements, and also where there is more structure, where there is research being encouraged and research taking place.

Cherrie: So kind of two folds to it, where research is being encouraged and where research is taking place?

Nurse 8: Yes, yes.

Cherrie: So what sort of research do you think would help the environment to be a good clinical learning environment for nurses?

Nurse 8: I think initially it is more around staff motivation, looking at staff motivation and looking at things that incentivises the teams, because the work is quite difficult and although it is a medium secure, there are different medium secure wards, the acuity of the patients is different from say similar medium secure wards in an NHS trust, and certainly the low secure wards would probably be classed as medium secure wards in some of the hospitals that I am

aware of, also it would be probably look at the advocacy of care for patients so that we are delivering evidence based care, and the aim would be to improving our practice.

Drawing on Benner's (1989) ideas of the primacy of caring and the ideas of reframing, where she invites us to think about having one's own current understanding of the situation, helps us to be able to reframe the situation. She goes on to say that in order to reframe a situation one requires the ability to get in touch with the meanings and concerns that are involved in the situation, so that one has an understanding and feels able/equipped to challenge this, as this is the first step in reframing the situation. So, this nurse spoke about the different influencing factors on how care can be provided. However, through these processes she learned a lot and has been able to be a role model to other nurses as they revisit how care is provided to/with patients who present as agitated or violent. Within the conversation with the nurse, she was telling a story of constraints and she was also able to reframe the story to highlight the opportunities that were also present. Here the nurse also shared her views on learning and what is needed for learning to take place. She spoke about having time to engage in learning, having protected time to engage in micro teaching, supervision as a place where learning from all disciplines can take place, staff motivation, evidence based care so that nursing practices can be improved, which will also improve the quality of care patients receive. With these gems at the forefront of my reflections I draw also on Bernstein's (1983) ideas of praxis, where he shares with us the notion of praxis as being the ability to understand the interplay of making meaning or as I understand it we need to have an understanding of our social world in which we live, making meaning in all its complexities. This then heightens my curiosity to understand how the nurse was proposing to enhance her practice and that of the other nurses within such complexity; I will background this curiosity and return to it in the next section of the text where I explore the usefulness of supervision through which a clearer picture might emerge about my curiosity.

How does supervision influence learning in a community of practice?

Here I offer exemplars of two nurses as they both shared their views and experiences of supervision and how this might co-create a learning community of practice within inpatient psychiatric wards. Scaife et al (2001) suggest that the primary purpose of supervision is that of ensuring the welfare of patients and enhancing the development of the supervisee in the work place. They suggest that in order for supervision to be effective it should perform the function of education, support and evaluation against the norms and standards of the profession and of the community. They describe supervision as an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. In these exemplars the nurses shared their continuing views on how supervision is important for learning to take place within inpatient wards; my sense is where this is possible community of practices could develop.

(Episode/ Exemplar Number 16a)

Cherrie: Ok, and I would like to ask you a bit about how often do you receive clinical supervision? I know that you have just mentioned supervision, so it is a good point to follow up on. So how often do you receive clinical supervision and do you feel that it has improved the learning environment?

Nurse 13: First thing that I would like to say is that I see it as very important, it is very important thing supervision and it really improved the clinical environment on the ward. Unfortunately on my ward it is very difficult to set time for supervision especially during the course of the shift itself, because sometimes you come across issues that you need to clarify and to talk about it with your supervisor or somebody who is more senior, maybe because of the nature of the work and also sometimes I think that it is down to the supervisors themselves, there is no time allocated for supervision. There can be time booked in terms of theoretical time but there is never really time to do it anywhere. And there is also unfortunately we could not do it because the ward was very busy and also I have realised that on my ward if you want to reflect on certain clinical issues or have supervision on certain

clinical issues some supervisors unfortunately are not keen or conversant in those areas so they will rather avoid sitting down and having supervision with you.

Cherrie: What do you think would make it better? What do you think will make a difference so that the clinical area becomes a learning environment?

Nurse 13: Having training across the board.

Cherrie: So training?

Nurse 13: Yes, people should really sit down and assess themselves as well and together with their supervisor and their ward manager and identify their training needs, areas that they need improvement and further personal development really so that they can also share that information and supervise other nurses on the ward.

Cherrie: So assessment of skills, training needs and someone sitting down and going through these with the nurses?

Nurse 13: Yes, yes.

On reflection I was struck by the importance of the meaning of clinical supervision to these nurses, as Nurse 13 experienced difficulties in attaining her need for clinical supervision. The nurse knew what she needed but was unable to highlight this to her supervisor, so that supervision becomes a joint collaboration between them. On reflection I was curious about how this nurse might be able to have some influence on how the environment could become a clinical learning environment which might in turn co-create a community of practice, where the team will support each other to maintain learning. This thinking pointed me to Shotter's (2008) ideas on responsiveness, where he invites us to remind ourselves that through a process of essential and creative discovery, where we enter into living dialogically structured relations, with each other in the circumstances that we might find ourselves in, then it is possible for us to respond in a spontaneous way which is only possible in dialogue as mono-logical ways of relating close down possibilities of how to go on. With this nurse it would seem that she was

not able to have dialogue with her supervisor and her more experienced colleagues which closed down the possibility of having supervision.

Senge (1999) reminds us of the impact on the manager's understanding of how the organisation informs its employees, what mental models are more profound than others, also that we all have assumptions, and that we always see the world through our mental models, also that mental models are always incomplete. This way of thinking invites us to ponder on the nurse's views of how difficult supervision is to access. We might want to be curious about the mental model of organisation as much as that of the ward that this nurse works on. Bernstein (1983) invites us to think about what is possible and shared the metaphor of having horizons. He talks about a horizon as being a range of vision that includes everything that can be seen from a particular vantage point. He goes on to say that a horizon could then be seen as limited and finite, yet it is essentially open, for to have a horizon is not limited as it allows us to see what is nearest but to be able to still see what is furthest. He further described the difficulties in trying to understand a horizon other than our own. He suggests that we should seek a fusion of horizons whereby our own horizon is enlarged and enriched. I understand this in relation to this nurse's view on supervision as her having a horizon which does not fit with her supervisor's horizon, or that of the ward environment and the organisation. In the transcript below we continued our dialogue as Nurse 13 shared her views about aspects of the environment that improved her ability to learn.

(Episode/Exemplar Number 16b)

Cherrie: Excellent, what aspects of the clinical environment do you believe have improved your practice in care delivery and how has it done so? What aspects would you say have improved your abilities to provide care?

Nurse 13: I think that the few sessions that I have had on supervision and reflections I have managed to ventilate how I feel on certain issues in how best that I could improve myself in terms of the care that I delivered, my perception of care delivery, how I should relate with patients, what I should do in certain areas.

Cherrie: And how often would you say that you have had that opportunity?

Nurse 13: Twice per month.

Cherrie: And that you think has helped?

Nurse 13: It has helped and it is something that I have realised much later, since I started nursing. Before then it was very difficult to have time for any supervision. Because you sit down and think that I am not happy with the kind of care that I am giving the patients and how the patients are progressing on the ward and then from there it kind of improved to where I would sit down with my supervisor and say I think that I would need more time with you and so that I can reflect with my supervisor.

As we continued our dialogue, I asked Nurse 13 what aspects of the clinical environment she felt had hindered her abilities to carry out care of the highest standard. She responded by saying:

‘It is a lot of things; some of them are even personal issues as well as she had noticed some senior nurses who were so conservative in their ideas of nursing that they cannot openly discuss patients’ care and therefore could not guide you in the proper way of delivering care by guiding you in what needs to be done’.

The nurse continued to say that she wanted to share certain practices on the ward, like as a nurse you feel that patients need more time. The nurse began to talk in an animated way as she shared her story of when a patient comes on to the ward by saying:

‘they are very unwell so you say hello, you try to orientate them to the ward, but there is more than just orientating them to the ward, there is more to be done, you sit down with them, you find out what they want and how best we can help them to deal with their situation’.

The nurse went on to share her thoughts saying:

‘but I think that there is more that should be done after that and for me, I personally think that it is about sitting down with them and coming up with some support, it could be CBT sessions, psychotherapy sessions, but very few nurses do that on the ward and from what I have gathered they do not know how to do it so they would rather avoid it’.

On reflection I connected this nurse's views to Benner's (1989) ideas which suggested that nursing had many interfaces in order that care can be connected to a whole. Benner suggests that nurses should extend their practices from the most immediate to the nurse-patient relationship, which I in conversation with this nurse noticed her to be having as her highest context marker in her care delivery. One curiosity which I was struck by was how this energy could be shared among the team so that a community of practice could be further developed. In the episode below I will show a dialogue with Nurse 9 as we talked about her views of the clinical environment.

On further reflection I became curious as to what might be needed for a fusion of their horizons to take place which might in turn create possibilities of how to go in practice. Lave and Wenger (1991) invites us to think of the importance of structuring resources for learning in practice as a possible way of co-creating a community of practice. They go on to suggest that a community of practice is one where participation is in an activity system, where there is a shared participation in the understandings concerning what they are doing and what that means in their lives and community. Seikkula and Arnkil (2006) talk about the importance of the healing elements in dialogues, where they suggest as practitioners we engage in the importance of dialogue in everyday practice. They go on to suggest that we are present as an entire human and living person and not only as a neutral professional applying some method. In making sense of this in relation to the nurse, she was clearly stating her understanding of what is needed in the environment, however sadly lacking, when she said 'people should really sit down and assess themselves as well as together with their supervisor and their ward manager and identify their training needs, areas that they need improvement and further personal development really so that they can also share that information and supervise other nurses on the ward'. On reflection it seems that this nurse was in touch with what is needed to form a community of practice and was struggling with what are the next steps or how to go on in the clinical area. In the episode this nurse who is a very experienced qualified nurse shared her views on the importance of clinical supervision which had many similarities with the previous nurse, who

was also a qualified nurse with less experience. In the example below Nurse 9 is a senior registered nurse manager working on the acute mental health ward. She has twenty five years of experience of working in a number of acute mental health wards.

(Episode/Exemplar Number 17)

Nurse 9: Yeah, clinical supervision is obviously very important, because clinical supervision enables all of us to learn and especially in nursing, things change whatever you learn during your three years training, then you come to the ward and things change, there is current research out if you are using a drug couple of years ago, when you come back and there is something better than what you were using previously, so clinical supervision and lifelong learning it is very important.

Cherrie: Right, what are your views on what creates a learning environment?

Nurse 9: Again it has to be from yourself and how motivated you are, whether you want to learn or whether you want to just to be happy for the last ten years with no change, but clinical supervision again enables people to reflect on their practice, look at how they can improve and whether again it is do with when they have done something how this can be improved and how can they do it better the next time, it is about improving yourself continuously.

Cherrie: right ...

Nurse 9: And it is to do with having student nurses on the ward.

Cherrie: ...

Nurse 9: Having GP trainees, that creates in itself a learning environment, because new people coming in, you are learning from them and you are teaching them also.

Cherrie: This sound really good.

Nurse 9: Yeah,

Nurse 9 on the other hand appeared to have a sense of the shared responsibilities in supervision and seemed more able to access supervision where it becomes a learning space for her development. Nurse 9's ideas on supervision heightened my curiosity as to the inequality sometimes in accessing supervision which can impact on the nurses being stuck in the beginner stage of their practice development while the nurse for whom supervision is an accessible resource might move with much ease into an expert stage of her practice development. I was struck by what resources are offered to make possibilities rather than constraints. In what follows I will share explorations on resourceful communities and the dialogical.

Resourceful community: the dialogical and its usefulness to practice

What is a resourceful community? What is dialogical? Shotter (2005a), Seikkula and Arnkil (2006) and Bertrando (2007) invite us to think about what it means to be dialogical. Here I explore what a resourceful community and being dialogical might mean to psychiatric nurses working within such complexity of care delivery.

(Episode/Exemplar Number 18)

Cherrie: What areas of the clinical environment do you find useful?

Nurse 13: (pauses) to be honest I am somebody who is everywhere really (pauses) ... I suppose it is about implementing the nursing interventions and at the end of the day, evaluating what you have achieved really in terms of assessing and progressing the patient's care.

Cherrie: Right, so you have found that a bit useful and do you find that you have got time to do that?

Nurse 13: I do, like usually when you sit down to do your care notes at the end of the shift you would have had your one-to-one with the patients, and if you have been through a

pattern of shifts during the week you can re-assess and see has there been any progress in the care delivered to the patients.

Cherrie: ...

Nurse 13: And how useful it has been.

Cherrie: So that area, of being with your patient that you have found to be useful?

Nurse 13: Yes, and one-to-one sessions with my patients and getting to know what exactly they need and how best we can help them. I always feel that it is a patient centered approach and they are the masters in their care. So if I can sit down with them, and be in an environment where they can tell me exactly what I need to do to help them.

Cherrie: And do you find that you get the time to do that, you said earlier on that at the end of the shift where there is a regular pattern of shifts you might be able to assess their progress, does this happen on every shift or?

Nurse 13: Unfortunately this does not happen on every shift because there are some shifts where it is very busy, busy in the sense that there are some very unwell patients and there are days where there is almost like chaos on the ward... Where it is really busy and you are trying to contain patients on the ward more than engaging them in meaningful interventions on a one-to-one basis.

On reflection when I thought about why I was asking the nurse whether she had time to deliver care, I was stuck in the mental model of the organisation, organising the nurse, and hence there would be no time for much appreciation on care delivery. I was expecting the nurse to say that she did not have time to carry out these tasks. Here the nurse is talking about how she creates a space for reflections when she is on shift. She was clear that at the end of the shift she would seek out how the other nurses felt the shift had gone. The nurse was able to reflect on her practice and was able to state with clarity that what gave her satisfaction in her job was caring for the patients. Benner (1989) talks about the need to be able to walk that journey with your patient taking account of all aspects of the patient and treating the patient firstly as a person.

Benner (1984) invites us to think about our practice as nurses. She invites us to consider the need for mentoring and supporting both expert and beginner nurses. Benner talks about the transition from novice to expert practitioner. She suggests that the expert nurse perceives a situation as a whole, she uses past concrete situations as paradigms, and she is able to move to the accurate source of concerns without wasteful consideration of a large number of irrelevant options. Here I want to remind the reader of the levels of expertise that the experienced nurses hold in comparison to the less experienced nurses, and to how the clinical environment could become a learning environment for both.

(Episode/Exemplar Number 19)

Here I ask **Nurse 9**, what areas of the clinical environment did she find to be useful and what was the most useful part of the clinical environment? **Nurse 9** responded by saying that she thought that people enjoyed the environment the most, she went on to explain that she had got dual roles, one of management and the other of looking after the patients. **Nurse 9** said 'The clinical environment is what I like best as it is the time where I spend with the patients, having one-to-one, doing medication, being involved, doing things like ward round, so that clinical environment I prefer more'. I was curious and asked **Nurse 9** what would she say keeps her doing both aspects of care giving and why did she do it? I said to **Nurse 9** that it was my understanding that as a manager she did not necessarily have to give medication, and be with the patients and that she could just decide that you will like to do managerial stuff? **Nurse 9** answered and said 'No, no'. I then asked her what makes her want to do those other aspects like clinical stuff? Her response was that she had a view and thought that as a manager if you are managing people who are nurses, you yourself need to have that knowledge of being able to do medication. She shared a story of practice with me where the ward had a new trolley and she wanted to go and see what it was like and to learn how to use it herself to be able to give medication so that when she asked the nurse with whom she is supervising whether the trolley was any good and whether or not it was quicker, more effective.

One reflection that I had was these sorts of practices make for the clinical environment to be an environment where learning through practice can take place. Nurse 9 went on to share her enjoyment of the clinical area and the fact that she felt comfortable in both roles as manager and nurse. She continued by saying that:

‘You cannot choose to say well I am only doing the managerial bit or I am just doing the clinical bit, you have to do both’.

I asked her about whether she felt that by working expertly in both roles that she was being a role model for nurses.

Nurse 9’s response was ‘Yes, and also I think that working alongside the nurses and doing shifts with them and doing observations level and if I worked with sometimes bank nurses doing observations and when I spend time talking with the patients, and the bank nurses see a qualified nurse doing continuous observations and engaging the patient in doing activities and talking with the patient, then they might say ok, is this how observations is done and then she would do it, it is like role modeling as well’.

We continued our conversation as I asked about her views about the clinical environment being a learning environment when there is a serious untoward incident.

Nurse 9: When we do have a serious untoward incident, the staff feels oh my god we have failed, everybody gets quite stressed, it is very anxiety provoking, but again we have not sacked anybody, we have not disciplined anybody when there is an untoward incident for gross misconduct so we have not, you know, we will often say that we are telling you this so that you will learn from it, any incident, you know, you don’t make it like why didn’t you, we always have to question our self as to why this happened and you do an autopsy all the time

in your head as to why this has happened, what could we have done differently, we always question how we could have prevented that, how can we stop this from happening again.

Cherrie: So you reflect with your team all the time?

Nurse 9: Yes, all the time we reflect, and if we have got a seven day report to do, reflect ,and yesterday we had a seven day report to do and one of the things that came out was we, it was a very simple thing, because this patient was refusing to take her PRN medication and because the patient was refusing and there is not anywhere in the prescription to write that she is refusing to take her PRN there is nowhere to write down a code for refusing say 1, 2 or 3, but if you do not write this down in your clinical entry then there is no record of this to say that the patient was disturbed and was refusing medication, so the patient absconded, but there is no way now to go back and check that the patient was offered PRN and was refusing because there was no entry in the care notes, so that is one of the simple things that, and then we said oh my god yes, so now we have to make sure and write an entry every time the patient was offered PRN and refused, we have to document it.

Cherrie: So you would say documentation and record keeping is useful for the environment to be a learning environment.

Nurse 9: Yeah, yes, very useful, because if you do not have the proper documentation and record keeping, then how do we go back and check did we offer this patient PRN medication or not. So that is something that came out yesterday from our seven day report.

One of many reflections I had was that this nurse was a very experienced nurse and had started her nursing career as a health care assistant, working her way through the nursing hierarchy to now becoming a nurse manager. Her sense of reflection and learning was something that she seemed connected with in a way that invited her team in the process of reflections on and in practice. I was struck by this nurse's abilities to put in place structures that would safeguard the patients as well as the nurses that she was responsible for. A theoretical concept that helped with my understanding was Benner's (1984) ideas on becoming an expert practitioner. Within this concept Benner talks about the expert nurse who sees the situation as a whole, where she

uses past concrete clinical cases to move to the position that is needed to be taken without wasteful consideration of a large number of steps that would be irrelevant choices, when faced with clinical situations where difficult and life saving choices are needed. Here the nurse talks about her ability to reflect and how the team gets involved in the reflection process, with the intended outcome of this situation not reoccurring in the future. Another theoretical concept was Oliver's (2005) ideas on reflexivity where this nurse is sharing how she was able with her team to reflect and become accountable for making choices, taking actions as they contributed to the process of good practice. In the episode/exemplar below the theme of the nurse's views on the clinical environment continued. **(Episode/Exemplar Number 20)**

Here I ask the nurse about her views on the clinical environment:

Cherrie: Yes, yes, and having a teaching environment, it sounds like it is a teaching environment that you have, very much of a teaching learning environment?

Nurse 9: Yeah, yeah, because teaching is not only that you go and do courses, and you do a degree, teaching is not only like when you are having one-to-one like in clinical supervision, it is ongoing.

Cherrie: Your environment sounds quite good (I paused for 2 minutes as someone came to room where we were having the interview requesting information about an assessment/meeting for a patient.....)

Nurse 9 asks whether 'Is it for me'? I responded by saying that it was for both of us and that it was regarding a meeting for one of her patients, and that I had delegated the task of the assessment. I proceeded to ask **Nurse 9**, what were her thoughts/views as to the learning within such a busy clinical environment as we just witnessed the busyness of this? I proceeded to say with so much happening all at once it is a good example of this. **Nurse 9** said 'Yeah, yeah, you can plan things and organise things as much as you want but there is always the clinical issue, the clinical patient care comes first. She proceeded to give me an example of the nature of the busyness of the ward. 'So, we have a teaching session and we have to cancel it because other things crop up when you are dealing with people. The meeting had not been planned for today; I had a message yesterday to say that there was a meeting today at 1 pm on the ward so you can see how difficult it is'.

Cherrie: If I were to ask your clinical supervisor what he\she would have to say if they were here and heard our conversation so far in this interview? What do you think they might say?

Nurse 9: I would like to think that the supervisor would agree with me that nurses need time to think about the day to day practice. They would need ... my supervisor would agree that clinical supervision is very important and would agree that by not having feedback on your performance how would you improve? If no one tells you, that you are not doing this right, and for the next time could you do it this way, because if no one tells you, you would think that whatever my idea is, that is the best one.

Cherrie: That it is the norm?

Nurse 9: Yes without realising that it is not the norm. I can see that supervision is very important, and I am sure that my supervisor would say that supervision is important to be able to enable people to become confident in their practice, to become more efficient and to improve. You improve with experience but you also improve with people giving you feedback on your performance, isn't it?

Cherrie: And if I were to ask your colleagues what have they noticed about your abilities to practise in the clinical environment, what do you think that they might say?

Nurse 9: I would hope that they would say that my clinical abilities are quite efficient. I would hope that they would say that they see me as a good role model, good teacher, but you really need to ask them(laughs)...

Cherrie: So you think that those are the things that they would say?

Nurse 9: Yeah, yeah, I hope that they would also say that I do support them and that they can see that if things are not right then I would help to put it right and to find ways about how to go about doing things the right way.

On reflection what struck me was the ability of Nurse 9 to reflect on her practice in such a way as to bring to the forefront key practices such as being a role model for nurses from both the NHS as well as from the agencies who supplied nurses on an ad-hoc basis. This nurse was able

to draw on her experiences of being a nurse in an acute inpatient psychiatric ward; she knew what the detailed level of involvement meant for care to be of a good quality. Her example of her involvement in the learning process with the new medication trolley brings to the forefront her ability to set criteria by which to measure the nurses for whom she is accountable, as with her criteria set she can measure the appropriateness with which the nurses practise as they used this medication trolley. I was curious as I reflected further on the nurse's ability and competence with which she shared her passion that 'patients' care came first'. I would like to add that this seemed to be at the expense of further training and development. As this nurse had such a wealth of experience to share, further training and development seemed to her to be not as important, as she felt that she had the knowledge needed to provide best care for her patients. This I thought could result in nurses not keeping up to date with current practices and as a result not providing the care that the patient needed, but instead caring for the patient can then become uncaring as the level of ongoing expertise will come to an end if training and development ceased to exist or existed in such a partial way that care is no longer care. Supervision formed a regular part of her concerns as she valued these in a way that is hopeful for learning to unfold. Shotter's (2006) witness thinking as opposed to aboutness thinking, where he invites us to think about what it means to be inside a dialogue, were theoretical concepts that I found as useful tools to help me express my understanding of what the nurse was sharing with me and how I was understanding her and making sense of our dialogue.

I also felt that the nurse was expressing her sense of being competent in a way that new knowledge seemed difficult to penetrate. A theoretical concept that helped me to make sense of the transcript was Senge's (2005) ideas of seeing from within where he suggests that as you move within an organisation you can learn more about the organisational culture through careful observation and reflective participant observations than from reading the organisation mission or value statements. He goes on to say that by doing so we can begin to develop the capacity to see from within the whole of the organisation in which we work and live. He invites us to immerse our self in the process of activating our imagination and applying it in different working sessions. This he said would allow us to start sensing the organisation's culture as a living phenomenon, where the concrete particulars of the meeting that you are a part of will

become embodiments of this living process. I understand this to mean that Senge was in fact talking about what Shotter (2006) calls witness thinking, to be in the moment experiencing with the nurse as she shared her stories. My reflection on the nurse's views was one where I felt that the nurse was inside her organisation and invited me to be a part of being inside the organisation in a way that I had not been privileged to be in before. Here I was as a nurse and manager and this nurse was sharing freely with me her views on how the environment could become a resourceful community of practice, where dialogue is free flowing in such a way that practices become clearer. Shotter's (2006) theoretical concept of witness thinking has given me a vocabulary in which I am able to share with the readers my understandings of the analysis of the conversation with this nurse.

Now I will explore what seems to be the lack of time to care and reflect on their practice which the nurses call 'protected time'. During the course of my interviews with psychiatric nurses, there arose many stories about lack of time to carry out basic nursing care, like spending time with the patients to hear and validate their concerns. Spending time with the patient in a meaningful way appears to be limited due to the pressures and demands of others for their time. Basic care becomes an effort as nurses' time becomes limited to formulating care plans with the patient. Here I will use exemplars from nurses to illuminate their concerns and explore when there is time to care how much this is appreciated by all.

(Episode/Exemplar Number 21)

Cherrie: What do you think needs to happen for nurses' voices to get heard, for example in a situation where you know that it is a dangerous situation, but you have been told that you have got to do what is asked by a senior manager? What do you think might make a difference?

Nurse 10: The way things are I think that things would never change or they will wait until something goes really horribly wrong, I think that we should be listened to and also people who make these decisions should come and work on the wards to see exactly what it is like, it is like a two handed thing; on one hand they are saying that you are not reaching these targets and they are saying you are not completing the have your say questionnaires and we

are not spending quality time with the patients and on the other hand there is pressure on us to take more and more patients which I think ...(pauses)...

Cherrie: I am trying to get a sense of more and more and what does that mean? Is that more and more for less? Because you seem to have more and more patients but less staff to do the job it sounds like?

Nurse 10: Yes, and even if you have got a ward that is really busy, it tends to fluctuate, because sometimes you could have a full ward but they are settled and it is quite peaceful and things are ok and at other times the mix is wrong and you know that it is all a bit volatile and you have got high risk patients.

Cherrie: So from your experience as a qualified nurse what would you say is a good number of patients to have in any one clinical area at a particular time, in terms of acute wards?

Nurse 10: I think ... (pauses) ... probably a maximum of maybe fifteen on a ward with the same ratio of staff that we have now.

As I reflected on this conversation with the nurse I was struck by her worry that 'things' would need to go horribly wrong before someone with authority intervened, as the nature of the ward environment seems almost too busy for adequate care to be given with the patients. I was also struck by the concerns that this nurse shared with regard to the expectation of others on them in relation to the amount of tasks/duties that they are expected to perform, with an environment where patients are sometimes volatile and as a result are high risk patients. I was curious about the responsibilities placed with the nurses who have to care for such high risk patients within the framework of fewer resources to carry out these nursing tasks. I was also curious about the different diagnoses of patients all on the same ward, and wondered whether having a ward where the entire patient population is experiencing the same type of mental health concerns would be a helpful or useful way of providing care. Another concern of the nurse which struck me was that they felt they were told to do many things which at times contradicted other aspects of care delivery and the suggestion by the nurse that these others did not know what was taking place in the clinical areas, and therefore did not have the

knowledge to make these decisions. As a result of this conversation with the nurse and other conversations with nurses during this research inquiry process, I have invited the multi-disciplinary team (MDT) to be involved in working on the ward in a way that allows for an experience of the daily clinical encounters which the nurses are presented with, so that a better understanding is achieved. One reflection I had was the lack of voices within the nursing arena and how nurses might begin to give this feedback to management so as to elicit their support.

(Episode/Exemplar Number 22a)

Nurse 10: And obviously there is still the protected time.

Cherrie: Protected time?

Nurse 10: Hopefully it would be so fantastic we would probably not need it, which is less time doing all this monitoring.

Cherrie: What sort of monitoring are you doing at the moment?

Nurse 10: Asking them the Patient Environment Team (PET) questions and I have got an issue with those. I think we are going to create a problem, because if you keep asking somebody over and over again at every opportunity if they feel safe on the ward they would start thinking why shouldn't I?

Cherrie: ...

Nurse 10: I think that they are counterproductive.

Cherrie: How often do you have to ask these questions?

Nurse 10: Every shift.

Cherrie: ...

Nurse 10: Or maybe once every shift, but.

Cherrie: It is still once in a day?

Nurse 10: And sometimes more than that.

We did not further explore this concept of protected time, instead going on to talk about the busy nature of the ward and the impact that this was having on nursing care. On reflection the nurse was indirectly talking with me about the need for time to reflect which she was finding difficult to achieve. The nurse was worried about the task that she was requested to do and found that there was potential for high levels of anxiety provocation as the patients themselves showed some concerns when asked on a regular basis whether or not they felt safe on the ward. This way of working fits with how managerialist processes work, where there are no specific ways of managing care as there are to managing a car factory for example. This can result in nurses' autonomy and their quality of care being hugely compromised. Taptiklis (2008) talks about managerialism as having views that assume a non-human world, he further elaborates that managerialism then develops models and prescribes solutions only in terms of its own artifice. Also that management becomes the need to control the organisation as far as possible down to its tiniest interactions. Taptiklis (2008) suggests that management needs to be reframed as a practice, a craft, in which the challenges of services and supporting of practitioners can be continuously articulated, reflected on and further refined. This he argues would have the impact of attainment of deep professionalism rather than as they currently are, which is simply as accelerants of the bureaucratic process.

(Episode/Exemplar Number 22b)

Cherrie: Where do you find the time to do that? Because you have got to sit with them at some point, because I was just thinking about the ward being so busy and...

Nurse 10: Yeah, anyone that is available, people will go around with the machine to do it and then there is the have you say questionnaires as well.

Cherrie: So there would be less time doing this monitoring because it will be so good that it will speak for itself.

Nurse 10: Yes, yeah.

Cherrie: So the ward environment will speak for its safeness itself?

Nurse 10: Yeah, yeah I think so... (pauses)

Nurse 10: I think that nurses should have a lot more access to information or it should be more accessible, not only myself have I just discovered the library and I think that the student nurses are quite good and they will search out information if you tell them about the intranet, that is a good thing the intranet to be able to find things, resources that are safe to use.

Cherrie: So you would point them in that direction?

Nurse 10: Yeah and use things with them and always I think especially with the HCAs I am really into doing their NVQs with them and I think that there should be more assessors on the ward, because I think that, that keeps everyone familiar with the policies and things and just sometimes the things that you sometimes take for granted, you are sort of questioning why do we do it that way or am I doing it in the correct manner.

Here the nurse seemed to have tapped into possibilities that can make a difference in the clinical environment as she shared the need for access to learning as she questioned her own learning. She shared how she found that accessing information is an important part of learning. She also went on to share her training and learning as she took part in the teaching of Health Care Assistants and student nurses. The nurse spoke about the need to know what the organisation's policies were so that her knowledge could be informed knowledge.

Rules, culture, practices, what are they?

During the exploration of exemplars drawn from psychiatric nurses working with such complexities, rules, culture and practices were brought to the forefront as care is carried out within inpatient mental health wards. I will draw on a number of theorists from the social constructionist framework to explore these aspects as told by nurses.

(Episode/Exemplar Number 23a)

Nurse 10: I think, going right back to the beginning, I think that it is right to have that culture of... and I thought of when we have (pauses) ... we have like reflections sometimes and I sometimes feel that, that is not very productive. We might talk about an incident and nobody is there who would say why not look up the policy and read what it says and what this policy means to us and how we use it, things like that so it is not ongoing..., people doing presentations on anything like Danzapine and registration. There are lots of issues which just come up during the course of the day or in the course of a week.

Cherrie: So what happens in the reflection meetings?

Nurse 10: I can say they are usually very negative

Cherrie: ...

Nurse 10: They are not very focused and I do not think that anybody really gets anything worthwhile out of it.

Cherrie: Would you come up with an action plan after the reflections?

Nurse 10: Yeah, yeah,

Cherrie: You do?

Nurse 10: Not, well I suppose we do, but limited.

Cherrie: Is it used as a point for criticism or is it used as a point for learning?

Nurse 10: Blame and criticism I think.

Cherrie: So blame and criticism?

Nurse 10: (pauses)

My reflections on how supervision and learning was carried out on this ward were key points as I reflected on our dialogue. Nurse 10 said 'We might talk about an incident and nobody is there

who would say why not look up the policy and read what it says and what this policy means to us and how we use it, things like that so it is not ongoing...,' the need to have knowledgeable and competent nurses on duty strikes me as a point that this nurse was making. My sense was that having supervision after an incident was important mainly if the staff who were involved in the incident were present so that they could be supported by their colleagues and shared learning could be co-created, where nurses with more experience would share how they managed a similar incident. This connects with Benner's (1989) ideas of caring being primary as it sets up the possibilities of giving and receiving help. As nurses it seems that it is not always possible to be cared for by management, or to ask for care, as this might be seen as a weakness in the nurse to be competent in her caring role. We continued our dialogue in the episode which followed:

(Episode/Exemplar Number 23b)

Cherrie: What would you replace it with if you had a magic wand? Or how would you do it?

Nurse 10: I think by encouraging everyone to try and take some part in it, and if we are talking about what went wrong with an observation then you know that exactly, so that people have actually got information there, asking people to present or someone would say I will present this policy today or I will look up this type of treatment that we have been asked to use, so it is more (pauses) ...

Cherrie: Having it like more like a sort of teaching session?

Nurse 10: Yes, more like teaching sort of focus on what should we do differently as the most important thing, but I think that, that gets lost.

Cherrie: So it gets lost in the kind of what went wrong?

Nurse 10: Yeah, and sometimes we would never revisit it even when we have a type of action plan, not even to look to see if we have been working any better, so more continuity as well.

Cherrie: So continuity for the staff team?

This nurse on reflection was asking for regular informal supervision in the clinical area so that learning can take place. She was also asking for supervision to be structured with meaningful discussions and explorations so that the clinical area becomes a learning environment. By her many pauses the nurse seemed to be showing her skills to reflect her concerns by slowing down her thinking processes so that she becomes more aware of how she forms her own understandings and the ways in which this can influence her actions. I was struck by her sense of the wards being a community of practice where learning of various kinds becomes the guiding principle in creating clinical learning environments.

Nurse 10: Yeah, yeah, and maybe that willing and as well in my ideal thing about group supervision.

Cherrie: Group supervision? What about the clinical hands on care? How does that feel like for you working in the clinical environment? Do you think that things could be done differently? And if so how?

Nurse 10: (Pauses) I think I just get stuck on the wards and you don't think about it and that how it is, probably more areas where you can just talk with service users.

Cherrie: So kind of more time for the service users?

Nurse 10: Yeah, I think that there is (pauses) ... a lot..... (pause) recently I have been thinking that respect and dignity is quite a difficult one but when you are on a continuous or supportive observations with somebody (pauses)

Cherrie: So respecting dignity.

Nurse 10:...and also on the ward there is also one lot of communal area, not to isolate somebody but to have them in another area but still sociable to have more places.

Cherrie: More areas to be?

Nurse 10: Yeah, yeah, even if it was in an area I do not know ... (pauses) ... like in a hotel lounge where you could have your little quiet conversations with other people around and you are in the same room.

Cherrie: So with other people around?

Nurse 10: So not where you have little areas where I am talking to so and so and everyone can hear your conversations. I would not say confidential things but just.....

I was struck by her views of how the ward could develop productive ways of learning. The nurse went on to share that sometimes reflections do not include the key people that were present when the incident took place. The nurse found these reflections to usually be negative, not very focused and did not believe that anybody gets anything worthwhile from it. The nurse felt that having a structure to the reflections might help, also her point of being invited to take part. Her thoughts on the possibility of having teaching sessions, and action plans that are actually followed up on, was something that also struck me. Also her views that continuity and group supervision was something that would be useful to create a culture of practice which can influence care delivery. This nurse spoke about the importance of respect, dignity and time to care for the patients in respectful ways. I was struck by the nurse's ability to reflect on her practice and identify what is needed for care delivery to be competent and safe. She also talked about the value of group supervision and if used well this can create reflections that are meaningful to the nurses.

Conclusion\Summary

During the period of working with psychiatric nurses within these various inpatient wards, and in the process of interviewing the nurses, as I attempted to put their views at the forefront, I was able to draw out some findings that expressed their views and experiences of their working in inpatient psychiatric wards, and how being in that community of practice has offered them the possibilities for more opportunities than constraints. In the exploration of a community of practice it became an interesting discourse as for me a community of practice continues to be a never finished community, and one which remains open to reflections, new knowledge and new practices where old practices are questioned by all in the community.

The findings that were drawn from the experiences of the nurses are listed below. These findings connected in many ways to the research questions that I set out to inquire into. These findings will be further explored during future writing as connections will be made to these and other experiences and views from the psychiatric nurses working in inpatient wards.

1. Nurses were aware of the need to put the patients' care at the heart of everything that they did, offering patients the possibilities of more choice and control over their health care needs.
2. Nurses were aware of what practices are needed, however somewhere, somehow they had forgotten how to always do so, in the sense that their voices seemed to be silent where their needs needed to be expressed.
3. During the interviews with nurses in varied nursing inpatient wards, the skills and abilities of the nurses were very much present, however there was a shared sense of not being given the resources that they needed to carry out their work to a competent level.
4. The nurses' use of their code of conduct to assist in the care given to patients was an aspect of care that was noticeable, with experienced and less experienced nurses in their practice.
5. It was also noted that dialogue happens in context where nurses feel supported and where the episode of care in which they are engaged is also supported in a way that has a team approach and resourceful pulling together of skills and abilities.
6. The lack of space or spaces for the nurses to use for reflection was also brought to the forefront.
7. The needs expressed by nurses to have supervision after an event or after a critical event had taken place.
8. There is a high level of expert nursing care needed in these inpatient wards and the need for more expert nursing practice presence.

9. What was lacking was the knowledge that a community of practice is never a completed process; rather it should be unfolding, able to work with complexities, able to challenge and respect others' views, simultaneously working with teams which have a high level of expert knowledge, where the team creates a space or spaces to share their expertise.
10. The need to attend planned learning spaces so that knowledge can be shared and gained.
11. Throughout the three areas that I inquired into, which were acute adult, secure adult and secure adolescent wards, what was strongly echoed was that the psychiatric nurses all felt that they needed a voice within the organisation and its hierarchy of team structures within these wards and there was a felt sense that the nurses wanted and at times needed more expert nurses working in the teams.
12. These areas of care are highly complex, difficult and therefore need research based work where practices can be evidenced so that higher levels of learning can take place. Self motivation was also a key factor in the learning process shared by these nurses.
13. Nurses reported that they needed time to reflect on their day to day practices.
14. Nurses feeling the need to have feedback on their work performance as this was important to them in helping with the building of their confidence in their practice.
15. Nurses feeling the need to have protected time to care and reflect.
16. Nurses shared their concerns about the different diagnoses of patients that are all cared for on the same ward and the complexities that this adds to their ability to provide competent care.
17. There were fewer resources available to them to carry out more tasks and to be able to allow them to provide caring and safe practices.
18. The destruction of negative reflections when nurses are faced with difficulties on the ward, these reflections were described as not very focused and that these reflections were used

for blaming and criticism. The nurses felt that having inclusive reflections to share information would help the process.

19. The need to revisit policies and procedures and knowing what one can and cannot do when working within the framework of the organisation.

20. The need to make changes to the physical environment will make a difference as the spaces that are available are limited and do not lend themselves to sufficient patient privacy or confidentiality when 1:1 sessions are needed.

In the next chapter I explore some of the concerns and worries of the psychiatric nurses and myself which were brought to the forefront, as I read and re-read the transcripts and reflected on how nurses viewed their abilities and sense making of learning within inpatient psychiatric wards. Also how my curiosity was ever present as I reflected on the different stories shared around lack of time to reflect, to think, to sometimes understand the complexities which the nurses faced in their daily care delivery within these inpatient wards. I will share my reflections on these as I developed as a person, a practitioner, as a manager and as a researcher working within a health context.

Chapter Seven

Co-creating reflexive spaces in which to work: their influence on psychiatric nurses' views and experiences on how they were able at times to co-create reflexive spaces during their practice within Inpatient Psychiatric Nursing

In this chapter I explore some theoretical concepts as tools to understand the ideas of nurses co-creating a space in which they can reflect on their practice. I will draw on exemplars where nurses shared their views and experiences with me. I will then share my reflections on the exemplars, making connections to systemic and social constructionist concepts as well as authors from the management and leadership field. I will write in segmented fragments ensuring that connections are made to the whole. I aim to write about **1. Making sense of our social worlds. 2. Reflexive spaces. 3. Competent practitioner. 4. The coming together of practices that create a reflexive space. 5. What gets created when one is in that reflexive space?**

1. Making sense of our social worlds: As I tried to make sense of the transcripts where nurses shared many stories about their views and experiences of what creates a clinical learning environment within in-patients psychiatric wards, I began to also think about where and how in-patient psychiatric wards originated from and what connections might be made with these nurses' experiences of these wards. I became curious as to how nurses working within inpatient psychiatric wards understand and make sense of what their task and responsibilities are when faced with shortage of staff, cuts in services and a complex nature of care needed by their patients. How do they begin to make meaning, draw on already existing skills and knowledge and form a team of expertise that is needed? One connection I made, in the quest for making sense of the nurses' stories and the fundamental need to work as a team was with Pearce (2007), who suggested that making meaning is as fundamental to being human as forming packs is to wolves. He goes on to suggest that there can be no meaning without action and no action without meaning; however these concepts can be differentiated and by doing so we can at times recognise critical moments and make decisions about how to respond or act

into these decisions. Psychiatric nursing has a history dating as far back as 17th century. A psychiatric disorder, according to a medical model understanding, is an organic as well as psychological condition such as psychoses, neuroses and personality disorders. In the next exemplar a nurse is talking with me in a way that I thought she was trying to make sense of her social world and how she was able to share her social world as a nurse and her desire to create learning in her clinical area. Nurse 2 is a qualified psychiatric nurse with ten years experience of working in a number of inpatient psychiatric wards. She has been working on the secure male adolescent ward for the past year. She is also a registered general nurse, with seventeen years experience as a registered general nurse, working on a variety of medical wards. **Episode/ Exemplar Number 24 a:**

Cherrie: So what are some of the presenting illnesses of these patients/ service users/ adolescents that you work with? What do they present with?

Nurse 2: Quite a wide scope really; when I first started working here we had people with schizophrenia you know the classic symptoms and then incorporated in that is the sort of, for example psychosis usually due to illicit substance, substance abuse and also behavioural attention deficit disorders, young men who have problems with authority and non compliance with medication when they are out in the community; it is a lot more than that but this is to just name a few.

Cherrie: It seems to be that quite a few of them have been abusing illicit substances from an early age.

Nurse 2: That is what it appears to be of late.

My thoughts were that the need for support and supervision to work in this area of care was necessary for nurses as there seemed to be huge variations in the care that was needed for each individual adolescent, for care to be effective and make a difference in the young person's life. Benner (1989) suggests that the nature of a caring relationship is central to most nursing interventions and that this depends on the nurses' abilities to be flexible and diverse which

shows itself in her involvement in the situation at hand. In our dialogue which follows we explore supervision and support that is much needed to allow for reflection.

Cherrie: Yeah, how often do you receive clinical supervision? And does this help to create a learning environment for you?

Nurse 2: Well, right, clinical supervision supposed to be every six weeks, since I have been here, well since I have been on D ward I have had two and I have been here a year.

Cherrie: Ok, so

Nurse 2: It is not really that

Cherrie: So you could have more is it?

Nurse 2: Yeah I could have more yeah, yes but I think, well not making any excuses or anything but we have had a recent high turnover of staff and the team leader structure we now have, is just getting it stabilised.

Cherrie: What are your thoughts about clinical supervision in terms of the clinical environment? How do you see it? Do you see it as something that is hugely necessary? What are your thoughts about it in order to make the environment a learning environment?

Nurse 2: This is important as from a clinical point of view this is an opportunity really to look at areas where if a person feels that they are not adept at certain clinical skills or information or gap in their knowledge to be able to, well it is an opportunity to address those deficits.

Cherrie: Would you say that having clinical supervision is important to make the clinical environment a learning environment?

Nurse 2: Yes, yes I think so, because it improves the quality of care that we give to the client group that we are looking after, the patients that we are looking after.

This nurse knew what was needed to improve the care that she provided to the patients and felt a lack of input from her organisation to fully support this process. She felt that the possibility to provide better care was in sight as the team began to readjust to the new

structure in place. This nurse expressed a sense of hope for how things could be in the near future and I was curious as to what led her to this position. On reading the transcript from our conversation my curiosity was satisfied as this nurse had felt supported by her organisation in the recent past, she was sent on various training courses that met her needs as a nurse and was happy with the outcome. Her sense of her organisation was that this was going to be better as the new team came together in creating their social world in relation to caring and nursing their patients. Benner (1984) talks about the expert nurse feeling within her a sense of what is needed, what the situation calls for and knows how to respond without the need for a manual to guide her through her competences to carry out the care that is needed. This nurse seemed to fit that ideal of an expert nurse, understanding that her role is a constant learning process if her care is to remain at the highest standards. We continued our conversation:

Cherrie: So it improves the quality of care, so what are your views on what creates a learning environment? What would you say?

Nurse 2: A good learning environment I think would have a good skills mix of staff and it would also be good if staff could give tutorials. It does not have to be long day thing; you could give half an hour instruction. In half an hour you pick a topic and you give a talk on it; you could prepare a talk over night and give a talk on it in the morning meeting. That is if we had our morning meeting we could give a talk on it. I know we have our therapy session run by U for staff every Thursday I think or is in once per month?

Cherrie: And what about the mentorship course? How is that going to help the environment to be a good environment and a learning environment?

Nurse 2: A good learning environment, well a good learning environment for the people, well it is quite an important position to be in to mentor somebody to pass on and encourage somebody as they are the up and coming learners of the future that is very important skill and position to be in

Cherrie: So training nurses for the future

Nurse 2: Yes, training nurses for the future is important, yes they will be the managers of the future I am not going to be around forever, am I?

Here this nurse was thinking beyond the here and now practices, to how nursing in the future could/should be, she was having a vision for the future where the nurses who have good mentoring will provide better care. Her sense of her own mentoring was something that was shining through in her expressions. I on reflection was making connections to Bernstein's (1983) ideas of a horizon as not being a closed horizon but something that is open, one where we can look into the distance and see not only what is nearest to us but to also see beyond it. He suggests that a horizon is something into which we move and that which also moves us. We continued as she shared her views and experiences with me as to what for her creates learning within the clinical environment.

Nurse 2: I thought that a good team structure helps as you can learn from other colleagues, things that I would do a certain way if I see a colleague that (pauses) taking a role model, somebody that does things in another way that I consider to be better than how I would do it, then I would discuss it with them and take a page from their book, and use that.

Cherrie: So kind of how would you say that you have achieved your learning? How would say this?

Nurse 2: Learning from my peers, yeah they are my peers, my equals

Cherrie: So learning from peers, and taking a leaf from their books as you would say

Nurse 2: Yeah, yeah, taking on a role model, role modelling, like management, somebody that say like B, am I allowed to mention names?

Cherrie: Yes, if you wish to do so

Nurse 2: Well when I first came here B was a team leader and I learnt quite a few good things from her, in particular discipline and self respect and boundaries and how to talk to young people in a way that does not make them feel threatened, even when I saw the way she handles aggression, she is able to get them to think so you have done this act of violence, to be specific so ok you have broken the television screen how did you

think, how did that benefit you, she asked those open ended questions (yeah) and would then encourage that young person even in their angry state to think about what they have done and they would and then it is as if what we will call in Dialectical Behavioural Therapy (DBT) the, I forgot what they call it now, it is like what we will call a chain analysis and break it down one by one I see the way she will do this and get them to calm down, which they did and then they will realise what a silly thing that they did, they wish that they had not done it and now they can realise

Cherrie: So that was that something for you that makes the environment a learning environment?

Nurse 2: Well the way you talk to people

Cherrie: Yes, yes

Nurse 2: Well the way you talk to people and address certain acts of aggression

Cherrie: Yes, yes, you seem like you have learned a lot from B

Nurse 2: Yeah, like I said she was ah... I miss her in a way, even when we had supervision and informally she was a good mentor that way.

Having a good mentor was something that this nurse valued as it seemed to have added to her confidence and developing practices. On reflection I noticed this nurse's abilities to reflect, pause and think about what she needed to practise, to care for her patients, which from her experience would be of value to other nurses, and her vision for the here and now and also for the future. I drew on Senge's (1999) ideas on shared vision as something rooted in an individual's own set of values, concerns and aspirations. He spoke about genuine caring being a shared vision that is rooted in personal visions. I would now turn to reflexive spaces, what are they? How do they get created or co-created? Who is invited and who is not invited into these spaces? In making connections with social constructionist theory, Oliver (2005) talks of the importance of being able to be reflexive in our practice. Pearce (2007) talks of context as creating meaning. This nurse during the process of sharing her views was able to link her

experience of learning to a particular context where the mentoring that she received was an invaluable experience for her.

2. Reflexive space: Oliver (2005) suggests that in being reflexive one might take the position of practising to embrace how we make choices about how we think and act. We are then responsible and accountable for our choices, our actions and our contribution to the systems within which we relate to those around us. Oliver (2005) suggests that a non-reflexive space is one in which we are thinking in relation to our own individual choices, wants and preferences. In my making sense with what Nurse 2 said, Shotter (2008) suggests entering into living, dialogically-structured ways of relating with others in events or circumstances, and allowing these situations to call out spontaneous reactions from us; this will allow for our engagements and responsive understandings to emerge and become available to us from within the unfolding intra-action. This was a theoretical concept that helped me to understand the abilities in this nurse to be reflexive. Shotter (2008) further stated that if we, however, adopt a monological way of being and treat such others within inter-actions as dead forms, then this way of engagement would be unavailable to us. Therefore, when one takes into account reflexivity, one must consider how we engage within a dialogue with the others and the othernesses with which we interact. I understand reflexivity as the ability to think about your surroundings, practices and engagements, always looking for other possible ways of doing and relating with people. The current teaching practices of nursing staff could be described as a clinical task being taught in the classroom, with lack of teaching in the clinical area in which care is provided. Nurses described a number of reasons for this: the lack of an adequate staffing ratio to meet the complex needs of the patients, a lack of senior skilled nurses on each shift on the wards and the lack of spaces for reflection due to such open criteria for the variety of mental illness with which patients are currently admitted into hospital seeking treatment for.

(Episode/ Exemplar Number 24b) brings to the forefront both a reflexive and non reflexive space in which to practise and the ability of the nurses to create these spaces when constraints are ever present.

Cherrie: Is it just on going? What are your thoughts about how this can be for the nurses? This research is more about how can the nurses learn and create a clinical learning space?

Nurse 9: To have protected time to have one afternoon where, maybe an hour or two hours, like they have for doctors, quite often we cannot bleep them as they are on their teaching session. I am thinking why can't we have that, say one afternoon where there is no ward round, with whoever the nurse is on the ward, where the permanent core staff will have day to day running of the ward, they could be allocated an hour one day in the afternoon where this is their protected time.

Cherrie: Where they could go and read a magazine, go and read some research pertaining to their work or spend it doing something of interest to their work?

Nurse 9: Yeah, or just having somebody, just having, you know the new Resperidone Constar (this is a new anti psychotic medication, administered in intra muscular form for the treatment of psychoses) some of the nurses do not know how to do it, just to teach the nurses how to administer the drug, to have an hour for someone to come, this could be one of the senior nurses, to teach them how to use it, where we are not disrupted by other things happening on the ward.

Cherrie: So that would be their protected clinical time with the patients, not protected for the nurses to study or to read a paper on nursing or to discuss clinical care? Is it clinical time to be with the patients?

Nurse 9: Yes, clinical time to be with the patients, there is no protected time for staff we have not been given permission to have an extra nurse coming so that you can go off and do your supervision, as there would be two nurses off the ward if that were to happen. So we try to do it after handover where the hand over finishes at 2.15, I am saying to the staff to do their supervision say 2.15 to 3.15. But again is getting staff to think differently, because they would say well I want to be there because it is now time to be planning the shift and I cannot take myself out of the shift, and again it is difficult. I still feel that the clinical supervision well they do not want to stop and reflect on their practice, they more want to deal with things then and there if a situation happens then they want to say that they have got somebody to ring and sort it out, but they do not see that it should be protected time where they should stop and reflect and learn.

Cherrie: So from your view and your experiences you would want staff to have that protected time where they can reflect on their practice and in doing so the environment will become a clinical learning environment?

Nurse 9: Yes, yes.

On reflecting on the nurse's views of what consists of reflexive time I became acutely aware that this nurse did not believe that nurses on her ward wanted to have time to reflect, rather her views were that the nurses needed to 'think differently.' I became curious as to how and what would need to happen so that the nurses begin the process of thinking differently. There seem to be several ways of how learning to care might be demonstrated. Here this nurse felt that there were disruptions in how other nurses felt learning had hindered their ability to carry out new ways of care. Here the nurse pointed to the positioning of the doctors in the hospital which was that they were in a more valued position than the nurses on the wards were in and therefore had more privileges for learning opportunities. Here I drew on Benner's (1984) ideas of the novice to competent practitioner, where she talked about the constraints placed on nurses when working on units/wards with extremely high staff turnover as the opportunity for learning and becoming a competent, reflexive practitioner simply could not happen under those circumstances. Benner (1984) suggests that the most skilled practitioners happen when nurses are provided with the opportunity to gain comparable experience and develop a shared language with clinical colleagues. She suggested that managers should foster stability in order to maximise expert clinical performance in nurses.

My observations from these conversations were that: in talking together with other nurses their capacity and ability to improve their practices will grow to a higher competency level. Being able to have time/times when they can pause from the daily activities. Creating arenas for reflections and having the ability to know when they needed to do so will improve their ability to be reflexive. By coming to reflexive spaces where they can share stories of reflections on practices will all contribute to creating reflexive spaces in which to develop their practice. On reflection I believe that a reflexive space was co-created for Nurse 9 as she began to tell her own views on what learning and having a reflexive space means for her. Nurse 9 seemed to

struggle to co-create with the nurses a space for reflection, thinking and learning. My own reflections on reading the transcript from Nurse 9 was that there are many ways of learning to provide care and I wanted to know what the nurses were able to create/co-create within the spaces that might be made available to them. I used my own sense of being a nurse and the sometimes lack of time, space and motivation to move into a specific space which one can call a learning space; there is an idea that as a nurse you learn on the job. I became curious to understand how one knows that they are learning on the job and how this learning is or could be understood and shared. I drew on Pearce's (2007) suggestion that each of us are agents in the process of making social worlds and that there are many social worlds. He suggests that if we want to live in better social worlds we will have to make them. With this at the forefront of my reflections it became clearer that the nurses, which included Nurse (9), were sharing their practices by talking about how it would be possible to create learning, they were starting the process of creating their social world in co-creating caring, learning environments. On reflection of the episode of learning that this transcript brings out, I understood Shotter's (2008) ideas of being in dialogue with others as we work with the situation at hand as we continue to explore with each other within the living moment of a situation, we can then learn the unfolding dynamics of the situation at hand; however if we distance ourselves from the situation at hand and talk about the situation as an abstraction, our learning becomes aboutness as opposed to witness which involves being and learning within that situation.

3. A competent practitioner: following my curiosity to make sense of what skills and knowledge a competent practitioner has that can be shared with other practitioners to develop learning environments. How can these be noticed? How does one become a competent practitioner? To bring this to the forefront I have chosen this episode below from a transcript with Nurse 8, **(Episode/ Exemplar Number 25):**

Nurse 8: I think that I would probably break it down into two, personal attributes and professional attributes and many others, so really just on a personal level for that individual to relate to any patient as a fellow human being and talk to them as another human being

rather than a patient which can create distance and create boundaries or limitations and just to be honest with the patients because sometimes when people have got mental illnesses what they are saying is very true sometimes, they do have valid gripes and sometimes we do not treat them as well as we can, to just be honest and say that I agree with you and look at how to make their experiences better, and also to give feedback, sometimes patients can be really challenging to me and I have also taken on the approach that I want to be honest with them and reflect to them on how their behaviours affect me because I also want them to treat me as a human being not just as a professional who they can abuse and treat negatively and also just to be quite creative in the way that I work. I have got a lot of talents and things that I like to use as mediums to try and encourage the patients to bring out the best in them, for instance I am quite playful sometimes and patients who are difficult to engage with, I can be quite playful but able to set boundaries and parameters, and still engage with them on a level where maybe especially the learning difficulties patients, where I see it most and I can really come down to their level and interact and build a rapport on that.

Cherrie: So start from the bottom and get to know the patient on a personal level?

Nurse 8: Yeah, yeah, that is right.

Cherrie: And build on that.

Nurse 8: The ward philosophy of where you are working and to follow through the model of care that is ascribed to that clinical area and you know if I am going to do anything different it is in negotiations and discussion with other team members.

Cherrie: Right, right.

Nurse 8: Because there is always scope to work eclectically with other therapies say like with DBT; also to let other people know what I am doing and how I am doing it so that they can also support the patient when I am not there so it does not seem like Nurse 8 is the only one who can have a good relationship with the patient, and just to draw from the knowledge that we gain from our nursing practice and not to get swallowed into bad practices that sometimes we see within the clinical areas and take an interest in things that are new to me,

go away and look them up or find someone who knows and get them to share what they know with me.

Nurse 8 is able to reflect on what makes for good care and learning. I was struck by her words that a patient should be related to as a fellow human being. This nurse was in touch with what Shotter (2005a) calls witness thinking and what I call witness practice where she was showing how she had a great sense and clarity in respecting the dignity of the patients in her care. She went on to say that they should be spoken to as another human being rather than as a patient. One curiosity I had was that of the meaning of the word patient as this nurse felt that being a patient can create distance, the need for boundaries and/or limitations in the relationship between the person and professionals. The sense that one needed to have these words as the guiding principles in order to provide good care created for me a sense that this nurse was able to be reflexive. I was connecting to my own experiences of being a nurse and also that of being a patient and the very strong stories that I have of how one must be treated, holding at the forefront that as a nurse you always treat your patients as you yourself would like to be treated if you were in the position of being a patient receiving care for whatever your ill health might be. I also connected to Oliver's (2005) ideas that there is a key moment in communication where a choice is made about how an interpretive act will determine future contexts. Here the nurse was making that moment a real point of reflection as she also connected to her many talents and her ways of working which highlights her sense of working as a person with her own values as well as working with her team members, where she spoke about working with the ward philosophy, the model of care ascribed to the clinical area and doing so in negotiations and discussions with her colleagues in the team.

Here I have used CMM levels of context to explore in a visual way what gets created when nurses are in reflexive spaces.

Contextual Force

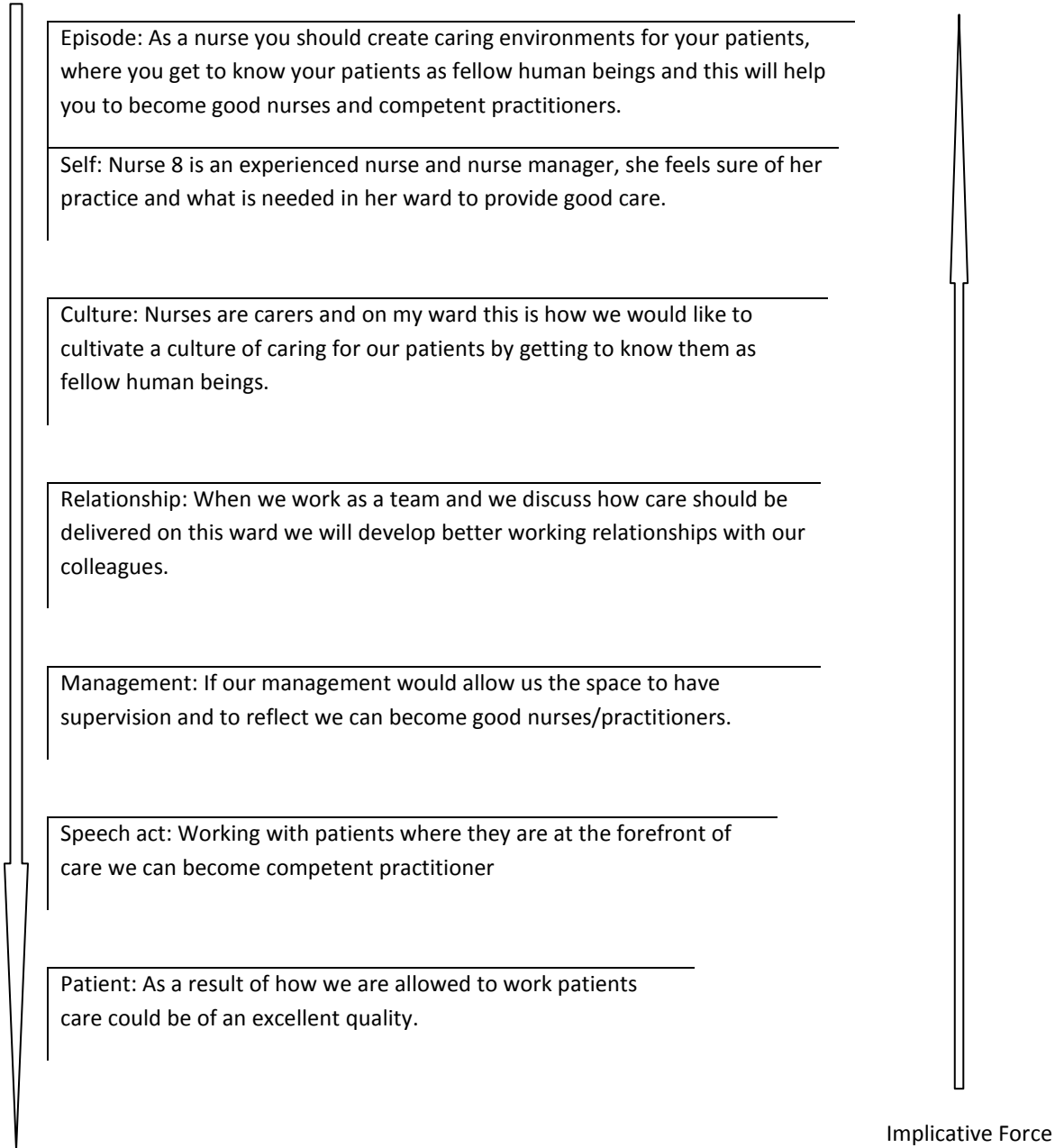


Figure 8.5 CMM levels of context

Adapted from Pearce (1994 p. 347)

4. The coming together of practices to create a reflexive space: Oliver's (2005) idea of morally reflexive abilities seemed to capture the nurses being able to co-create reflexive spaces in which to deliver care. Oliver goes on to highlight noticing and questioning actions and reactions of participants in the conversation, to include oneself, giving meaning to what is noticed with reference to contexts of influence, such as culture, relationship, and identity narratives and their rules for taking up moral responsibilities. The way in which we are able to notice links and contradictions among a complexity of context for self and others, our ability to coordinate feelings, meaning, and action for self and with others, the ability to justify one's actions with reference to the complex set of accountabilities to those involved gives us a set of guiding principles and concepts by which as professionals we can co-create reflexive spaces in which to practise whatever the context calls forth, be it for nurses within inpatient psychiatric wards or with leaders in organisations. The transcript below highlights some practices which bring to the forefront the possibilities of the bringing together of a practice in inpatient psychiatric wards where reflexive practices point to a different way of working.

I have chosen a transcript from Nurse 8 which brings to the forefront the ideas of creating reflexive spaces. **(Episode/ Exemplar Number 26)**

Cherrie: How do you think the patient might notice if these things were happening? What sort of things that you would see from the patients if all of this stuff were happening in the learning environment?

Nurse 8: You would probably see high levels of engagement by patients in therapeutic interventions that are offered, the patients would be able to give feedback, like in the volumes of complaints sometimes is indicative of things not being as they should be and the volumes of complaint would be reduced, and I think that the patient length of stay could be impacted by well trained staff.

Cherrie: So do you think that their stay would be less? How would you know about the length of stay? What would you see happening?

Nurse 8: I think that you might see, well it may not necessarily impact on how long the patient stays, but more about their quality of life, more about re-equipping them with life

skills and how they progress in their care pathway. Because sometimes you might have patients who for instance may stay on one-to-one observations, but there is no actual objective reason for someone to stay on one-to-one observations for a long period of time, and it just means that their abilities to engage in other more meaningful therapeutic activities is delayed, their risk is exaggerated but not measured. Yeah, I think the clinical, the multi disciplinary team meetings that take place I find that useful, the ward rounds, the clinical reviews of patients, when I worked on S the case conferencing that we did at least once every other quarter for each of the patients, where we introduced a behaviour incentive plan for the patients so that it is part of their care planning and risk management strategy.

Here this nurse is sharing her views and experiences of the much needed time for reflection and reflexive practices on these inpatient wards. On reflection my question about length of stay of the patients as a sign that the nurses were reflecting on their practice and doing something that was different and helpful to recovery processes was something that connected to seeking out a measurable factor in an environment where learning is taking place. I was connecting to my own values of who I am as a person and a professional; my thoughts were how can these ways of working be shared with others so that patients' care is of a high standard, where the learning of a practice can be shared in a noticeable way? Here the nurse was connecting to the level of engagement in the therapeutic programmes by the patients as a measurable factor in noticing that the nurses were doing a different kind of caring which involved reflexive practices. The nurse felt that by having fewer complaints by the patients that their care needs were being met and the environment was becoming a learning environment where staff were able to access training that will improve care delivery.

Here a diagram figure captures how I related CMM levels of context to express my sense making as to how the nurse understands how managers could help to co-create reflexive spaces:

Contextual Force

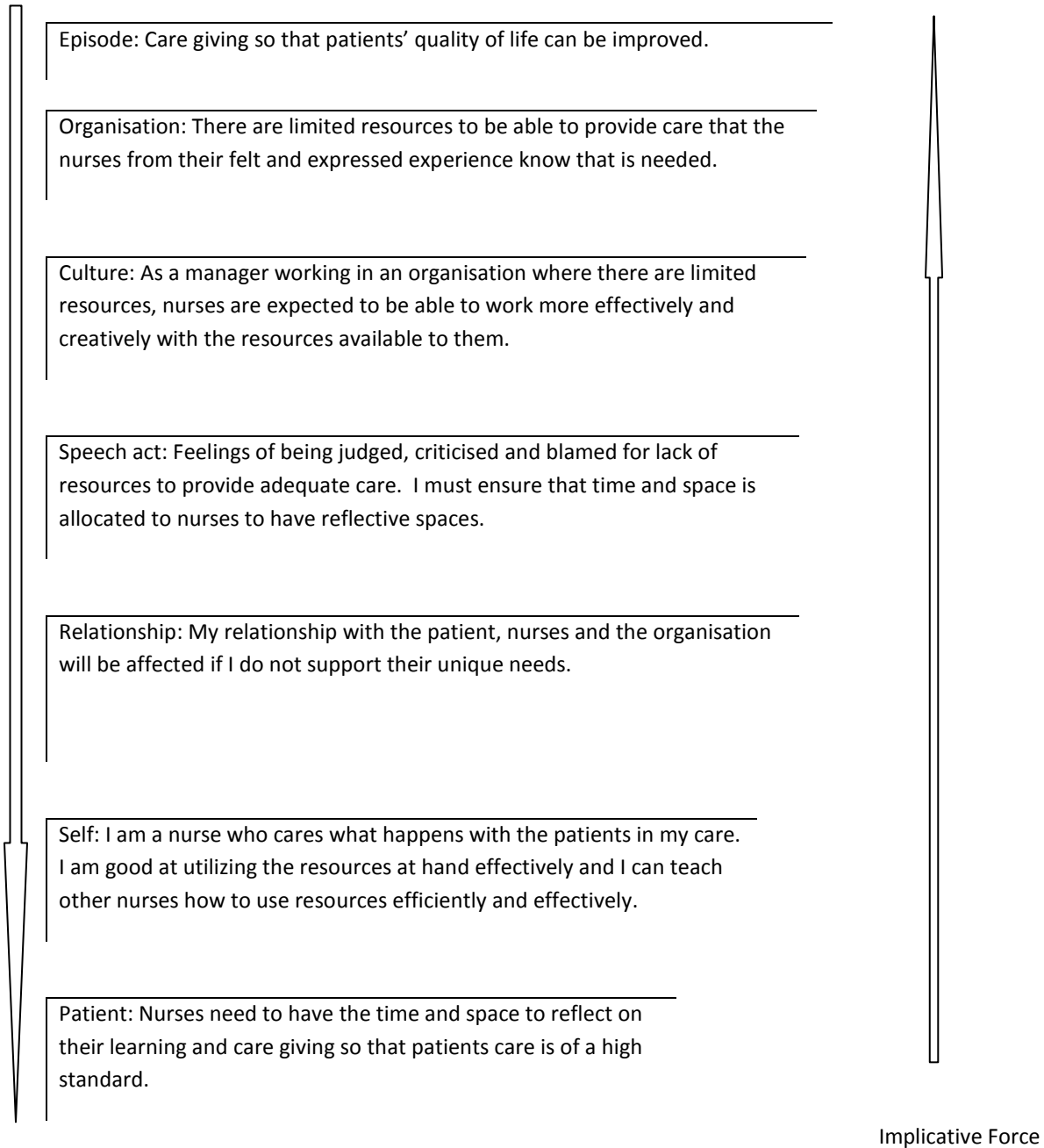


Figure 8.6 CMM levels of context

Adapted from Pearce (1994, p. 347)

I became curious of **what gets created when one is in that reflexive space: In Episode/ Exemplar Number 27**, Nurse 8 shared her views about the impact of having training, learning and spaces to reflect on how care can be delivered to patients on these inpatient psychiatric wards. She described this by saying,

”And I think that it has impacted on the quality of care that we deliver and the patients’ abilities to recognise their illnesses and the triggers and how they can respond differently. I also value the training that is offered in this clinical environment. We have the mandatory training that is offered and then we have the other training such as DBT training. We have Rapid Assessment Interface Discharge (RAID) training, this has been recently introduced, and we have the risk assessment training the HR20. We have the Health of the Nation Outcome Scales (HONOS) training although this has been recently started. We also have the prevention and management of violence (PMV) which considers the kind of patient group where we have the majority of patients with forensic history. It makes a huge difference in the breakaway training that we receive, in terms of maintaining your own safety and intervening appropriately with the effect that their propensity of their injury is reduced.

I found myself asking the nurse ‘What about the patients, what is their say in this?’ This created a change in how the nurse was sharing her views on what she felt that the patients were experiencing. Her response was that

‘The patients are not very happy about it particularly for B ward. I mean I have only been care taking on this ward for two and a half months but the profile of the ward is changing because we are having more acutely ill patients coming in because of the high demand on waiting list on S ward, with the profile of the ward changing and with the therapies having more of a focus for rehabilitation, the result is that you have less staff and more incidents. With this framework of working, it means that you do not have time to do more therapeutic work with the patients, so yeah, the patients do complain and the volume of complaints has increased”.

I became aware of the shift in the focus on what is not possible. On reflection I was taking the nurse into difficulties rather than possibilities. This brought forth another story, one of constraints instead of affordances. Both stories were important as it helps in the reflexive process of what can be possible when the wards are in turmoil, as these are also moments

when changes can happen. In my next question to the nurse this was apparent as I asked her, so in that sense what impact do you think that this has had or is having on the clinical environment in terms of learning and development? Her response was:

“Well learning is squeezed out, because that is something that cannot be measured, so staff will prioritise the things that have got deadlines and reports that need to be done and be followed up on and really people tend to work more in crisis mode to just get through each shift, in terms of quality of documentation, it, you know, it suffers”.

On reflection the nurse was having two stories of what gets created within these wards, her story of learning taking place and enriching the care provision and another story of learning being squeezed out, making high quality care difficult. This nurse also shared her experiences on what it means to be creative and the impact this has on the environment in terms of learning and care delivery. I was struck by the nurse as she shared her views on how she would see high levels of engagement by patients, where a therapeutic intervention was offered. Shotter's (2005a) idea of witness as opposed to aboutness thinking was something that I felt was demonstrated in her views as she was able to articulate her sense of the importance for therapeutic interventions when caring for patients. This nurse was setting the context for care by her desire to enrich the care provision, which Pearce (1987) refers to as creating our social worlds as context creates meaning which in turn gives us the tools to communicate our feelings into actions.

Where the nurse talked about learning being squeezed out which makes caring difficult, the concept of managerialism would appear to have had an impact on her views as management did not seem interested in the quality of care. I was also reflecting on my own management experiences in the clinical environment and how much I was influenced by managerialism. Where the management team interest seemed to be of a superior nature, where it positioned itself in a sphere above and beyond normal human existence. Also where management was most concerned and interested in control and predictability, where they know what was best for the nurses in these hospital wards. Taptiklis (2005) suggests that we must replace inefficient social networks, where several conversations might be required to reach the right person, and

develop organisational overlays in the form of markets and networks that would help professionals to work more horizontally across its whole sphere.

In expanding on Taptiklis suggestions I will demonstrate by way of listing the layers of hierarchical bureaucracy and the difficulties that nurses face within the managerialism style of working: 1. The Board of Directors. 2. Chief executive. 3. Lead nurse. 4. Service manager. 5. Modern Matron 6. Ward Sister/Charge nurse. In order for extra nurses or adequate nurses to be on a particular shift, the Registered nurse first needs to request this from the Ward Sister, who in turn need to request this from the Modern Matron who then needs to request this from the Service manager who in turn makes this request to the Chief Executive and the Board of Directors. This level of hierarchy can cause miss-communication and a delay in having adequate staffing levels to allow for care to be delivered in a competent and high standard. This also affects the quality and quantity of time available for learning to take place in the clinical environments. But it is not only many levels of hierarchy that can cause miss-communication ; it can also be caused by the communication being one-way (upwards), as well as only being expressible in quantitative terms of numbers and not meanings. Managerialism in its doing removes personal contact between the nurses and managers from taking place, the consequence being a top-down style of managing, as managers adopt a one size fits all way of relating. Within managerialism, managers in being removed from the clinical areas, have very little understanding of what is required in them. As Taptiklis suggests there is a need for more horizontal ways of working in order to be able to facilitate caring and learning. One suggestion is that nurses should be given more authority to make a decision on what the clinical needs of the ward calls for and be allowed to act on these decisions and then inform the lines of accountability of her/his decision.

Having a creative way; (Episode/ Exemplar Number 28) I wanted to follow up on a previous conversation with this nurse about her having a creative way and we began our conversation by me asking her: ‘What is a creative way, tell me more about having a creative way?’ Her response was

'A creative way might be to even work with another ward or two other wards where they could send staff to say B ward and then the staff from there can then free up staff to do teaching for an hour so that and that will be equal then to say that ward not having someone say for their break. You would have at least two or three people sitting down and sharing information, may be with a research piece or reviewing their clinical practice, and I think that I will also get the consultant psychiatrist involvement in the delivery of training because there is so much expertise around forensic mental health care. There is however not really any scope of delivery within the current training packages and that just leaves people doing the best that they can with the knowledge that they have. When you think of forensic patients and the concentration that we have here, it is a really serious issue that we have here and this will probably need to be addressed. I will probably think of inviting drug reps as well, I know that their budgets are cut down as well, but there are a number of staff who are willing to come in on their own time'.

On reflection of the above nurse's views and in concluding this chapter, I offer my summary of the ideas of co-creating reflexive spaces in which to work. The nurses were sharing their views and experiences by living how this way of working and learning would look and feel like. For me this was a moment of reflection on how creativity can lead to changes that at first seemed to not be possible. At times it seemed that these nurses struggled to focus on what might be possible and would return to the problem saturated stories of lack of abilities to cope and to be able to do the care at hand. This resonates with Senge's (1999) idea of the mental model of the organisation, where old stories are hard to change as they become embedded in a way of practice. In making connection to my initial research inquiry questions I was curious as to whether the nurses working in these contexts could account for their learning within the care environment and how they might be able to inspire other nurses to learn and develop their practices. This curiosity led me to think about the resources which the nurses draw on and their creativity in which these could be employed. For example, when Nurse 8 talked about how nurses might be able to review and reflect on their practices if they were able to access support

from doctors and other nursing colleagues from other wards. Also how the nurse was able to see possibilities even where there were limited horizons. Her views of the importance of looking towards other possibilities within the organisation which might help to develop learning within the clinical environment by seeing the resources that might be available which might make for caring environments. Nurses were able to reflect on the importance of having good mentors. There was from the nurses a sense of the environment needing to be one where time was created for best practice and learning to take place.

The need for managers to support them in creating these learning spaces was something that I was struck by. For me this highlighted the nurses' sensitivities to their own inadequacies to be able to imagine a horizon/s where there would be possibilities to develop their caring skills and abilities. The need for adequate supervision in the clinical environment was voiced by all the nurses as something that is much needed and would be welcome in their quest to improve their learning. Their increased enthusiasm for caring was a real expression of their commitments to the patients that they provided care for/with. Another aspect that struck me was that these nurses had a shared set of values that they all felt was needed for learning and best care to be achieved. On reflection my questions invited the nurses into a space whereby they were able to voice a sense of an unvoiced need which they all felt was needed and necessary for best care within the clinical environment. This opportunity also brought to the forefront a reflexive space in which to think about their learning and practices.

Another reflection was that the nurses were also at times able to create space where they felt a shared sense of validation of their views and experiences. There were a number of similarities in the nurses' views, which pointed to the need for further learning spaces to be created in order to create reflections and reflexivity in the care that is provided to this client group. Qualified nurses' views in comparison to non-qualified nurses' views of what creates a clinical learning environment were similar as they shared their experiences and views on what events create learning environments and what the further needs were to be able to have more creativity in this process. This was shown in the three non-qualified nurses sharing that there was no time to reflect on their practice or to experience clinical supervision as the wards were

always short staffed, which pointed to the clinical environment mostly not being a learning environment, views also shared by their qualified nursing colleagues.

Chapter Eight

Reflections on the managerial practices conducive to care in psychiatric nursing

This chapter considers **1.** My experience as a manager, clinician and researcher, **2.** My reflections on what I have learnt during the process, and where I will take this. **3.** The main messages for psychiatric nursing and nurse managers. **4.** How can we put words to experiences that otherwise lack words? One might therefore say that words without lived experience are empty, and lived experiences without words are blind (Shotter, 2005b). Morgan (1997a; 1997b) suggests that it is impossible to develop new styles of organisation and management while continuing to think in old ways. He talks about the influence of old thinking as a way which often constrains what can occur. Morgan suggests that we need to develop new images of our organisation that can help us to imagine new forms or ways of practising. I am connecting to my earlier writing in chapter 5, on the organisation and management embracing the metaphor of a spider plant, where its roots are grounded and can be spread out in many directions, each with new roots. This image can, I think, help us to gain fresh perspectives on the management and design of our organisation and leadership responsibilities.

Some of the characteristics of the spider plant, which connects to the management practices in inpatient wards, are that there are several types of inpatient wards: acute, sub acute, rehabilitation, low secure, medium secure, forensic, as well as specialist wards, for example child and adolescent wards and perinatal mental health wards. These can be seen as offshoots of the spider plant which are similar to these single wards with their specialised areas of care. This is then supported by the main headquarters, as with the spider plant having a central pot from which it has its offshoots. Then there is the sturdy nature of this plant that can grow in difficult conditions, which fits in with the sturdy nature of the nurses and their tireless efforts to provide care in difficult situations.

The image of the spider plant with its many offshoots, usually in small clusters, is one way of understanding the transcripts from the nurses, as they request to develop smaller wards with fewer patients. Their views in doing so are that they remain sturdy and the supply of staff could

be used more effectively, where the wards were divided into smaller wards with skilled staff. A vision held by the nurses was one where each staff working on the other wards would be skilled nurses who would support teaching and create learning spaces within these wards. Another vision for these wards would be where staff can also rotate to other wards. This they feel would thus create a skilled staffing ratio where staff can work across the various wards, where they would share their learning; developing new skills and sharing these with other nurses.

This way of working would also create spaces for reflection and reflexive practices as staff would have the competencies to support each other on the various wards, taking turns to have ward-based training. Being able to work across these wards was another possibility that might allow for cross boundary dialogues in how best practices can be done, in how learning can be experienced and how nurses can have reflexive spaces in which to work.

New ideas which emerged in the interviews, in comparison to how the wards are currently practising, were that each ward would now have 10 inpatient beds in comparison to 20-26 inpatient beds. Another was that each ward would be able to share their specialist knowledge and skills across these wards, teaching students from various disciplines. This would equip staff to work across these units in a safe and competent manner, as at times there are concerns that staff are unable to work across the other wards in a safe and competent manner due the lack of skills which would enable them to do so.

The need to care for the spider plant is short term as once the plant is growing it becomes more self sufficient and sustainable as it grows offshoots and these offshoots develop into further offshoots. With this principle at the forefront it could be adapted to the small units, which once established will not need a high level of maintenance, thus freeing up spaces to co-create learning environments. In thinking of the spider plant as a metaphor, it has a central pot or base. As with nurses there is a management structure holding the nurses together in terms of the management of these inpatient wards. When considering the role of the central pot or base, a more decentralised style of leadership and management is needed, where managers and leaders have an understanding of the need for nurses to be able to have creative spaces in which to learn and develop their practice. Each ward, though attached to the main organisation

in terms of its growth and development, will also be accountable to a line manager who would also be a part of the team as well as to the central body. Within this framework there would also be a structured line of accountability for each of the wards that would flow into the main central pot by the line manager or leader, who values and understands their way of working.

My idea in using the spider plant as a metaphor for how nurses might create clinical learning environments is a way of creating fresh dialogues with great insight into the constraints and difficulties that they might encounter while working on the various inpatient wards. As the new stems channel the flow of resources, in a top down way there would be green growth emerging. A concern that one might need to be mindful of would be where the resources are limited as this might create offshoots which are brown or drying up, this might happen where the nurses are working a lot of extra hours.

One idea of the use of the spider plant and its connections to the new type of inpatient psychiatric ward that is needed for learning to take place is that they can grow large while staying small, a type of growing that replicates these wards in a decentralised yet joined up fashion. In having a central pot as it is currently, this can be a liability as it is expensive, slow and inflexible. Another way of using the spider plant as a metaphor is that of developing ways of building one's own activities around a large number of small, highly differentiated pots, in one larger pot, where the organising of the smaller pots can be discussed and a way forward agreed as to how clinical learning environments can be co-created.

The examples below explore with the nurses their views of how involved they felt that they were in the 'central pot' or management decisions as to how best a clinical learning environment can be co-created and what needed to happen in order for this to be possible. I drew on Shotter's (2008) ideas of being dialogical to be reflexive in the conversations with the nurses. Shotter (2008) suggests that if we can enter into living dialogically-structured relations with events, or circumstances, and allow them to call out spontaneous reactions from us, an understanding will become available to us that would otherwise be unavailable if we were to adopt a monological way of engaging with others.

Another concept that I used to reflect on as I explored the transcripts from conversations with the nurses was from Oliver's (2005) ideas on reflexivity, where she suggests that when we practice reflexivity we make choices about how we will think and act. She suggests that we become responsible and accountable for our choices, actions and contributions to a relational system, in doing so we position ourselves and others. Oliver further shared her sense making of reflexive inquiry where this way of thinking positions us reflexively in relationship to ourselves, others and the stories we make which are then told.

Morgan's (1997a) ideas of the use of metaphors that one can draw on to illuminate our organisational practices was a helpful concept in exploring the transcripts from my conversations with the nurses. I also found Senge's (1999) ideas of our mental models shaping how we go on in our practices useful in my reflections and sense making of my conversation with the nurses. Also useful was Bernstein's (1983) ideas of 'horizons', as he suggests to have a horizon is having a range of vision that includes everything that can be seen from a particular vantage point, a something that is not closed but rather open, a something that is always in motion, and that which moves us. This connected with Benner's (1984) ideas of the 'movements' which take place in our practices as we move from novice to expert practitioners. I was mindful of my own reflections as I hold the nurses' views in the forefront, always trying to background what were my own views and experiences in these wards, as I myself was a nurse with considerable experience in inpatient psychiatric wards.

I have chosen to share this episode where nurses shared their opportunity or lack of opportunity in being involved in policy and procedures. I will call this **relating with others (Episode/ Exemplar Number 29 a)**

Cherrie: So what opportunities do you have in relation to creating policies and procedures? Have you got any involvement in creating policies and procedures?

Nurse 10: None, not that I am aware of, I guess that some of the feedback that we give on our working environment, there was feedback on a survey about the environment and I guess that, that would have helped and I supposed all the things indirectly that we do, all the incidents that we fill in and things like that.

Cherrie: So kind of an indirect involvement with policies and procedures?

Nurse 10: Yeah, yeah.

Cherrie: So would you get a policy handed down from management saying that this is a new policy coming out, what are your views and would you like to add anything to it; would you get such request and would you be involved in it at that level?

Nurse 10: I have never had the experience of that, might be that I have miss things, like draft things, but I have never been invited to comment.

Cherrie: So you have not been invited to comment on it?

Nurse 10: No I have no idea about that really.

Nurse 10 seemed unsure of whether or not she has had any involvement in creating or co-creating policies or procedures. She was then sure that her involvement in this aspect of the environment had not happened. I was curious as to how it was possible to be involved in care when the process of how care should or could be done had no input from the clinical staff working on the ward. I found myself trying very hard to get possible answers that I wanted to hear, that this nurse has had some indirect involvement with policy and procedure formation.

On reflection I saw myself asking questions that positioned the nurse to respond by saying, 'Yeah', 'Yeah', I was looking for the slightest involvement from this nurse as I pressed on with my questions, this time getting a more sure answer from her as to her involvement with policies or procedures. Her response was 'I have never had the experience of that, might be that I have miss things'. On reflection I could see that I had missed things as a manager and inquirer. I was looking for my own reassurances that management usually work in a collaborative way. I was making connections to the spider plant metaphor where the 'central pot' is meant to be feeding the off-shoots, this being that the managers are meant to involve all their staff in the process of reviewing, co-creating policies and procedures. However, this was

not the case. Hence these nurses were feeling that their voices were mostly not heard and therefore isolated from management in a way that hinders growth and development.

I reflected on Shotter's (2008) ideas on the importance of dialogue as a tool to bring forth a way of working and relating with each other where 'witness practice' could take place. However, in this dialogue with the nurse, it would seem that 'aboutness practices' dominated, where policies were done by management and handed down in their completed format for the nurses to follow and implement in their practices. This reflection is a moment for me where changes in my practice have taken place as I am now more aware when asking a question to staff or colleagues why I am asking what I am asking. My questions to staff about what was possible on the wards, in terms of access to training, access to staffing as needed and access to policies and procedures both in their creation and delivery, were something that I felt was important for creating clinical learning environments in inpatient psychiatric wards.

In making connections to the metaphor of a spider plant to explore the managerial practices conducive to care in inpatient psychiatric wards, the idea of the spider plant as having 'umbilical cords', as lifelines, was something that I was struck by, and which seemed fitting with the new ideas of creating clinical learning environments. As with the spider plant metaphor, the nurses who took part in this inquiry were reaching out and searching for new grounds in which safe, competent practices could be carried out. Like the spider plant, they have received their nurturing and nourishment from the 'mother plant', this being the organisation and management. When the nurses are educated and begin to co-create clinical learning environments, it would then have 'rooted' like the spider plant and would be able to sustain good and high quality practices, then the cord would no longer be necessary and this would free up time and space to develop other aspects of the clinical care, possibly in the community.

A possible constraint that this posed is that as nurses, as managers, one needs to look for the pit-falls of the traditional patterns of thinking about control and accountability and be aware and not get enmeshed in un-necessary report-writing, rule following requirements and other hierarchical requirements that can make this way of working an extension of the central pot

bureaucracy, as this will defeat the purpose of changes in one's way of working to co-create clinical learning environments.

One idea to avoid this pitfall would be to have the wards accountable to the central pot in a flexible way that allows for safe creativity in creating spaces for learning to take place. Where there is a more open-ended style of collaborative management, where the umbilical cords have the characteristic of one that evolves and changes over time, where dialogue and learning are the main priorities, then local learning clinical environments can be established. As a manager (central pot) one needs to be mindful of what help the nurses need to flourish, what are the mutual requirements for sustaining and developing their learning which will in turn develop the clinical area so that the highest standards of high quality care take place?

In my reflections on the opportunities nurses had to be involved in the level of staff that they felt were needed to carry out safe care, I found again that nurses felt that they had a lack of influence in this aspect of the organisation. I will call this '**Relating with others**'. Here the nurse was asking for what are basic human rights for the environment which was to have more access to fresh air, and for the patients to be able to have walks.

In **Episode/ Exemplar Number 29b** I was exploring with the nurse her views of whether she felt involved in the co-creating of a clinical environment that was conducive to learning.

Cherrie: What about the staffing levels in the clinical environment, have you got any say in that?

Nurse 10: Sometimes we do, we would say that we really do need an extra staff because of such and such that is happening or we have not been able to cope.

Cherrie: And is it easy to get a member of staff when you ask for one or do you find that it is hard to do?

Nurse 10: To find the person or....

Cherrie: To get the permission to have the person.

Nurse 10: Sometimes yeah, but you need to have a good rationale and really state why and I think that the times that we don't, we then have to have it recorded.

Cherrie: Right, right, so you keep a bit of a log?

Nurse 10: ...

Cherrie: So if you were to wave a magic wand what would you say would create the most ideal learning environment and then we could probably look at what is a good enough learning environment for nurses?

Nurse 10: My ideal learning environment I think that it would be(pauses).....it would be a unit on the ground floor so that we can easily access exercises, fresh air, the dreaded smoke breaks but just to be able to get that access and I think that, that would make the environment a lot, lot better.

Cherrie: So access to fresh air and walks.

I was curious about how the nurses and managers (central pot) negotiate and define the strands needed for a shared sense of overall vision, and the values that get created when learning is valued and shared amongst the team. With this agreement at the forefront for creative spaces for learning in the clinical environment, where the nurses can learn without detailed control or hindrances, the various parties can then self-organise their activities in an autonomously safe and yet in an integrated way, as they would know when they are working within agreed parameters.

They would know when they are stepping outside of these parameters; they will know when further discussion and consultation will be necessary as in connecting with the spider plant. The offshoots remain autonomous yet connected, as with the various wards they can remain as individual small wards yet connected to the central pot. The expectation is that space is given to clinical learning in these wards which should deliver highly skilled and competent nurses. Nurses who will then be able to continue to teach other junior nurses to be highly skilled and

competent with the result being a ward/s which delivers high quality care. This can then be measured by admission and discharge rates, readmission rates as well as length of bed stay days. This can also be measured by the quality and quantity of complaints and staff turnover, and by the number of nurses seeking employment on these wards. It is important that the wards have shared understandings and agreements as these would be crucial in creating a shared frame of reference through which the management (central pot) and the nurses on the ward/s (offshoots) can operate in a harmonious way without direct control.

I was struck by the spider plant metaphor, the idea of the umbilical cord management style as a possible vision of how management can enhance their practices within these wards in such a way that it is conducive to caring and learning clinical environments. As the umbilical cord manager is interested in sharing understanding as a means of creating integration while maximising the space, autonomy and the staff ability to self organise these ward/s, while she/he operates with minimum, rather than maximum specification and control. Morgan (1997a) suggests that we be familiar with the pathology in most organisations as many organisations have over-controlling managers (central pots), where the managers at the centre tend to define too much and impose too many requirements, their focus is on maximum specification rather than minimum specification.

In sharing my thoughts of how we relate with others I have chosen to share **Episode/ Exemplar Number 29 c**

Nurse 10: And I think that this unit will have really strong contacts with the CATT and the care coordinators, maybe that is going back to one of the questions before but because we have so many out of area patients we do not have that input or contact with these teams that we could have.

Cherrie: So do you get to have contact with or see some of the Crisis Assessment and Treatment Team (CATT) people with the out of areas patient or is this something that is rare?

Nurse 10: We do not so much but now our CATT will assess for the out of area ones so, just to have more interaction especially from the people that support service uses in the community,

to actually be on the ward and spend some time with the service users, because they often see them in a different environment and they probably have got a lot more and they can probably offer something as well.

Cherrie: So the clinical environment will be on the ground floor with more CATT involvement, fresh air and a space to walk, would you introduce anything else from your experience of being there? We spoke a bit about having fifteen patients.

In my thinking about these inpatient wards as separated yet connected, the umbilical cord style of management is most fitting as it allows for decentralisation with some need to be fed centrally, hence this approach needs to be flexible, with learning at the centre, it should be based on dialogue designed to explore and meet mutual needs, in this sense of staff, managers and patients. The 'organisation bumblebees' approach could be a useful way of being decentralised from the management (central pot) and keeping the nurses on the ward/s (umbilical cord) attached. This can be done by having managers being invited into these wards, where nurses can share their learning, and where resources can be accessed to facilitate this learning process. Also by managers going to the various wards and assisting in the facilitation of sharing of good practice, where they also assist in the facilitation of the use of resources across the different wards would help in creation of learning environments. In taking part in such ways the managers (central pot) know what is taking place without the need to have forced entry, with rules, specifications and limitations. The use of this metaphor has helped me to develop new images through which I can see and understand new actions and behaviours which help to shape my practices, my learning and knowledge. Below I would like to point out the spider plant with its bumblebees as a way of encouraging the images of the metaphoric use of this plant.



Figure 8.7 Spider plant

ORGANISATIONAL BUMBLEBEE

Adapted from Morgan (1997a. p.84)

Stories of good practices

Here I explore with the nurses stories of good practice. I will aim to demonstrate how I position myself within these stories and how I felt positioned as I share my own reflections as a researcher/co-researcher, as I am mindful that I might have interjected my own stories of influence. Throughout the research inquiry process I was positioned as outsider/insider researcher (Penman, 1994; 1996). As I reflected on these positions I connected with Hannah's (1994) ideas on how we make sense of our cultural values, Hannah suggests that we should pay attention in how we tell our stories of who we are within a relational context and how this might have an influence on what we are doing or set out to do. I was curious about how the

nurses might experience me as a female nurse during the research inquiry as there were mainly female nurses taking part in the research inquiry. Fitzgerald et al's (2010) ideas on appreciative inquiry were useful as it helped me to bring forth the stories of good practice which emerged from the nurses. My own sense of nervousness as I met with each nurse was something that struck me as I tried to ground myself in the knowledge that I am human also, with my own stories. I connected to Lang and Mc Adam's (1995) ideas of how one gives account to one's stories and the systemic descriptions that are embraced in the making sense and telling of these stories. Lang and Mc Adam (1996 unpublished) talk about the concerns that we have when we meet someone for the first time and how we then co-create a context in which to talk with each other is very important. I was concerned and excited by the prospect of talking with the nurses as they shared their views and experiences with me, this felt a very privileged and yet humble position to be in.

As stories of good practices emerged as experienced by psychiatric nurses within in-patient acute wards, I will draw on Benner's (1989) ideas on the primacy of caring where she talks about the nurse as a care giver. Where caring is her main driving force, where things matter to her, where she feels connected to things that matter and where in her world caring feelings, thoughts, action and knowing how to be is of great importance to her. She goes on to invite us to think of caring as setting up the condition that something or someone outside the person matters and creates personal concerns. Benner (1994) also suggests that the expert clinicians are not difficult to recognise as they frequently make clinical judgements or manage complex clinical situations in truly remarkable ways.

Below I discuss what is co-created when nurses are supported and involved in policies and procedures for creating safe working environments where there are possibilities for high quality care.

(Episode/ Exemplar Number 30)

Cherrie: What opportunities that you have in relation to creating policies and procedures?
This could be local?

Nurse 4: Local policies I am usually involved in, if there are any local policies that need changing or adding or updating then I am usually involved in those, but I have been given opportunity ... we are writing a new hand-cuff policy and because I am trained to train people in hand-cuffing. I am going to be involved in writing that policy.

Cherrie: And is that a hospital wide policy

Nurse 4: Yeah, a hospital wide policy.

Cherrie: And you have got that opportunity?

Nurse 4: Yeah, yeah.

My reflections as I was connecting to the idea of the nurse's involvement in the co-creating of a policy on the use of hand-cuffs, was that this nurse seemed to have had the necessary clinical expertise in using the hand-cuffs. As this makes for safe practice in this clinical area which is a secure adult mental health ward, where there are a number of forensic patients being admitted for treatment of their mental health illnesses, then it's right and important to have the nurse's input in how policies and procedures could be useful tools to assist the nurses on the ward to provide safe care to all the patients and also to their colleagues.

Benner (1984) suggests that as psychiatric nurses working in the clinical environment you are placed in a unique function, by the nature of the psychiatric illness and the context of the ward in which you work. Nurses learn to understand the patients with their particularities. With this at the forefront it is very important for nurses to be involved in policy and procedure formation, so that they have a better understanding of how best these can be used. In trying to establish how this nurse's views and experiences contribute to the clinical learning environment, I proceeded to ask her the following questions as we continued our dialogue:

Cherrie: Ok, what are your views on what creates a clinical environment, what are your thoughts about what makes the environment for nurses a learning environment?

Nurse 4: A learning environment as in for me?

Cherrie: Yeah, and for your colleagues.

Nurse 4: Having a hierarchy, I think creates a learning environment. Obviously to have on our ward support workers, staff nurses, team leaders, ward managers and then above that is the clinical managers and that hierarchy does create learning, a learning environment, because obviously there is always somebody there, that you could learn from and that is including like myself as the team leader going to a support worker who is on the frontline all the time and everything like that and there is always learning opportunity from them as well and also having, a Resource Library of some sort which we do not have here, but I think that having evidence based work that is available to us will help as well.

Cherrie: And where would that be? Where would you say that this would be on the ward?

Nurse 4: Well there will be some like evidence based practice should be on the ward, we have got a back office with some evidence based stuff, but the majority of hospitals that you go to you have got a Resource Library, which we do not have here which is external to the ward.

Cherrie: Ok, is there anything else that you think might make the clinical learning environment in terms of the patients' impact / input if needs be? Do the patients have any input as to what they think that staff might benefit from?

Nurse 4: I am not sure really, obviously patients divulging personal information and their background history and things like that can obviously help you learn, it is always going to help, especially when it comes to personality disorders there is often background history that plays a huge, has a huge impact on whether somebody does or does not develop a personality disorder, so just by the patients divulging certain information to you is a huge learning opportunity.

Cherrie: And then that is taken and fed back to the team as a form of learning?

Here this nurse was clear that having a hierarchy in the nursing structure helps create learning environments. In her view having a leader and someone that you can go to for support and guidance with a clear line of accountability, was important for learning. Also to have a ward that is staffed adequately, this will of course create time, and space to learn and to teach other nurses working on the ward.

On reflection Morgan's (1997a) ideas of the spider plant metaphor of the organisational bumblebee were useful as the nurses learn and develop the various skills to work across wards, as they talk with their leaders and share ideas of the best way that care can be carried out with their patients. As you learn a lot from your patients on how to be good nurses, Benner (1984) suggests that as nurses you must be able to learn and develop an expertise in listening and in understanding what an illness means to the patient, as well as what constraints this illness holds for the patient, always working towards helping the patients to work toward their recovery milestone.

I used the notion of reflexivity as I engaged in dialogue with nurses working in inpatient psychiatric wards. I drew on Senge's (1999) ideas of how the organisation's capacities to work with mental models involve both learning new skills and implementing the institutional abilities that help these skills to be learned and developed into the everyday practice. I was having at the forefront Senge's (1999) ideas on the importance of being able as a manager to reflect on your own mental models, allowing your prevailing assumptions to be brought into the open. He suggests that as managers, one must not believe that one's views are facts and the only views available. Rather as a manager you must be able to have the ability to inquire into your own and others' ways of thinking, for if you are unable to do so, your abilities will be limited in experimenting with collaboratively new ways of thinking. In drawing on these concepts and reflecting on my dialogues with the nurses I would call the practices with the psychiatric nurses, and my sense making as a manager, exemplars of **positioning and being positioned**. I would like to show below a picture of the spider plant where different positions are taken or given to the functioning of the organisational bumblebee metaphor.



Figure 8.8 Spider plant

ORGANISATIONAL BUMBLEBEE

Adapted from Morgan (1997a.p.84)

(Episode/ Exemplar Number 31)

Cherrie: Ok, ok, what are your views as to what creates a clinical learning environment?

Nurse 5: I think a whole wide range of things really; I think firstly to do with maybe the set up of the unit. I think that it needs to be sort of go along with the philosophy of that unit. Secondly the staffing, the skills mix and the quality and the type of staff that are employed on that unit and also the type of client if they are appropriate to that environment then obviously that will create a learning environment, I think that these are the key things.

Cherrie: When you say quality of staff what do you mean?

Nurse 5: Terms of their skills their training, basically their skills and what training that they have had.

Cherrie: And when you say type of adolescents what do you mean?

Nurse 5: I think adolescents that are sort of appropriate to that service, so that is what I mean by the type, so if say we were going to bring in adolescents that have conduct disorders and you were to have adolescents say that have psychoses and you bring them together then you have sort of a problem, then that interferes with that learning that makes the area a non-learning environment.

Cherrie: So psychoses and conduct disorder cannot be in the same environment?

Nurse 5: From my experience I have seen that it has been quite a disaster to have those two in an environment together. It sort of disturbs the milieu of the clinical environment and the atmosphere.

Cherrie: Ok. Would any of your other colleagues have the same views?

Nurse 5: Yes, from my experience of sort of group supervision and just from general discussion with other staff I felt that they were inclined to that idea that it was quite disruptive and those two did not go hand in hand (pauses) ...

Nurse 5 was a qualified and experienced psychiatric nurse, who felt that the environment needed to follow the protocol and philosophy set by the ward, as the adolescents admitted to this ward did not meet the criteria for admission on the ward. Here the nurse seemed to be stuck as she was not able to describe or share any learning experiences from being on the ward, at the same time she was clear in a detailed way about the diagnoses of the adolescents being admitted, and that the combination of having such a diverse set of adolescents in the same ward was making learning difficult.

On reflection I was curious as to whether the nurse realised that she and her colleagues had in fact learnt that having the diverse group of adolescents was making different types of learning difficult, however learning was taking place.

Supervision for this nurse was something that she felt was lacking as for her she felt that having group supervision would have been a useful way of personal learning and creating clinical learning environments. On reflecting on the possibilities available for this nurse, who can she talk with in a way that creates possibilities? I connected with Seikkula and Arnkil's (2006) ideas on networks and dialogues that are at the boundaries between and within professional and personal networks. They suggest that one's attitude, outlook and one's way of thinking have equal if not more importance in understanding the significance of relationships for an individual. They go on to suggest that multi-agency contexts are complex, with this complexity extended to the families or the patients as well as the wider staff team. Through further questions and dialogue with the nurse she was able to identify what sort of activities, events and context **help to create learning, in the (Episode/ Exemplar Number 32)** below. We continued our dialogue.

Cherrie: Ok, and going to the next question, how often do you receive clinical supervision and does this help to create a learning environment?

Nurse 5: Ideally I should receive clinical supervision once every month, but in my clinical environment because it is quite a volatile environment which can be quite disruptive because of violence and aggression hence it becomes a very busy unit and also because it is a 24 hour acute admission unit it is not possible to have supervision once every month because you are so busy that you just do not have the time and you find that you can go into three to four months before you have any supervision.

Cherrie: So supervision is not possible due to the nature of the ward?

Nurse 5: Yes, (pauses).

Cherrie: What are the effects of not being able to have supervision over let's say a period of three months? What sort of impact do you think that this could have on the clinical environment in terms of its learning in terms of nurses developing into competent

practitioners? Do you think that this has an impact on the competencies of the nurses? Do you think that their competencies will be more or less?

Nurse 5: I think that the competence of the nurses can be reduced, because you will find that the nurses are quite frustrated. There is a lot of frustration and that people are getting burnt out and people have no appropriate channel to vent their concerns, their frustration, even to ask questions, so people are always sort of complaining amongst themselves and there is a negative vibe going on, because people are not sort of channeling their emotions, feelings and their views appropriately and they are just muttering among themselves as they go along in that quite difficult environment and then that just impacts negatively because you have people phoning in sick and even on the job you can actually see that people are not actually performing to their maximum (pauses)

Cherrie: What do you think may need to be different for people, to start to begin to perform at their maximum in terms of us looking at the clinical environment? What would be useful in helping to develop the learning that takes place within that environment?

Nurse 5: I think that there needs to be a structure in place, quite a robust structure in place around supervision and it needs to be sort of really air tight where regardless of what is happening on the unit there is a provision for supervision whether it is by just getting extra staff for a couple of hours so that you can take people away and give them that supervision in a way that they have time to have that supervision.

Cherrie: Ok. What area of clinical supervision? What area of the clinical environment that you find most useful? What is useful about the clinical environment? The way it is at the moment?

Nurse 5: Well (pauses) I am actually having to think about it (pauses) at the moment what (pauses) ... I cannot think of anything that is very useful because generally, (pauses) ... the unit that we have at the moment is not sort of a very good environment for adolescents, it is more tailor-made for I think adult patients with less aggression and violence so it is actually counterproductive really to the type of clients that we have.

During our dialogue Nurse 5 seemed to have a great understanding of how this ward was not being a clinical learning environment. She had her strong views of how learning was not taking place and what was needed for learning to take place. In one of her responses with what can create learning she was clear that supervision was lacking and very much needed. Her sense of the clinical environment not being able to meet the needs of the adolescent patient was said with clarity. On reflection here this nurse was highly competent and needing support to share her competence with her colleagues. However, she was struggling and did not seem to know who she should be talking with for change to be possible. She was certain that a clear structure was needed and that supervision needed to be very high on the agenda for learning to take place. Her expression on staff morale and the staff having unhelpful corridor conversations and staff not feeling able to carry out their care duties to the standard that is needed and expected of them was something which struck me as a ward that was in crisis. I was struck by the power of her dialogue with me and felt that the organisation as a whole needed to respond to the needs of the staff as well as the adolescents on the ward. Here I connected with Senge (1999) who suggested that our best ideas and insights fail to be put into practice due to deeply held mental models, as these take us into limited internal images of how the world works. These images limit us to familiar ways of thinking and acting. Our ability to begin to manage these mental models, testing and improving our internal pictures of how we would like our organisational world to work, holds promises for creating learning organisations and remains a challenge to us. One thought that I had was that this nurse was in fact learning as we talked about the next steps that were needed from her to change the ward into a safer and better ward where clinical learning is very important. Some theoretical concepts that I reflected on to help me to put words to what I felt was taking place were from Bateson's (2000) ideas on the difference that makes a difference, where he described sameness as differing from difference, where he described a difference as an idea which cannot be localised, where there are an infinite number of differences within a dialogue, but only a few of these differences make a difference. Bateson ideas for me suggest that as nurses we should always be interested in noticing the difference that could make a difference in how we as nurses might create learning in our clinical environments. I understood that to be that by the nurses having similarities in the

views and experiences, they now needed to have a greater sense of what is needed to make a difference that matters to the ways in which learning might take place on these wards so that differences that make a difference in care becomes possible. Cecchin's (1987) idea on curiosity and neutrality was a concept which I held during the research inquiry process as I talked with the nurses, being ever mindful about my own experiences of working on acute psychiatric inpatients wards. I also found the use of Harre and Langenhove's (1999) idea on positioning theory helpful in my thinking of the analysis or meaning making from the transcript of the nurses. Harre and Langenhove (1999) suggest that positioning comes with numerous types of speaking rights which are afforded by different discursive positions where rights, duties and obligations contribute to this positioning, giving rise to who has the right to speak in or out of turn and in what contexts. Within the research inquiry process this meant that I had to position myself in a state of calm reflections, taking at times a position of curiosity, neutrality, always reflecting on the various positions that I either took or was positioned into.

Another concept that I found useful was Kendall and Wickham's (1999) idea that we should not look for causes to a problem rather we should look for contingencies, as most of us get into the habit of looking for causes. My use of this idea was to bring out the feelings of what already exists in the context of these wards, bringing to light its constraints as well as its possibilities, where the focus was what was happening in the wards rather than what was the cause of the happenings and working in terms of meanings.

As we continued our dialogue we explored what I will now call **stories of difference** from a nurse working on the secure male adolescent ward. **(Episode/ Exemplar Number 33)**

Cherrie: So at the moment the unit is counterproductive?

Nurse 5: Yeah, yes, (pauses) ...

Cherrie: If you were to kind of make it productive, what sort of things would you take out of it and what would you leave in it?

Nurse 5: I would take away the massive open spaces which are there because you then find that the huge open spaces are where clients have lots of time to mill around and that is

when sort of fights start and you have little peer groups and that is when the aggression starts. I would have more rooms and then I will decorate it in a way that is a bit teenager friendly and also instead of having traditional one bedroom long corridors I will split the corridors into two where you can then have sort of high dependency area and an area where they are sort of getting better and ready to move on and you manage it like that.

Cherrie: Why would you do that because that sounds really interesting and it sounds like that is something that you have given a lot of thought?

Nurse 5: Probably from the current set up which we had there seem to be quite a lot of problems where because everything is down one corridor you have a mixture of people that are getting ready to leave the unit because they are well and then you have the people that are just coming in and they are quite in the acute phase of their psychoses or their problems and they are all mingling together and it could be quite frightening for the patients and because of that you have things like bullying and it is quite difficult to monitor and keep a handle on so if you separate them then it is easier to manage as they will be on two different corridors and it is smaller groups rather than have fifteen beds in one corridor so if one person is unwell and to use the word 'kicking off' then you have all the others watching that and you do not know what impact that this is having and yeah that sort of thing.

Cherrie: Ok, what aspect of the clinical environment do you believe has improved your practice in care delivery? And if so, how has it done so?

Nurse 5: (pauses) Can I come back to that question as I feel that I need to think about it?

Cherrie: Ok, ok, what aspect of the clinical environment has hindered your ability to carry out a high standard of care?

Nurse 5: (pauses) ... basically I would say again the set up, the structural set up of the clinical environment because the unit is supposed to be very therapeutic and as I have said that everything is down one corridor and you have got huge open spaces even if you are in a little room which is within that open space and you are trying to have therapeutic engagements with the patients, it becomes really difficult because things are going on right there outside of a thin glass window, it is really noisy, you cannot really have that concentration and that therapeutic milieu where you are having a nice discussion and it is really therapeutic ,

because you are trying to do something really therapeutic and it is all going on outside and I have found that really difficult and

Here on reflection I was able to see how difficult it was for the nurse to see possibilities for learning within the clinical area. On reflection I became curious about our dialogue and was asking myself many questions, the main one being, how can dialogue help to facilitate stories of differences and what type of dialogue was needed for these stories to emerge? On reflection this question was answered by my ability to ask circular questions and being present and engaging throughout the interview process with the nurses. I was also able to remain curious and mindful of my position within the organisation as an insider/outsider researcher, by reminding myself that the nurses' views and experiences of what creates learning in the clinical environment were the most important voices in the research inquiry. The nurse came alive with possibilities by telling these stories of differences of how and what she thinks needed to happen as she talked about the space in the environment not being conducive for care to take place. She spoke about having more rooms, these rooms being decorated in an adolescent friendly manner. She spoke about being able to split the corridors so that the ward could be divided into specialisms which would make the ward better to manage, with fewer possibilities for the patients to get into fights with each other and being able to provide the appropriate care that is needed for the patients. This nurse seemed to have given this idea much consideration as to what possibilities there were for better care to take place on the ward. On reflection the change in her responses seemed to be at the point where I asked her what aspect of the clinical area she believed had improved her practice in delivering care. I sensed that this nurse did not believe that the clinical area on this ward had contributed anything to her practice and therefore wanted me to know that her knowledge was not from being on this ward as the ward environment as she saw it was not the best place to be.

This I believe shifted her back into the position of problems rather than possibilities, where the environment becomes a place where learning is difficult if not impossible to create learning in its current state. In **Episode/Exemplar 34** I will share moments that I was struck by during my dialogue with the nurse as we discovered that she has in fact learnt a lot in the clinical environment and was also able to teach other nurses in the environment.

Cherrie: So that you would say, has hindered your abilities to carry out your work of the highest standard?

Nurse 5: Yes it has been and for me to really have a proper audit as to whether the work that I am doing is actually working I do not know whether it could have been better if we were in a different environment you know things like that.

Cherrie: Ok, I guess that this has answered some parts of the question which is what aspect of the clinical environment that would help you to improve your ability to practise, as you are already thinking of audits and changes

Nurse 5: Yeah, yes

Cherrie: Ok, ok, has the clinical environment improved your confidence to work on the wards?

Nurse 5: It has, do you mean like other wards?

Cherrie: Yes and also to work on your ward

Nurse 5: It has very much with it being twenty four hours of acute, you do not ever know what presentation that you are going to get and I have worked with different clients with different presentations and have had the opportunity to be at the front to make decisions and this is very challenging, a very challenging ward but we have come through it and I can happily say that it has boosted my confidence, because I have had to use my clinical judgement, use all my nursing skills and you know it is nice to see when you have had positive results at the end and that has really boosted my confidence

Cherrie: Ok, em, if I were to ask your colleagues what they think about how you are working, what do you think that they might say? If I were to ask him/her what they notice about your abilities to practise, what do you think that they might say?

Nurse 5: (Laughs, laughs) I probably think that they would say, probably quite happy with sort of my leadership skills on the shop floor, possibly during incidents and things like that where you have got a very difficult frightening situation and I would probably be at the forefront and you know support the team and not be scared and you know just be a good team leader really and I would hopefully boost other people's confidence as well and work as a team player, I think that they will probably say that

Cherrie: Ok. What would you say about you that helps you to do that? What are your abilities that make you a leader, a team leader and a role model for the junior nurses? What is it that you bring to the team to make that possible?

Nurse 5: I think it is because I am calm. I do not panic, I do not know how I have learnt it, I think that it is probably over the years working in different environments, but I am quite aware that I am quite calm when there is an incident, I am really calm and I try to think very quickly as to what needs to happen and I liaise with other teams of what we need to get together and we are in it together rather than just handing down what needs to be done and then we are all in agreement and we go in and do something, and just having that confidence and you know making your team feel that you are confident about what you are doing and you know what you are doing really and the experience that I have got since I qualified, the years of experience also helps.

Reflecting on this nurse's views and experiences as she shared these with me I was able to assist her to identify areas of practices which had been good learning experiences for her and her colleagues despite the environment being twenty four acutely ill health care needs and the challenges that this brings with it; the nurse felt able to use her clinical judgement which in turn boosted her confidence. Nurse 5 who in episode 1 did not seem to be able to reflect on her practice was towards the end of her interview able to talk about her leadership style more reflectively. She was able to draw out her strengths of being a calm and non-panic person when in an incident. She shared her ability to be able to think very quickly in difficult situations and to work well with other ward staff and team members. She was able to highlight how much she

had learnt despite her initial feelings that the environment did not offer learning opportunities to nurses.

Summary

Here I would like to sum up my learning on my reflection on the managerial practices conducive to care in inpatient psychiatric wards. I would also like to share some of the findings from the nurses as we engaged in dialogue about what might be needed for these wards to become clinical learning environments. What I found useful was the possibility to use Morgan's (1993; 1997a; 1997b; 1989) ideas on the use of metaphors to help us to visualise our organisations and our practices as managers and leaders. I was able to look at the dialogue with nurses and question my reasons for the questions that I asked and my part in the dialogue in relationship to what was called forth in the dialogue, a concept from Andersen (1990) where dialogue is a two way process where reflections and self reflexivity are used to inform how we become transparent in our being together. The use of the spider plant as a metaphor to explore the dialogue with nurses was particularly helpful.

Drawing on the concepts of a number of writers, for example Bateson (2000) who talks about problems as being systemic and that we are all part of larger systems and that the part can never control the whole, to understand the nurses who took part in the research inquiry, they all have a part in the wider system and in order for change to take place management and nurses need to reach a synthesis of views on how to move to a position where a clinical learning environment becomes possible, where due consideration is given to what is needed for all. I would argue that unless management changes their ways of working and understanding of what is needed in the clinical environment in order for learning to take place, nurses will continue to struggle to provide high quality care that can only be possible by having learning spaces within these environments. A research inquiry is called for, inquiring into how managers/management understand whether they feel that it is important to have learning

within the clinical environment and what is needed to create these learning environments within inpatient psychiatric wards.

Cecchin's (1987) ideas on hypothesising, curiosity and neutrality were concepts that I used to remind me of the need to focus on what was important for the nurses to talk about during the interview, especially as I also worked within the organisation. An example of this was that I reminded myself not to hold on to my own truism of what was important for the nurses. Some of the findings from these dialogues illustrated the considerable learning that took place in these clinical areas. Nurses felt that supervision was lacking within these areas, and when it did take place it did not address the main needs of the nurses, therefore they were requesting that supervision takes place in a more regular and planned way. Some nurses were requesting that supervision took place informally in the clinical environment on a daily shift by shift basis. Another was that the wards needed to have skilled trained nurses on shift so that they can share their learning with other nurses on a daily shift by shift basis. Another was that nurses needed a clear structured line of accountability so that learning can take place in a helpful and structured way. Nurses were requesting smaller wards with better lay out as the wards were not always fit for purpose. They were requesting that the wards are staffed to a safe level, allowing for better patient care and creating space for learning within the clinical environment.

Generally the nurses were pleased with their work and felt that they were doing their very best to work with the resources that were available to them. The concepts drawn upon also brought new ways of understanding dialogical meetings with the nurses as well as helping me to think beyond my own understandings, thus creating possibilities for me on how to go on in my practices. The chapter that follows brings this thesis to an end.

Chapter Nine

The coming together of an inquiry: suggesting learning improvements within the clinical environment in psychiatric inpatient wards

In this chapter my aim is to highlight the findings of the research inquiry. In punctuating my results, I will show how important the nurses felt that their work had been and continues to be. I will revisit the research questions and the topics that were explored and I will offer a summary of each of the key factors in the previous chapters, making connections to the research questions and my reflections. This chapter highlights the nurses' views on the possibilities of working in an environment where there are more resources and where care matters to those nurses giving the care as well as to those receiving the care. I show how the research inquiry topics assisted me in illustrating the challenges as well as the enjoyment that the nurses were involved in throughout this journey. As they continue to tirelessly work on the various inpatient psychiatric wards; also the courage and love for their caring roles that they have shared with me.

In Chapter One, I set out my reasons for being interested in doing this research inquiry and why now. As this process concludes, my initial reasons have become stronger. For the findings from the research foregrounded for me the kindness and willingness with which nurses started on their journey to become nurses, and how over time this kindness had remained. However, the environment that they were providing caring in needed to change in such a way that the nurses can continue to care for their patients with much more knowledge, enthusiasm and passion.

As I continued with my exploration of clinical learning environments within inpatient psychiatric wards, I felt that I now had a better understanding of why I had felt such disquiet while on the ward that my father was cared for. I now feel that some major changes must take place within these environments so that nurses can have the time and space needed for their learning and development in providing best quality care.

As I revisited the themes and findings that have emerged, I have come to understand that their views and experiences of their learning within clinical environments were not always heard.

Indeed their voices were rarely ever listened to or in fact understood. I remain interested too in Shotter's (2008) ideas on 'Aboutness' thinking versus 'Witness' thinking. Shotter reminds us to think of the uniqueness of others and not to see them as part of a problem-solving process as this leads to them being all the same. Rather we must enter into a dialogically structured relationship with these unique others which will help us to understand how to go on in practice with them. My thoughts were to do with how nurses can engage with senior nurses and management to find a way/s to go on together in the process of improving the clinical learning environment for the nurses.

Both qualified and non-qualified nurses talked with me about their views and experiences as to what kinds of events, communications, and advice from their colleagues, specific teaching times and other informative experiences helped them to work towards understanding their learning needs, and what would help them create a clinical learning environment within their various inpatient mental health wards. They mostly all agreed on the lack of learning opportunities that they all felt were needed within the clinical environments or wards. I was struck by their self reflexivity, thoughtfulness and at times, frustration in trying to create learning spaces, appropriate to their identification of their learning needs. On reflection my thoughts were that the nurses knew what was needed to equip them with their learning. However, they may not have had the opportunity to share these with management staff who could support them with their learning needs. There seemed to be a barrier between them and the hierarchy as to how they might gain access to their learning needs.

In Chapters One and Two are my reflections and further thoughts as to why I chose to use these concepts to illuminate my research inquiry as opposed to other theoretical concepts that I could have used within this research inquiry. I found the use of Social Constructionist and Systemic Ideas useful tools to make sense of the conversation, dialogue and the written transcripts that came out of these conversations with the nurses. After considering other methods of analysis I decided that discourse analysis was what I wanted to work with. I also felt that discourse analysis for me was the best way of bringing forth my sense making of the conversations and dialogue with nurses, as it felt closer to social constructionist and systemic

ideas of how one might make sense of one's social world; these concepts focus on identifiable themes and patterns of lived experience or observed behaviour (Burck, 2005).

When exploring what accounts emerge about what constitutes a clinical learning environment and how these stories contribute to clinical practice, Chapters Four and Eight brought some of this to the forefront as the nurses shared their views and experiences of what a clinical learning environment would look, feel and be like for them. My initial sense was that each nurse might tell a very different story of what a clinical learning environment meant to them. However, as the process went on, my sense was that their stories were in fact very similar. They all had a sense of what was needed, and what was lacking in the clinical learning environment, though there were experienced, less experienced, qualified and non-qualified nurses who took part in the research inquiry. The nurses' realities and expectations were also very similar; this all pointed to the basic needs for the environment to have time, spaces, and experienced nurses on each shift.

As I reflected on the nurses working in these areas of great complexity and the findings from my conversations with the psychiatric nurses, I was struck by what I would say remains on-going work for the nurses, namely the ability to further reflect on the implications for the patients in these clinical environments. Also in how they relate with their managers or leaders, to whom they might be able to share their accounts about what constitutes a clinical learning environment. These nurses were able to identify areas of training that they felt would be helpful both to their learning and their developing confidence to seek out those who could influence the system to act on these possibilities of releasing time to learn. The nurses were able to talk about their need for further development and for the senior team to support them in developing their ability to inquire further into what aspects of the clinical environment would contribute to their practices in providing high quality of care for patients, and what aspects would be detrimental. This they felt could be done through regular clinical supervision, be it formal or informal in the day-to-day care that they were providing to/with their patients.

In Chapter Five, I was struck by the nurses' views of their felt sense of being over organised by the organisation's management and the constraints that this way of feeling imposed on their sense of care delivery expected of them. During the course of my research interviews, nurses discovered that learning had happened in the ward environment even though they had not yet realised it. I came to understand the level of dissatisfactions that nurses felt in a way I never had done as a manager, as nurses shared their experiences of not experiencing learning that they felt that they could apply to their practice. This they felt was as a result of the organisation's ways of hindering their staff learning, through ways in which the organisation organised them.

Some nurses said that they felt that they needed and would have liked to have experienced, a different kind of learning. However, they were not always able to express in what way or how they would like the learning experience to be. However, some of the nurses were able to practise caring in a different way despite being in an organisation which they felt or experienced as organising their practice in ways which constrained them. Benner's (1984) ideas of the expert practitioner, as being someone who frequently makes clinical judgements, someone who is able to manage complex clinical situations in truly remarkable ways and holds a vision of what is possible in a clinical situation, was something that struck me about the nurses as they provide care in complex situations. My view is that expert nurses were able to work in a competent manner despite the sense of the organisation over organising their practices, as they were able to sense which of the limited number of organisational possibilities were open to them so that their choices allowed for their practices to be learning experiences as well as to provide sound clinical care.

As I reflected on the ideas of nursing communities where shared knowledge as a way of practice could be developed across the wards, thus freeing up learning spaces, chapter 6 outlined some of the nurses' views, experiences and ideas on developing a community of practice that was open ended and not a closed community of practice. I was struck by the abilities of the nurses to be able to share their views in such a clear and concise way, such that I was able to get a visual picture of what a community of practice would look and feel like both

for the nurses and for the patients on these wards. I came to understand during the process of writing and talking with the nurses that I had not realised that a community of practice is never a completed process; rather it is an unfolding vision within which staff felt able to work with complexities, able to challenge and to respect others' views, while simultaneously working with teams which have a high level of expert knowledge, and where the team creates spaces to share their expertise.

There was a felt need by the nurses to meet in planned learning spaces so that knowledge can be shared and gained. Throughout the three areas that I inquired into, which were acute adult, secure adult and secure male adolescent wards, what was strongly echoed was that the psychiatric nurses all felt that they needed to have a voice within the organisation and its hierarchy of team structures. Within these wards there was also a felt sense that all nurses wanted, and at times needed, more expert nurses working in the teams. I was most struck by the ways in which the nurses were aware of the need to put the patients' care at the heart of everything that they did, offering patients the possibilities of more choice and control over their own health care needs. Another finding which I was struck by was that although nurses were fully aware of what practices were needed, they were often silent when their needs needed to be expressed. There was a shared sense throughout the wards that the skills and abilities of the nurses were very much present. However, there was also a shared sense of not being given the resources that they needed to carry out their work to a competent level. It was also noted that dialogue happened in contexts where nurses felt supported, and where the episode of care in which they were engaged was also supported in a way that had a team approach and a resourceful pulling together of skills and abilities.

There were a number of difficulties that the nurses encountered during their care delivery. Some of these were that there was a lack of spaces for the nurses to use for reflection, there was a continuous echo from the nurses of the need to be able to access clinical supervision after an event or after a critical incident had taken place. There was a sense of abandonment by the senior management team as the nurses continued to need high levels of expert nursing care

in these inpatient wards and as the need for more expert nurses to be present in the clinical environment was something that they felt was lacking.

Some findings of creating 'reflexive spaces' were also articulated and shared during the research inquiry process, which highlighted some difficulties as well as possibilities. In Chapter Seven, the importance of having a good mentor was raised as a possibility of creating clinical learning environment. Benner (1984) suggests that management should aim to staff the wards so that nurses, who are experts in relation to the particular patients admitted on the ward, are available for consultation at all times. This connected with the need for the nurses to share their views and experiences of the clinical environment if a learning environment is to happen. Having a good mentor is thus something that this is valued. It adds to confidence and development of best practices. On reflection, the nurses' abilities to reflect, pause, and think about what they needed to develop their practice and to provide best care for their patients, was something that struck me. I was impressed by how they shared their experience and views of their vision, for the here, now and for the future. I was connecting to Senge's (1999) ideas on shared vision as one that is rooted in an individual's own set of values, concerns and aspirations. He spoke about genuine caring; about a shared vision rooted in personal visions.

In Chapter Eight, I discussed my thoughts on the managerial aspects which are conducive to creating spaces in which learning can take place. I found Senge's (1999) ideas of our mental models and their influence on shaping how we go on in our practices a useful concept that I used in my reflections and sense making of my conversation with the nurses. Another useful concept that I used in my reflections was that of Bernstein's (1983) idea of horizons, as he suggests to have a horizon is to have a range of vision that includes everything that can be seen, not only from a particular vantage point, but also beyond it; a horizon is not closed but rather open, something that is always in motion, and that which can also move us. Another concept which I used in my reflections was Benner's (1984) idea of the movements and developments that can take place in our practices as we move from novice to expert practitioners.

Throughout I reflected on whether there were any differences or similarities in nurses' views and experiences on what creates a clinical learning environment within acute adult, secure

adult and male adolescent mental health inpatient wards. What I discovered was that all the nurses shared very similar views which were related to what is needed for basic and best care to be carried out on the various wards. As I reflected on the research questions that guided the research inquiry, I asked myself how do I begin the process of identifying areas of learning that might be applied to other areas of learning and practice, so that patients' care remains of a high standard? I identified the areas of training that nurses felt might be helpful to their learning. We explored what factors would improve the quality of care that nurses provide and what would help them in co-creating standards for how the clinical environment could become a learning environment for them.

We reflected on the implications for the patients in these clinical environments, in relation to the different accounts held by staff about what constitutes a clinical learning environment. We were inquiring into what aspects of the clinical environment contributed to staff practices in the provision of high quality of care for patients and what aspects are detrimental. Both qualified and non-qualified psychiatric nurses took part in this inquiry. There were experienced and less experienced psychiatric nurses. What I found out was that despite their levels of education, experiences or whether they were qualified or non-qualified their views were similar in that they all wanted better spaces in which to carry out their caring duties.

Qualified and non-qualified nurses working on these wards seemed discontented with the way they were treated and respected as professionals. For example, they reported not being able to access more in-house or external training. They felt if they had received such training they would be better equipped in their own development and, as a result, they would be better able to care for their patients, thus providing best care.

Both sets of nurses did not mention being paid more or less for the work that they were doing. This did not seem to be an issue for them. What seemed to matter to both sets of nurses was that the care that they give to the patient was of the best standard.

Summing up the findings

1. Nurses that were not receiving clinical supervision were more lacking in their abilities to relate with their patients in ways that were caring, supportive and understanding, resulting in more incidents than the nurses who were having supervision on their clinical work, (Nurses 3, and 5 being examples of this) even if the supervision was not on a regular basis. Staff reported feeling frustrated and getting burnt out, and their competencies to deliver safe care was felt to be reduced, when supervision was not available to them for a number of months (Nurses 8,10, 13,12).
2. Having a space for supervision from a suitable qualified person, whom you can approach with concerns, being able to explore meaningful events in the clinical areas where learning can take place, and being able to share reflection, will also create clinical learning environments.
3. Staff felt that having regular informal daily supervision to address the current clinical issues at hand was needed.
4. Having a hierarchy in the nursing structure also helped as it created learning environments, as it felt containing when anxieties and worries were contained. This contributed towards created spaces in which learning can take place.
5. Having a ward that is adequately staffed will free up staff to learn and to be able to teach other nurses on the ward.
6. Having protected time to learn and teach others creates learning.
7. Nurses having the skills and experience to work across wards will also create time and spaces for clinical learning environments.
8. Nurses being involved in creating policies and procedures will also create learning environments, as sharing of skills can develop as nurses understand why they are expected to carry out various tasks and the implications for safe, high quality care.

9. Nurses having a resource library on the ward so that books and articles are accessible to nurses.
10. Being able to draw on other members of the multidisciplinary team to teach on topics that the nurses felt would be relevant to their wards.
11. Nurses were aware of the need to put the patients' care at the heart of everything that they did, offering patients the possibilities of more choice and control over their health care needs.
12. Nurses were aware of what practices are needed. However somewhere, somehow, they had forgotten how to always do so, in the sense that their voices seemed to be silent when they needed to express their needs.
13. During the interviews with nurses in varied nursing inpatient wards, the skills and abilities of the nurses were very much present; however there was a shared sense of not being given the resources that they needed to carry out their work to a competent level.
14. The nurses' use of their code of conduct, to assist in the care given to patients, was an aspect of care that was noticeable both with experienced and less experienced nurses in their practice.
15. It was also noted that dialogue happens in contexts where nurses feel supported, and where the episode of care in which they are engaged, is also supported in a way that has a team approach and resourceful pulling together of skills and abilities.
16. The lack of space or spaces for the nurses to use for reflection was also brought to the forefront.
17. Nurses expressed the need to have supervision after an event or after a critical event had taken place.
18. A high level of expert nursing care is needed in these inpatient wards and the need for more expert nursing practice presence, if a learning environment is to be created.

19. What was lacking was the knowledge that a community of practice is never a completed process; rather it should be unfolding, able to work with complexities, able to challenge and respect others' views, simultaneously working with teams which have a high level of expert knowledge, where the team creates a space or spaces to share their expertise.
20. The need to attend planned learning spaces so that knowledge can be shared and gained.
21. Throughout the three areas that I inquired into, which were acute adult, secure adult and secure male adolescent wards, what was strongly echoed was that the psychiatric nurses all felt that they needed a voice within which the organisation, and its hierarchy of team structures within these wards, and there was a felt sense that the nurses wanted and at times needed more expert nurses working in the teams.
22. These areas of care are highly complex, difficult and therefore need research based work where practices can be evidenced so that higher levels of learning can take place. Self motivation was also a key factor in the learning process shared by these nurses.
23. Nurses reported that they needed time to reflect on their day to day practices.
24. Nurses feeling the need to have feedback on their work performance, as this was important to them in helping with the building of their confidence in their practice.
25. Nurses feeling the need to have protected time to care and reflect.
26. Nurses shared their concerns about the different diagnoses of patients that are all cared for on the same ward and the complexities that this adds to their ability to provide competent care.
27. There were fewer resources available to them to carry out more tasks and to be able to allow them to provide caring and safe practices.
28. The destruction of negative reflections when nurses are faced with difficulties on the ward, these reflections were described as not very focused and that these reflections were used

for blaming and criticism. The nurse felt that having inclusive reflections to share information would help the process.

29. The need to revisit policies and procedures and knowing what one can and cannot do when working within the framework of the organisation.

30. The need to make changes to the physical environment will make a difference as the spaces that are available are limited, and do not lend themselves to sufficient patient privacy or confidentiality when 1:1 sessions are needed.

What are the future implications for psychiatric nurses, ward managers/senior managers, practices on the wards, for teachers/tutors/mentors of nurses and the multidisciplinary team working in these inpatient wards? What are the implications for current and future practices within psychiatric nursing research? One idea would be that nurses form support groups with other nurses within or outside their clinical environment in which best practices could be shared. Nurses first need to find their voices to approach their nurse leads on the wards or the nurse lead for the hospital or organisation and set up courageous conversations as to how best practices can be achieved and what learning is needed for this to happen. Another is that nurses access their nursing bodies, the Royal College of Nursing (RCN), also the [RCN Direct](#), a 24-hour information and advice service, and the Nursing and Midwifery Council (NMC) (2008) and for nurses to be involved in audits or research that will highlight or help to bring the changes that are needed within psychiatric nursing care.

In considering the implications for ward managers, I would suggest that they have team meetings with the nurses in which the nurses could talk about the needs of the wards and therefore as a nursing team build their confidence to have further conversations as to the changes that they would like to see on these wards. Managers could spend some time on the wards on a shift basis to gain some experience of the grassroots' needs of the wards. They should also ensure that the nurses are receiving clinical supervision, that there is protected time to care for the patients and that staff are receiving the necessary training and development to meet the needs of the wards to enable best care to take place.

In terms of the implications for practices on the wards the nurses who took part in the research inquiry said how much the opportunity to take part in a research, where their views and experiences were sought, has in fact helped them to bring to the forefront the difficult and complex situations that they are faced with on a daily basis. Some of the nurses said that they will have further conversations with their colleagues, their matron and their lead nurses on how they can all make a difference in how clinical learning environments could be created and built on, so that nurses would be able to ask for the support that they needed in these wards.

In terms of the wider ward disciplinary team and for teachers/tutors/mentors of nurses working in these inpatient wards, more joint working is needed as staff support each other. Teachers, tutors and mentors of nurses should find ways of spending more time in the clinical areas/wards so as to gain experience of what is needed to train and develop nurses so that these wards become clinical learning environments for everyone that spends time within the wards. Further research is needed in how the MDT as a whole team approach can use these findings to provide best practice and better experience for patients and nurses working on the wards.

In summary I believe that this research inquiry has answered the research questions that informed the line of inquiry as the staff shared how they have developed a greater understanding of their individual learning needs as well as those of their colleagues. Throughout the research inquiry there were several themes that emerged which I hope to explore further in the future. One of the themes that I was most struck by and that I will be exploring in the near future is protected time for nurses to reflect on their practice during the course of their daily duties on the inpatient psychiatric wards.

Appendices

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