

Abstract

Aim: This study explored the ways experienced mental health nurses working within a local acute mental health NHS Foundation and Teaching Hospital Trust felt about being unobtrusively observed in their everyday clinical practice. Participants were recruited from eight local units: four Community Mental Health Teams (CMHT), one Crisis Resolution Home Treatment Team (CRHT), one in-patient ward, one in-patient rehabilitation unit and an Assertive Outreach Team (AOT).

Methodological approach: The work of Paulo Freire was used as the theoretical lens which 'positions' and influences my study. Collage-Theme board technique (used as an initial ice-breaker exercise) and ten semi-structured focus groups were facilitated away from the usual work setting. Thirty-five nurses participated in this study. Focus groups were digitally recorded, transcribed and analyzed thematically. Collages were digitally photographed and ideas and metaphors explored.

Findings: Eight main categories emerged from the focus group data. These were: inviting observation, making observation work, practice confidence, a chance to shine, organizational non-transparency, under the microscope, drowning in data, and capturing the wrong data with blunt tools. These come together into one overarching study theme - Transparency in Practice. Categories discussed using the sub themes of Learning Opportunity and Scrutiny are considered from the twin Freirean perspectives of liberation and oppression.

Discussion and application: Participants identified positive and negative consequences of being unobtrusively observed. Staff valued the opportunity to enhance their clinical practice by working with colleagues and did not perceive this as unduly intrusive. Constructive feedback from peers was welcome. Frustration however was voiced about the amount of paperwork they were expected to complete. They felt this detracted from the time they could spend with patients and that many of the existing 'systems' did not capture the complexity or richness of their role. Staff welcomed the opportunity to participate in the development of new audit trails that reflected accurately what they did, and saw this as a collaborative 'bottom-up' and 'top-down' necessity. Issues of voice, visibility and oppression resonate throughout the focus group narrative. Insider practitioner research provides one way of contributing to this developing knowledge base by building a greater understanding to underpin the complexities of front-line nursing practice. Specific recommendations for Trust consideration and adoption are made.

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AUTHOR'S DECLARATION

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed:

Date:

Dedication

This thesis is dedicated to the continuing memory of Gladys Whiles. You are rarely far from my thoughts.

CHAPTER 1

INTRODUCTION TO THE STUDY

This Chapter provides the context for the research and explains the rationale behind the methodological approach I adopt.

1.1 Setting the scene

We are observed in many different ways. There are CCTV (Closed Circuit Television) systems in every town and city centre, speed cameras on the roads and store detectives, both uniformed and plain clothed, in most large chain stores. As we approach a speed camera zone we respond to the visual signs and we automatically slow down to avoid incurring a fixed penalty fine and having our driving licence endorsed. In reality it does not matter whether the camera is functioning or not. The mere belief that it is working or that it could be working so that we could be caught on film is sufficient temporarily to modify our behaviour. We internalize being watched and through self-surveillance we become our own internal policemen. We do this by acting in the same way we would if there were an actual police officer visible. We become self-regulating and self-managing and for a short period of time afterwards we will continue with this adapted response until we gradually lapse back into our usual behaviour or believe we are no longer being watched or cannot be detected. The belief that we are being observed, alongside the inability to verify or refute it, has thus achieved its intended purpose. Bentham's prison panopticon model, described in Chapter 2, will be used to explore this idea further within a mental health setting.

Nurses work in an increasingly panoptic¹ culture, subject to the disciplinary gaze that professional regulation, clinical governance and mandatory risk management systems impose upon them. Their clinical activity is increasingly overseen,

¹ Panoptic - including everything visible in one view – discussed in Chapter 2.

monitored, controlled and subjected to a rigorous auditing cycle (Epling et al., 2003). Direct observation can assume many guises. It may be in the form of senior nurses working alongside junior staff, watching how they administer an injection or interact with a distressed patient or relative. It exists when a junior nurse watches a senior colleague role model good practice or demonstrate a complex technique. It may take the form of a hospital manager shadowing senior nursing staff to evaluate their clinical leadership skills. Or it may be present when patients gossip and comment about nurses with other patients or with their visitors and carers. Direct observation can exist in peer reviews as nurses request constructive feedback from each other on how they are performing, as part of their own continuing professional development. It can also be a part of post-incident analysis, where nurses meet together following an incident to debrief, look at what happened, and identify how things could be done differently were a similar situation to arise.

Indirect observation can also take many forms. It can be found in audit trails where patient health care records, staff sickness profiles and incident forms are monitored against an agreed standard. This is done to ensure that nurses are conforming to policy guidelines and are reporting the right information in the right way and at the right times. Using this process, individual staff can be identified and called to account for shortcomings in their practice; they can be required for instance to explain why a written entry is not dated, signed, legible, written in black ink, and so on. Minutes of meetings can likewise be scrutinized to see who said what, where, why, when and how. Hospital CCTV footage, which monitors the physical whereabouts of patients at any given time, can be used to capture the movement of staff over a twenty-four hour period. Patient satisfaction surveys can also be used to monitor nurses' activity on a ward indirectly and to gauge whether they are spending enough face-to-face contact time with patients, be it in a ward or community setting.

Even something as positive as the principles of reflective practice and clinical supervision which at first sight appear the least panoptic and perhaps the most benign of activities can have indirect observational potential. The introduction of clinical supervision was politically motivated and a centrally driven initiative to help assuage the public's waning confidence in the NHS following the sensational media profiling of the Beverley Allitt scandal (Beverly Allitt was a nurse found guilty of four murders and nine attacks on other children at Grantham and Kesteven Hospital in 1993). The resulting Clothier Report (HMSO, 1994) was used to help manage public fears by introducing a top-down managerial system of surveillance that would help monitor staff, professionally regulate them and make their practice visible and accountable to avoid further tragedy. Gilbert (2001) suggests that the ritual of confessing by self-disclosure functions as a form of covert surveillance, disciplining and moderating the activity of the practitioner and bringing out into the open previously hidden or censored thoughts and feelings for public inquiry and examination. He argues that this could have a silencing effect because it serves as a means of monitoring the activity of individual practitioners. By making nurses visible, managers can subject them to modes of surveillance that separate, measure and quantify them as individuals. Whilst this may ensure practitioner accountability and safety to practice (Bishop 1994; Butterworth et al., 1996), White et al. (1998) contend that it is also an intrusive management strategy aimed at observation of professionals by professionals. As such, as Gilbert argues, it should be more actively challenged and criticized.

Another example where surveillance activity can occur is the nurses' station or the equivalent office space of a Community Mental Health Team (CMHT). A nurses' station is a centralized work space or a hub within a ward or a shared community space. It is where nurses meet to hand over information to one another and write their clinical notes, a place used to plan and coordinate care with other nurses and allied health care professionals. Nurses' stations tend to be in areas that provide the widest possible view of patients, for obvious reasons (in

an out patient clinic they are located either in an open plan office, with the front reception team or nearby) but they also have staff surveillance and data tracking potential. The mechanical equipment used by nurses at the station has audit functionality and can be used by those who are not there to police and monitor the activity of those who are. Furthermore, photocopiers can be programmed to identify date, time and the number of copies made. This information can be used to help monitor usage and likely wear and tear, to aid maintenance schedules, and to assist in the timely replacement of parts. The same process, however, can also be used to police its usage. Large print runs can be easily traced back to an individual clinician and explanations sought as to why multiple copies were needed. Email, fax, and the Internet can all, likewise, be programmed to store, retrieve, and analyze content and usage. Or consider security swipe-cards, used to control access to and egress from a building; they provide a navigational foot map of an individual's physical movements and whereabouts within a given location. Whilst this can help staff feel safe and secure in the knowledge that others will know where they are, an important consideration in acute mental health in-patient care where clinicians work with a volatile and often angry patient group, it is equally important in Community Mental Health Teams where lone nurses facilitate nurse-led clinics and see patients on an individual basis. It may also, however, make them feel scrutinized and spied upon. The growth of a computer surveillance capable culture within the ward work-place (based on individual user name and password) means that timed audit trails of logging on and off times and specific computer sites accessed can now be compiled and linked to an individual user. Staff are increasingly being called to account to explain what they were doing and why they were accessing specific electronic patient records or websites in the course of their shift.

It can be seen that there are many different ways that staff can be directly and indirectly observed in their everyday clinical practice. This can be by computer, CCTV, paper systems, other colleagues, patients, relatives and system-designed

processes. It is no wonder then that Zuboff (1988) likened this to an 'Information panopticon'.

We are becoming a surveillance society (Thomas, 2009). As I became more aware of the number of ways I could be indirectly observed at work I started to question the ideological nature and purposes of unobtrusive observation. I wondered whether my nursing colleagues perceived it as welcome organizational support and a safe platform from which to work with an increasingly complex and litigious patient group, or whether it was seen as an unwelcome intrusion which inhibited risk-taking and limited decision-making choices for fear of the consequences. Given the increasing workloads and time pressures faced regularly by front-line nursing staff, I rather suspected that they may not have thought about the issue at all.

Watts and Priebe (2002) recognize the growing paradoxical tension faced by nursing and medical staff in the delivery of contemporary care: staff are paternalistic and reactive to patients because they are routinely called to account for their actions and required proactively to manage risk. In imposing treatment they are seeking to empower, but by empowering they inadvertently control. An example of this is when a nurse gives medication to a patient who is detained against their will under a treatment section of the 1983 Mental Health Act (Amended 2007). The action is taken legally, in the best interests of the patient, to restore wellness but it is rarely perceived in this way by the individual who does not realize that they are unwell in the first place. Being called to account for one's actions (Taylor, 2003) and being mindful of the need for transparent practices and paper audit trails can be a double-edged sword. Whilst clinicians are encouraged to become self-regulating and autonomous practitioners, internalizing their behaviour and actions to agreed societal norms, it remains to be seen whether this is a spurious or misleading rhetoric deliberately disguising a greater level of covert control exercised by managers (Rose, 1996).

In his key thesis, *The McDonaldization of Society*, the critical theorist and sociologist George Ritzer (1993) noted the growing attraction and appeal of the ubiquitous and technological Weberian “Iron Cage” production-line processes exemplified by the McDonaldization phenomenon. Ritzer (1993) warned that the McDonald's concept, "affect[s] not only the restaurant business but also education, work, health care, travel, leisure, dieting, politics, the family and virtually every other aspect of society" (Ritzer, 1993, p.1). He focuses on four illusory pillars that premise and epitomize McDonaldization - efficiency (elimination of unnecessary effort), calculability (a tendency to measure quality in terms of quantity), predictability (knowing what to expect), and control (through the substitution of nonhuman for human technology) - and draws parallels with the delivery, institutional bureaucracy and the increasing rationalization of the modern health care process. Focussing on the inherent risks that the irrationality of rationality poses for the social landscaping of society, Ritzer (1993) warns, like Weber (1864-1920) before him, that the endless introduction of streamlined, highly programmed and rigidly scripted bureaucratic systems and processes negates and constrains the skills, creativity, spontaneity and focussed imagination of the individual. In the field of healthcare this risks patients being treated as ‘factory-farmed’ products to be processed on an endless sterile mass conveyor belt of ‘care,’ ‘dispatched’ from one department and system to another as they are diagnosed, coded, Mdoctored and Mcnursed. This study will be open to the possibility that the concept of employee observation has created highly scripted, rationalized and ‘McDonaldized’, practitioners who feel stifled and unable to work creatively and innovatively; fearful of being called to account for working imaginatively and for taking calculated clinical risks which are off the McDonald menu. Sewell and Barker (2006) question whether this is caring or coercive? Malign or benign? It is a theme I will return to in Chapters 5 and 7.

A preliminary literature search to identify what had been written about this area showed that whilst many English-language journal articles had been published on participant observation and health surveillance programmes, little had been

specifically written on how mental health nurses felt about being unobtrusively observed in a clinical setting. This suggested that any contribution I made could be original. I would not be simply replicating or validating another researcher's work. I would be influencing and adding to the knowledge base of nursing.

As I began reading about the panopticon and the clinical gaze (Foucault, 1991) I realized I was already starting to gaze back at and to question the power and the purpose behind a system that had been gazing at me for many years. It felt strangely liberating, as though simply knowing about it, and naming it, gave me a sense of control of which I had not previously been aware. Whilst nothing tangible had changed, something more fundamental had, which was my awareness. I wondered whether colleagues would feel the same way and so I decided to ask them. I knew they would be a valuable source of information and feedback.

I found myself increasingly reflecting on the following practice-based issues: Did being unobtrusively observed help to achieve good practice? Did it hinder? Did it police? Did it paralyse? Could being unobtrusively observed be used to professional advantage? Could you get the system to work for you? I resolved to answer these questions methodically and systematically and I used the Johari Window model as a framework to help to anchor and explore these ideas. This is discussed in greater detail in Chapters 4 and 6 of the study. I also discussed my preliminary thoughts with tutors from the University of Brighton. Encouraged by their enthusiasm that this was a credible line of inquiry I enrolled on the 2005 professional doctorate programme.

Having an idea I considered worthy of academic study, I naturally wanted to check out my thinking with others and I did this using the process of problematization. Problematization is the art of highlighting an idea or an argument by first recognizing it and framing it as a problem worthy of intellectual debate; it is, as Heaney (1989) says, the in-depth analysis of problems through

discussion with others. As hands-on knowledgeable doers, nurses do not always problematize practice-based issues and do not always feel valued or respected by other professional groups. They often describe feeling oppressed, powerless and marginalized (Roberts, 1983, 2000). This is a theme I will develop in Chapter 3 when the work of Paulo Freire is introduced. As a senior front-line mental health nurse, I still find it easier to discuss my thoughts with colleagues in my immediate professional area. There seems to be less of an unspoken power dynamic and I rarely feel the same need to impress my peers that I do with other allied health care professionals. I therefore wanted to design a study that would make nurses comfortable enough to voice their views as openly and honestly as possible. I wanted to capture nurses' views and engage staff in a mutually respectful dialogue. These principles helped me to design and shape the methodological base of my study, and allowed me to make explicit the values underpinning it.

I wanted nurses to be part of the problematization process and to do this I knew I would need to tap into the oral tradition of nursing (Flaming, 2003; Walker, 2000; O'Brian and Pearson, 1993). Nurses communicate key information about patients to each other throughout a shift, be it in a community or in-patient setting, by verbal exchange, and a nursing handover is used by the outgoing shift to brief the incoming team. The handover is a short meeting where the staff going off shift give a verbal report to the staff taking over from them about the patients in their care. This is done to pass on essential information and ensure continuity and safe practice. Nurses spend a great deal of time talking with patients, other nurses, clinicians, and carers and communication is seen as a core nursing skill. I thought that if I could design a study that involved nurses talking to each other they would be more likely to take part than if I used a questionnaire or survey approach.

Familiar with some of the ideas expressed by Paulo Freire and the importance he placed on the spoken word I appreciated the value of using his approach to

inform theoretically, and methodologically to situate, my research. Freire (1993a) valued dialogical exchange as an arena where both participants learn, question, reflect and participate in meaning-making as a social process involving shared understanding. It can result in transformative change and much richer information; it is often liberating and empowering and gives those who feel silenced and marginalized permission to speak and to respect their own voice. Freire maintained that learning is a continuous process developed through dialogue and communication (Freire, 1993a). As an informal educator he took learning out of the classroom and recognized, first hand, the importance of validating and affirming the opinions of others. I thus decided to use the work of Paulo Freire as a theoretical lens through which to explore and understand my findings.

Freire emphasized the value of talking, thinking and doing in small groups of like-minded individuals and he used the opportunities available to him. I tried to do the same. Action Learning Sets are an integral component of the professional doctoral experience at the University of Brighton. Action learning is a process based on cycles of planned reflection and subsequent action. It invites participants to learn and to share their experiences with each another, and involves setting goals and formulating a plan in readiness for the next set. This is done at a mutually agreed ring-fenced time. It is a technique that complements the cultural groups favoured by Freire because it promotes the value of listening to and respecting the views of others. I used learning sets as an opportunity to explore preliminary ideas with other professional doctoral students in my cohort, using sessions to begin the process of designing a credible study that would help capture the local voice of front-line nurses, and one that would also retain work-place relevance.

Small focus-group research seemed an obvious forum in which to engage colleagues in this collegial process. Group discourse, characteristic of focus-group design, can act as a natural emancipatory catalyst and a dialogical tool for

discussion (Padilla, 1993; Fulton, 1997). It identifies the themes and the issues of the people (Freire, 1993b) and it gives them a voice, provided they feel they can talk in a safe space (Johns, 1999). I wanted to capture these values in my own study recognizing also that as with any tool there were limitations to using this approach.

Using focus-group methods this thesis explores the ways experienced mental health nurses working within a local acute mental health NHS Foundation and Teaching Hospital Trust felt about being unobtrusively observed in their everyday clinical practice. It was undertaken within my employing Trust because I wanted to hear and validate what local nurses had to say and I also thought local recruitment would be easier. A group of qualified mental health nurses was invited to participate in the study, constituting a purposive sample. Several of the individuals I approached worked in teams and they negotiated operational cover from their colleagues to avoid compromising direct patient care. Others expressed a preference to come as a group and agreed to meet during lunch. Both perspectives were accommodated. I became very flexible in my approach towards data generation.

I approached eight local units (four Community Mental Health Teams (CMHT), one Crisis Resolution Home Treatment Team (CRHT), one in-patient ward, one in-patient rehabilitation unit and an Assertive Outreach Team (AOT))². These units were selected to enable a deliberately local perspective to be captured, and not because of any pre-identified problems associated with unobtrusive observation, from either a nursing or managerial perspective. This point is important because I wanted to be able to share and discuss my findings with other comparable units within and outside my own Trust. I also wanted my

² Community Mental Health Teams (CMHT) support patients in their own home. Crisis Resolution Home Treatment Teams (CRHT) offer short-term community based interventions and help expedite discharge for patients admitted to an in-patient setting. Assertive Outreach Teams work with patients who traditionally disengage from mental health teams and have chronic illnesses and long term and enduring mental health needs.

colleagues to feel valued and not as though they were part of a remedial and corrective process. All units were willing to participate in my study and appeared genuinely pleased that a question they had not previously thought about in any great depth was being asked. In reality I found that the numbers of staff expressing initial interest and actually committing to focus group data generation varied from group to group. I soon realized this and factored it into the recruitment strategy and the time I allocated to this section of my study.

1.2 Summary

Surveillance has become a pervasive feature of modern society. It is almost taken for granted. This study explores how nurses feel about being unobtrusively observed in their everyday clinical setting; it provides an opportunity for front-line practitioners to voice their views and, perhaps more importantly, to feel they are being heard. Finally it makes some key recommendations, based on study findings, for senior managers to consider with a view to implementation.

I have deliberately tried to record my experiences and the emotions I felt as the study progressed, in the belief that this would help 'ground' the research and 'earth' the process. I wanted to make sense of my thoughts as I went along and to do this in an open and transparent way which I could share with others. I have tried to weave these into the text from the outset. They are aided by the reflective research journal I was encouraged to keep by course supervisors throughout the research period. Chapter 2 provides a summary of the literature search undertaken at various stages of the research process.

CHAPTER 2

SETTING THE SCENE – LITERATURE REVIEW

This Chapter summarizes the findings from the two-part literature review I undertook prior to starting my actual research. It provides evidence of an identified gap in contemporary nursing knowledge and the impact of workplace surveillance I planned to investigate. The operational definitions I have adopted are explained. The dystopian view of unobtrusive observation as one-sided monitoring and intrusion by the state will be counter balanced by an alternative perspective that recognizes modern surveillance as a national necessity. Jeremy Bentham's panoptic model will be introduced and discussed and its limitations then highlighted using examples drawn from telephone call centre research, a tele-monitoring project and contemporary clinical practice. The ethical dilemma created in balancing these tensions is explored using examples taken from information technology (IT) and NHS health care informatics. The principles of proportionality, legitimacy and reciprocity are seen as key. A systems-based panopticon developed from Bentham's original work is developed in Chapter 6 of this study.

2.1 Literature search strategies

The literature searches undertaken to shape this thesis involved a combination of online electronic research databases (CINAHL and Allied Health Literature, 1982-present, Pre-CINAHL, PsychINFO, 1887 to present, Royal College of Nursing (RCN), Proquest Nursing Journals database), systematic hand searches, serendipitous references in texts, and ancestral searches (searching the references cited in other publications). Search terms used were Mental Health Nursing, Observation, Panopticon, Surveillance, Health Care Informatics and Audit. Searches were limited to English-language documents. Direction was also obtained from the taught components of a Professional Doctoral course and the

honest and critical reflection that took place with course supervisors and with peers in the action learning sets that were an integral element of the course.

A literature search using the above databases failed to identify any previous published research on how experienced qualified nurses felt about being unobtrusively observed in their clinical practice and confirmed that few studies have reported the actual experience of the watched subject (Haggerty, 2006; Lyon, 2006). Holmes (2001, p.11) raises this question but then fails to address it systematically. This suggested that any contribution I made would be original; I would not simply be replicating or validating another researcher's work.

2.2 Defining operational terms

The word 'surveillance' derives from the French *sur* 'over' + *veiller* 'watch'. It means to observe closely (Compact Oxford English Dictionary, 2005). Marcellus (2004) refers to the etymological origin of the word surveillance: 'sur' as over and 'veillance' as vigil or watchful, and highlights its benign connotation, a view supported in the field of medical epidemiology where surveillance refers to the technique of tracking disease pattern dispersion within the general population (Sewell and Barker, 2006). Surveillance can also refer to the technique of data profiling in the detection of crime. This is a process where a set of characteristics of a particular class of person is inferred from past experience and data-holdings are then searched for individuals with a close fit to that set of characteristics (Clarke, 2003). It can also be used to predict risk patterns, for example of diseases.

In 2006 (p.11) the Surveillance Studies Network defined surveillance as "purposeful, routine, systematic and focussed attention paid to personal details, for the sake of control, entitlement, management, influence or protection." There is general recognition that the instruments of surveillance are no longer solely visual but can also include complex cutting edge digital technology such as heat-seeking systems, sensing devices, satellite imaging, tracking equipment and the

interception of telecommunications (also known more colloquially as 'wiretapping').

There are two broad types of surveillance; mass surveillance and targeted surveillance. Mass surveillance is also described as passive or undirected surveillance and examples of this include CCTV monitoring (Closed Circuit Television) and computer databases. Targeted surveillance, as the name perhaps implies, is directed at a specific individual for a specific purpose. It can be overt or covert and it is usually perceived as intrusive in nature.

Gaze is a concept developed by Foucault (1980) and is defined in the Compact Oxford English Dictionary (2005) as: to "look fixedly, a fixed or intent look." Schroeder's (1998) operational definition states that to gaze implies more than to look at - it signifies a psychological relationship of power, in which the gazer is superior to the object of the gaze.

The clinical gaze can be defined as the detached, scientific, objectifying professional gaze that contrasts with the subjective surface gaze of earlier generations, "less expert, but more humane" (Shapiro, 2002, p.161). The analytical clinical gaze is often used as a literary metaphor to describe an evolving and emerging relationship between a doctor and patient or a patient and nurse. For Shapiro (2002) it is not the gaze per se that communicates but rather the person who does the gazing.

Parker and Wiltshire (1995) identified three separate elements of the nurse's gaze. These are the nurse's scan (*reconnoitre*), the clinical gaze (*savoir*) and the nurse's look (*connaissance*). The nurse's scan is often described as a frequently performed wide and visual panoptic sweep of the unit. Scanning for nothing in particular, it is conducted frequently and often sub-consciously. It is done to gain a quick visual impression and acts as a temperature gauge of the area. It is used to sense potential problems and unit 'hot spots'. Akin to Benner's (1984) expert

performer, a skilled clinician is often able to grasp intuitively that something 'feels wrong', and, by prompt remedial action prevent it from becoming an actual incident. However, if asked to explain afterwards how they knew, the nurse will typically respond 'it just felt wrong'. It is a skill that is refined and honed over time and can be finely tuned to sense the emotional tone of the ward and the dynamics of the staff team. The clinical gaze described by Parker and Wiltshire corresponds with Foucault's (1991) medical gaze, silent, gestureless, probing, never visible, whilst the nurse's look is informal affective and personally owned, it is one that often has warmth, intimacy and empathy and it possesses knowing understanding.

2.3 The asymmetric gaze and the influence of the panopticon on my study

Lawler (1991), Cheek and Rudge (1994), and Holmes (2001) agree that contemporary mental health care has mirrored some of the architectural features of the panopticon penitentiary or inspection house. Increasing use is made of audio-visual equipment, CCTV cameras and visual monitoring devices to observe ward activity and improve security for patients, visitors and staff. Holmes (2001) however suggests that whilst mechanical observation may serve as a useful technical support, it also has a surveillance function. It constitutes an asymmetrical or one-way gaze which can threaten the privacy and dignity of patients at a particularly vulnerable point in their lives. Such surveillance principles can apply equally to the observation of nursing activity.

The term panopticon is used as a contemporary social metaphor to describe the multi-faceted power potential inherent in the National Health Service (NHS) as a 'system' per se. This includes line management structures, clinical supervision, and the multiple local and central bureaucratic processes that increase the likelihood of a nurse's practice being observed both literally (by CCTV cameras) and figuratively (by audit trails, paper records, computer logging on and off times, and so on). Reflection, self-censorship and self-regulation are some of the key intended consequences of this perspective.

The concept of the panopticon, Greek for 'all seeing', was based on the transparent management system and the 'ever-open eye' of inspection (Semple, 2003, p.140) created by the philosopher Jeremy Bentham in 1785. Originally developed as a model prison, Bentham maintained from the outset that the same principles could equally apply to a school, hospital, factory or any large social institution which required orderly observation of a large number of people at any one time. His main idea was to create a building that operated as a humane, efficient, and effective functional machine whereby a prison inspector (or equivalent) could see and observe his prisoners without actually being seen or observed himself. In reality this would create the illusion of omnipresence or constant surveillance regardless of the actual number of guards on duty at any one time. The prisoner would never know whether he was being watched, and one warden could equally observe one prisoner or ten prisoners simultaneously. Believing he was subject to constant monitoring or a regime that he was unable to confirm or refute, Bentham believed that the prisoner would eventually internalize the gaze of the panopticon and the gaolers' objective of discipline and control and participate in his own surveillance and self-discipline. He would do this by monitoring his own behaviour and by assuming he was always being watched he would eventually end up watching himself. Warriar et al. (2004, p.1) conclude that given such a regime the external illusion of an all-seeing eye would become an inner reality of self-policing. The modification in an individual's behaviour that this was designed to create seemed analogous to the speed camera effect discussed in Chapter 1 of this study.

Foucault (1991, p.204) described Bentham's eighteenth century panopticon as a "laboratory of power, designed to punish, subjugate and manipulate." Semple's (2003) study of the development of the panopticon penitentiary however provides an alternative view. She argues that Bentham's own vision of the panopticon was of "a beautiful building, a stately pleasure dome comparable to the Rotunda at Ranelagh and Dublin or the circus of Bath" (p.114), and she notes that detailed sketches of the building in Bentham's manuscripts and papers, now housed in

the British Library and the Library at University College London, depict a “faerie palace, tinted in muted shades of pink and grey” (p.114). In his own words Bentham (cited by Semple, 2003, p.116) described the panopticon as a glazed iron cage: “it will be a lantern; it will be a bee-hive; it will be a glass bee-hive; and a bee-hive without a drone.” Solitary and sequestered, there were to be no communal refectory workshops or sanatoria and prisoners were to be confined to their cells with only basic sanitation.

Figure 2.1 Panopticon drawing devised by Jeremy Bentham (1791)



Obtained from <http://wikipedia.org/wiki/Panopticon> Accessed online 6th June 2008

Bentham based his design on three basic interdependent principles, lenity, severity and economy (Semple, 2003). ‘Lenity’ was the primary rule that whilst deprived of liberty the prisoner should not be deprived of food, shelter or health and would not be treated cruelly. ‘Severity’ was the recognition that the prisoner must be punished for his crime, and ‘economy’ was fundamental to the success or failure of the project. Bentham explained his ideas in meticulous detail in a series of letters and a plan of management he sent to a friend in England from

Russia in 1786. These letters, and more importantly the postscripts he subsequently wrote in London in 1790 to Sir John Parnell, Chancellor of the Irish Exchequer, contain diagrams of the proposed observatory and have become a useful archive of his developing ideas. Two key concepts and five processes underpinned the panoptic structure. The two key concepts were visibility and unverifiability: success was dependent on developing a system which was visible but unverifiable thus creating an awareness that whilst an individual could be observed by the panopticon at any given moment in time they never knew if or when it was actually happening (Foucault, 1991).

The five key processes which provide the detail of the concepts framing Bentham's panopticon are described by Strubb (1989). They are panoptical inspection, certitude of punishment, covert observation, invisible omnipresence and hierarchical panoptical organization. The key premise of panoptical inspection was that the prisoners (or those watched) would adapt their behaviour if they thought they were being observed, hence the illusion of permanent visibility. Certitude of punishment was the expectation that negative consequences would always result from inappropriate behaviour. Covert observation was a belief that you were being watched constantly regardless of what was happening in reality. This was achieved by the twin processes of conspicuity and unverifiability created by the architectural design of the central watch tower. Invisible omnipresence was the illusion of the all seeing gaze of the inspector: "awed to silence by an invisible eye" (Bentham, p.78-79, cited by Semple, 2003). Hierarchical panoptical organization was the management system put in place to monitor the inspectors who in turn watched the prisoners.

2.4 Problematizing the panopticon

Holmes (2001) notes with regret that modern psychiatric care has re-created many of the features of a custodial panoptic environment, carefully disguised as therapeutic care, "where the walls are transparent and the ceilings hear ... and the care remote" (p.10 and 12). This, he says, has been supported by the

scrutiny of an electronic eye which reduces the environment for the observation of human suffering to a human laboratory and hides the ones that watch. Surveillance technology however is no longer a one-way model limited to the top-down structure imposed by Bentham's panopticon - it can also be lateral or inverted. Lateral surveillance involves workers of a similar grade watching other workers of a similar grade. It is two-way, symmetrical and transparent peer-to-peer surveillance (Andrejevic, 2006). Inverted or bottom-up surveillance recognizes that the watched can (and equally and frequently do) watch their watchers. Examples from telephone call centre research, the findings of which equally apply to a mental health care setting, are now used to help describe, examine and problematize the complexities underpinning the contemporary panopticon.

Bain and Taylor (2000, p.2) and Wickham and Collins (2004) have challenged the earlier assertions made by Fernie and Metcalfe (1997) that telephone call centres have become the new white-collar sweatshops "rendered perfect" (p.3) by the "tyranny of the assembly line" and the supervisor's gaze, incorporating the authoritarian and electronic managerial surveillance mechanisms described in Bentham's original carceral structure. Bain and Taylor (2000) identified that experienced agents, contrary to the original panoptical regime, were often able to make an informed guess about when their work was going to be observed and were sometimes told in advance by their supervisors when this would happen. This is contrary to a key concept of permanent but potentially unverifiable visibility inherent within the panoptic machine. There is also a growing appreciation by many managers that an overly monitored workforce is less likely to be productive or loyal to the organization than workers who feel trusted and who have a say in how they negotiate, organize, and manage their own work load (Bain and Taylor, 2000).

Call centres are often regarded as places where low paid and recalcitrant workers can be policed, monitored and 'corrected' using the gaze of the

panopticon to supervise and discipline them. This implies that an adversarial relationship exists between the manager and the managed and suggests that all workers require a stick and carrot approach. Timmons (2003) notes the obvious over-simplification of this model which fails to take account of the wider setting in which the research is conducted. Taylor et al. (2002) conclude that call centres vary in complexity, market, size, and the product knowledge required by the agents and as such cannot be considered uniformly. This suggests that looking at the workplace solely through the traditional lens of panoptic style surveillance provides a one-sided perspective that can be flawed and problematic.

Lankshear et al. (2001) undertook an ethnographic study over a five month period of call centre employees' responses to electronic monitoring in a leisure and travel company. They were particularly interested in understanding the impact of surveillance-capable call monitoring technology on the workforce and wanted to explore this from both employer and employee perspectives. The researchers reported positive unsolicited feedback from several of the call centre agents about their pay perks and the general working conditions of the workplace, such as the ability to negotiate the pattern of unsocial hours they worked. The study specifically focussed on the attitudes and feelings of the call centre staff towards a new marketing initiative introduced by the company whereby workers had to request a deposit from customers to reduce 'ghost booking'. In addition, staff had to try to influence customer holiday choices to raise the revenue the company received on unpopular destinations. Agents received no extra training to implement these changes and the research team reported an unprecedented increase in angry and rude calls to the call centre, from unsatisfied clients.

Call centre employees were aware that they might be routinely monitored by their company but also appreciated this was an expensive process that would in reality take time away from the supervisor's other administrative roles and responsibilities. In practice this meant monitoring was unlikely to be a routinely

performed function. Call centre monitoring or “aural surveillance” (Wickham and Collins, 2004, p.4) can also be achieved by an Automatic Call Distribution System (ACDS). This system distributes and routes incoming calls to the first available agent and it can also be used to time and record the length of the call and the subsequent logging off period. Logging off time is the period between putting the receiver down at the end of one call and picking it up again for another call. Calls could be monitored by supervisors either listening in real time or taping the conversation to listen to at a later date. This was often done for training purposes.

The researchers found a discrepancy between the supervisors’ and the shop-floor workers’ views on how often calls were monitored. Shop-floor workers felt they were monitored infrequently, whereas supervisors said they frequently monitored calls. Supervisors’ desire to be seen adhering to company policy to create the right corporate impression may go some way towards explaining this anomaly. Staff knew they were more likely to be monitored at certain times than at others, such as during their probationary period or prior to a planned appraisal. They were prepared for and accepted this. Some staff advised the researchers that they would be told in advance when the supervisors were going to tape them. Staff sometimes requested that a call should be taped by signalling to a colleague or supervisor. They did this as a way of protecting themselves against the possible consequence of angry and dissatisfied customers. Staff took pride in the quality of service they offered and emphasized that this took priority over the number of calls they answered. Confident in their own ability, agents often reported they did not worry about being monitored because they knew they were offering a good service and felt sure this would be corroborated by a tape recording.

Whilst these researchers have focussed on gathering nurses’ reactions to the introduction of modern technology to assist with their work, no previous research had actively sought to ask the practitioners how they felt about their actions being

continuously monitored and their daily work increasingly observed; nor had they questioned how this then may have affected the way nurses worked and the positive or negative impact it had.

A recent study by Essén (2008) conducted in-depth, face to face, semi-structured interviews with a purposive sample of seventeen participants (53% of whom were women) in a tele-monitoring project; all were aged between sixty-eight and ninety-six years and lived in their own homes in Sweden. The study was undertaken to identify the impact of continuous and active electronic care surveillance on their perceived privacy. A tele-monitoring service was developed and introduced into parts of Sweden in 2006. This initiative required the user to wear a wrist watch type piece of equipment that had sensors embedded into a small monitoring device contained within it. The sensors collected 'activity data' about the wearer around the clock and this information was subsequently digitally transmitted to a call monitoring centre. Abnormal activity patterns, detected as deviations from normal baseline activity specific to the individual, alerted call centre staff and triggered a response by way of an alarm system. Consistent with conventional life-line devices the wearer could also activate the personal panic alarm facility within the device if they felt ill or needed to summon help quickly in an emergency.

Two contrasting perspectives on being monitored were reported. Care surveillance was primarily seen as positive and enabling but it was also considered to be negative and constraining. The majority of the respondents (sixteen) reported that tele-monitoring was a useful system. The knowledge that help would be available if needed made them feel safe and secure and increased their independence and sense of freedom. Participants took comfort in being constantly 'watched over' in this way. One participant, however, described the same electronic care surveillance technology as a violation of her right to privacy. She disliked the intrusion into her personal life and her perceived loss of liberty.

At her request the tele-monitoring service was discontinued and she returned to the system of support she had used prior to the study.

This literature review confirms the complex, multi-faceted nature of surveillance research. It recognizes the value of participating in the surveillance process as an active and willing agent. It also appreciates the one-sided dystopian views of feeling monitored and observed by data capturing and data gathering mechanisms. It challenges the assumption that surveillance is always malign and never benign, recognizes the context dependent nature of surveillance and builds on the concept of the prison panopticon by providing an alternative perspective that recognizes the importance of social inclusion and choice.

The perception of nurse-to-nurse and manager-to-nurse observation, either as welcomed organizational support, or as negative, invasive and intrusive surveillance, is finely balanced (Adams and Sasse, 1999). It is likely to be individual, situation specific and a naturally evolving and fluid dynamic. The transition and role mastery required to graduate successfully from a student nurse to a credible neophyte can be likened to a rite of passage (Tradewell, 1996), “the thrill of success quickly dissipated with the shock of reality” (Siragusa, 1996). This is a well documented classical phenomenon called the ‘theory-practice gap’. It is also known as ‘culture’ shock or ‘reality’ shock (Kramer, 1974; 1981).

With this in mind, I broadened my literature search using the research data bases already previously described and by introducing the new search terms: Newly Qualified Nurse Support and Feelings to examine how newly qualified nursing staff felt about being observed in their clinical practice as they made the transition from student nurse to staff nurse. This was an area I knew had been studied from the work undertaken by Kramer (1974; 1981). I sought to identify whether there were any useful lessons I could learn from this research direction.

Newly qualified nurses are expected to be competent and proficient to practice independently and without direct supervision at the time of registration (UKCC, 1999; NMC, 2004). Instead they often report feeling unprepared and unfit to practice (Higgins et al., 1999). Lacking the knowledge, skills and expertise necessary for independent practice, junior nurses feel immensely relieved knowing there are quality controls and checks in place to monitor their activity (Clark and Holmes, 2007). These can prevent an inexperienced practitioner from working outside their limited domains of competence. Removing these controls can result in nurses feeling unsupervised and unsupported (Higgins et al., 1999). In short, inexperienced nurses welcome support (Burton and Burton, 1982; Kersten and Johnson, 1992). They acknowledge skill deficits and value help from senior nurses. Fear of failure, concerns about making mistakes and “fumbling along” (Gerrish, 2000, p.473) are transitional practice issues experienced by most junior nursing staff. The evidence base suggests that newly qualified practitioners positively welcome the opportunity to have their practice observed and closely monitored as they learn the ropes (Gerrish, 2000).

Conversely over-monitoring or feeling unduly observed can erode an employee's sense of autonomy, perceived trust and decision latitude. It can create work-based powerlessness and role strain (Ambrose and Alder, 2000). Feeling overly watched and scrutinized can result in increased stress levels and decreased social interaction with co-workers and supervisors (Irving et al., 1986). It can also lead to anger, frustration and fatigue (Smith et al., 1992).

In 2009 the House of Lords Select Committee published their 2nd report for the session 2008-2009 called Surveillance: Citizens and the State. The Constitution Committee appointed by the House of Lords is required to examine the constitutional implications of all public bills coming before the House; and to keep under review the operation of the constitution. The report recognized the need for systems to combat crime, counteract terrorism and improve administrative efficiency. It acknowledged the technological sophistication of computer data-

bases and electronic surveillance systems such as CCTV monitoring (or more accurately public webcams), number plate recognition and biometrics. These have become ubiquitous, they are almost taken for granted and have become “today’s normality” (McNulty, 2009, p.12). The report also emphasized the need for caution recognizing that technological advancements should be carefully monitored and managed to avoid the invasion of an individual’s right to personal privacy which is protected by law.

In 2004 Richard Thomas, the then Information Commissioner, expressed his concern in the Times newspaper over the Government’s proposals to introduce a national identity scheme and the creation of a database that would hold details of all individuals over the age of eighteen years. He remarked that the United Kingdom was in danger of “sleepwalking into a surveillance society” and said the implications of new information technology initiatives needed to be better understood and controlled to avoid infringing or undermining an individual’s personal rights to privacy and freedom. His remarks were timely when one considers that everyday life has become the subject of routine surveillance and an electronic footprint is created simply by the making of a phone call or by leaving one’s own house and walking down the street. Meyrowitz (2007) maintains “surveillance technologies are now so pervasive, yet so subtle - many occurring automatically as we engage in purchasing, driving, or walking down a street - that they may transform the texture of everyday life without most of us being aware of the change” (p.20). Publicly accessible databases such as the Electoral Register, and digital identities including Internet banking details, contain detailed personal information about an individual. Despite reassurances about complex encryption technology safeguards, system failures can and do still result in identity fraud. This can result in loss of personal security and creditworthiness and it is both inconvenient and time consuming to have these corrected. It is clearly an area that has generated mixed public views, created ethical dilemmas, and one that requires careful regulation.

The Royal Academy of Engineering (RAE) (2007) Report, entitled Dilemmas of Privacy and Surveillance Challenges of Technological Advancement, was tasked with influencing public policy making and helping design systems that avoid and manage these risks. The report aimed to: forecast realistic developments in Information Technology (IT) over the next five to ten years; raise public awareness; look at the likely impact on the citizen; and to make some realistic recommendations to ensure that the benefits of digital technology outweigh their perceived costs. It focuses primarily on the use of information technology in surveillance, data-capture and identity management, defined as the access to administration and audit of information used for identifying people. The report emphasizes the need for engineers to design new technology with digital rights management and privacy in mind and it highlights the proposed benefits of reciprocity and trust. Reciprocity is a two-way process of openness and honesty between the 'watcher' and the 'watched'. Clarity of purpose, achieved by explaining how, why, when, and for what purpose an individual is being watched or monitored, is fundamental in the realization of this process. The reciprocity ethic values the importance of legitimacy, necessity and proportionality and introduces an element of choice to the observed. It also gives individuals an opportunity to ask questions and recognizes their right to challenge a system that can feel unduly intrusive. Regulation reforming existing legislative frameworks and a code of practice to establish agreed standards are urgently needed to provide adequate safeguards that will restore public confidence between the citizen and the state. This will have obvious resource implications.

A qualitative study looking at qualified nurses' attitudes towards a computer-generated patient care plan initiative was undertaken by Timmons (2003). His study looked at the attitude of twenty-eight nurses working on adult acute wards across three District General Hospitals in the United Kingdom. Semi-structured interviews were facilitated, taped and then transcribed. The main focus of the study was to look at the resistance of nurses to this project. Timmons (2003) notes that this initiative had been introduced by a project manager who, as a

nurse prior to this project secondment, was familiar with ward routines and perceived as a credible practitioner in the eyes of the staff. He comments that staff surveillance was not the intended purpose of the study. Despite this, staff resented being monitored at a distance, described a loss in their professional autonomy and discretion and cited these as the reasons behind their collective 'resistive compliance'. In a similar study by Lankshear and Mason (2001) nurses learnt to bypass the surveillance capability of an electronic system by sharing passwords with one another to access an educational programme. By doing this, wittingly or unwittingly, they "rendered individual monitoring impossible" (p.144) and in doing so avoided being tamed and moulded by a system that could be used to analyze and domesticate.

2.5 Health care informatics

As I began a preliminary analysis of my findings I started to appreciate with fresh eyes the competing demands of the data collection, audit trail completion and paperwork systems nurses use to evidence and justify the decisions taken on a daily basis. Information is essential in the delivery of effective nursing care. It is integral to quality health care provision. It has become a key NHS priority. The value attached to health care informatics has been restated by the Government in its NHS white paper, Next Stage Review (DOH, June 2008b). This review was commissioned to ensure that an effective strategy, translated into a practical framework, is in place to support the information technology (IT) requirements of the NHS.

Health care informatics is a generic term. It is variously used to describe "information, technology, processes, analytical tools, techniques and governance" (DOH, June 2008a, p.6). These are all needed to support contemporary mental health care clinicians in providing a responsive and effective 'needs led' service and are fundamental to Clinical Governance. They are the main driving force behind the modernization of the National Health Service.

Clinical Governance is the “system through which NHS organizations are held accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish” (DOH, 1998). This is essentially a regulatory framework with definable outcome measures. It has been used in recent years to help restore waning public confidence in the NHS following a series of major inquiries into organizational and system based failures. Clinical audit is one of the principles underpinning this process. It is used to ensure continuous improvement. Clinical audit is an instrument used to record, measure and capture the quality of service delivery. It is defined as a “quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery” (NICE, 2002). This is recognized as a dynamic and continuous process of innovation and change.

In a growing consumerist culture NHS Trust boards have become increasingly fearful of costly litigation, negligence, and compensation claims (Machell et al., 2009). Audits are used to help drive quality and monitor health care standards. Robust accountability mechanisms are seen as an essential safeguard, and visible paperwork systems a valuable quality assurance process.

Written and electronic records are easily audited and a clinician is held to account and ‘performance managed’ if these are found to be deficient or lacking. This can instill organizational fear and anxiety amongst staff. It increases the likelihood of practitioners recording excessively and defensively rather than documenting what is actually clinically relevant. Time spent completing paperwork reduces the amount of time available for direct patient contact. In recent years paperwork systems have assumed greater importance than the less

visible aspects of nursing care which cannot always be seen or directly measured. Records have thus become administrative rather than clinical tools and little more than an “elaborate accounting mechanism” (Allen, 1998, p.1229). Hardey et al. (2000, p.209) refer to this as the “Janus-faced” nature of documentation. On the one hand it serves as a valuable source of information and communication, by recording knowledge that influences and informs decision making and risk taking, and on the other, the same tool provides a means of organizational surveillance and scrutiny. It is a process increasingly used by managers to control and shape professional practice.

Staff are constantly required to reposition and realign themselves to ensure that clinical interests, one priority, are not overshadowed at the expense of the other, administrative ones. Failing to see the clinical relevance of complex administrative tasks which take nurses away from the shop-floor and the core business of caring, Parish (2007) questions whether the personal and professional principles of a clinician become compromised by organizational drivers, institutional values and government targets. This means clinicians are less likely to want to become involved in the initial process design of the latest ‘new system’ or to be committed to the development and maintenance of the auditing cycle needed to sustain it.

The involvement of nurses in the review of Trust paperwork systems and streamlining of complex bureaucratic processes, to ensure administrative tasks do not adversely detract from nursing, is supported by the Royal College of Nursing (RCN) (2009). The RCN recognize that paperwork needs to be relevant, ‘fit for purpose’, and needs to support clinical activity (the RCN is the professional body for nurses. It acts as a policy steer ensuring the views of its members are heard). Lack of clinical input, perceived value, and time pressures are often identified as the main reasons why implementation is not ‘owned’ by front-line staff (Lelliot, 1995). This is an obvious organizational barrier, since staff engagement is critical to its success.

The development of NHS metrics and clinical dashboards is seen as a practical next step in collecting and collating information to ensure local clinical services are relevant, transparent and open to public scrutiny. A clinical dashboard is a simple and visual graphical display of a number of pre-determined key indicators relevant to the clinicians for whom it is provided. Used to assess and monitor effectiveness and to drive up standards it will require staff to provide additional information on performance and quality outcomes. 'Metrics' are the measurements shown on the dashboard. It is argued that these 'real time' local toolsets will complement existing NHS initiatives by equipping front-line staff to deliver fast, efficient and effective care (NHS Health Informatics Report (PHI), DOH, 2008). These will be measured against national data sets and form a repository of local knowledge.

Awareness of informatics and their value has since been heightened through a development by the NHS Institute for Innovation and Improvement (2008) known as Releasing Time to Care: The Productive Mental Health Ward. One of the foundation modules of this programme is called Knowing How we are Doing and it introduces measurement systems that aid ward performance. This encourages wards to measure and track performance in areas such as direct care time, length of stay, patient and carer satisfaction and so on. The principles supporting the Productive Ward are discussed widely across the organization and eventually will inform the way all clinical teams work within an in-patient and out-patient community setting.

2.6 Summary

Surveillance can act as a 'street light' in the public domain protecting the many from the few, or it can act as a 'searchlight' in specific cases (The RAE, 2007, p.11). It is a multi-faceted process that requires scrutiny and examination in its own right. This research study will focus specifically on how experienced qualified mental health nurses feel about being unobtrusively observed in their everyday

clinical practice. Existing knowledge about the transitional support systems, actively welcomed by student nurses as they graduate to become newly qualified practitioners, formed the starting point of this inquiry. The importance of balancing workplace support to avoid disempowering experienced clinicians is recognized. Bentham's prison panopticon is described and Foucault's contribution through the metaphor of the clinical gaze is acknowledged. The changing culture of the NHS and the importance attached to audit and health care informatics is highlighted. The Department of Health Informatics Review (DOH, 2008a) and the introduction of metrics and clinical dashboards are briefly discussed. Chapter 3 focuses on the methodology supporting the research design and introduces the influence of Paulo Freire whose ideas are used to form the interpretive framework of the study.

CHAPTER 3

METHODOLOGICAL APPROACH

In this Chapter I discuss the epistemological stance I adopt and I explain my decision to write in the first person. The ethical tensions created by an insider practitioner research perspective are acknowledged and the principles of reflexivity are explained and used to help reconcile these. Freire, the man and his methods, theoretical and practical, are explored and used as the theoretical lens which 'positions' and influences my study. Problems associated with his approach are then discussed and used to personal advantage. The values I wanted to underpin my research are highlighted and form a thread running throughout the study.

3.1 The nature of knowledge

I am of the view that social scientific knowledge is inevitably not neutral, it is a political process created and re-created in an ever changing socioeconomic climate where some bodies of knowledge are afforded legitimacy and greater voice than others. Different political values will always mean that some ideas will be accepted by some and not tolerated by others. As an organization subject to changing political control the direction and 'acceptability' of NHS health care reforms and the individual's responsibilities within this system will always be contentious and driven by the interests of the dominant party.

I think that whilst there is a 'real world' 'out there' capable of being known, objective reality can never be 'captured' per se; it can only ever be represented and negotiated. Ideas are moulded and constructed through dialogue and lived experience, and knowledge will naturally vary in authority and in its potential to enable or limit. Whilst some beliefs will become commoditized and even reified to assume an unchallenged 'virtual' reality, others will not. Knowledge and sense-making are therefore socially constructed, subjectively based, value laden,

linguistically defined and influenced by our history and culture. The generation of ideas in this way means that knowledge can never be certain, never finished or infallible and always mutable and context dependent. Freire calls this stance one of epistemic uncertainty, and McLaren (1990), one “continually struggled for” (p.117).

The purpose of critical social theory is to “expose oppressions that may place constraints on individual or social freedom” (Wittmann-Price, 2004). Critical social theory is predicated on the fundamental premise that some groups are oppressed, marginalized, disadvantaged, disenfranchised and subjugated by the real or imagined socio-political dominance of others. Critical social theory epitomizes the work of Paulo Freire (1921-1997), Brazilian educator, philosopher and political activator whose ideas will be explored and then adapted for my own use later on in this Chapter.

3.2 My decision to write in the first person

I made the decision to write in the first person because I wanted to feel as though I was present within my text and I wanted to own my words. I felt I could not do either by writing in the third person as this seemed to remove and distance me from my study and the active part I had played in it. Most of the research papers I had previously read were quantitative experimental studies; I found them to be dry, remote and impersonal. Their sense of immediacy distanced by the formality of the language used, they lacked presence and authorial voice. Whilst I have learnt much from their content, I knew that given the opportunity I would want to try to enter into a real relationship with my reader and to engage their attention from the outset by being open, honest and visible. I also wanted to share my thoughts with my prospective readers as I went along by weaving my ideas and thoughts into my narrative. Writing in the first person gave me an opportunity to do both.

However, I did not find it an easy process. Writing in this way was awkward and it made me feel clumsy and inarticulate. It was not a style I was used to and it worried me that I might seem grandiose and egotistical when deliberately privileging my own centrality in the text (Jasper, 2005). It felt as though I was inflating my own importance and donning “a cloak of competence” (Hass and Shaffir, 1987, p.70-71) without having earned the right to do so. My fear was that I was adopting a façade others would easily see through. I felt intellectually phoney (Pinn, 2001) and very self-conscious when handing my preliminary work-in-progress to others to read and comment upon; people whose opinions I valued. It worried me also that they might think I had grown apart from them and forgotten that I was a front-line nurse who claimed she liked to get her hands dirty. I wanted to engage actively with my study participants, to hear what they had to say, and to ensure that neither my voice nor the voices of my participants were lost, muted or overshadowed by others. That would be the very antithesis of the focus group inquiry I planned to use in my research and antithetical also to the emancipatory and liberating messages embedded within the Freirean approach I was trying to adopt. My hope was that writing in the first person would allow me to strike the sort of balance indicated above, and so I persevered.

3.3 The advantages and disadvantages of insider research

I was aware of the potential tension created by my three competing roles of front-line clinician, colleague and researcher. I also recognized the conflicting power dynamic present whilst facilitating focus group discussions with team members I line-managed. However, I wanted to give participants a space to be heard and to feel valued, and I reasoned that the flattened hierarchy of contemporary mental health nursing would enable staff to voice their views openly and honestly, especially if I was ‘up-front’ with my colleagues and participants about these issues from the outset. I believed my approach would help us engage in dialogue that a research ‘stranger’ unfamiliar with the practice setting may not achieve. A few years ago the team I work with had agreed, albeit reluctantly, to participate in some shop-floor fly-on-the-wall research exploring mental health nursing practice

in acute in-patient settings. They felt uncomfortable with the idea of being questioned and observed by someone they did not know and the intended purpose behind this project was not as clear as it could have been.

The research consisted of a series of interviews and observations carried out across five NHS Trusts in South East England during 2000/2001. The findings from this research were published in a book called *Institutional Breakdown* (Clarke and Flanagan, 2003). As a front-line nurse on one of the wards involved in the study, it can still evoke powerful feelings of anger and betrayal in me as I reflect back on the experience. The book concluded by recommending the abolition of in-patient settings in their present form. My team was dismayed at the way we were portrayed. For weeks after the findings were published staff were left feeling confused, 'used' and misrepresented. Colleagues felt that much of their feedback had been taken out of context and that it failed to capture accurately the difficult conditions in which they worked. In addition, many staff questioned the motives behind the study and why the aims and intended purpose had not been made explicit. Punch (1994, p.186) calls this sort of approach an espionage model of research, where the researcher infiltrates the organization with their own secret agenda and then acts as an agent provocateur inciting indiscretion (Kirk and Broussine, 2000, p.19). I can still remember how professionally compromised I felt by an external colleague inveigling her way into our confidence, and then using it to her own academic advantage and without our ever having the right of reply. This remained uppermost in my thoughts, and cognizant of this I did not want knowingly to do the same. I found myself reflecting wryly on this experience as I sought ethics approval for my own study.

As an experienced nurse I felt I had ready access to the back stage world of mental health nursing and that this would allow me to 'get inside the heads' of my participants and to understand and make sense of what they had to say in a way someone from outside the profession may not. I thought my insider nurse status might enable me to gain insights that I may not otherwise have achieved. I also

hoped that by checking out my assumptions with staff I would avoid distorting their views. However, the ethics committee expressed concern that staff would feel unduly coerced to participate and unable to decline. They also thought that staff would say what they thought I wanted to hear and not what they really believed. Unable to reassure them to the contrary, I agreed to revise my recruitment strategy and invite study participants only from outside my own clinical area. In this way I dropped the role of colleague and simply became a nurse and a researcher. Whilst I felt a whole range of emotions following the initial ethics committee feedback, I had to admit there was justification for the decision they had taken and with the passage of time I was able to appreciate their perspective. I used the principles of reflexivity to help me achieve this.

3.4 Reflexivity

Reflexivity may be defined as the discipline of thoughtful, self-awareness and the sensitive analysis of the “inter-subjective dynamics between the researcher and the researched” (Finlay and Gough, 2003, p.ix). I used this process to try to recognize the assumptions and biases that I might bring to my own study. When I have been aware of them I have tried to make these explicit within the text. Van Maanen (1988, p.73) likens the process of reflexivity to a confessional tale, a transparent narrative of the self. Executed well, it seeks to act as a “springboard for interpretation and more general insight” (Finlay, 2002, p.215). Deeny and Chambers (2004) describe a similar technique they call re-oxygenating the experience; a process used to re-examine a situation and then make sense of it in the ‘here and now’. I tried to do this with action learning sets, project supervision and by talking my ideas through with my work colleagues. I encouraged them to ask me awkward questions in the belief that this would help me to challenge my own assumptions.

3.5 Paulo Freire – the man and his method

I believe that introducing my ideas about Paulo Freire and discussing his influence on my own study helps explain the rationale for choosing the

methodology and the tools I have employed. Paulo Freire was an educator, liberator, and teacher. Born in 1921 in Recife in the state of Pernambuco, North East Brazil, into a middle-class Catholic family, Freire experienced first-hand the consequences of the Great Depression of 1929 (Freire, 1993a). He described how, at an early age, hunger had an impact on his ability to learn, and he openly shared these experiences in later life to demonstrate the possibility of triumph in the face of adversity (Freire, 1993a).

Freire recognized education as an important social tool in overcoming oppression. Seeing the illiterate person as empty, marginal, and subordinate, he describes this as “the concrete expression of an unjust society” (Freire, 1985, p.10). In 1963, Freire worked with Brazil’s Minister of Education, President João Goulart, on a large scale literacy campaign, teaching agrarian campesinos (farm and land workers) to read and write and thereby enfranchising them at a time when only the literate could vote.

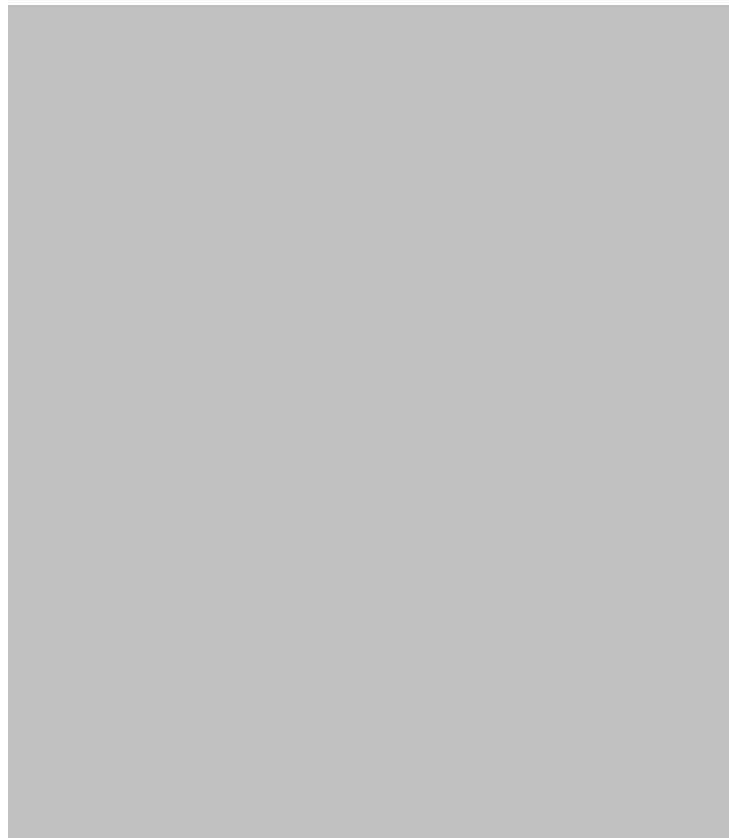
3.6 The influence of Freire on my study

I first became aware of Paulo Freire in the late 1980s. As a mature general nurse doing my RMN (Registered Mental Health Nurse) training with a small cohort of five peers, I remember being instantly attracted by the powerful sense of partnership and collaboration that emanated from Freire’s thinking. I can still vividly recall the main themes of his work that the tutor tried to convey. There are no teachers and no pupils, only those that have knowledge and those that do not. Some of us are old and some of us are young. Some of us have done things and some of us have not. It is the dialogical exchange that we have with people that is important and which leads to the greatest learning. Freire (1993a, p.61) put this rather more eloquently: “no one teaches another, nor is anyone self-taught. People teach each other mediated by the world.” He strongly rejected the idea that students were empty vessels passively waiting to be filled with knowledge by the teacher. Instead he believed the two should work together and learn

alongside each other (Freire, 1993a). I have tried to do the same in this study by using focus groups and I believe I have learnt much during this process.

An epiphany moment came in my thinking the first time I saw the Italian Renaissance artist Raphael's beautiful fresco *Causarum Cognitio* (Knowledge of Causes), more popularly called *The School of Athens*. Painted for Pope Julius 11 around 1509 and 1510, it depicts Greek Philosophers Aristotle and Plato, the two key protagonists of the fresco, walking in a peripatetic style through the Lyceum. The face of Plato is popularly believed to be that of Leonardo Da Vinci.

Figure 3.1 The School of Athens



Obtained from www.wikipedia.org/wiki/TheSchoolofAthens Accessed online 14th November 2007 'Original in Colour'

As can be seen, Plato is holding a copy of his *Timaeus*, a theoretical treatise, in the form of a Socratic dialogue. He is pointing up to the ethereal heavenly realm and is wearing clothing denoting the fire and air elements. In contrast, Aristotle is

holding a copy of his *Nicomachean Ethics* and is motioning downwards towards the ground. His brown and blue robes indicate the elements of water and earth that represent the grounded and material. Together they seem engaged in a creative dialogical exchange in which “the learner assumes the role of knowing subject in dialogue with the educator” (Freire, 1993a, p.29). For me this picture epitomises the central tenets of Freire’s philosophy, advancing knowledge through the development of an egalitarian ‘working with’ relationship which does not manipulate, domesticate or sloganize (Freire, 1993a, p.149).

Freire maintained that authentic thinking does not take place in ivory tower isolation; rather it is a co-operative inquiry facilitated by communication in the real world (Freire, 1993a). He maintained that the empowered teacher not only teaches but also learns, while the students, in being taught, also teach. This is achieved through a dialogical co-production and not a monological method (Freire, 1993a). I deemed this somewhat ironic at the time as I remember it being taught in a didactic teaching style where the tutor stood at the front of his class and spoke at, rather than with us in the “sleepy sonority of the teacherly voice” (Shor and Freire, 1987, p.124). It was Freire’s *bête noire*, the “banking system of education, narration sickness” (Freire, 1993a, p.52) at its very best! Freire rejected the idea of the teacher personified as a “depositor, prescriber, domesticator” (Freire, 1993a, p.56), which he described as anaesthetizing and inhibiting. He believed that education was a political activity and could never be neutral. It could either domesticate people or help to liberate them. He also believed that knowledge should not be imposed upon learners and that given the right environment and conditions everyone was capable of learning. Whilst I can clearly recall the obvious dissonance between what was being said and the way it was delivered Freire’s ideas made a lasting impression on me.

I can remember thinking how down to earth and practical Freire’s philosophy seemed. Freire lived the pedagogy he taught and as a student I aspired to develop the qualities of integrity, fidelity, humility and respect Freire conveyed. It

was therefore with a sense of eager anticipation that I obtained a worn copy of his *Pedagogy of the Oppressed* (1970)³ from my local library. I wanted to absorb its contents and make it my own practice reality but it proved far from easy reading. I felt sadly let down by what I perceived at the time to be esoteric and obscurantist language. Freire wrote *Pedagogy of the Oppressed* during his sixteen years as a political exile and yet this book seemed to distance him from the very people, the dispossessed and marginalized campesinos, for whom he had lost his liberty. It was full of neologisms and abstract, idealistic, esoteric language far removed from the culture circles he facilitated in the shanty towns and slums of Brazil. It has required many re-readings to unravel and make sense of his views. I now think I understand the basic concepts, but I still have difficulty with some of the finer philosophical points and I have sought secondary sources such as Taylor (1993) for clarification before returning to Freire's own words. I found his talking books, a series of dialogues with Ira Shor (1987), easier to comprehend. Even so, unused to this style of informal narrative and active engagement with the reader, I found myself feeling immersed in the script of an experimental and creative play. I had to keep reminding myself I was being invited to transform my own world by first becoming critically aware of it and that I was not simply passively reading a dialogue between two like-minded friends.

Freire (1993a) proposed education as an active, participatory dialogical or conversational process involving problematization of lived experience: "the students - no longer docile listeners - are now co-investigators in dialogue with the teacher. The teacher presents the material to the students for their consideration, and re-considers her earlier considerations as the students express their own" (Freire, p.62). As the facilitator of my own focus groups I planned to engage participants in a discussion about how it felt to be unobtrusively observed, to try to understand how it felt from a front-line nurse's perspective. I then planned to use this to help inform future practice. Freire calls this approach praxis. Praxis is action; it is the synthesis of theory and practice in

³ My study is based on the 1993 version.

which each informs the other. It is a dialectical cycle of action - reflection - action linked to values and the creation of generative themes (complex experiences charged with political significance). This can awaken and reawaken critical consciousness by liberating and empowering social action for change. It is the pedagogy of possibility. Praxis according to Freire is pivotal to liberation. It is the process by which we obtain mastery and self agency and transcend the collusive actions in which we unwittingly, naïvely and passively participate. Praxis is characterized by self-determination (as opposed to coercion), intentionality (as opposed to reaction), creativity (as opposed to homogeneity), and rationality (as opposed to chance). It is a continuous process.

For Freire this approach was not without problems. Whilst I obviously did not envisage the obstacles faced by Freire, I was still aware of the tension that can be created by performing emotive and often sensitive research in my own field of practice. This is a thread that runs throughout Duncan-Grant's (2001) critical organizational ethnography of clinical supervision activity, among mental health nurses. In it he highlights the importance of the management of organizational emotions to avoid the real sense of personal isolation that can be experienced when unknowingly set up as a champion in one's own field of research practice.

Duncan-Grant (2001) identifies the unspoken return expected by Trust sponsors and policy makers who have invested time, money, and often their own credibility in supporting student doctoral research. He highlights the need to separate the organization's management of its own emotion from the values of the researcher, recognizing (in this case) the social construction of what observation might mean for the Trust at a corporate level. The normative power differential invested in the hierarchical scalar chain, privileged groupings typical of large bureaucratic corporate organizations (such as the National Health Service (NHS)), and the perceived threat posed by an insider-research perspective (which might unsettle the dynamic), were important principles I needed to heed in the planning stages of this research.

I was mindful of the occupational fate of Duncan-Grant who thought it necessary to move and change roles because he felt unsupported by the Trust where he was undertaking his research. I was also mindful of the quotation at the beginning of his ethnography: "If a man does not keep pace with his companions, perhaps it is because he hears a different drummer. Let him step to the music which he hears, however measured or far away" (Thoreau, 1999, p.290). Duncan-Grant (2001, p.191) described how some of his colleagues privately supported his ideas but nevertheless felt that publicly they "needed to distance themselves" from his research project and his ideas because they "challenged the organizational hegemony" (p.192).

I was very aware of the potential for producing an overly sanitized piece of work that would not be an accurate representation of what staff really felt by setting an unconscious tone (by my own actions and words); by somehow communicating what I would and would not allow to be voiced in my focus group sessions. I risked knowingly undermining and silencing or gagging my prospective research participants by providing a forced dynamic, and whilst I was a work colleague in a different setting, I knew from an early stage in my research that I would need to create psychological and emotional distance when I donned the cloak of an insider researcher. My desire to please the Trust as one of the major sponsors in my research process and to write what they wanted to 'hear' needed to be brought to the fore, acknowledged, owned, and then deliberately bracketed to avoid my writing an account that won corporate approval whilst bearing little credible resemblance to the tensions and emotions actually voiced by front-line clinicians. Inevitably this required a degree of authorial pragmatism on what I included and judiciously edited in the final account and it tested my ability to 'think on my feet' during focus group sessions. Asking difficult and awkward questions (Ballinger, 2003) in my own practice arena was potentially a lonely business. I can never be certain that I achieved textual balance or represented

views accurately. However, I was aware of this and the transparent audit trail which was in place for the study helped to monitor progress.

3.7 The value of adopting Freire's methodology in my study

I found Freire's methodology persuasive, convincing, and credible. Freire recognizes the ability to change even when oppressed by a dominant ideology that favours another. He acknowledges the practical consequences of challenging the dominant discourse and he describes these using his own personal experience. His ideas sit comfortably within the domain of contemporary mental health nursing where nurses, like Freire, often feel submerged in a culture of silence; here they feel they lack the legitimacy to compete successfully against the dominant medical discursive frameworks embedded within nursing knowledge (Cheek and Rudge, 1994, p.585). This leaves nurses feeling impotent and marginalized, lacking influence and voice. Burkhardt and Nathaniel (2002, p.17) argue that "nursing today is at a crossroads, free of many of the restrictions of the past", but "yet not fully franchised as a profession with power and authority." Lacking the critical consciousness to engage in political struggle, nurses, I believe, need to bring to the fore their marginal voice by 'reading their world' and then transforming it, becoming more than "the weak echo of the medical voice, saying what has already been said, voiceless on those matters that are at the heart of nursing practice" (Parker and Wiltshire, 1995, p.151). To achieve this change I suggest nurses need to engage and debate in a meaningful discourse with those traditionally seen to be in authority, asserting their own informed views. Before we can do this, however, we first need the courage to recognize and believe that we have an important contribution to make and we need to formulate and own our own ideas and opinions. I feel that Freire's methodology and the tool of problematization offer us the scope to achieve these goals and I wanted to use my research to facilitate this process.

Freire acknowledges that challenging the status quo can involve risk and requires a willingness to move away from the comfortable and familiar. This struggle of confrontation he calls a transformative process (Freire, 1993a), whereby in transforming one's world one also transforms oneself. He argues that it is man's fundamental "ontological and historical vocation to be more truly human" (Freire, 1993a, p.37). Watson (1999), a respected nurse theorist, agrees and maintains that the discipline of nursing is experiencing its own ontological insecurity about what it is and what it should be. This is something not many nurses will have thought about in any great depth. Giving front-line clinicians time away from the responsibilities and distractions of their core business and the opportunity to engage in a meaningful debate with peers is an important first step in heightening self-awareness. Developing the confidence to speak and find your voice without fear of ridicule takes great personal courage. I hoped my participants would feel able to discuss their ideas with honesty and, in so doing, gain personally as well as give something to the process. This involves a concept which Freire calls critical consciousness.

Critical consciousness is an individual's ability to read political situations, and to overcome inequity and socioeconomic injustice. It involves "inserting yourself into your own history by naming the word/world. By doing this the word becomes the reality" (Taylor, 1993, p.35). In my opinion critical consciousness can be likened to the process of gaining psychological insight by the breaking of fixed rigid dysfunctional behaviour patterns. Awareness and a willingness to change and grow are elements of an iterative process requiring critical self-appraisal. Critical consciousness involves an understanding of the underlying dynamics that foster, fuel and maintain current behaviour as a limiting situation to be overcome (Freire, 1993a). It involves confronting contradiction, distorted thinking and the perceived social superiority of some ideas over others. Passive collusion and victimization help maintain the status quo by avoiding reality and the discomforts of change. This process can assume many different guises. It can cushion and buffer or it

can act as a catalyst to enable the individual to take personal responsibility for their own thoughts, feelings and behaviour.

I had been fascinated by Freire's ideas for years and wanted to see whether they would translate into a modern health care setting where nurses might learn from the underlying simplicity (disguising a much deeper complexity) of his message and benefit from the potential liberation that it promised. This was a model that I felt sat comfortably within the domain of nursing. Like Freire, mental health nurses regularly employ a "syndicate of theories and insights" (Taylor, 1993, p.6) and mix and match their methods to therapeutic advantage. A skilled clinician knows that what works well with one patient will require adaptation and modification if it is to have the same success with another. An inflexible, one size fits all approach does not translate well into a mental health setting where patients' needs vary tremendously. Underlying this skill is a desire to know the patient, to hear what is not being said, and to see what is not visible. What is important is an ability to see beyond the obvious. Underpinning this approach is the development of an authentic engagement in a practical and meaningful dialogue. This means that nurses need to select their vocabulary with patients on an individual basis so that, unlike my first encounter with Freire, they are not 'put off' by complex technical language or jargon they do not understand.

I was mindful of placing a contemporary spin onto work originally written in the nineteen seventies knowing the political and economic climate and landscape of the present was significantly different. Freire however was less concerned about this. He actively encouraged his readers to use his methods as they saw fit: "I don't want to be imported or exported. It is impossible to export pedagogical practices without reinventing them. Please, tell your fellow American educators not to import me, ask them to recreate and rewrite my ideas" (Ayers, 1998, p.3). I have honoured this admonition and by using Freire's framework as a sound and credible platform from which to build and subsequently develop my own ideas I

have made a number of specific recommendations which are discussed in Chapter 7.

Freire used culture circles (trade unions) as a way of engaging workers in meaningful dialogue outside a formal classroom setting. He asked them to identify core words which were often charged with local and political significance and had personal meaning and a lived reality in their lives. This he called the vocabulary universe of the people. In his first book, *Education: The Practice of Freedom* (1976), Freire identified 17 core words used in the state of Rio Grande de Norte which constituted such a vocabulary. These included 'favela' (slum), 'chuva' (rain), 'arada' (plough), 'terrano' (land), 'comida' (food), 'enxada' (hoe), 'tijolo' (brick), and 'riqueza' (wealth). Freire called these 'generative' words and often portrayed them in a visual, pictorial and realistic codified form. Using a process called decodification the word and picture were broken down into component parts or parsed syllables. New words were generated from each of the newly formed syllables. Freire maintained that since culture is transitory, made by people, it can also be transformed by people, just as people are transformed by it. He called this transformation process breaking the culture of silence. It has become closely associated with the Freirean Literacy Method.

I have adapted his interactive approach for my own study and have used the contemporary equivalent of a collage (theme board technique) and focus groups. I wanted staff to spend time gathering pictorial images of everyday situations from coffee-table style magazines that might help them think creatively about their job and the ways they might feel unobtrusively observed. Like Freire I wanted staff to select images and text that had work-based meaning and relevance to them, rather than impose my own ideas or vocabulary. I then facilitated a semi-structured focus group discussion. I did this to encourage nurses to engage in a dialogical conversation with each other, enabling them to reflect on their own practice reality in a way they may not have considered previously or be able to do on their own.

3.8 Critical commentary

Freire's methodology *per se* is not without critics, "pilfered piecemeal" by many (p.6) for their own cause. Gibson (1994) argues Freire's philosophy has assumed an iconic reified commoditized status and, internal contradictions and inconsistencies within his work are often overlooked as a consequence. Gibson (1994) gives the example of the master-slave (oppressor-oppressed) relationship frequently cited by Freire, pointing out that issues around racism are never addressed or resolved in any systematic way in Freire's texts.

Freire's early work is dense and it is full of mystical principles and abstruse *izations* that can make his ideas seem inaccessible and difficult to comprehend. He is often accused of being idealistic, unrealistic and utopian (Taylor, 1993). In his early writing Freire offended the women's movement with his use of sexist language ('man', 'men' 'he', 'his' and so on). This was not his intention; he was simply writing using the literary conventions and norms of the time, and he was happy to amend his work (or have it amended) to make it gender inclusive and to reflect the changing zeitgeist.

Freire placed great personal importance on getting to know and understand the real issues of local people and "considered himself a man of the harsh frontiers of Northeastern Brazil" (p.5). He extolled the value of living among the oppressed to do this and yet as the Minister for Education for many years he was based in Sao Paulo Brazil, the largest and most industrialized city of the country, distanced from these realities. Freire used his experiences to develop the dialogue of literacy and he used phonemic flash card lists or sight cards as a practical teaching aid. Flash cards or slides were used to aid word recognition and the choice of words put on them was generated from the discussions he facilitated with local culture circles. Taylor (1993) and Gibson (1994) note, however, that many of these lists contain the same words (such as 'tijolo' and 'voto' (brick and vote)). Taylor and Gibson question the extent to which the words were

constructed by the influence of the group facilitator. Both suggest independently of each other that culture groups conducted in regionally diverse areas such as slum cities, coastal towns and agricultural colonies are likely to have had different 'here and now' issues and are unlikely to have generated the same words, unless the groups were heavily prompted to do so.

The subtleties of language (verbs, adjectives, pronouns and so on) are also understated in Freire's pictorial codification technique which relies exclusively on nouns. As Taylor (1993) notes, if Freire explained how words are connected to each other using this method, he did not record it formally. In addition, the social nature of liberation represented by family, community, friendship circles and so on is also absent from this approach and yet recognized elsewhere by Freire as being a significant catalyst in the liberating process.

Freire claimed to value dialogue and the importance of discovery learning, seeing education as a collaborative process and a co-operative inquiry where "knowledge emerges only through invention and re-invention, through the restless, impatient, continuing, hopeful inquiry human beings pursue in the world, with the world, and with each other" (Freire, 1993a, p.53). Doubt has been cast on this by Taylor (1993) who suggests that the flash card lists are simply primers or prepared texts and thus a benign or enlightened form of Banking Education. Freire steadfastly maintained that education was always a political act and it could never be value neutral. Yet he encourages the teacher to become neutral by adopting a 'not tell but question' classroom attitude - these two approaches contradict and cannot be reconciled.

Taylor (1993, p.34) refers to Freire as an "erudite poacher who sought out and repossessed other ideas in order to enlarge and restock his own intellectual domain," later noting that "it is not possible to unravel neatly the diverse skeins of influence in the multi-layered appliqué of his thought." In addition to this eclectic interpretation, many Freirean critics observe that he still never defined his

understanding of the concept of oppression or the term literacy, leaving this for others to explain. Despite all these shortcomings his critics remain his fiercest admirers and the contribution he has made as an informal liberator and thinker is acknowledged as a promethean legacy.

Mindful of these shortcomings I have chosen to adopt a writing style that is inclusive and accessible to a wide and diverse audience. To aid clarity and comprehension I have defined the operational terms that I have used and I have invited and thoughtfully responded to the editorial comments that I have received about my study design and my 'position' within it. Like Freire I value a practical 'hands on' approach to understanding and I take ownership of the limitations, flaws and contradictions within my own study. I believe that, by making these transparent and explicit, I will enable my readers to gain a greater sense of 'me' as a person and as a practitioner researcher, and also of the principles I value.

3.9 Conclusion

Influenced by the ideas and theoretical perspective of Paulo Freire I have used an ice-breaker theme board technique (collage) and focus group method as a questioning and dialogical approach to engage nurses in an informed discussion about how it feels to be unobtrusively observed. These are practical tools which raise conscious awareness, promote praxis, and fore-front the emancipatory and often untapped power potential within shop-floor nurses. This process harnesses the liberating potential inherent in social activity and the collective construction of knowledge. Chapter 4 will describe how I put these tools into actual practice.

CHAPTER 4

THE TOOLS AND METHODS I USED IN MY STUDY

This Chapter provides the rationale behind the practical tools I selected to engage participants in my study and it explains how I selected, recruited and analyzed the data thematically and used Freire as a theoretical lens for exploring and understanding the data. The Johari window model is introduced and then used conceptually as a reflective tool. This is a theme I will return to in Chapter 6 of the study when I use the model to help capture the group process in developing collective understanding. Study measures and participant characteristics are discussed and practical details of the focus group interview schedule, equipment and the procedure I followed are provided. The reasons behind the decision to use a collage technique and focus group design are then explored moving from the theoretical reasons through to the practical ones. In setting out the structure for this Chapter I have adopted a systematic approach and I have used a number of sub-headings to help guide and signpost my reader through the maze of ethical and pragmatic decisions I needed to make as an insider-researcher during the study. The transcription process, project management and the study dissemination strategy are also detailed.

The Nursing and Midwifery Council (NMC, 2008, p.5) observes that nurses have three things in common, “experience, knowledge and opinions”, and it recognizes these are “traits that can’t be bought, they can’t be sold, but they can be shared.” I wanted to design a study that would identify and then record how nurses felt about being unobtrusively observed at work and I appreciated that, to do so, I would need to create an environment in which they would feel psychologically safe. I used the practical tools of collage and focus groups to help me achieve this. Reflection and the theoretical influence of the Johari Window informed my thinking and are now explained.

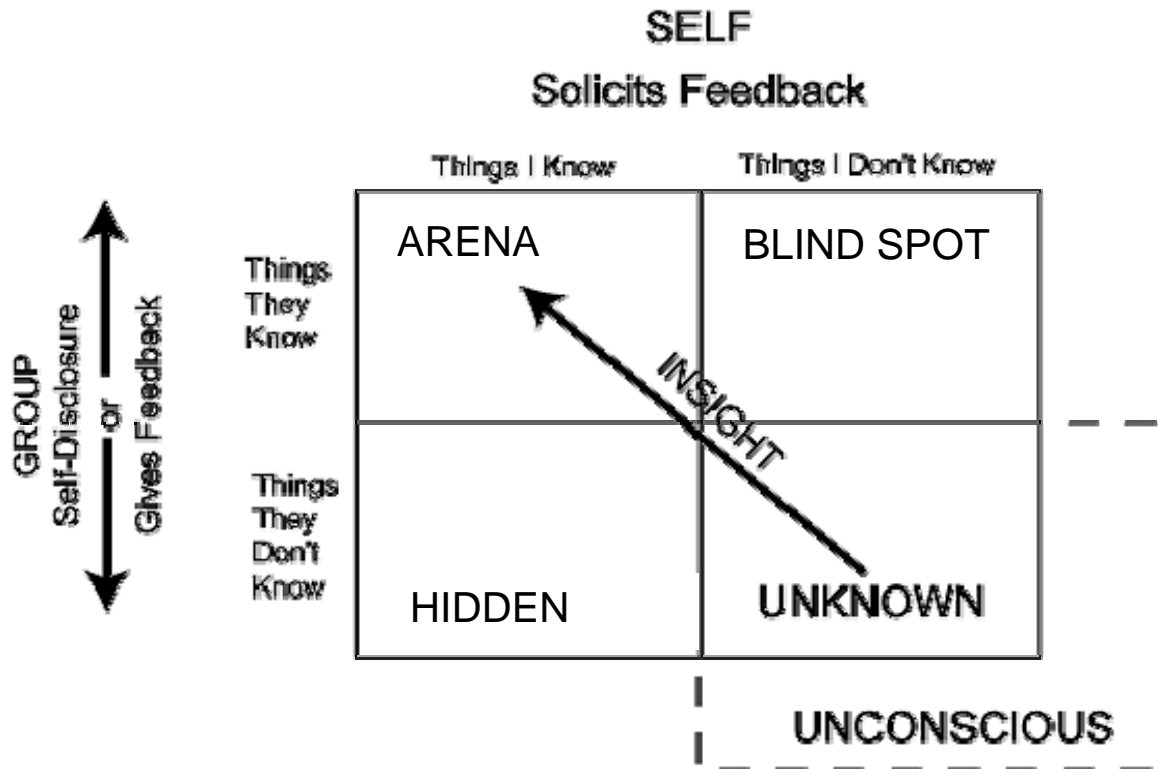
4.1 Reflection and the theoretical influence of the Johari Window

Peshkin (1988, p.17) notes that one's subjectivity is like a garment that cannot be removed. It is persistently present in both the research and non-research parts of our lives. Contemporary nursing theory places increasing emphasis on the positive role that reflective practice plays in enhancing professional development and heightening self-awareness. Reflection can be defined as permission to break from 'performing' in order to consider the 'performance' and the need to plan future 'performances' (Joiner, 2002, p.74). This process promotes critical thinking (Hahnemann, 1986), links theory and practices (Schön, 1983), empowers practitioners (Carr and Kemmis, 1986), and promotes social and political emancipation (Smyth, 1992; Heath and Freshwater, 2000; Johns, 2001). Freire (1972, p.99) argued that critical reflection is an integral step towards action. Paul (1995) expounds the virtue of Intellectual Courage: awareness of the need to face and fairly address ideas, beliefs or viewpoints which have not previously been considered.

I used the Johari Window model of self awareness as a vehicle to help drive this conceptual process forward. The Johari Window is a metaphorical information processing tool or 'disclosure/feedback' model developed by American psychologists Luft and Ingham (1955) during their research into group dynamics. I found this to be a useful and practical tool and in Chapter 6 of this study I have used it to help consolidate and summarize my study findings.

The Johari Window consists of four quadrants or windows of self awareness. An example of a blank window can be seen in Figure 4.1.

Figure 4.1 Empty Johari window



For artistic convenience the window quadrants are classically depicted as equal in size, but in reality they have permeable boundaries determined by the degree of openness and insight disclosed by the individual or organization using this model.

The Johari window panes are interdependent. As the size of one pane changes it forces the corresponding panes to alter. The 'Arena' or 'known to self and others' pane of the quadrant is knowledge which is freely known or publicly shared. The larger the 'arena' quadrant of the window becomes, the fewer 'secrets' the person or organization has to hide. It is therefore indicative of a more open and transparent culture. The 'Façade' or 'hidden' quadrant of the window contains information only known to the individual and no one else. It is the 'public' face or 'social mask' individuals present to others. Self disclosure is therefore required of

the individual possessing this information if they are to share it with those who do not have it. This involves an element of risk; once the information is shared it cannot be retrieved and it is not always possible to determine in advance how the information revealed will be received by a third party. This means that disclosure can have important individual and organizational consequences (emotional, financial, legal and so on). The 'Blind spot' or 'unknown to self' quadrant of the window consists of information known by others but not perceived by the individual. It typically includes weaknesses and ego defences which unconsciously shield the individual from stress and tension. Left unchecked it has the potential to fester, and can become dysfunctional, and inhibit role growth. It can be accessed by feedback and self development. The 'Unknown quadrant' (unknown to self and others) of the window can be defined as collective ignorance. It is information that cannot be accessed by anyone.

I applied this model at a theoretical rather than practical level to develop my own awareness. For practical purposes information can be crudely divided into the following four domains:

- Accessible/will share
- Inaccessible/will share
- Accessible/will not share
- Inaccessible/will not share

The aim of research using this model is to increase collective knowledge and understanding in the 'Arena' quadrant of the window and to facilitate the safe disclosure of information in the 'Façade' window. I sought to increase information in the participants' Accessible/will share domain of the Johari Window. I also used it to access information in the 'Unknown' domain and to help focus group participants to become more aware of their own individual and group blind spots.

Focus group discussions, preceded by magazine picture collage (theme board) exercises, were used to raise the groups' conscious awareness of being

unobtrusively observed in their everyday clinical practice. In so doing, it naturally tapped into the inaccessible/will share quadrant of the model by encouraging participants to 'give voice' to previously unarticulated ideas. Quirk et al. (2006) recognize contemporary mental health units as 'permeable institutions' and the Johari Window model provided an excellent tool for accessing this permeability. It enabled participants to embrace altered insights by checking out assumptions and ideas with peers. The lines dividing the four panes of the window are arbitrary and often likened to window shades, which can move vertically and horizontally as information changes. This happens through a process called feedback solicitation. Trust and a willingness to take risks in the safety of a group setting increased the possibility of nurses disclosing information that ordinarily would remain unspoken and unprocessed in the Accessible/will not share domain of the window.

The Johari model recognizes that growth and understanding are a function of shifting ideas and norms and, like Freire, it celebrates the view that the more we know about ourselves the more self-determination we have (Hase et al., 1999). This is captured from an organizational perspective in the Modified Johari Window displayed in Table 4.1.

Table 4.1 Modified Johari Window and the Dark Side taken from Hase et al. (1999)

	Things I know about myself and I am prepared to disclose	Things I know about myself and I am not prepared to disclose	Things I don't know about myself
Things others know about me and they are prepared to disclose	<i>The Open Arena</i>	<i>Threat Powerlessness Ambush Blackmail Whistle Blowing Manipulation</i>	<i>Blind Spot Dissonance Surprise Despair Ego Defence</i>
Things others know about me but they are not prepared to disclose	<i>Embarrassment Exhibitionism</i>	<i>Conspiracy of Silence Co-dependency Collusion</i>	<i>Glass Ceilings Horizontal Violence</i>
Things others do not know about me	<i>Deviance</i>	<i>Self-protection Deceit Secrets "The Lie" Façade</i>	<i>Stereotyping Prejudice The Unknown</i>

4.2 The role of the collage exercise

A magazine picture collage, also commonly called a theme board, was used as a preliminary ice-breaker exercise. I experienced first hand the creative potential of collage during a first year professional doctorate workshop facilitated by a tutor at the University of Brighton. Initially sceptical and cynical about its value, I learnt quickly to appreciate the part collage could play in stimulating and capturing ideas in a visual medium. I have since used this technique on many other occasions with different audiences over the last five years, and I am pleased that I made the decision to take a risk and experiment with a new tool as I believe that it has paid dividends.

Freire (1993a, p.54) stresses the importance of avoiding what he called the digestive concept of knowledge where “the teacher chooses the words and then proposes them to the students” and a collage strategy enabled participants to create, construct and then talk about their own emerging themes. It did not ‘force’ new ideas or de-contextualize existing ones and it seemed a natural starting point for the dialogue that would follow in the focus group discussions.

The naturalistic component of focus groups is particularly rich when respondents know one another (Wilkinson, 1999; Kitzinger, 1994) and the collage was used as an opportunity to encourage nurses to talk together and to share ideas in small groups. As group members became absorbed in the shared nature of the task I hoped that they would become relaxed and feel comfortable around their peers in preparation for the main focus group. As they became less self conscious within a group setting I anticipated that participants would ‘behave normally’ with each other and want to crack jokes, argue, chatter, support one another and talk ‘over each other’ as they would naturally in their own practice-based setting. This would help to create and harness a natural environment in preparation for the focus group session that followed.

A group creative ice-breaker exercise can also act as a catalyst and encourage people to think imaginatively and innovatively together (Coats, 2006). I hoped it would promote a permissive culture, helping to overcome participant reticence and lower natural anxiety. Collage is a technique that involves a strong visual approach (Parsell et al., 1998) and it helps “crystallize ideas into easily understood patterns” (Bligh, 1992, p.183). It contrasted markedly with the verbal bias inherent in the main focus group discussions which I also planned to use, and it provided useful balance.

Participants were asked to individually flick or browse through a selection of glossy ‘coffee-table’ style magazines and Sunday paper colour supplements, chosen for their high visual content. They were then asked to cut or tear out any

pictures, images or slogans that showed how it felt to be unobtrusively observed in their clinical practice. An image of a female holding a child, which could be seen as either positive, supportive or nurturing or conversely parental and controlling (depending on how the image was perceived by the individual), was used as an example. I explained that this was a simplistic interpretation based on obvious polarities and that there may have been many other ways of viewing this image. Colleagues were advised that they could approach the task in any way they chose and were made aware that title and word cuttings could all be used on the final collage. The collages were photographed using a digital camera and can be seen embedded into Chapter 5 and Appendix 12 of this study.

I quickly realized that staff did not appreciate me purchasing new magazines for them. Many commented it was sacrilegious to tear up their favourite glossy magazine before they had had a chance to read it in the privacy of their own home. There was lots of laughter as they inevitably chose to read the text out loud, typically the problem page, or shared celebrity gossip not known or forgotten about. I had been concerned that they would think the idea of producing a group collage childish and tried to reassure myself that it was a credible Freirean technique regularly used by allied health disciplines with good results. I was enormously relieved that staff genuinely seemed to enjoy doing something clearly very different from the routine of their usual working day. They visibly relaxed 'into' the activity and I gradually learnt to do the same by 'trusting the process'. Some groups chose to stick their pictures and text on individually as they went along, negotiating use of the shared space with their colleagues. Others 'nominated' one person from within the group, recognizing from the outset that the end result did not really matter.

Using this technique participants were encouraged to begin to think creatively about the meanings and feelings they attached to being unobtrusively observed; it was a tool that I used to help foster an atmosphere where meaningful "relationships formerly unperceived" could be explored (Freire, 1972, p.33). I

used the collage as a practical and modified codification tool, as Freire (1993a) recognizes codification as a process that enables critical reflection. Codification in this context is the representation of reality by the visual medium of the magazine pictures.

The images and metaphors provided by these group collages were used by some, but not all, as material for focus group discussion. Collage is a powerful, innovative and hands-on creative process that often triggers comments and free associations that would not have been generated using other mediums (Landgarten, 1994). I hoped that individuals, having focussed on their contribution towards their group collage, would feel less self conscious talking to each other, as they would already have established a working relationship through the completion of this preliminary task.

I advised groups that they had about forty-five minutes to complete their collage and they were given access to a table, chairs and materials (scissors, glue, magazines, A1 size card and so on). I gave staff a time prompt after thirty minutes. Refreshments were freely available during the collage exercise. The magazine picture collage, and focus group meetings were facilitated in a relaxed, comfortable and (where possible) neutral environment away from the direct clinical areas. This was in a room away from the busyness of their usual working environment and at a mutually agreed venue, near enough to their usual work base to avoid impacting too much on their working day. The creation of a relaxed and permissive working environment was recognized as essential.

Participants were seated casually for the collage exercise and in a circular arrangement for the focus group discussion. This enabled clear lines of vision to enhance communication pathways. Having introduced the collage task I stayed in the room with the group but tried, as Hansen (2006, p.131) suggests, to 'fade into the background' to avoid the perception that I was observing what I wanted to be a fun, relaxed session. I used the time to prepare mentally for the focus group

discussion. However, this was not always possible and sometimes I naturally found myself becoming part of the group, sharing humour and anecdote as they 'gelled' together. I did not tape group dialogue during these collage sessions and I made this clear at the beginning of the exercise.

The images and ideas produced using this technique were used to develop personal and group insights that may not have been readily memorable or available without such a trigger (Ferszt et al., 1998). I did not use health-related magazines or trade journals. Bligh (1992) notes that these are often too text laden to be of practical value and they can stop people naturally thinking outside a medical or nursing framework.

Although magazine picture collage can be used to assess and treat people in therapy as they identify and project their ideas onto their work (Landgarten, 1993), such skills lie beyond my own expertise, or the intended aims of this research. Participants were advised clearly that there was no right or wrong way to approach the task, and that the collage was simply a vehicle for promoting discussion. They were also advised of the non-competitive and collegial nature of its focus. Wilkstöm (2000) (cited in Williams, 2002, p.57) notes that: "there are no absolute truths or facts when visual art is discussed, argued about and debated," a view which complemented the Freirean philosophy underpinning my own study.

4.3 Focus groups

The role focus groups played in generating the primary data in this study is now explained. I recognized the value of using a focus group approach for a number of pragmatic reasons. I felt that staff would be more likely to take part in my study if they thought that they could discuss the participant information sheet with others who might be attending. As previously identified, nursing is an oral tradition and I thought that they would value time spent talking together collegially more highly than time spent completing an impersonal anonymous survey or

questionnaire on their own. I hoped that they would want to be involved in the chance to do something different. I also appreciated the practical difficulties and time pressure of capturing individual views.

I am also aware of the limitations associated with a focus group design. Small focus group numbers may have compromised the anonymity of my participants and it is possible that colleagues within the local mental health field will be able to recognize contributions from their peers. This had not been intended. Coding the data to provide a transparent audit trail, together with the thumbnail detail used to introduce the transcript vignettes, will have increased this likelihood. The meaningfulness and the transferability of my findings to other practice settings will be diluted as a consequence of these reduced numbers. Balancing the need for focus group structure without compromising the spontaneity of group dialogue whilst also being conscious of inevitable time constraints also proved a challenge and I was ever mindful of remaining faithful to the Freirean principles I had opted to adopt in this study.

Focus groups are an effective method of exploring areas of uncertainty (Jackson, 1998). They can be defined as a technique “using a semi structured group session, moderated by a group leader, held in an informal setting, with the purpose of collecting information on a designated topic” (Carey, 1994, p.226). The effectiveness of focus group techniques in generating rich description in nursing research is well documented (Reiskin, 1992; Dilorio et al., 1992; McDaniel and Bach, 1994; Crawford and Acorn, 1997).

Focus groups have also been described as “a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment” (Kreuger, 1994, p.6). They are recognized as an effective tool for gathering meaningful and unique insights about an individual's experiences and the concepts that have shaped their beliefs. Focus groups “examine not only what people think but how they think and why they think that

way” (Kitzinger, 1995, p.299). They can be used as the primary source of data collection and as a self-contained technique (Morgan, 1997), or as I did, in conjunction with other methods. They provide a natural opportunity to learn alongside the participant (Madriz, 2000). Freire (1993a, p.53) observes that learning “emerges only through invention and re-invention, through the restless, impatient, continuing, [and] hopeful inquiry human beings pursue in the world, with the world, and with each other.” I was keen to take full advantage of this.

Their main value lies in their ability to capture the richness and depth of respondents’ own words (Stewart, 1990). “As participants answer questions, their responses spark ideas from other participants. Comments provide mental cues that trigger memories or thoughts of other participants - cues that help explore the range of perceptions” (Krueger and Casey, 2000, p.40). This can often result in innovative and creative thoughts emerging from within the group that would not have been voiced in individual interview. It is a means of “laying bare” the culture and assumptions of a particular setting, by tapping into the “interactional elements [that are] at the heart of the interview process” (Sheppard et al., 2008, p.65). I attempted to do this by capturing these insights and then making “collective sense” of them (Morgan and Spanish, 1984, p.259). Krueger (1994, p.19) notes that, using such a model, participants are “influencing and influenced by others” as would happen in everyday discourse. In this way focus groups provide a useful social context for meaning-making (Wilkinson, 1999; Iwasaki et al., 2005), and the co-construction of views by the “sharing, acquiring and contesting of knowledge” (Lehoux et al., 2006, p.2096).

A number of central assumptions about focus groups have been discussed by Lederman (1990). These are that:

- Individuals are important sources of information
- People are able to report and verbalize their thoughts and feelings
- A group’s dynamics can generate authentic information
- Group interviews are superior to individual interviews

- The researcher as facilitator can help people recover forgotten information by focusing the interview

I used a focus group approach to allow me to capture and take advantage of the spontaneity of individuals' thoughts within a group setting. I hoped that as participants voiced ideas collectively they would stimulate, generate and bring to the fore ideas for development. The synergy and creativity of this process was particularly important given the limited time commitment available to staff. Zikmund (1997) notes the snowballing effect that thinking out loud can create and I was keen to build on and take advantage of this.

I advised my participants that I was there to learn from the group and not vice versa; this is a technique that resonates with Freire's own dialogical methods. Millward (1995, p.282) advocates that a stance of "incomplete understanding, but not complete ignorance" be adopted. 'Casting' the presentational self into a 'playing the innocent role' (Hermanowicz, 2002, p.486), required a sensitive balance, to avoid being seen as patronizing and inauthentic.

The synergistic effect of a group setting and the opportunity for participants to listen to and build upon one another's ideas and insights was, I felt, particularly valuable in capturing the essence of the question focus. Hansen (2006, p.123) suggests that this can be a useful 'quality control check' where participants naturally evaluate and question each other's statements. Morgan (1988, p.28) notes that "focus groups are useful when it comes to investigating *what* participants think but they excel at uncovering *why* participants think as they do."

Use of the focus group approach allowed me to enter briefly into the unique frame of reference of my research participants and to uncover, discover, explore, clarify and 'give voice' to meaning at both an individual and group level. This added a valuable understanding of what it might feel like to be unobtrusively observed in clinical practice from many differing perspectives. It is a tool that

validates the socially embedded and contextual nature of knowledge (Kitzinger, 1994, p.117).

4.4 Participant recruitment

Participants were invited to the study by a simple poster campaign. Having first sought permission to do so, these were prominently displayed in the communal areas and offices of the eight local units selected for the research (Appendix 1). The units were, four Community Mental Health Teams (CMHT), one Crisis Resolution Home Treatment Team (CRHT), one in-patient ward, one in-patient rehabilitation unit and an Assertive Outreach Team (AOT). The poster made it clear that I would be willing to see staff on an individual basis if they preferred. I also sent a personalized letter to all qualified nurses working on these units (Appendix 2) as I had initially anticipated that I would be able to engage with all interested nursing staff. I made a follow up telephone call or sent an email two weeks later to prompt a response. Nurses agreeing to participate were sent a confirmation letter (Appendix 3) and received a reminder phone call or email one to two days before the scheduled focus group. I recognized that facilitation of more than one group would be needed if there was a good response from a particular Nursing Band.

Nursing Bands are the clinical grading structure used by the National Health Service (NHS) following the Agenda for Change (AfC) initiative and are used to define role responsibilities. There are 9 Bands, Bands 2-4 are unqualified staff, Band 5 staff nurses, Band 6 charge nurses, Band 7 senior charge nurses (or equivalent), Band 8 modern matrons (or equivalent) and Band 9 managers. Band 5 nurses range from newly qualified staff nurses through to experienced senior staff nurses, depending on post-registration experience. As teams became aware of my research I was invited to attend staff meetings to discuss my study proposal with them. This proved to be invaluable although I always made it clear that participation would be voluntary to avoid renegeing on what I had previously negotiated with the local ethics committee and what I knew to be good practice.

4.5 Inclusion criteria

Mental health nurses with eighteen months' post qualification experience working in either a substantive, bank or agency capacity in eight local units within the designated catchment area were invited to participate in this study. The units involved were four Community Mental Health Teams (CMHT), one Crisis Resolution Home Treatment Team (CRHT), one in-patient ward, one in-patient rehabilitation unit and an Assertive Outreach Team (AOT). I originally envisaged that substantive post holders would provide a 'richer' source of material. However, I also recognized that key insights may be obtained from the cross fertilization of experiences gained from bank and agency staff who regularly worked (on an 'as needed basis' covering sickness and annual leave) in these different units and teams. Since staff were not paid to attend the focus groups (as they were conducted during normal working hours), bank and agency staff would have needed to attend in their own time. I was realistic enough to recognize that this would considerably (if not totally) reduce the pool of study participants available to me as I imagined that they would naturally de-select. In reality many of the nurses participating in the study worked in a substantive community health role during the week and did occasional bank shifts on their days off.

4.6 Exclusion criteria

Staff who were unqualified or newly qualified, were not employed by my own employing NHS Trust, or who did not provide a signed informed consent form, were not allowed to take part in the study.

4.7 Informed consent

The Participant Information Sheet (Appendix 4) and Consent Form (Appendix 5) were used as tools for obtaining participants' written consent in response to explicit information provided about the study. This ensured that all study participants were able to make an informed decision based on a comprehensive understanding of what they might expect. Protecting confidentiality and balancing

the risk of harm with the potential benefits were integral to the study and the techniques I used. These guidelines were used to ensure that participants were treated justly and equitably. Schneider (2000) reminds the researcher that security and consent are processes not products and it was important that I respected these principles.

Participants were free to withdraw from the study at any point and without explanation. I emphasized this to allow staff the opportunity to change their minds. Potential subjects were supplied with a written information sheet to help them identify whether they wished to participate (Appendix 4) and all participants were asked to sign a consent form (Appendix 5). This form gave me permission to audio tape the focus group discussion and to include selected anonymous quotes.

4.8 Study measures

There were three study measures. A simple demographic questionnaire was devised to enable me to paint a basic thumbnail sketch of my participants. These measures were basic to avoid intrusion (age, gender, self-described race and ethnicity, grade and experience). A copy can be seen in Appendix 6. The information generated using this questionnaire was analyzed to yield descriptive statistics (frequencies, percentages, mean, standard deviation and so on). I also used the collage (already discussed) and the focus groups. Core questions were identified to guide focus group discussions although in reality these merely acted as a prompt and were not rigidly followed. A list of additional open-ended questions was also drawn up as a broad framework for the focus group interviews. Flexibility of use was obviously required on the day and they acted as a cue rather than as a prescriptive set of questions I felt I must ask.

4.9 Participant characteristics

Ten focus groups involving eight different local teams were facilitated over a five month period between February and June 2008. Group sizes ranged from 2 to 6 with a total of 35 participants. There was a mean attendance of 3.5 per group (standard deviation = 1.8). Eleven men, representing 31.4% of the total sample, and twenty four females (68.6%) took part in the study. They consisted of 3 experienced Band 5 staff, 26 Band 6 nurses and 6 Band 7 staff. The age range of the participants was between 30 and 58 years (mean 44.8 years, standard deviation 6.1 years). Experience ranged from 18 months to 35 years with an average of 15.8 years in mental health nursing (standard deviation = 8.2 years). Staff represented 5 different ethnic backgrounds, as can be seen in Table 4.2.

Table 4.2 Focus group participant ethnicity profile

White (British)	29	82.9%
White (Irish)		
White (Any other White background)	1	2.9%
Mixed (White and Black Caribbean)	1	2.9%
Mixed (White and Black African)		
Mixed (White and Asian)		
Mixed (Any other mixed background)		
Asian or British Asian (Indian)		
Asian or British Asian (Pakistani)		
Asian or British Asian (Bangladeshi)		
Asian or British Asian (Any other Asian background)		
Black or Black British (Caribbean)		
Black or Black British (African)		
Black or Black British (Any other Black background)	3	8.6%
Other ethnic groups (Chinese)		
Other ethnic groups (Any other ethnic group)	1	2.9%
Participant declined		
TOTAL	35	100.2%

* Rounded up to one decimal point.

A summary of the focus group interview schedule is displayed in Table 4.3.

Table 4.3 Focus group interview schedule

Date	Number	Male	Female	Number of non attendees	Band	Duration of focus group
14.02.08	3	0	3	1 did not attend	6	57 minutes
15.02.08	4	1	3	0	7	1 hour 1 minute
21.02.08	4	2	2	0	6	56 minutes
11.03.08	6	2	4	0	6	43 minutes
13.03.08	2	1	1	1 did not attend 1 forgot 1 cancelled	6	52 minutes
08.04.08	3	1	2	Manager of a local Community Mental Health Team withdrew 3 staff on the day of the focus group for operational reasons	6	1 hour 6 minutes
24.04.08	2	1	1	1 cancelled at the last minute	7	48 minutes
07.05.08	3	2	1	1 arrived 30 minutes late and then left again – not included in the numbers	5	35 minutes
27.05.08	4	0	4	0	6	43 minutes
30.06.08	4	1	3	0	6	41 minutes
Total	35	11	24			

Band 5 = 3, Band 6 = 26, Band 7 = 6

4.10 Focus groups in practice

Focus groups were organized to enable nurses of similar Bands to work together. In this way homogeneity of group members, in terms of core responsibility of grade, was maintained. Collegiality is recognized as an integral facet of professional culture (Freidson, 1994) and this strategy was deliberately adopted to enable staff to talk openly and freely with one another. It was also used to help capitalize on people's shared experiences (Kitzinger, 1996; Wilkinson, 1999; Krueger and Casey, 2000). Kamberelis and Dimitriadis (2005, p.903) note that "The synergy and dynamism generated within homogenous collectives often reveal unarticulated norms and normative assumptions." In this way, change can occur as positions of oppression become realized and articulated (often for the first time) resulting in heightened self-awareness and collective political consciousness. Madriz (1998), however, issues a note of caution contending that the researcher's definition of homogeneity may vary from the participant's reality.

Where possible, groups were mixed to include a cross section of the units used; this was done to enhance the richness, depth, breadth and fertility of the data sets. It was also a practical consideration to ensure that the safety of the respective units was not clinically compromised by 'draining' and depleting it of staff resources. Clavering and McLaughlin (2007) have challenged the traditional view of consciously building homogeneity into focus group design, recognizing the benefits of crossing multidisciplinary divides and deliberately seeking heterogeneity. Some teams, however, elected to participate together and this view was respected.

4.11 Equipment

The focus group sessions were audio and digitally taped and later transcribed in full by orthographic transcription onto a word processor. This prevented me from being distracted during the actual focus group meetings. I had considered videoing the focus group sessions to enable observation and analysis of the

groups' paralinguistic cues. This may have yielded important additional and supplementary information not observed at the time (Polgar and Thomas, 1995). It may also have enhanced validity of the raw data (Polgar and Thomas, 1995). However, after careful consideration I recognized that this may have stilted focus group dialogue. It may also have created an inadvertent paranoiac effect, skewing my question focus. Van Maanen (1988, p.137) notes that, "the sensitive ear is perhaps more crucial than the sensitive eye." I therefore decided to audio tape the focus groups instead.

Sound was picked up by the strategic placement of an Olympus Digital Voice Recorder (DS-30/40/50) with a two-Channel Professional Microphone (ME30W). Directional microphones were positioned on two mini tripods and placed equidistant from the recorder. As an extra safeguard, in the event of technological problems, a Sony ICDB300 - 64MB Digital Voice Recorder and Sony Shoe Box Cassette Recorder TCM-939 (with Full Auto Shut-Off Cue and Review Function) were also used. I made a clear announcement when the taping was about to commence to avoid the collection of unintentional audio footage which would then become a 'grey area' under data ownership law because I had not sought permission to use it. I also explained that there would be an inevitable time delay as I would not be able to start all three tapes simultaneously.

My decision to adopt a technological safety net in the form of three tape recorders was vindicated when I forgot to switch the pause button off on the box cassette for one group and failed to turn the Olympus Digital Voice Recorder on for another. I was greatly relieved that I had not lost valuable data; more importantly I had not wasted colleagues' time.

I had feared colleagues would feel inhibited by the presence and visibility of the recording equipment. Concerned that this might silence them and that they would censor and sanitize what they had to say, I spent a great deal of time reflecting on this prior to the focus group discussions. I recognized that the times I had felt

most betrayed and psychologically 'used' at work had been occasions when I had felt misquoted, that my comments had been taken out of context, or that I did not have the right to reply or to explain the rationale behind what I had originally said. They were not the times when I had voiced and articulated controversial or unpopular thoughts and opinions and been heard accurately. On these occasions I felt able to justify what I had said and why I had said it. As I have grown into my role and developed my clinical practice I have felt more able to challenge the 'system'. I hoped staff would use this opportunity to question their own and each other's ideas in a genuine 'Freirean' exchange. Whilst I cannot be certain, I felt that capturing what staff had to say onto tape allowed them to speak for themselves; to have their own view of the world heard, confident that they would be quoted correctly without risk of being paraphrased, misunderstood, or having the impact of their message diluted. Freire called this righting and writing the world and daring to be other. It formed the taproot of his thinking (Taylor, 1993).

I had imagined that my rather cautious use of three different audio taping machines would act primarily as a technical safeguard, a 'back up' in case of mechanical failure or human error when switching the machines on and off. However, I quickly appreciated the value of listening to the focus group sessions on all three systems. Words that sounded faint and indistinct on one machine often sounded clearer on another and I used this to personal advantage. Also, downloading the digital recording onto my laptop computer, with its two integral speakers, changed the quality of the sound, and provided an additional validity check.

Full orthographic and word processed verbatim transcripts of the focus groups were made. Sound files were downloaded onto a database. The reflective diary that I (erratically) kept to record research highs and lows consisted of illegible handwritten notes and Dictaphone thoughts. These often occurred to me in the middle of the night. As such they have not been submitted. This was a recurring discussion point with my supervisory team. They questioned whether I was

denying them access to a rich resource of inner thoughts and feelings, fearful of exhibiting vulnerability and self doubt. Where possible I tried to weave these reflective and critical insights into the study as it progressed. Although regularly cajoled to the contrary I always resisted the idea of totally laying bare this journal in its crude and uncensored format.

Gilbert (2001) likens the act of reflective practice and supervision to penitential 'acts'. He uses the metaphor of the supervisee 'confessing' by self-disclosure to the all knowing and all seeing supervisor who critically listens, 'collects secrets' (Perron et al., 2005) and has the power to 'absolve' the penitent of transgressions. He can also discipline and publicly castigate. Unlike a priest and the confidentiality and anonymity of the 'black box' (confessional), the supervisor's silence is not assured. Reporting up the chain of command is a more likely consequence. Whilst I had no doubt that my carefully selected supervisors would not betray my trust, I was ever mindful of the local research performed by Clarke and Flanagan (2003) discussed in Chapter 3.

As an emic nurse researcher I naïvely assumed I would have unique insights into the vocabulary and nuances used by my colleagues. However, there were still many occasions during the collage and focus group discussions when clarification was required. I am sure many subtle 'digs' aimed at other teams went over my head. I was conscious of trying to avoid 'defending' my own practice discipline when negative (but probably true) comments were made about in-patient services.

Ideas came slowly as I played and replayed the tapes and read and re-read the transcripts. I discussed my preliminary thoughts and ideas with Action Learning Set peers and my supervisory team. The metaphors used to describe key focus group themes came from a number of diverse sources. I 'allowed' myself to be open and receptive to ideas. These will be explored in Chapter 6.

The dynamics and atmosphere of each group differed enormously. Some 'launched' into a seemingly authentic dialogue with each other almost immediately. They 'unpacked' ideas as they spoke. They contradicted and corrected themselves as they went along and realized what they had said. Others proceeded with caution and the group felt more strained and the conversation stilted. As I replayed the tapes, I found myself wincing as I heard myself time and time again rush in to fill a silence. It seemed unending in real time and fleeting when caught on tape. I found myself wondering 'what if I had not interrupted?' But I quickly realized that, despite this, I had and that no amount of regret would change this.

4.12 My role as a researcher

To enhance the 'richness' of the focus groups, I encouraged debate, acted as a conduit for ideas, validated the legitimacy of individual views and ensured that the group was not overly dominated by stronger participants. My primary role (whether as participator, facilitator or observer) was to help create a non-threatening environment so that all group members would feel able to share their views openly and honestly (Reiskin, 1992). Comments that I did not fully understand at the time were clarified by a simple 'what does that mean?' as suggested by Millward (1995). I often did this by letting the group dialogue continue and then clarifying points of uncertainty at the end. This gave me time to try to understand for myself before I asked and it also avoided disrupting the session.

As my project progressed, my role within the organization changed to reflect the leadership style preferred by the Trust at this time. I became less clinically focussed and more managerially driven needing now to prioritize and plan the work of others. I began to appreciate the difficulty I would have obtaining the views of newly qualified staff for my research. Inexperienced nurses are less likely to be found in a community setting, lacking the experience required to work

as autonomous practitioners, and as I began to have more professional contact with the two acute in-patient sister units across the Trust, I recognized the ethical dilemma I faced. I now worked closely with Band 5 nurses and attended their professional development days, which meant that they might have felt pressured into project participation. I was anxious to avoid this. As I began to realize the enormity of the task I was undertaking I made a conscious decision to limit my study focus to experienced mental health nurses.

4.13 Conducting the focus groups

I used a researcher focus group discussion guide (Appendix 7) and question prompt (Appendix 9) to help structure the focus groups. I tried to build question latitude and flexibility into this. This guide was adapted from Levine and Ligenza (2002) and it provided me with a useful reference template and a structured sequential 'crib sheet' to enable the focus groups to function smoothly. I negotiated group ground rules to ensure that the psychological safety of individuals was respected. These ground rules can be seen in Appendix 8.

Where possible, participants were seated around a small table for a number of practical reasons. During the initial stages of the focus group discussion, when there was the inevitable awkwardness over who would 'start the ball rolling', it created a natural protective shield, a psychological barrier. It enabled intimacy as the group developed, allowing group members to lean forward. It provided a useful platform for the audio taping equipment and microphones and often it avoided disrupting the prior arrangement of the room. However, in practice some groups chose to remain seated around the table they had used to complete their collage and some chose to move to the separate area (when space permitted) that I had already set up with the tape recording equipment and directional microphones. In reality, seating arrangements and group size did not seem to influence whether participants made reference to the collage in their focus group and it did not appear to affect the quality of the recordings.

4.14 Procedure

I met with staff during 2008. A minimum of three focus groups were needed to capture separately the views of nurses from each of Bands 5, 6 and 7. In reality, because not all staff were able to attend at the agreed times, I continued to run groups until saturation of information was reached. I realized this had happened when the focus groups were unable to provide fresh insights and what they were saying was simply a reaffirmation of previous narratives.

Light refreshments helped to serve as a natural ice-breaker. Morse (1998) likens the use of food to “reciprocity in action fostering cooperation and good will.” She advises that the “real currency in hospital” is “anything sugary and fatty” (p.147). It provided an informal thank you to study participants and it created a social and relaxed, unhurried atmosphere. Tea and coffee were also made available to those who wanted it after the focus group discussion. This provided a natural opportunity for group debriefing in a safe space where individuals could discuss their reactions ‘off tape’ if they chose to do so. This did not form part of the data set and participants were made aware of this.

I asked staff to turn their mobile phones off or to silent mode to avoid disruption. Each collage and focus group lasted approximately one to one-and-a-half hours and included two to six participants with a mean attendance of 3.5. I recognized that these were small numbers and below the ideal group size of 4-6 advocated by Morgan (1998). I return to this point in Chapter 6 when study shortfalls are discussed. Group size is inversely correlated with individual participation and optimal group sizing enables the researcher as the moderator to reorient a discussion or line of thinking that is going ‘off track’ (Millward, 1995). Recognition of participant attrition, nurses initially agreeing to take part in the study, and then exercising their right to change their mind, was ‘factored’ into the recruitment strategy. Whilst it is common practice to over recruit by 20% to build in contingency (Reiskin, 1992; Millward, 1995), in reality this was rarely feasible.

When fewer than three participants attended, a decision was taken whether to go ahead, recognizing that it was unlikely that those who had attended would wish to re-schedule. This is further discussed in Chapter 6.

To promote inter-group consistency and comparability I facilitated each of the sessions. Each focus group was digitally taped and in addition contemporaneous observational field notes were taken immediately after the groups. This was done to minimize potential distraction and the heightened self consciousness of group members created by note taking. These notes added to the richness, immediacy and rigour of the data sets by providing a record of details that could not be recorded by the audio equipment, such as the mood and feel of the group, (Hansen, 2006).

I took time to reflect carefully after each of the focus groups and recognized this as an important component of the study. I used the time to consider the initial rich but raw thoughts, intuitive untested 'armchair hunches' and the, as yet, unprocessed and unrefined 'stream of consciousness' questions that had occurred to me. I placed these in the margins of the field notes as a memo or aide-memoire for later clarification, distillation, synthesis and explanation of the textual meaning. Krueger and Casey (2000) maintain that while 80% of the data can be extrapolated from focus group transcripts, the remaining 20% is obtained from the insights and experiences that are formulated, 'sensed and felt' by the researcher(s) in the room.

4.15 Gaining ethical approval and access to the field

Take nothing but pictures ... kill nothing but time ... leave nothing but footprints ... to show you came by (Kay and Company, 1997).

Experienced front-line mental health nurses are tasked daily with the dual tension of balancing a patient's need for privacy, dignity and respect with the organizational need for corporate safety (both individual and collective). As a

novice researcher, naïve to the complex nuances of conducting a professional research project, I used these principles as useful compass points. They helped ground, navigate and orientate me and have provided me with much needed direction.

The potential for exploitive participant manipulation and the unwitting betrayal of subjects by distortion and bias were foremost research issues during the data collection process. I recognised that, by its very nature, surveillance strategies employed by nurses was at risk of potentially applying the very same surveillance techniques (in attempting to explore this issue), this remained uppermost in my thinking. It formed a focus for the main discussion thread in the academic supervision sessions that were integral to and ran alongside this research process.

This study was subject to ethical review as NHS staff were recruited as research participants. Approval was sought from The University of Brighton Health Professions Faculty Research Ethics and Governance Committee (FREGC) and requested and obtained in December 2007 from the Brighton East Research Ethics Committee, part of the National Research Ethics Service (formerly the local East Sussex NHS Research Ethics Committee (REC), managed by the Central Office for Research Ethics Committees (COREC) within the National Patient Safety Agency (NPSA) Ref: 07/H1107/137). NHS Research Governance ethics approval was also applied for and obtained in January 2008 from the Sussex Consortium Research Approval and Monitoring Committee (RAMC) (RAMC ID: 0950/SUPA/2007). Written managerial permission and researcher access were sought and obtained from the key gatekeepers, identified as the Associate Director (Adult Mental Health) and the Lead Nurse of the units invited to participate.

The Ethics Committee was happy for me to have a co-moderator sitting in the room with each focus group and taking written contemporaneous field notes, but

the Sussex Consortium Research Approval and Monitoring Committee (RAMC) expressed concern over the feasibility and potential cost of this proposal. I left a reference to the co-moderator in the Participant Information Sheet initially thinking I would be able to arrange an honorarium for a colleague working outside the Trust, but I advised participants of my change of plan during the ice-breaker exercise when this proved impracticable.

The 2004 Nursing and Midwifery Council (NMC) Code of Professional Conduct: Standards for Conduct, Performance and Ethics specify that a nurse must always act to identify and minimize risk to her patients and clients. Active intervention rather than passive observation was therefore recognized as necessary during the course of these focus groups if bad practice was discussed that required managerial follow up, even if this risked jeopardizing the future of the project. This was made clear at the beginning of each focus group.

There were a number of potential ethical tensions in the project that needed to be carefully and actively managed. Undertaking fieldwork in one's own employing Trust involves obvious potential and ethical pitfalls. This was made clear to the participants. It was explicitly stated at the beginning of each focus group when I read out the following verbatim script before discussing the ground rules:

Today I am here as a student researcher studying at the University of Brighton and not as a work colleague employed by the Trust. My questions therefore have a research focus. It is important to remember that I am still bound by The 2004 Nursing and Midwifery Council (NMC) Code of Professional Conduct: Standards for Conduct, Performance and Ethics. My first priority is still to uphold the professional image of nursing and respond appropriately if bad practice is discussed that requires managerial follow up, even if this risks jeopardizing the future of the project.

The irony of my position statement and its formality should not go unnoticed. In seeking to forefront and make sense of the overt and covert surveillance and observation practices to which nurses may be subjected, I invited them to participate in a focus group on covert observation and yet at the same time I

knew they risked being 'reported' by me if they disclosed anything that may have infringed or violated the code of conduct, by act of omission or commission, that we adhered to during this process. Whilst this ostensibly seems to constitute researcher contradiction, inconsistency and practice dissonance, in reality it typifies the very complexity of the task being undertaken. It was a research tension and a thread that ran throughout this research.

An acute awareness of the potential to cast my own researcher's 'shadow' inadvertently on the study by adopting this position was uppermost in my thinking. I knew that this could have been unwittingly done in a number of innocent ways. In the background there was always the fear of 'going native'. Alderson (1999) suggests that this happens when the researcher becomes too much of an accustomed insider instead of a questioning 'stranger'. Sandelowski (1994a, p.316) emphasizes the need for balance, saying "we have to make the familiar strange and the strange familiar." I used academic and clinical supervision as a vehicle to reflect on this and encouraged my colleagues and Action Learning Set (ALS) peers to challenge my thinking and assumptions throughout the various stages of the study in the hope that I might see things from different perspectives. By doing this I was provided with four separate points of reference to help me question and confront my personal and professional biases. However, I can never be sure that I succeeded; simply, my awareness was heightened.

Lewis (2007, p.273) observes the potential for tension in the disparity between what the researcher sees as important and worthy of note versus the views of her participants. She notes that this "risks muting participants' voices and representing them in ways with which they may not agree or approve." Smith (1995) highlights the potential for over disclosure in a focus group setting. This is compounded by the synergistic effect created by the group interaction. Patton (1990) cautions against study participants who disclose personal details that they had not originally intended to make public, who can later be privately very

surprised by the content of their conversation. He emphasizes the importance of building in the opportunity to debrief.

Participants were reminded of the importance of withholding information that may have been considered too personal or revealing. Group ground rules were negotiated to ensure the psychological safety of those involved before the group began. Participants were made aware at all stages of the recruitment process that their participation was purely voluntary, and that they were free to withdraw from the study at any stage and without explanation. This is a principle or process that is called refreshing or affirming consent. It was made clear that this would not affect the working relationship that participants had with me. If participants had become upset during the focus group they would have been given the opportunity to leave, to avoid their distress being recorded on tape which might have been embarrassing for them. In the unlikely event of the whole group becoming distressed they would have been asked collectively whether they wished to continue and to have their comments included in the main study findings. In reality this did not happen.

It was always possible that the focus group debate and the subsequent research findings would 'surprise' nursing staff colleagues and initially raise more questions than it addressed. This was likely to occur after, rather than during, the groups as participants needed time to assimilate and psychologically 'process' what was collectively said and what it might mean for them as individuals and at a team level.

To allay anxiety I gave the participants an opportunity to contact me after the focus group to 'check out' assumptions and hidden meanings if they would find this useful. This was made explicit in the 'ground rules' that were negotiated with each focus group set prior to commencement of the discussion.

The Senior Management Team representing the Trust were aware that the dynamic nature of the research process per se was such that assumptions and previously taken for granted practices could be questioned and challenged. They acknowledged that whilst this was ultimately progressive, acting as a catalyst for change, it could initially prove destabilizing for the teams involved as it would inevitably shift the status quo and the political positioning of the team.

The units involved in this research study had access to a work-based reflective group practice facilitator who would be able to follow through any concerns and tensions. He had been apprised of the nature of the research and as a practicing clinical psychologist was familiar with potential post research dynamics.

I informed study participants that the data I collected would be used solely for research purposes. They were advised that they would not be individually identifiable in the final report which may be published. Focus group codes rather than real names were employed in the data presentation. Only my academic supervisor and I had access to the collected data and the field notes. These were transferred to and stored on a password-protected database kept within a locked environment secure against unauthorized access. Interviews were taped and later transcribed for analysis. I made sure that I kept paper copies to a minimum. Group participants were requested to commit to and honour each other's right to privacy. They were asked to maintain confidentiality and not share focus group content or the views expressed by other participants outside the group setting. I knew that this was a parameter outside my control.

4.16 Pilot study

A pilot study was conducted with 3 Band 6 colleagues to identify potential technological difficulties. It was used to gauge internal and extraneous sound levels and to highlight any problems with question focus and so on, prior to the main study. It gave me a natural opportunity to identify whether the collage

technique was feasible and whether I had selected appropriate magazines (Appendix 12). I used pilot study data as part of the main study findings.

4.17 Critique

I am mindful that by using a local purposive sampling strategy I risked introducing a self-selection bias (staff choosing to participate, unrepresentative of their peer group). Social desirability and impression management effects (the desire to look good in front of others) may also have censored or skewed staff responses. Majority consensus masking minority opinion is a well recognized problem in group orientated research (Asch, 1951; Deutsch and Gerard, 1955; Carey and Smith, 1994) and it can result in group norms which silence individual voices of dissent (Kitzinger, 1995, p.300). Henderson (1995) cautions against 'thought leaders', dominant group members who monopolize 'air space' and 'talk time' (Carey, 1994, p.236), as they can overly influence quieter focus group members. Kidd and Parshall (2000) call this the principle of 'going along to get along'. Where possible I tried to recognize and involve quieter members in each group by using non-verbal inclusive signals (such as facial and hand gestures) but I cannot be sure I ever succeeded.

4.18 Transcription

Focus group discussion was converted to a textual format. Millward (1995) calculated that each one hour focus group session yields twenty to twenty-five pages of transcription. This provided large amounts of dense written material which needed to be systematically analyzed after the multiple focus groups had taken place. Millward (1995) strongly advises against the temptation to 'cherry pick' illustrative comments directly from the tape without fully transcribing it manually as this fails to capture the context of the insight and it loses the 'feel' and essence of where the comment 'sits' and is 'positioned' in relation to the full body of the text.

4.19 Textual data analysis

Polit and Hungler (1993) advise that analysis in qualitative research is essentially a pragmatic means of imposing order and sense on the large volume of information that has been collected. Analysis enables the researcher to find ways to tease out the essential interpretations from the raw data and to make it manageable (Ely et al., 1991). It needs to possess “systematic and verifiable” properties (Crawford and Acorn, 1997, p.16). At the same time it needs to ‘stay true’ to the imputed meaning originally intended by the research participant (Burnard, 1995).

Five systematic steps have been identified by Krueger (1994) to help organize the data gathering phase. They are:

- Sequencing questions to allow maximum insight
- Capturing and handling the data on audio tape
- Coding data and salient emergent themes
- Participant verification of the written report
- Debriefing and sharing of all reports by all researchers

The audio-tapes of the focus group sessions were transcribed verbatim to establish a permanent written record. Manual orthographic transcription was used to aid familiarity with the text. Initial analysis involved a preliminary ‘broad brush’ reading and re-reading of the transcripts. This was done to gain a coherent sense of the data and to identify and discover main themes and coding categories that could be derived directly from the text. Random segments of the tape were checked to ensure accuracy and any discrepancies were reconciled. Inaudible statements were acknowledged and omitted to guard against misquotations. A text note was then made of this to avoid unwittingly de-contextualizing the dialogue either side of this missing text. To aid textual clarity I adopted the transcription conventions used by Wilkinson (2003) and seen in Table 4.4.

Table 4.4 Transcription conventions

Transcription conventions
Underlining - emphasis
Hyphen at end of word - word cut off abruptly
Ellipsis (...) speaker trails off
Round brackets - used when I am uncertain what was said, but able to make a reasonable guess - for example (about)
Square brackets - enclose comments made by me. These comments include inability to make out what was said [indistinct], and sounds that are difficult to transcribe, such as [tch], or a stutter, as well as interactional features of note, for example, [laughs], [pauses], [cuts in], [turns to colleague]
(Adapted from Wilkinson, 2003 p.195).
I have added the symbol * to indicate that I have removed a colleague's name or deleted an expletive or profanity. I have used the word [sic] to show that unconventional grammar has been retained in its original form.

I used thematic analysis to interpret the focus group data and to identify the major issues discussed. Thematic analysis is defined as, "a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns" (Hsieh and Shannon, 2005, p.1278). Initial pencil and paper coding was used allowing the categories and names to emerge and "flow from the data" (Hsieh and Shannon, 2005, p.1279). Using such an approach, "words of the text are classified into much smaller content categories" (Weber, 1990, p.12) and this enabled me to make sense of complex data. Thematic analysis has a dual mechanical and interpretive component (Krippendorff, 1980). It is alternatively defined as, "a research technique for making replicable and valid inferences from data to their context" (Krippendorff, 1980, p.21).

I analyzed each focus group separately, recognizing it as a discrete unit (Kreuger, 1994). I also analyzed it again in combination with other focus groups. To aid coherence, data was 'fine grain' analyzed, sentence by sentence, and also by group. The value of using a qualitative computer generated data analysis software tool such as winMAX, NUDIST (Non-numerical Unstructured Data Indexing Searching and Theorizing) or NVivo was carefully considered against manual coding. (Computer analysis allows codes and variables to be generated using a "code and retrieve" system.) However, contemporary views on data analysis recognize the value of remaining physically close to the data by hand coding the core categories and themes. This is achieved with a basic 'long table cut and paste' technique on a word processor and by working from hard copies of the transcribed data.

As I analyzed dialogue I used illustrative quotes taken from the focus group transcripts to ensure descriptive validity making sure that the source of the quote could be traced back to the appropriate focus group participant. Duncan-Grant (2001) reminds his research audience of the importance of a scissors and paste method to remain faithful to the qualitative dictum of 'immersion in the data', to obtain a sense of the whole. This allowed greater visualization of the data (McCann and Clark, 2003). It also ensured that I remained close to and not 'distanced' from it. The focus group transcripts were printed onto different coloured paper. This enabled the coded statements from each group to be easily identified when they were separated from the main transcript. I then cut and pasted emergent themes onto black card, 'collage style', to help practically manage the data and reduce the likelihood of mislaying key themes and ideas. This technique helped develop themes. The process generated large amounts of unwanted paper 'off cuts' that I either burnt or shredded to avoid an inadvertent breach of participant confidentiality.

Burnard (1995, p.237) cautions against the belief that "soak[ing] up enough of the text" will result in "find[ing] its essence." Meaning, he argues, is imputed by the

participant. Burnard (1995, p.239) contends that despite attempted purity in the method, there can never be true extrapolation of the 'real' meanings embedded in the text. What was recorded merely captured the words of the speaker at that moment in time and "may not mean anything." The complexity and elusiveness of language and intense over focussing on the text, to the detriment of the silences, pauses and emphasis can paradoxically blur and distort what was said by assigning a meaning that was never intended (Burnard, 1995). The way it is said can therefore be as important as what was said.

Sandelowski (1994b) reminds the researcher that the very act of transcribing a text verbatim involves making a series of authorial and editorial decisions and interpretations that subtly change the original 'raw' data into an altered form. This will have important research consequences. She argues that it is a common but spurious misnomer to assume that a transcribed text per se can ever be an exact duplication of the original spoken dialogue. "Like the photograph, the transcript captures something, but not everything, 'out there' it also alters that something" (Sandelowski, 1994b, p.312). It was important to remember that whilst I would be transported back to the focus group as I read the text, by seeing and hearing the voice of the participant and how their point was expressed, the reader would not. This is also eloquently 'expressed' by the Italian dramatist Luigi Pirandello (1867-1936) who comments: "how can we understand each other if the words I use have the sense and the value I expect them to have, but whoever is listening to me inevitably thinks that those same words have a different sense and value, because of the private world he has inside himself too. "We think we understand each other: but we never do" (Pirandello, 1979, Act 1, p.10).

In 1927, Heisenberg, cited by Walvis (2003) described the principle of indeterminacy, 'the uncertainty principle'. This states that "what we observe is not nature itself, but nature exposed to our method of questioning" (Walvis, 2003, p.404). It is more commonly called observer dependency; "what is 'seen' must be interpreted in the light of, among other things, the way one looked" (Walvis, 2003,

p.404). Mauthner et al. (1998, p.742) observe that “the interpretation of data is [therefore] a reflexive exercise through which meanings are made rather than found.” It is important for researchers to remember that they can never be totally detached from the object of their study, but are participants in the investigative process.

The very act of transcribing oral speech into a written text transforms the words into a selective and constructed reality where the original nuances, intonation, pitch, pace and mood of the speaker are lost. Whilst a transcript will record what was said, it cannot accurately capture and faithfully preserve or record how it was said. Skilful use of notation may help set the scene and record the non linguistics used; it will not recreate it. Basic decisions about punctuation and use of emphasis can significantly alter intended meaning. Transcription can filter and skew the text. “What ends up on the printed page - the raw data - is actually already partly cooked: that is to say, many transformations removed from the so called unadulterated reality it was intended to represent” (Sandelowski, 1994b, p.312).

As I prepared psychologically for the process of identifying preliminary themes from the transcribed focus group conversations my journal entry (June 15th 2008) notes:

Figure 4.2 French truffle pig



Obtained www.margotbooth.home.comcast.net/margotbooth/pig.html
Accessed online 17th June 2008. 'Original in Colour'

I see myself as a truffle pig 'tethered' by various institutional, organizational, financial, ethical and time restraints over which I have little conscious control but I want to 'distance' myself from the idea that I am finding data. Rather I am making meaning. The Truffle man symbolizes my supervisory team, keen to keep me focussed, on track and productive.

Two key researcher questions remained uppermost throughout my analysis. They were: 'What is going on?' and 'What does this mean?' They helped me to seek out meaning and guided me and focussed my understanding through concurrent analysis and tentative theorizing. Stevenson (2005) contends that the richness of the research inquiry process is best delineated through a recursive and not a linear perspective. To support the integrity of the findings, alternate explanations were considered. Balance was clearly required. The importance of 'capturing' and not 'constructing' the essence of meaning - by appreciating my privileged position of research informant as actor in this drama - was seen as axiomatic in the directing and staging of this performance.

An initial coding scheme was generated using a recursive or iterative process (moving back and forth between data and analysis). To support the integrity of the findings, alternative explanations were considered by repeatedly returning to the data set. Verbatim quotations were used to give the reader the opportunity to make their own interpretations. Direct quotes were also used to aid illustration and to “provide immediacy and richness to the discussion.” This is a technique advocated by Reiskin (1992, p.201). Data analysis acknowledged the importance of maintaining objectivity and researcher ‘distance’ when interpreting the data, to avoid findings being based on my authorial biases rather than on fact with a supporting audit trail (Denscombe, 1998).

4.20 Safeguarding credibility

To enhance credibility the results of the final analysis and the research findings and recommendations were made available to the participating focus group members at the end of the research study for their final remarks and feedback (Appendix 13). Whilst I hoped that there would be general agreement about the description and accuracy of the work, I also anticipated that this study would reveal many aspects of being unobtrusively observed of which participants (both collectively and individually) had not previously been aware. This is discussed in greater detail in Chapter 6. An awareness of the need to explore unusual comments that may have contradicted group consensus was also important (Mays and Pope, 1995). One of the obvious advantages of audio taping the sessions was the scope it offered for continuing analysis and verification.

4.21 Rigour

A preoccupation with the concept of rigour and the “illusion of technique” (Sandelowski, 1993, p.1) threatens paradoxically to undermine the art, essence and creativity that distinguish the qualitative genre from its quantitative counterpart. It is the tacit and “evocative, true-to-life, and meaningful portraits, stories, and landscapes of human experience that capture the best test of rigour in qualitative work” (Sandelowski, 1993, p.1).

Researcher fidelity and trustworthiness are fundamental prerequisites and uppermost *sine qua non* imperatives in the empirical realization of this ideal. Sandelowski (1993) argues that as joint stakeholders in the research process researcher and researched will inevitably come to the focus group table with a diverse range of agendas, motives and 'truths' to tell. The narrative 'stance', and the authorial positioning assumed by the researcher will inevitably mean that some voices are heard above others. In striving to represent multiple realities, individual reality may become lost or distorted. As a credible researcher one should therefore constantly question who is the audience? Whose story is being told? And set the tone accordingly (Cohn and Lyons, 2003, p.40). Janesick (1994) refers to this awareness as the qualitative research 'dance' whereby all partners in the process are valued. Caution should therefore be exercised in the discourse of member checking, also known as respondent validation, as, "generalizations (of any kind) always tell a lie in the service of greater truth" (Barley, 1988, p.205). Denzin and Lincoln (1994) therefore advocate that member checking should be done in real time while all study participants are present. The focus group sessions therefore ended with a summary of the main discussion points, with me seeking verification from the participants, as a validity check, that this was an accurate précis. Face validity is thus strengthened by respondents confirming and refuting each other's ideas and comments in a genuine attempt at "realigning the balance of power" (Cohn and Lyons, 2003, p.45). It also makes transparent from the outset the real possibility that mutual understanding and agreement may not be reached and explains how this will be managed.

4.22 Validity and verifiability

It can be seen that a variety of different strategies were employed to ensure that validity and verifiability were central to the research process. They include for example, recording of focus groups using more than one piece of audio equipment to ensure accurate orthographic transcription; the summary at the end of each focus group to check my understanding of what was discussed; the

invitation to meet with me after the group to clarify issues of uncertainty; a focus group coding strategy to identify the source of participant narrative; and presentations of findings to staff inviting comment and debate. Rather than discuss these separately I have chosen to view these principles as a process running throughout the study and have included them within the main Chapter narrative to highlight this point.

4.23 Project management

A modified Gantt chart (horizontal time line) was used to provide a graphical illustration of the work schedule used to complete the project within the agreed timescales (Appendices 10 and 11).

4.24 Study dissemination strategy

Regular 'work in progress' updates were shared with the nursing teams participating in this research by tapping into a variety of existing in-house forums; these were formal and informal, local and central. Formal presentation to work peers took place at the regular senior staff 'away day' meetings that are facilitated by one of the Trust's General Managers throughout the year. The first of these was on 21st December 2006 when a project update was discussed. I also took the opportunity to prepare for the annual University of Brighton Work in Progress Conference in June 2007 by making a PowerPoint presentation to my Band 6 colleagues. It was also achieved by formal annual presentations at the University of Brighton's Research Monitoring meetings. A 'Work in Progress' presentation was delivered to the Trust's senior nursing staff on 12th March 2007 at the forum convened by the Trust's Executive Director of Nursing. I was invited back on 25th April 2008 and 4th December 2009 to give an updated progress report. The opportunity was taken to invite 'awkward questions' at the end. An academic poster was designed and presented to the Trust's Annual Nursing conference on 19th September 2008 (Appendix 14) and 12th October 2009 (Appendix 15). Band 5 nurses were apprised of the study (in its embryonic form) at their Band 5 development programme meeting on March 15th 2007.

Discussion during the question and answer session following this meeting primarily focussed on the subjectivity of both authorial and participant positioning, with the recognition that dialogue is never innocent, but rather loaded with subjective ideological and social values. I presented my preliminary research findings at the SUADE (Southern Universities Alliance for Doctoral Education) Conference on 17th April 2009. Informal sharing of ideas and the opportunity to 'defend one's position' in preparation for the external viva voce were integral components of the course's Action Learning that took place during the academic term. The opportunity to present at Trust in-house conferences will be sought nearer the completion of the study. Professional peer review scientific journals will also be approached with a view to publication.

4.25 The meaning of a text

Thematic analysis makes an implicit assumption that during focus group discussion people will say what they mean. It also fundamentally assumes that people will mean what they say. The meaning of a text, however, is ultimately determined by the reader. Meaning is not explicit in the text per se. It is indeterminate. It is the act of reading that creates the meaning. Different readers (and different readings by the same reader of the same text) will result in different understandings. The storying, polysemy of the spoken word, coherence of any given experience, and the meaning that is subsequently attached to it are therefore imputed and created by the 'reader' and not as originally premised by original authorial intent (Barthes, 1977).

4.26 Conclusion

This Chapter has provided a navigational route map of the various steps taken in the facilitation of the study and describes the roles played by an ice-breaker collage exercise and semi-structured focus groups. Difficulties are acknowledged and not disguised or denied. Benner (1994a) contends that, although a reader may not necessarily agree with an author's final interpretation or narrative account, they should always be able logically and systematically to follow the

pathways and the research trajectories that have been taken in its creation, and the transparency of the research trail used to inform this process. Chapter 5 will be used to discuss the findings.

CHAPTER 5

FINDINGS

This Chapter presents focus group findings. To help set the scene for this I have started with a reflective pause. I have done this to describe the organizational backdrop behind this stage of the study process. In addition it provides important information about the changing socio-political context in which the research is framed and subsequently analyzed. I then explain the relationship of the collage findings to the main focus group dialogue and go on to discuss collage findings using the digitally photographed collage pictures to aid understanding. Although the collages were never intended to be a primary source of data collection, they proved to be a rich source of metaphor and reflective material. They were a useful entry point into the focus groups and generated some key insights. These ideas were subsequently developed by participants within the focus group dialogue. Discussion follows showing how themes built up from focus group narrative led to the development of higher order themes. Findings are discussed through a Freirean lens.

5.1 Reflective pause

Before the findings are discussed it seems to me important to pause and set the context and emotional tone for the process. The decision to include a reflective commentary here and not elsewhere, whilst perhaps unusual, is I believe appropriate because it captures feelings that will undoubtedly have influenced and coloured my thinking. Periodically I invited myself to review this decision, but I always remained steadfast that this was the right place for the following commentary.

As I completed focus group data collection and entered into the thematic analysis phase of the research study, I began to appreciate with fresh eyes a picture I had

come to love and closely associate with my professional doctoral journey. Entitled *The Descent of Icarus* by the American graphic designer and illustrator David Bovey, it dramatically portrays Icarus, son of Daedalus, falling from the sky. I used this powerful image in PowerPoint presentations throughout the course as a creative literary metaphor to describe the fragility of the professional doctoral experience and its reliance on external factors outside the student's individual sphere of influence or conscious control. Like Icarus, a doctoral student learns quickly to take full advantage of opportunistic thermal currents (epiphany and critical learning moments) to personal research advantage. They are used to soar to new intellectual heights and to develop new ways of seeing.

Figure 5.1 The Descent of Icarus



By David Bovey

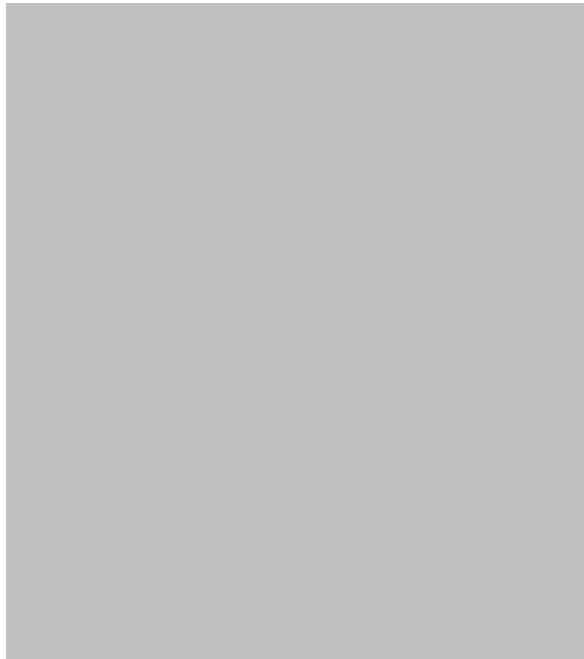
Obtained from <http://volaicaro.blogspot.com/2008/04/buon-compl> Accessed online 12th May 2008.
'Original in Colour'

The local climate changed and caught me totally off guard at the end of the third year of my study. I was advised unexpectedly that the organization no longer felt able to support my previously negotiated study leave. They wanted me to return to a normal working week, completing the study in my own time, or change role, if that was what I chose to do. I was given one week to decide and experienced a

range of mixed emotions. I knew instinctively that, until I had worked through my thoughts and feelings, any preliminary analysis of the transcripts would be biased and coloured by my own subjectivity and negativity. I found myself temporarily paralyzed by writer's block. Until I had named, owned, and managed my emotions I struggled to make sense of my sudden apparent and inexplicable indifference to continuing with the study, when all of the credible texts I had read had promised this would be the most exciting and uplifting part of the process.

I knew that if I suspended my project for a year to consider my options I would be unable to pick up the threads of the research. I would have wasted three valuable years of study and betrayed the encouragement of family and course tutors, and more importantly, let my research participants down. It was not an easy decision to make, and resulted in many difficult conversations with people whose opinions I valued. Finally I decided to continue with my study. I was not going to allow my correspondence with colleagues to be 'silenced' by the organization, irrespective of their motivation. It would have been the very antithesis of the Freirean method I had grown to respect, the adoption of a passive, domesticating, submissive position where conforming to the status quo meant that nothing would change. I therefore resolved to reflect and take action rather than reflect and take no action (Harden, 1996).

Figure 5.2 Austrian weather house



Obtained from <http://commons.wikimedia.org/wiki/Image:Weather> Accessed 8th July 2008 'Original in Colour'

My research journal (8th July 2008) notes:

Trying to achieve a successful work-research balance is proving difficult. It reminds me of pictures of the Victorian German and Austrian weather houses I have seen where the two characters are destined never to meet. If the fair weather character is visible, the bad weather character is hidden and vice versa. Similarly as parts of the study progressed I experienced problems at work. As work problems resolved I had methodological and design concerns about my study. The two never seem to complement each other. They seemed to accentuate rather than reconcile the theory-practice gap underpinning the philosophy behind the professional doctoral award.

Set against the backdrop of my analysis was my Trust's application to obtain Foundation Trust status. (Trust Foundation and teaching hospital status was finally achieved in August 2008 as I was analyzing data.) Targets now have to be reached or large financial penalties are incurred; staff are performance managed as they are increasingly 'called to account'. This has resulted in robust service re-design, financial re-scoping and benchmarking exercises. The ripple of tension

this sudden 'sea change' sent to local in-patient and community teams was palpable.

I felt I was experiencing at first hand the widening gap between the corporate rhetoric of the organization and practice reality. Strategic and operational arenas have always enjoyed an uneasy relationship within the NHS (Hamilton, 2001). The Trust claimed it wanted to invest in its workforce, its greatest asset. It is an Investor in People organization and emphasizes the importance of proactive human resource management. It has a contract with the local university to deliver a range of post-registration courses. The organization wants a skilled, competent workforce and yet it wants to see the same clinicians highly visible and omnipresent on the shop-floor. The message is a confused and mixed one. The re-negotiation of my role (without loss of study leave) allowed me to complete the final years of my professional doctoral course.

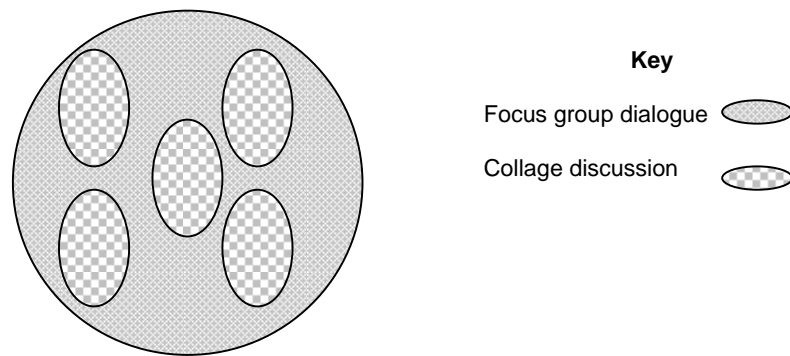
As a front-line clinician I took comfort in the fact that I was not alone in experiencing the impact this organizational 'sea change' would have on nursing practice and discussion in different clinical forums helped to confirm this view. The change in Trust focus will inevitably have influenced what staff had to say, how they chose to say it, and the examples they used, and I was keen to 'capture' this.

5.2 Group collage

When I was planning and designing this study I had not appreciated the value the collage would have in informing focus group study findings. I had envisaged it would simply act as a creative ice-breaker exercise. Three groups (groups 1, 2 and 3) initially confirmed this view and saw the collage as a stand alone exercise, to be taken at face value. Participants in these groups quickly 'moved on' from this part of the study and did not mention it again as they proceeded into their focus groups. However, seven of the ten groups (groups 4 - 10), the majority, made specific reference(s) to their collage during the focus group discussions. It

clearly informed their thinking and I realized quickly the value of analyzing their references to the collage exercise within the focus groups. It provided an added dimension to the study and has helped to inform the main focus group findings. Figure 5.3 is used to explain this relationship.

Figure 5.3 The relationship between the collage findings and the main focus group dialogue



The large, outer cross hatched circle represents schematically the focus group discussions that I facilitated with participants; the inner, hatched ovoid shapes within the circle represent the collage related discussions within these groups. The diagram shows how I teased the collage references out from the main focus group findings to acknowledge the richness of the insights that were obtained by the collage exercise.

Table 5.1 provides a summary of the collage references and their location within the focus group narrative. It can be seen from the page numbers that groups tended typically to reference the collage at the beginning, middle and end of their focus group. The collage seemed to act as a practical compass point helping to give direction and structure to the main focus group discussion.

Table 5.1 Summary of collage ideas within focus group text locations

Group	Nursing Band	Collage images - titles as referenced by participants	Location within the focus group text
4	6	The recipe So special Best foot forward	Page 1 of 47 Page 21 of 47 Page 37 of 47
5	6	Keep calm	Page 1 of 34
6	6	The onion It's a trend	Page 8 of 43 Page 9 of 43
7	7 and 'Acting up' Band 8	Taste of success	Page 2 of 20
8	5	Up front Respect Communication face to face	Page 1 of 19 Page 12 of 19 Page 12 of 19
9	6	Lady smiling drinking coffee On yer bike Rocking to and fro The dagger There's a seed of mental illness in every one of us	Pages 1, 2 and 3 of 27 Page 3 of 27 Page 3 of 27 Page 24 of 27
10	6	Feelings and ownership Fantasy holiday The clock 50% less Free	Page 2 of 24 Page 7 of 24 Page 7 of 24 Page 14 of 24 Page 20 of 24
Total	7 groups	20 References	

Many of the images chosen appear emotive and almost cathartic in their power and intensity. There was light hearted banter between colleagues throughout this exercise. Many staff commented that they had forgotten how enjoyable 'sticking and gluing' could be. Parents in the group often said that they used this technique with their children as a way of encouraging self expression and imagination. Despite being told to the contrary (at the beginning of the exercise) several individuals within the groups still commented 'you're not going to analyze this are you?' (Analysis in this context meant psychoanalytic interpretation.) Although this was said in a jokey tone, they seemed to be seeking reassurance that this was the case.

The powerful use of metaphor behind the images selected by some of the participants was striking. There was a raw intensity and a power behind their words and pictures. It literally made me 'catch my breath' as they explained their ideas to their colleagues. I knew instinctively that they were saying something really creative. I found myself momentarily distracted from the group dialogue. I coveted and wanted to capture and make instant sense of what they had said. I had to ground myself on each occasion to return to the 'moment'. To help explain findings a demographic profile of participants on a group by group basis is displayed in the next Table.

Table 5.2 Demographic profile of participants

Focus group	Participant	Gender	Ethnicity	Band
1	1	F	White British	6
	2	F	Black or Black British	6
	3	F	White British	6
2	1	M	White British	7
	2	F	White British	7
	3	F	White British	7
	4	F	White British	7
3	1	M	White Any Other Background	6
	2	M	White British	6
	3	F	White British	6
	4	F	White British	6
4	1	F	White British	6
	2	F	White British	6
	3	M	White British	5
	4	M	White British	6
	5	F	Mixed (White and Black Caribbean)	6
	6	F	White British	6
5	1	F	White British	6
	2	M	White British	6
6	1	M	White British	6
	2	M	Black or Black British (African)	6
	3	F	White British	6
7	1	M	Black or Black British (African)	6
	2	F	White British	7
8	1	M	White British	5
	2	M	White British	5
	3	F	White British	5
9	1	F	White British	6
	2	F	White British	6
	3	F	White British	6
	4	F	White British	6
10	1	F	White British	6
	2	F	White British	6
	3	F	White British	6
	4	M	Filipino	6

Table 5.2 has been used to code focus groups and individual participants' narrative. For example when referring to focus group 1 participant 1, the text is coded FG1 P1. Cross referencing this code against the table will enable the

reader to identify the associated narrative is the voice of a white British Band 6 female mental health nurse. Age, experience and exact place of work have been deliberately omitted to honour the pledge of anonymity I negotiated with the participants during the recruitment phase of the study. I have used my own initials to identify the occasions when I asked a specific question or used a group prompt to facilitate discussion. Table 4.4 in Chapter 4 describes the transcription conventions used.

5.3 Group collage findings

Group collage findings are now discussed. In each case, to aid clarity I have explained the context in which the collage was mentioned. This is followed by the relevant focus group transcript written in italics.

At the beginning of group 4, Band 6 community mental health nurses were looking at the group collage and the contributions made by their colleagues. After a few seconds of silence the following exchange took place.

(FG4 P4) [Looking at FG4 P6] Intrigued by the recipe.

[FG4 P6 had used a menu recipe on the collage.]

(FG4 P1) Yeh! What does the recipe mean?

(FG4 P6) I guess the recipe, erm; it went through my mind that it does help if you know what you're doing ...

[Group Yeh.]

(FG4 P6) And over the years I feel that's improved for me. I know what I'm doing now. I've got my own checklists, I've got my own strategies, I've got my own tool box, of interventions and confidence, I guess, and that was the word I was

looking for in there that I couldn't find to go with it. So when I saw the recipe, I thought well I'll cut that out because it kind of highlights the importance of having that fundamental, you know, the ingredients ...

(FG4 P1) Mm.

(FG4 P2) Method.

(FG4 P6) The method, although we are not that task orientated, you know there is a very right way of practicing and there's a very wrong way of practicing.

(FG4 P4) That's where that comes from [points to collage words] 'so special' that sort of confidence. That it's ok, to, you know to put yourself under the ...

(FG4 P1) Under the microscope.

The feeling of being under the microscope was a theme that the participants returned to later in their narrative. I had asked them what kind of adjectives might describe how it felt to be observed.

Participant 5 pointed to the collage and said "*Best foot forward.*" This is in the centre of the collage and is upside down. The group laughed and her colleagues responded.

(FG4 P1) Exposed, at times.

(FG4 P2) Exposed. Scrutinized.

Focus group 4 collage



These two ideas of 'practice confidence' and 'scrutiny' are also picked up in other groups and examples now given. They formed two of the eight focus group categories discussed later on in this Chapter.

(FG7 P2) ... I think being unobtrusively observed I mean I put [pointing to collage] a 'taste of success' because actually being unobtrusively observed sometimes can actually bring your career forward, other people can see your good practice and can see things that you get lost in because you know busy shifts ...

Focus group 7 collage



(FG10 P1) Sometimes you can feel quite confident, being observed, you know, is a chance to shine out as I put on there [this collage is displayed later in the text]. It's a chance to show off different skills we have or maybe it brings up deficits as well.

A slightly different stance is taken by a participant in focus group 5 who begins to explain how the thought of being observed makes him feel quite anxious. This is captured by his images and focus group narrative.

(FG5 P2) I suppose it still invokes some feelings. You know you are going to be observed. So I suppose as I put on there [pointing to the focus group 5 collage], its kind of yes keep calm, you do know that it's happening, so I think it helps to get away from that first of all. Almost like lose that 'I'm being watched feeling' and then focus on what you're doing.

His colleague responds by commenting.

(FG5 P1) I guess we are unobtrusively observed all the time aren't we?

Participant two pauses, reflects on what his colleague has said, and responds.

(FG5 P2) I suppose there's more than just one layer to it isn't there? I suppose we are being unobtrusively observed via, I don't know, our management supervision, our clinical supervision, our risk assessments, our NMC [Nursing and Midwifery Council] standards of record keeping and medicine administration ...

He trails off and his colleague agrees.

Focus group 5 collage



In focus group 9 a participant explains why she had selected an image of a dagger as the unwanted gaze. Her words are chosen with great care as she describes observation as a powerful surveillance tool; a means for staff to observe one another and stab one another in the back by using the information received to personal or organizational advantage.

(FG9 P3) ... that's partly about, you know, very simple things going on that other colleagues have observed and then gone off and reported, not particularly accurately, ... it can actually be a very negative thing for some people and actually affect their career quite significantly.

Her colleague comments.

(FG9 P1) So it's the unobtrusive bit that actually was not 'up front' ...

This leads the group on to discuss the importance of portraying an image of confidence even if it is not always actually felt.

(FG9 P3) Who did that one? [Pointing to the image of a lady smiling, drinking coffee. This image is hard to see on the collage.] That intrigued me.

(FG9 P1) Me! Because that and that [she points to two other pictures on the collage] if I was being observed I would want a smiley confident pose but actually in reality I'm likely to look a bit anxious about being observed because I feel, yeh, I'm being judged.

I sought clarity on who might be judging her.

(FG9 P1) The person who's observing ...

(FG9 P2) I think also for me it will be me judging myself.

(FG9 P1) Yeh.

(FG9 P2) Wanting to know that I'm looking like this [she points to the image of the lady smiling, drinking coffee].

There was group recognition that sometimes it felt more important to make a good impression than others.

(FG9 P2) There are still situations where perhaps because of the person who's observing you, you really, really want to look like this [points back again to the image of the lady smiling drinking coffee and laughs]. More so! Perhaps if it's managerial observation or if you're in a situation of teaching sometimes, because you want to come over as being this capable practitioner ... you know unflappable.

The group continues its discussion about wanting to present an external façade of confidence and to be likened to someone who is described as the television presenter Fern Britton.

(FG9 P4) ... dynamic, adventurous, confident.

Her colleague comments that in reality, she vacillates between feeling confident in her own ability and having self doubt, and she points to the collage.

(FG9 P3) ... sometimes I guess for me I swing back and forward or rock back and forward between feeling quite confident and feeling actually quite anxious.

(FG9 P1) Yes.

(FG9 P3) ... sometimes being observed kind of feels like being in a nursery. And it can make me feel quite young again depending on who's observing me and

what the situation involves. But I'm very aware that I can rock back and forward just in a session by being watched.

The group discusses a phrase that has been stuck onto the collage. It reads:

"there's a seed of mental illness in every one of us." They decide they should adopt it as their team motto because it describes many of their own thoughts and feelings. There is group awareness that these emotions are no different to issues commonly discussed with patients.

There was recognition amongst the members of focus group 10 that confidence levels vary.

(FG10 P1) I guess it depends really on how you are that day. Sometimes you can feel quite confident about being observed.

Focus group 9 collage



An image of an 'onion wearing glasses' was used by a Band 6 nurse in focus group 6.

Focus group 6 collage



It was explained as follows:

(FG6 P1) *Erm that business I said about the onion yeh? [Points to the collage] with the glasses on.*

(FG6 P2) *Hm.*

(FG6 P1) *I thought about that afterwards. And I mean when you peel an onion it's just layer after layer and nothing in the middle.*

(FG6 P2) [Laughs.]

(FG6 P1) [Laughs.] So the onion with the glasses on is actually quite a good metaphor because when you peel all this observation away there's actually nothing in the middle. There is no core in the middle, too, nothing to reflect it back at us. I think that's the issue.

The same participant goes on to develop his thinking and discusses the role audit plays in modern health service delivery.

(FG6 P1) ... I put on there [pointing to the collage] about trend that there's this trend at the moment that everything has to be measurable, quantifiable, even our therapies. Even our therapies have to be measurable ...

Group 10 recognized this and the impact it had on patient contact, one participant noting:

(FG10 P3) And they get very much less than that [points to collage with text saying 50% less]. Don't they? ... You know. There's always this sense of what can I hive off here?

She was referencing the need to prioritize her case load and decide who she should visit and who would be 'safe' to leave for another day.

The importance of 'censoring' the supply of magazines I obtained from various sources was brought home to me in group 8 when a colleague noted with wry humour.

(FG8 P2) I thought it was quite apt that you bought a magazine with an image of guns on it with the sub-heading Better Stalking!

[This had been accidental on my part.]

Focus group 8 collage



His subsequent insights about feeling audited, monitored and pressured to complete paperwork were themes which emerged time and time again in the focus group discussions. In this example staff were commenting on the perceived 'hidden agenda' behind a managerial request to read a file of new Trust policies that had been updated, and to sign against each policy to confirm they had read, understood and agreed to implement it. Staff were not given extra time to do this.

His colleague (FG8 P3) had previously pointed to their collage and remarked about whether, as she had put it, things were always 'up front'.

(FG8 P2) ... it does feel like being stalked and it does, ... it feels just that somebody somewhere has come up with this so that if we get something wrong they will just say we told you, you should have done it this way. And it gets in the way. The irony is that we have less time to actually do the job that we're supposed to do, because most of the time we are being audited and having to

get our notes and everything up to date so, actually the patients, we don't get to see much of at all.

This led on to a discussion about the halcyon days of nursing when less emphasis appeared to be placed on paperwork and nurses felt valued and consulted.

(FG8 P3) You see years ago you were saying what did an old matron do or a staff nurse? You know, I don't know, but surely they didn't have hundreds of bits of paper, surely they just ran their ward?

(FG8 P2) I mean I always say I don't ever want to go back to the romantic rose tinted glasses thing because it wasn't all perfect.

(FG8 P3) Yeh.

(FG8 P2) But I definitely feel as though there was, and I think I kind of put it there [pointing to the collage] there was face to face communication.

(FG8 P3) Right.

(FG8 P2) There was another thing there [referencing the group collage] about respect, but I didn't put that in, but respect was kind of a given thing ...

In focus group 10 participant 1 also makes indirect references to respect as she notes.

(FG10 P1) ... I think sometimes when we don't get feedback as to how we're doing, you kind of feel sort of confused and a bit in limbo really ...

Time pressure and feeling observed were also ideas expressed by participant 3 in focus group 10. She comments:

(FG10 P3) ... I do think these words [points to the upper right hand corner of the collage where she has cut out the words 'old fashioned'] were picked out for me. This clock, ticking clock, bell jar sort of time piece, being observed and the fact that I feel quite old fashioned now. It is hard to adapt to new things.

Focus group 10 collage



Her colleague responded by commenting.

(FG10 P1) ... it seems that you know more and more the emphasis is on money.

This led on to a discussion about the importance of feedback and how 'bottom-up' practitioner views were fed into 'the system' to try to influence care but 'top-down' feedback was rarely received in return.

(FG10 P4) I suppose it's the black and whiteness of this sort of job really. For me it's interesting doing this cutting out [points to the group collage]. I actually couldn't put, or in the end decided I didn't want to put the good bits with the bad bits, so I am trying to think of [points to one half of the collage], Yeh this is a picture of, you know, my sort of fantasy holiday away from it all, being alive, being free, you know, looking forward, and then [points to the other half of the collage]. It was all these horrible pictures and all these horrible words that had to be away from the nice ones. I suppose that's my way of coping.

In this section of the Chapter I have looked at the images and metaphors generated from the collage group exercise to begin to understand how nurses felt about being unobtrusively observed. These ideas are now further developed within the focus group discussion.

The mood and atmosphere of the focus groups varied enormously. I was particularly struck by the sense of 'resigned despair' that pervaded the atmosphere of one of the groups (group 10). I wanted to come out of 'researcher mode' to tell them what a fantastic and admirable job they all did in very difficult circumstances. I knew this would not be appropriate. I felt sad hearing, first-hand, skilled and experienced colleagues using the language of oppression and I wanted to be able to actively challenge it by providing an alternative perspective. Instead I stuck to my 'script'. When I transcribed the tape however, I was surprised by the number of questions I had asked the group. 'Initiating' questions to raise consciousness and critical literacy is recognized by Shor (1992) (a disciple of and collaborator with Freire) as a legitimate liberating technique.

(GS) How do you feed that back into the system then? How do you say to managers, there's a sense here that I'm a principled practitioner and somehow you're compromising some of my ideals?

I had not been conscious of this at the time and as such was unable to acknowledge and 'bracket' my thinking. I asked a similar question later on in the group.

(GS) Do you see yourself as able to change the system? Cos there's this sense of, I don't know, almost oppression, that we're working really hard, it's not appreciated and yet I still need to be defensive, because I am just waiting for the day when something goes wrong.

[Group Yes.]

(GS) And actually, I really am giving you 150%.

(FG10 P2) Yes.

(GS) So how do you manage that? Because that is not a good place to be is it?

I asked this again on a third occasion.

(GS) How can you change it then because you're all saying similar things as really experienced practitioners? You know what you are good at, and actually it's about being out there [points outside] and doing 'what nurses do' and yet you're kind of, I don't know, submerged and bogged down and drowned by all the stuff that gets in the way. Do you see yourself challenging that? Or is that just how it is? As a nurse today?

This was re-echoed later in the group.

(GS) I wonder why nurses don't rally together. Because we make up 45% of the workforce, we are a very powerful base and I guess you're all saying similar things in slightly different ways. And I guess your colleagues aren't saying

anything that different. But it's interesting that we 'allow' ourselves to be in this position when collectively we are very powerful.

The response:

(FG10 P2) I'm just too depressed to do anything about it!

The group laughed at this remark and there was a cathartic 'moment'. I sensed beneath the humour of the words there was an underlying truth as well. This was not lost on the group. They were describing feelings of oppression and alienation. They felt downtrodden and subjugated by 'the system', powerless, or so they thought, to do anything constructive about it.

5.4 Focus group reflections

The dynamics and atmosphere of each group differed enormously. Some 'launched' into a seemingly authentic dialogue with each other almost immediately. They 'unpacked' ideas as they spoke. They contradicted and corrected themselves as they went along and realized what they had said. Others proceeded with caution and the group felt more strained. I tried hard not to impose my own agenda on the group too early, to avoid making the conversation stilted. I was equally mindful that we were there for a purpose. It needed to be a directed and focussed group discussion. There were occasions when I achieved this more convincingly than others. As I replayed the tapes, I found myself wincing as I heard myself time and time again rush in to fill a silence. It seemed unending in real time and fleeting when caught on tape. I found myself wondering 'what if I had not interrupted?' But I quickly realized that, despite this, I had and that no amount of regret would change this.

In the early stages of this Chapter's development I found myself naturally reflecting on why some staff had agreed to participate in the study whilst others had not. I wondered what had motivated those who took part, and was interested

in what had stopped or inhibited those who had not responded to the recruitment phase of the study. I obviously could not ask them. This may have been perceived as coercive. It would have stepped over the line of free and informed consent which I had negotiated with the ethics committee. I liked the unsolicited explanation, again in the form of a metaphor, which emerged during focus group 3.

(FG3 P3) I think nurses are a bit like Harry Potter really. They can choose to put their invisibility cloak on or they can take it off and be as visible as they like. That's how I see it. I mean you know the fact that we're here today with you is because perhaps all of us are very keen to be visible and keen to keep our profile in nursing and recognize that actually what we do is worthwhile. The fact that if, you have been trying to invite people to come then perhaps the Harry Potters have put their cloak on and are happy to be invisible. And I think that that's quite significant ... So yeh I think that nurses can be very visible. Perhaps they get their eyes poked too much, or they get pushed too much.

This sentiment is echoed by her colleague as he remarks.

(FG3 P1) ... the people that I consistently respect are good clinical ward nurses. You can be as high profile or low profile as you want to be within this job ... Anyone can sit in an office and kinda pull the strings because you can and it is a bit like being the site foreman. You know you can just take an 'overview' and let other people get their hands dirty ... They're doing it at arm's length. They're doing it via ecpa⁴ they're not doing it on the coal face ... The people I enjoy working with are the ones who can do both.

His colleague agrees.

⁴ Ecpa is an abbreviation for Electronic Care Programme Approach. This is a framework for assessing, developing, sharing and reviewing a plan of care with a patient and their relative/carer.

*(FG3 P3) ... you will find nurses who as an avoidance technique, because they don't feel competent or skilled, are very happy to be in the office because its safe, they don't have to interact, don't have to have their weak spots highlighted. They appear to be very good at paperwork, busy, shuffling files from one place to another and visible in the eye of the doctors. Well you know I spoke to **** and she seems to know what's going on. But does she?*

As staff 'unpicked' their practice and examined the motive behind their colleagues' inaction in the safety of a focus group setting, they seemed to be describing 'fear of freedom' and what 'could be' as important maintaining factors.

Full orthographic and word processed verbatim transcripts of the focus groups were made. Sound files were downloaded onto a database. The reflective diary that I (erratically) kept to record research highs and lows consisted of illegible handwritten notes and Dictaphone thoughts. These often occurred to me in the middle of the night. As such they have not been submitted. This was a recurring discussion point with my supervisory team. They questioned whether I was denying them access to a rich resource of inner thoughts and feelings, fearful of exhibiting vulnerability and self doubt. Where possible I tried to weave these reflective and critical insights into the study as it progressed. Although regularly cajoled to the contrary I always resisted the idea of totally laying bare this journal in its crude and uncensored format.

Gilbert (2001) likens the act of reflective practice and supervision to penitential 'acts'. He uses the metaphor of the supervisee 'confessing' by self-disclosure to the all knowing and all seeing supervisor who critically listens, 'collects secrets' (Perron et al., 2005) and has the power to 'absolve' the penitent of transgressions. He can also discipline and publicly castigate. Unlike a priest and the confidentiality and anonymity of the 'black box' (confessional), the supervisor's silence is not assured. Reporting up the chain of command is a more likely consequence. Whilst I had no doubt that my carefully selected supervisors

would not betray my trust, I was ever mindful of the local research performed by Clarke and Flanagan (2003) discussed in Chapter 3.

As an emic nurse researcher I naïvely assumed I would have unique insights into the vocabulary and nuances used by my colleagues. However, there were still many occasions during the collage and focus group discussions when clarification was required. I am sure many subtle 'digs' aimed at other teams went over my head. I was conscious of trying to avoid 'defending' my own practice discipline when negative (but probably true) comments were made about in-patient services.

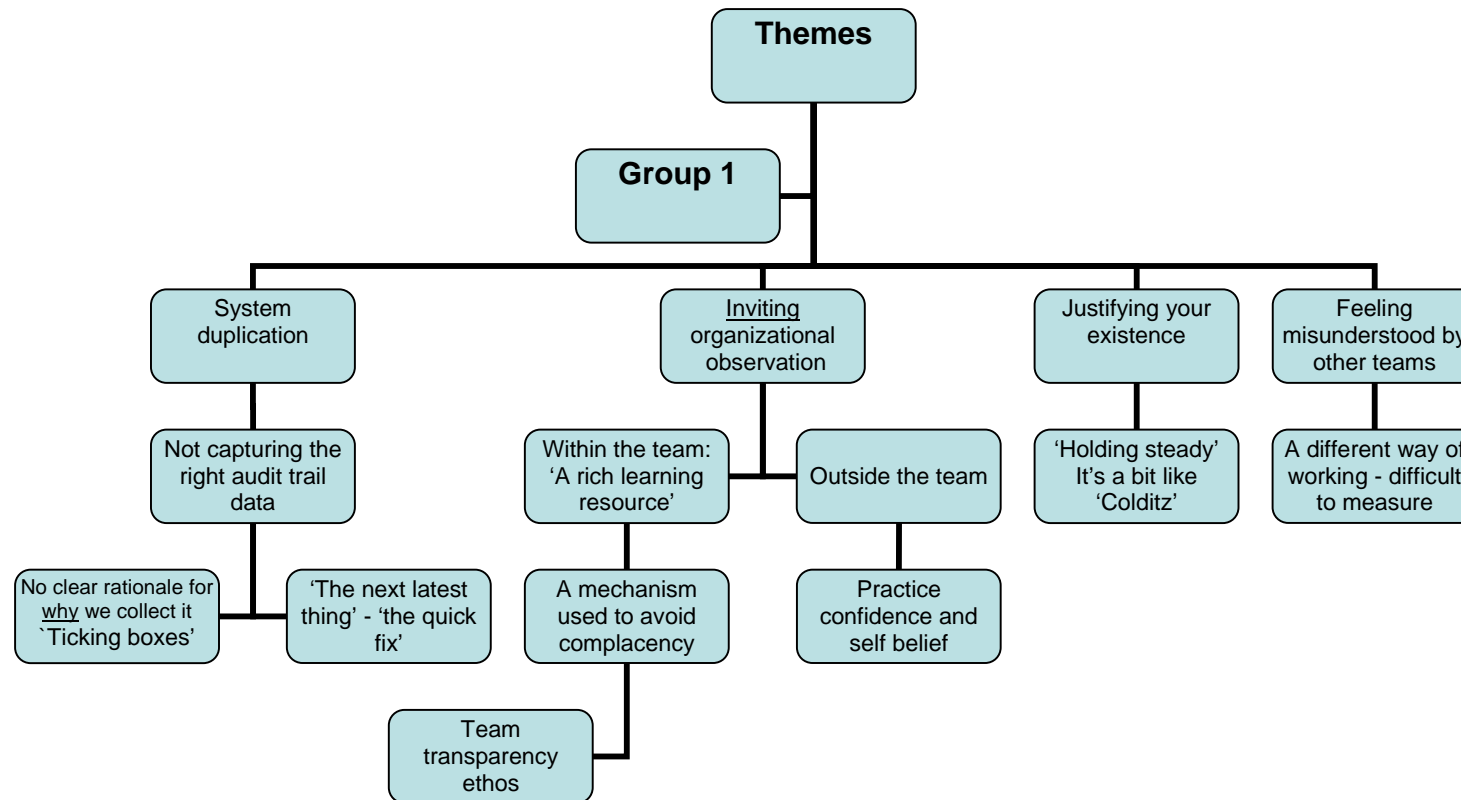
Ideas came slowly as I played and replayed the tapes and read and re-read the transcripts. I discussed my preliminary thoughts and ideas with Action Learning Set peers and my supervisory team. The metaphors used to describe key focus group themes came from a number of diverse sources. I 'allowed' myself to be open and receptive to ideas. These will be explored in Chapter 6.

5.5 Thematic analysis

Table 5.3 in the form of ten organizational charts show how themes built up from the focus group data led to the development of higher order themes summarized in Figure 5.4. As I looked through the themes on a group by group basis it became evident that staff had given an essentially balanced view of the ways in which they felt unobtrusively observed in individual clinical settings. They were able to identify many positive benefits of being watched and described how these were used to individual and team advantage. Staff also described practice-based tensions and gave clinical examples of areas they would like to re-negotiate with their managers at a corporate level.

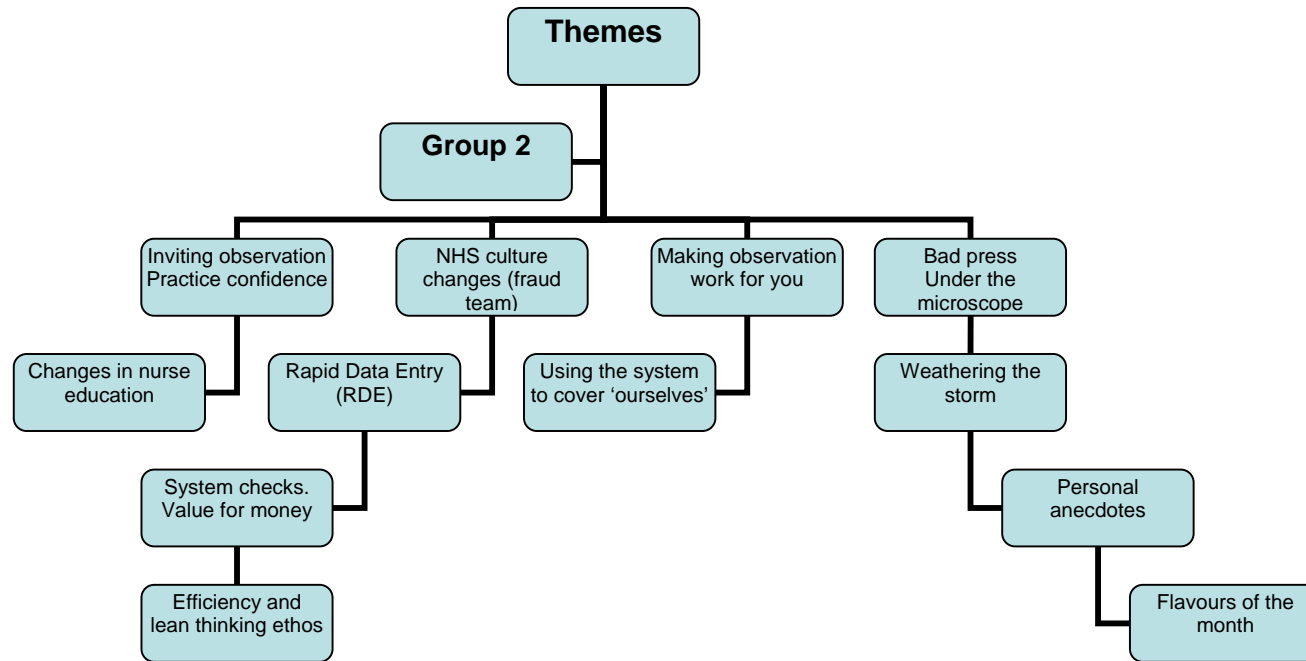
Table 5.3 Focus group 1 (Band 6)

Thematic analysis



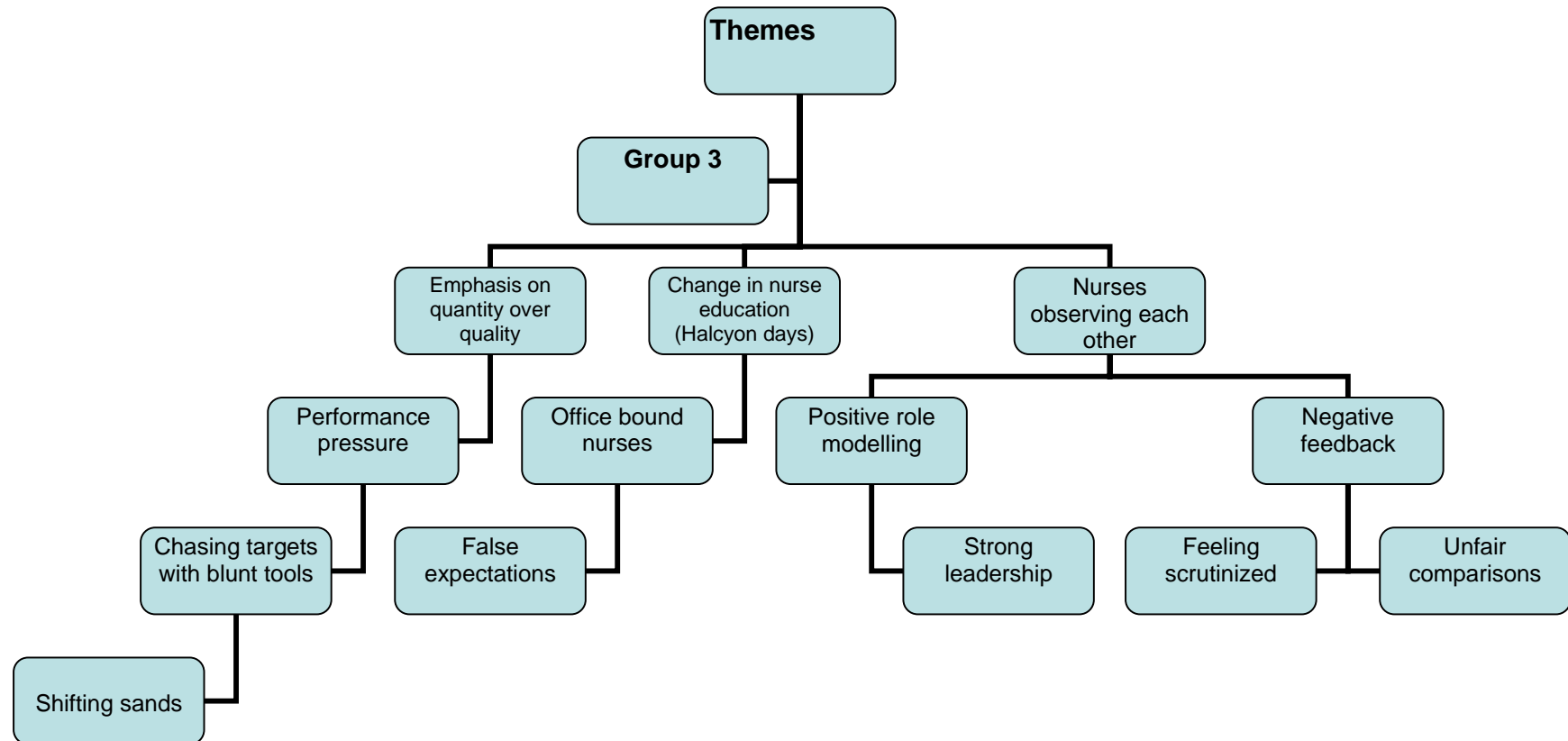
Focus group 2 (Band 7)

Thematic analysis



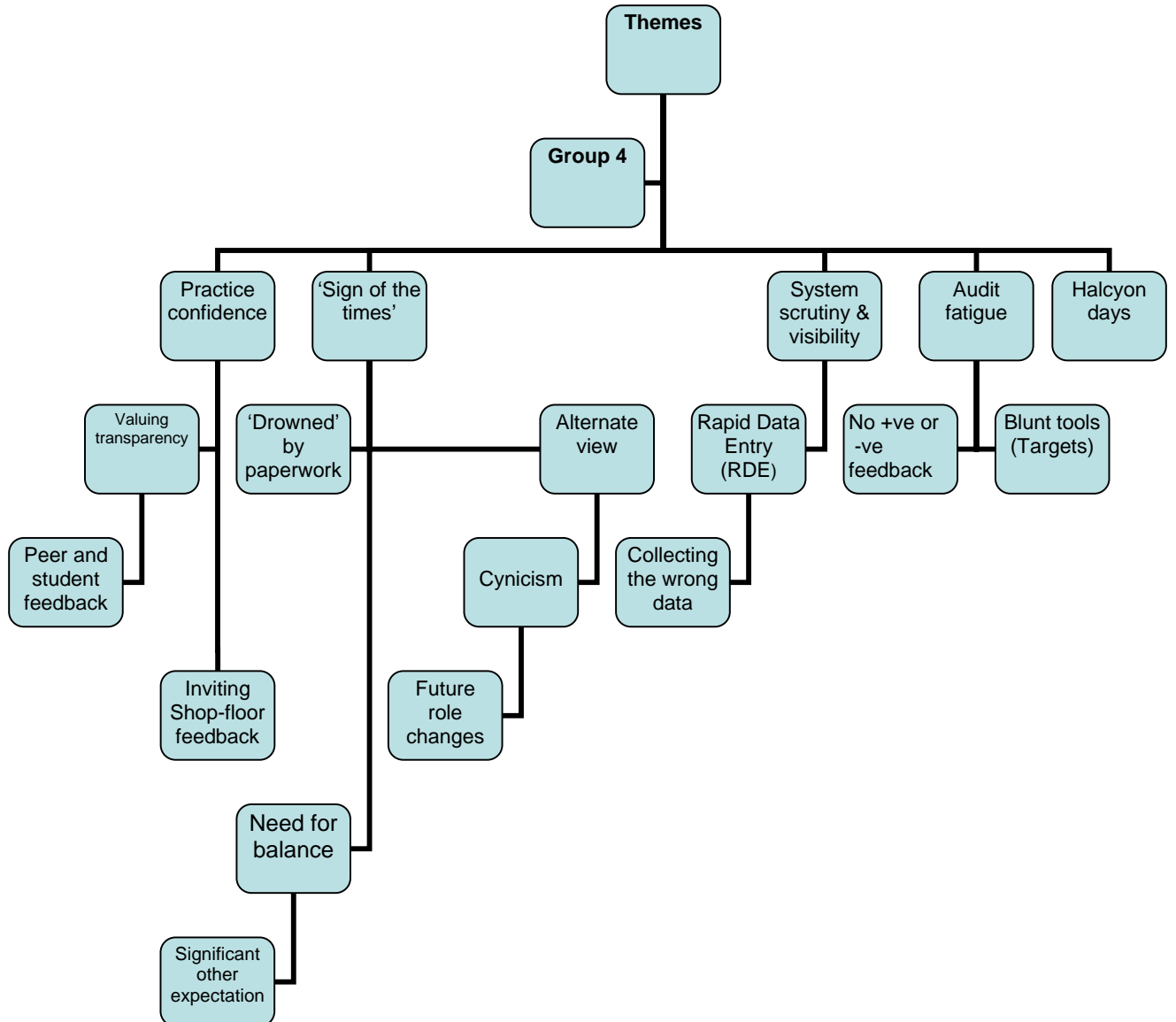
Focus group 3 (Band 6)

Thematic analysis



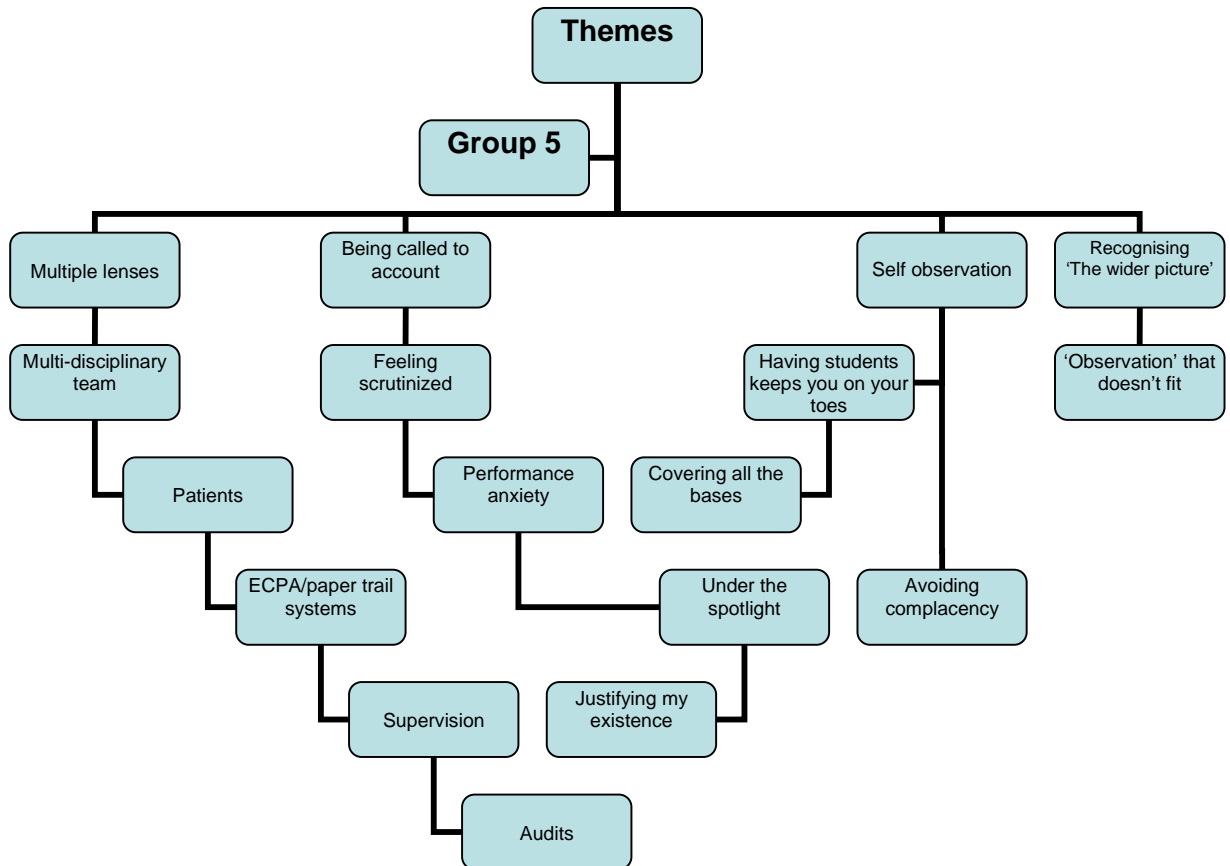
Focus group 4 (Band 6)

Thematic analysis



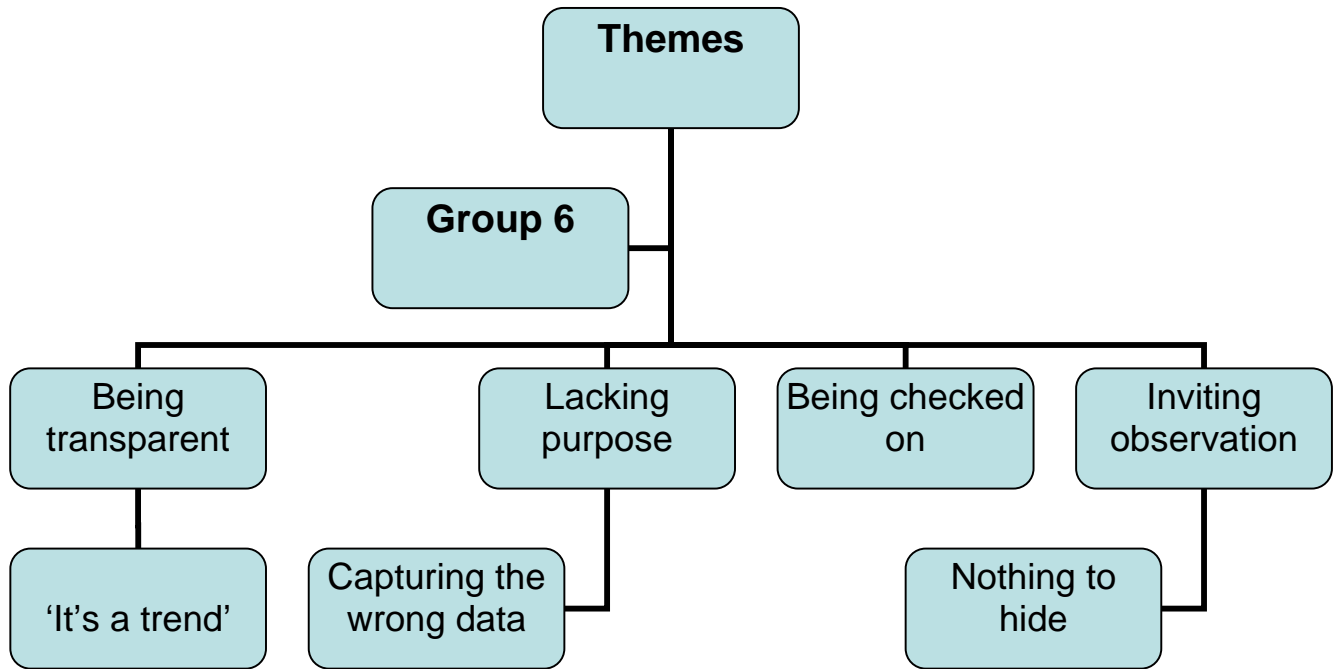
Focus group 5 (Band 6)

Thematic analysis



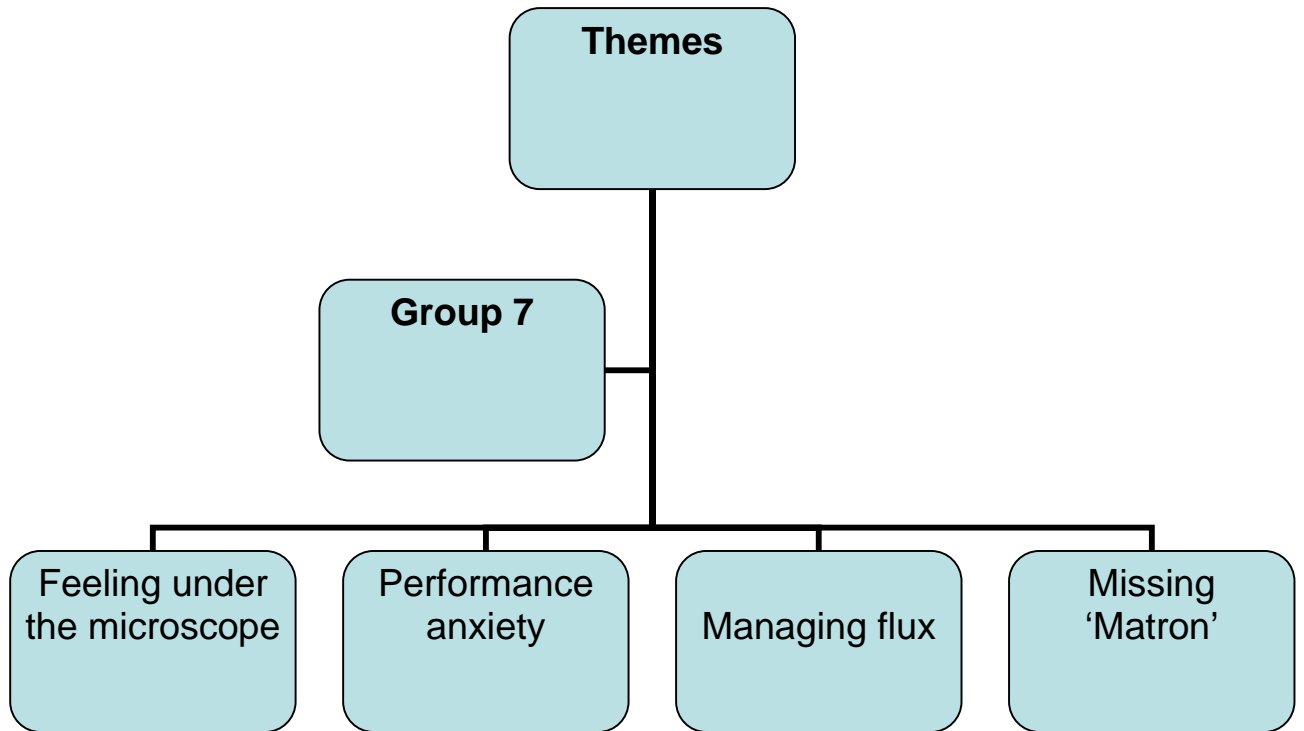
Focus group 6 (Band 6)

Thematic analysis



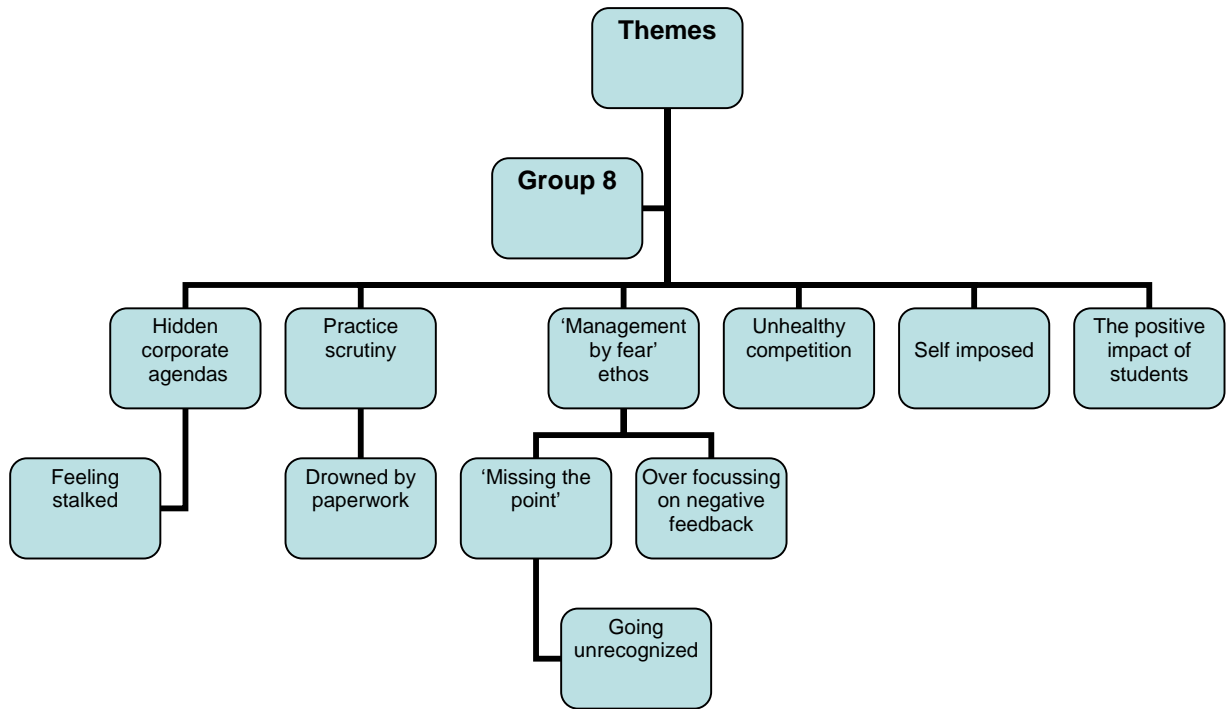
Focus group 7 (Band 7)

Thematic analysis



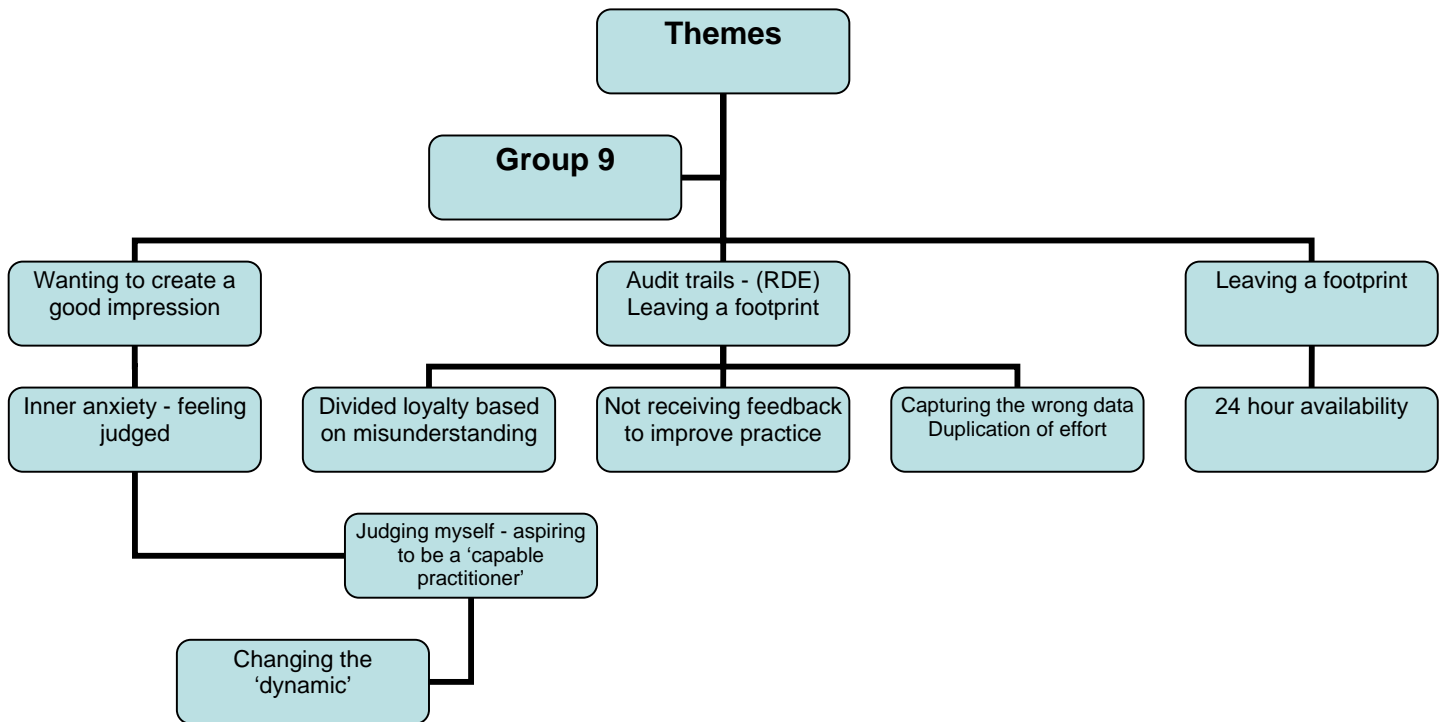
Focus group 8 (Band 5)

Thematic analysis



Focus group 9 (Band 6)

Thematic analysis



Focus group 10 (Band 6)

Thematic analysis

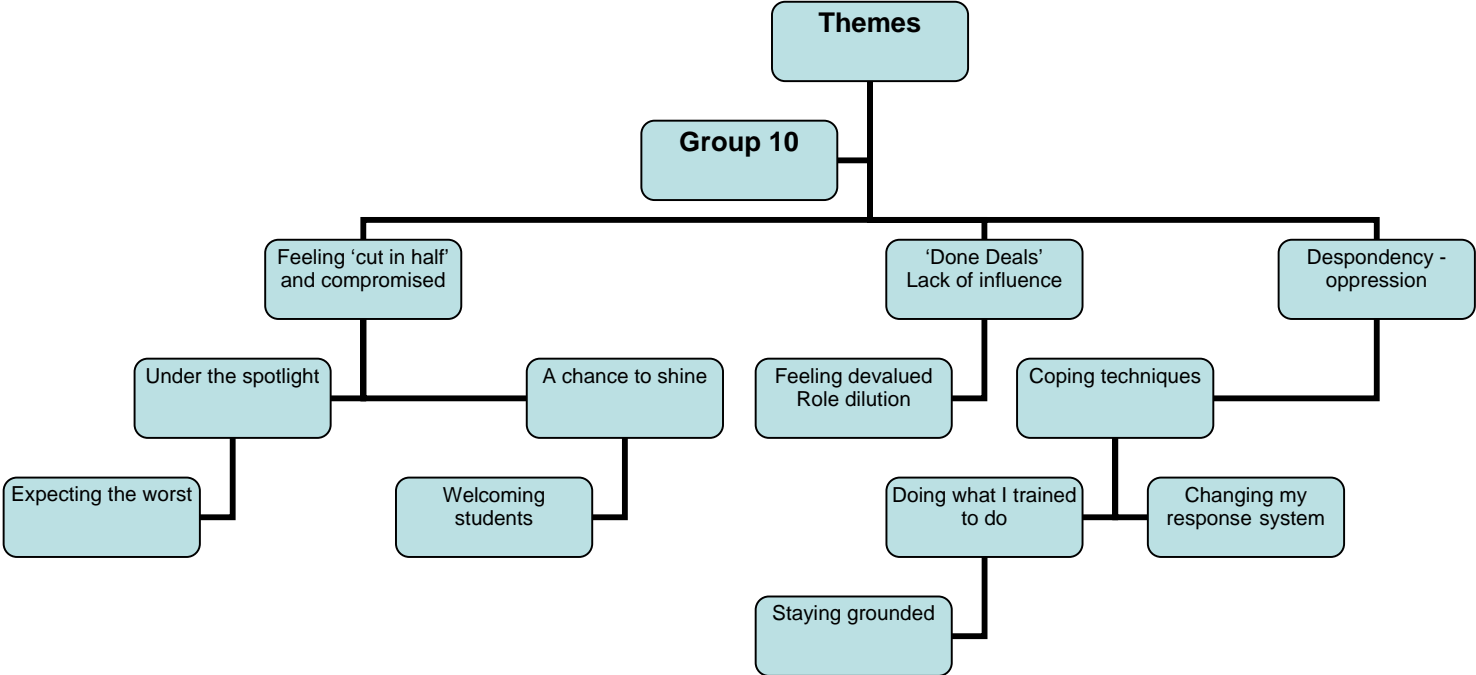


Figure 5.4 Higher order themes which emerged from the organizational charts

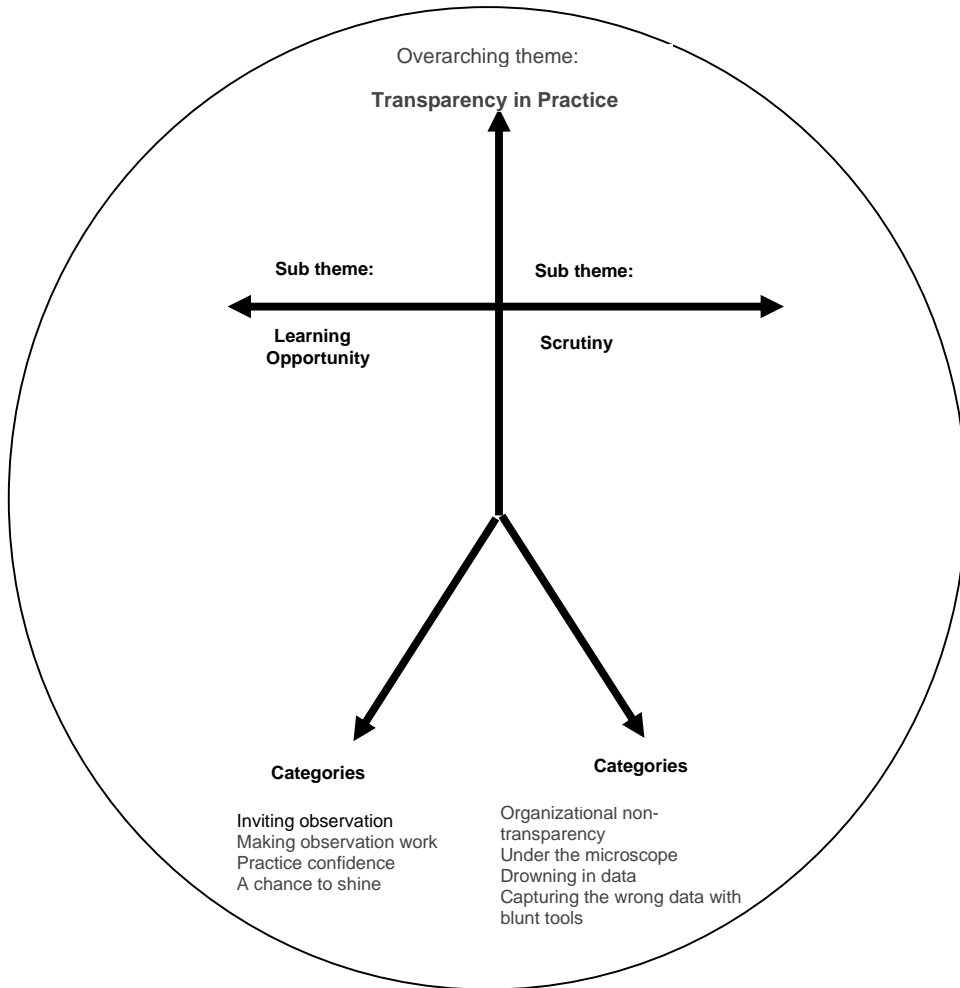


Figure 5.4 is used to demonstrate how the development of the eight categories and higher order sub themes of Learning Opportunity and Scrutiny were built up from the ten organizational charts seen in Table 5.3.

Eight categories emerged from the focus group data. These were:

- 1) Inviting observation
- 2) Making observation work
- 3) Practice confidence

- 4) A chance to shine
- 5) Organizational non-transparency
- 6) Under the microscope
- 7) Drowning in data
- 8) Capturing the wrong data with blunt tools

These eight categories come together into one overarching theme; Transparency in Practice. I have used this term because participants were either describing the ways they felt their practice was transparent and open to observation or they were commenting on aspects of the perceived non-transparency of the Trust's current organizational systems. Two sub-themes, Learning Opportunity and Scrutiny, are used to help explain their views from these two varying perspectives.

Where possible I have tried to use Freirean insights alongside focus group participant narrative. This has been done to demonstrate the Freirean thread running throughout the study. To help me analyze findings through this lens I devised Table 5.4 to display focus group themes and their related Freirean concepts.

Table 5.4 Putting focus group findings into a 'Freirean' framework

Positive themes Learning Opportunity	Related Freirean concepts Learning through education
Inviting observation	The potential to change Valuing education Co-investigation Embracing and tolerating uncertainty
Making observation work	Creative Action
Practice confidence	Becoming all you can become Feeling enfranchised Acting in spite of fear
A chance to shine	The practice of freedom Achieving transformation through dialogue this is a social process

Table 5.4 (continued). Putting focus group findings into a 'Freirean' framework

Negative themes	Related Freirean concepts
Scrutiny	Oppression
Organizational non-transparency	<p>Power over the oppressed</p> <p>Maintenance of the status quo by a maze of bureaucratic processes underpinning the modern NHS</p> <p>Recognition of this is an important stage in the pedagogy of the oppressed and the journey towards the goal of conscientization</p>
Under the microscope	<p>Caught by the 'gaze' of the organization</p> <p>Feeling an 'object' and not a 'subject'</p>
Drowning in data	<p>The struggle for freedom</p> <p>Feeling submerged and engulfed by 'the system'</p>
Capturing the wrong data with blunt tools	<p>Beginning to know the space in which we are⁵</p> <p>Seeing things as they could be and not as they are now</p>

⁵ Quote taken from Shor and Freire (1987, p.61).

5.6 Categories within the theme of Learning Opportunity

The sub-theme of Learning Opportunity consists of four interdependent categories. These are:

1. Inviting observation
2. Making observation work
3. Practice confidence
4. A chance to shine

These will be considered individually although they are very clearly linked and in reality often merge naturally into one another. Illustrative quotes have been selected from the focus group transcripts to help explain and contextualize the categories. These quotes, which often overlap from one category to another, build the rich tableau of experiences described by focus group participants.

1. Inviting observation

Staff welcomed unobtrusive observation as an opportunity to receive informal but nevertheless informed feedback from their peers, patients and the student nurses on placement with them. This feedback was recognized as a valuable learning resource and a practical reflective tool. Generating and sharing practitioner knowledge can enhance critical thinking. It is an investment in the future. It is a willingness to embrace doubt and tolerate uncertainty.

(FG1 P1) ... I think we do all observe each other both consciously and unconsciously ... but I think in a hopefully on the whole in a sort of positive supportive way, rather than in a negative way ...

There was an overall recognition in focus group 1 (all clinicians from the same team), of the importance of 'playing to team strengths'. There was awareness that working with patients over a long period of time could make a practitioner stale and lose focus and clinical direction. 'Checking out' with colleagues was seen as important. It was perceived as a useful way of avoiding complacency.

*(FG1 P1) ... I know I'm quite conscious of inviting observation in ... you know should I be doing this? Should I be doing that? Is it all right? And it's a checking out kind of observation. Is there everybody else in the team sitting around saying what the ***** [expletives deleted] is she doing? Or actually is it ok? So I know I am quite conscious of bringing stuff in for observation. Being mindful of the fact that I have been there a while and recognizing that you can get stuck. You can get stale. You can see things very differently.*

Her colleague responds, cautioning the need for balance.

(FG1 P3) On the other hand there's the 'if it ain't broke don't fix it' approach as well isn't there?

This was readily acknowledged. As a seasoned practitioner, role growth and confidence 'allowed' her to invite feedback. She may have felt less comfortable doing this in the earlier stages of her career.

(FG1 P1) There is, but that needs checking out sometimes.

Honesty and transparency were valued.

(FG1 P1) ... And you know that if you're not sure you'll say ... I'm winging it here or this is not a great skill of mine. You know you'll make that known to start with.

This is also described in group 4.

(FG4 P6) ... we need to be open and I like to think that I practice quite openly. And I don't mind having people sitting with me for assessments. ... And I think this sort of transparency is vital because we can end up by the autonomous nature of our roles, very, you know, sort of insular. I think that's quite dangerous. If you're not comfortable in having other people working with you, observing you, and you're not open to that, sort of, I'm not saying scrutiny but ...

Reflective practice and 'checking out' behaviour is picked up again in group 3 by a Band 6 nurse. She is talking about the positive experience of clinical supervision in her previous role as a community nurse.

*(FG3 P3) ... when I was community nursing in the **** area you had an external commissioner who was equal in terms of profession or background and who actually knew the context of your job and what you did, so you could actually say 'well I am taking this case. I'm getting very burnt out with this person, what else can I be doing? If anything'? And you would know that they would have a different alternative framework about it, so in that way your reflections on your own abilities could either be confirmed or somebody turn saying actually there is nothing more that you can, so as an observation tool, that was really useful ...*

The usefulness of working with colleagues and obtaining informal feedback was echoed in group 4.

(FG4 P6) ... we do assessments with each other, you know. It depends how we organize ourselves, sometimes, you know, we may take turns in asking questions or one person will do all the interview and the other person will sit and maybe intervene at the end. Or, you know, we do joint working in terms of interventions.

Her colleagues agreed with her observation. Encouraged by this she clarified what she meant by saying.

(FG4 P6) I think that's very useful. Because, you know, you can reflect back to your peers as well. You know you did that really well or you could have done that differently.

Focus group 1 participants recognized the strengths associated with collaborative ways of working. It was appreciated that this model was not always fully understood by colleagues from other clinical areas or disciplines within mental health. One participant felt strongly that it was this approach that was the defining feature of the Assertive Outreach Model. She believed this was a poorly grasped concept 'outside' her team.

(FG1 P2) ... it is not just about team work as in we all meet for review meetings and meetings. It is actual team work because we are actually taking huge strengths in that daily meeting and it's very different ... I think we are very different in how we team work and I think that's fundamentally what people don't quite grasp. And you can't. As you say unless you are in there doing it I don't know that you can. How can you explain that?

The value of being able to discuss in-house practice issues and obtain peer advice and encouragement is noted by the same participant. She describes the support received from colleagues when she feels she has used and exhausted the skills in her tool box. She sets the scene by describing her frustration.

*(FG1 P2) ... I've come to the end here I can't, don't know what I was doing but then someone like yourself or you know **** turns and says, Well actually **** they're doing this and they're doing that and they weren't doing that before and like I've just said oh right ok and just that reenergizes you to think ok you haven't lost it. You've, it keeps the, it keeps the normalization; it helps you to be more objective in seeing progress. Versus thinking oh I'm hitting my head against a brick wall here. I can't go any further.*

This sense of frustration was also mirrored in group 9.

(FG9 P4) And we've shouted at each other haven't we? I've come to a stop here! What do I do? How do I carry this over? Do another review or something? Usually one of us knows something!

Other teams referred to this as being able to role model and use the techniques they have observed and learnt from colleagues.

(FG3 P4) Cos we all work side by side we are all observing each other aren't we? And we copy each other, don't we?

(FG3 P2) Sort of model.

(FG3 P4) We imitate the good behaviour that we see in the nurses that work how we would like to be.

(FG6 P1) ... All the best nurses I know will steal good ideas off people all the time.

His colleague readily agrees.

(FG6 P2) That's how it's always worked. That's right. And that's right if you come up with something that's perceived to be positive. Your colleagues will look at that and think, Yes. And it gives them; it gives a way of refreshing what you do because you are being observed by others.

Focus group 2, Band 7 nurses (senior nurses) voiced frustration that offering positive feedback was misunderstood as misplaced sarcasm.

(FG2 P4) You give positive feedback to someone and they look at you as if to say 'are you having a laugh?' It's against culture! Nurses aren't very good at celebrating when they have done well.

And again later in the group.

(FG2 P4) ... sometimes that one negative comment that is made seems to stick in people's mind far more than the positive.

The importance of really 'knowing' the patient was recognized as central. Feedback offered without these credentials was perceived as well intentioned but misguided and misplaced and it was less likely to be appreciated or acted upon.

(FG6 P3) ... you get some really good suggestions but they don't actually know the client and whether you need to section them. I know it sounds like they need a section but they're not sectionable, you know, you need to see the person and ...

(FG6 P1) Sometimes it's intrusive. It's not a bed of roses.

The role of constructive feedback and challenge within this theme was also appreciated.

(FG6 P1) You know people will say what are you doing with that person? What's that about? Can you justify that? And that's fair do's.

His colleague protests.

(FG6 P3) But then you don't work in a way there's no rationale for.

He comments.

(FG6 P1) But you won't improve if you don't get challenged! [Laughs.]

A closely allied concept is a category I have called making observation work for you. It refers to staff accepting the need to work within the constraints of 'the system' and devising strategies to make this easier.

2. Making observation work for you

Focus group 1 participants described the value of team work. They used the experience gained from colleagues to mutual individual and organizational advantage. I asked them whether it had been through choice or for organizational convenience that they had chosen to participate as a group. They seemed genuinely surprised by my question.

(FG1 P2) For me taking part in this as part of a team I guess is just our general daily routine [laughs] ... we come in and discuss our anxieties, our fears, our concerns and pull in a group of ideas in which we are supporting each other; the frustrations, the good practices, erm, and risk taking. Yes and I think it's a privilege to have it. And I think that's a strength for us. We don't always agree with everything all the time.

(FG1 P1) Thankfully ...

(FG1 P2) But respecting that it's different opinions and different views and situations. Yes it's a plus for us I think to work as a team.

(FG1 P3) Yes and I must admit I hadn't really considered not doing it as a team really ...

*(FG1 P1) For me the unconscious observation is learning off someone else.
[Team consensus] yeah, absolutely.*

(FG1 P2) Because in your walk of life as well as in your practice if you become blinkered in an, 'I know it all way', I'm sorry! You're going to have big problems.

And if you're working in a team environment, you know, you pull on the strengths from each other.

(FG1 P1) Yeh.

(FG1 P2) [Continuing] and it's a resource. It's a rich resource. You know what would work with one client might not work with another. Somebody else may have tried something else and they can contribute and I think that's for me the, the positive.

In focus group 2 organizational systems and observation strategies were used to complete clinical audit.

(FG2 P3) I actually find it quite useful in that it focuses me when I do audits and then action plans. And if we are providing good working practices it's a means of being able to let other staff know that we're doing a good job. I don't necessarily think it is people watching me or trying to trip me up.

Focus group 5 participants described another layer of paperwork they had deliberately introduced as a team. They recognized the 'system' was not capturing all the assessments they were completing. In practice this appeared to 'dilute' the amount of work they had actually done. As a team they had devised an additional system that would address this administrative shortfall. Whilst this created additional paperwork, it now reflected actual rather than estimated work output. It was viewed as a victory for the shop-floor.

I commented.

(GS) Quite a creative answer to a problem really isn't it?

(FG5 P2) [Laughs.] Well I suppose it answers the system in the system's own terms.

I commented that this was an example where they had chosen to make their practice visible so that it would be deliberately noticed and the participants agreed with this.

The value attached to being unobtrusively observed and 'noticed' to aid promotion and career prospects was captured by group 7.

(FG7 P2) I think being unobtrusively observed, I mean, I put [pointing to collage] a 'taste of success' because actually being unobtrusively observed sometimes can actually bring your career forward.

(FG7 P1) Yes.

(FG7 P2) ... other people can see your good practice and can see things that you get lost in because, you know, busy shifts, and you get bogged down with all the stuff when actually, some people deal with situations very well. Its being able to say to that person, actually despite making a mistake or doing this you dealt with x patient, very well; you calmed the situation, de-escalated the situation, and these things, these little day to day things get lost in the big scheme of, this bit of documentation or that bit of documentation which I'm not belittling. I think it does need to happen, but I think that we're all too quick to pick up on the negative things that people do ...

3. Practice confidence

Practice confidence was a persistent theme permeating through all of the focus group data sets. It was variously described by participants.

(FG10 P2) ... occasionally I have a visitor, student, a student OT [occupational therapist] or social worker, who's wanted to come out for a morning. That's been quite nice and been a reflective tool for me. They've come back and said oh that's been really interesting and they've précised what the experience has been for them and why they've learnt from that, because they've observed the interaction between me and the patient and given feedback why they've thought it was a good verbal exchange.

This is expressed in stronger tones by Band 6 nurses in group 1.

(FG1 P1) ... It's the confidence and a belief in the approach that you're involved in. I think that, Yeh, I think a belief in what you are doing is important too. And I think that, that possibly has a knock on effect of developing your confidence and moving you on.

(FG1 P2) I certainly have less of an issue than I would have done coming back into nursing 10 years ago. I think you used to see it more as a challenge and as a threat whereas now I actually see it as something actually quite positive. I think for example - with ourselves where we do a lot of joint working, so a lot of our work will be going out on joint visits with each other, whatever discipline, whether its nurses, support workers, OT's, social workers whatever - you're constantly being observed in your clinical practice. I think we've all been in situations where somebody has taken the lead and you've said well actually that was really good and [laughs] said I couldn't have done that personally. And it's recognizing that in people. And other people saying 'look you take the lead because I really can't you know, I really can't; you engage better and I really can't handle that'.

Responding early on in group 2 to my opening question concerning how people felt about being unobtrusively observed, a male Band 7 senior nurse replied as follows.

(FG2 P1) I'm not really aware of it to be honest. I guess because I think my practice is ok. I'm sure I make mistakes like everyone else, but I am not worried about the practice that I have. So you know the unobtrusive stuff I'm not aware of. It happens! And it's there in the background and, it's only when you said the other day [here he is referring to a meeting when I was invited to discuss my study with prospective participants from his team], about some examples, did I think 'oh yeh that's a point they could check that up', but it's not something that sort of sits there. I guess the obvious stuff like when you see cameras around but, the other more unobtrusive stuff doesn't impact particularly.

The same participant goes on to add.

(FG2 P1) ... It's never worried me as a way of, 'oh this is people checking up on you.' Like we have Toil forms.⁶ We've devised a Toil form purely because people would say, oh I've got some Toil and you know we'd got no way of knowing whether they had, or they hadn't, so we had to take them at their word. So we devised that, and I guess yes it is 'us' checking up on them and yet to me it's just a, it's a tool that we use, so that everybody, knows where they are ... but, of course, if I take a step back, now, and listen to this, it's yes! [Laughs.] It is a way of checking up on people. It's only when you get something like this to actually step back and think, actually this is what I'm doing!

It was acknowledged that the emotions attached to being observed would vary on a day to day basis and throughout one's career.

(FG10 P1) I guess for me, there are various ways that we are observed unobtrusively and sometimes they can make sense and sometimes they don't seem to make sense. I guess there's a continual process of being unobtrusively observed by peers, by managers, and (what I've done in the collage really is

⁶ Toil is an acronym for Time off in lieu. Staff cannot claim overtime for excess hours. They can reclaim the time when it is organizationally convenient to do so.

about feelings and how that feels). I guess it depends really on how you are that day. Sometimes you can feel quite confident and being observed is a chance to shine out as I put on there [pointing to the collage]. It's a chance to show off different skills we have or maybe it brings up deficits as well.

Acting 'in spite of fear' enables the individual to become all they can become. Experience is an integral element. It is illustrated by the following exchange.

(FG4 P1) I think as you get older you get more experienced and you get more confident ...

(FG4 P6) Yeh.

(FG4 P1) and I think with that confidence comes the, I suppose it's ok to be observed ...

(FG4 P6) And Yeh and to tolerate the feedback. You think oh yeh cor I did mess up there or yeh and you know it's very healthy ...

The importance of receiving 'credible' feedback is a thread picked up in the following exchange.

(FG4 P5) I think we can accept the feedback if it's ...

(FG4 P6) If it's delivered properly.

(FG4 P5) Yes if it's delivered by our peers rather than I think by 'upstairs'. I think it's quite; it's healthier when we get it from our peers.

(FG4 P6) Upstairs! [Laughs.]

(FG4 P1) I think that on the shop-floor you know the observation is just fine.

'Upstairs' in this exchange refers to the senior management team.

4. A chance to shine

All groups commented positively on the role student nurses played in augmenting their practice. The inspiration for this category came from focus group 10.

(FG10 P1) It can be positive. Speaking from my own experience, the last time we had a student nurse here, I was her mentor. She was here for, gosh, it was quite a long placement for several months, with a short break in between. It was a great experience having her here because she was quite experienced. It was just really good. There was also that continuing questioning of me and my knowledge. It was just great having someone like that here because although they're not saying to you I think you're great, you do feel that the knowledge and experience that you're imparting and sort of sharing with them is hopefully going to make some kind of difference as well in their moving forward and their growth as a nurse. It was just a really, really positive time. I think it is generally when we have nursing students here isn't it? It's really good.

I asked another group.

(GS) What other ways do you think you can be unobtrusively observed because you mentioned RDE,⁷ and you mentioned ecpa? ...

(FG4 P6) Well there's students ... student nurses observing our every move in the office, how we relate to each other, how we conduct ourselves, how we organize ourselves ...

⁷ RDE is an abbreviation for Rapid Data Entry. It is explained more fully later in the Chapter.

Participant 2 in focus group 5 recognized the value of students for keeping him on his toes and avoiding complacency.

(FG5 P2) I love having students around. It gets you thinking. I've always got this fear of becoming very blasé. I think you can do in any job. I don't mean negligent but it's 'just another thing to do'. You've done it before, you know you can do it in a competent manner, but having people around to bring out all the, you know, all the knowledge that you do have, and to re-look at it and explain it back out again, I think is ever so important. I find that a really fantastic tool, and I enjoy the teaching as well. I really enjoy that side of it.

Others from different focus groups agreed.

(FG6 P3) It's the only way they can learn so ...

(FG6 P2) Yes because that's a learning situation and we welcome it. Again it's a two way process. There's nothing under-hand there. They know they are observing us because they are learning as they go along and we know we are role models to them and they are learning from us. So it makes it natural. It's a natural phenomenon where both sides gain from it.

(FG6 P3) Hm.

(FG6 P2) Both sides know what they are hoping to achieve and that's fine. When it's like that.

(FG7 P2) ... they're questioning more rather than just taking as read what someone has done or what someone is doing. They question.

(FG8 P3) In fact they keenly observe you. They're looking to sort of model what you're doing and how do you cope, how do you respond to that, what do you do?

... I think to be directly observed like that, it's more of a learning experience for them and then I feel quite happy to do that, cos, that's how you learn. I look at colleagues and I look at how they deal with things. There are positives to being observed if it's going to help someone and help you feel better or more skilled about what you're doing, it's a positive thing so it doesn't feel sort of oppressive or judgmental or anything like that.

(FG8 P2) ... I like having students. I think students are our life blood.

(FG9 P1) ... it's useful. Fresh eyes ...

(FG9 P3) ... students are a really good challenge in that ... For me I can actually be aware of my own goals and potential and students come along and say did you know about this, this and this? And you don't! I didn't know about that. A new policy that I should know about and they have a lot of up to date information and ideas and new challenges and new thoughts and new visions about things and that helps me certainly.

The powerful voice of students did not go unrecognized.

(FG10 P3) I was reading an article by Lord Darzi, the health consultant. It finished off with him saying if he really wanted to know what was happening in the health service he would ask one of the student nurses on one of his wards about what to change next.

She adds.

... students do have a powerful voice, and they can go away and influence the future of care.

5.7 Categories within the theme of Scrutiny

The theme of Scrutiny consists of 4 interdependent categories. These are:

1. Organizational non-transparency
2. Under the microscope
3. Drowning in data
4. Capturing the wrong data with blunt tools

The Compact Oxford Dictionary (2005) defines the word scrutiny as critical observation or examination. Synonyms include examine, watch, observe, survey, and inspect. Scrutiny (or its closely associated terms) was mentioned in a number of different ways.

Table 5.5 displays a basic word count or content analysis of the number of times the words scrutiny, scrutinized, watched, watching, observe(d), surveillance, and inspect(ed) were said on a group by group basis. The words examine, inspect and survey produced 'nil hits' using this method and so are not included. The terms scrutiny and scrutinized were used most in group 8. These were experienced Band 5 nurses. As staff nurses and not charge nurses or senior clinical nurses, they may have felt more unobtrusively observed than those of a higher band. The context in which these words were said is important.

Table 5.5 Focus group word count to determine frequency of core words

Group	Band	Scrutiny	Scrutinized	Watch(ed) Watching	Observe(d) Observes	Surveillance	Inspect(ed)	Total
1	6	1	2	0	17	0	0	20
2	7	2	0	6	16	0	0	24
3	6	1	2	5	1	0	0	9
4	6	2	1	4	15	0	0	22
5	6	1	0	1	26	0	0	28
6	6	0	3	5	51	2	6	67
7	7	0	0	14	46	0	0	60
8	5	3	8	4	6	0	0	21
9	6	0	0	3	19	0	0	22
10	6	0	0	2	15	0	0	17
Total		10	16	44	212	2	6	290

As I analyzed individual focus groups I found that staff were consistently able to identify positive and negative ideas about the ways they felt observed in a clinical setting. All groups expressed frustration at collecting data that lacked meaning for them, and said how difficult it was to capture and record clinical activity into time measured 'bits'. These had to be coded daily into an office based computer system (Rapid Data Entry). This was perceived to be very time consuming. Many staff joked that there should be a separate code to record the time it took them to input the data. Staff felt existing computer based codes needed to be re-defined. They described the way in which the system was used as a crude 'best fit' approach which skewed meaningful interpretation. One nurse commented that he had volunteered to help create the original codes and felt the system had been devised without any clinical nursing input. He cited an example: that there was no code for community teams to record the administration of a depot [long acting] injection. This is a frequent nursing activity. It has to be recorded under another code, such as face to face contact, when using the current system.

The 4 categories that fall into the theme of Scrutiny (Organizational non-transparency, Under the microscope, Drowning in data, and Capturing the wrong data with blunt tools) will now be considered.

1. Organizational non-transparency

One of the recurring themes in most of the focus groups was that whilst the organization wanted to see transparency in clinical practice it did not reciprocate this strategically in its own information requests. Staff wanted to know why they were collecting information. They wanted clear evidence that the information they were collecting was being used to help make effective and meaningful change. Many believed it was merely a paper exercise lacking purpose and worth. They felt decisions had already been made. This was expressed in a number of ways by participants in group 10 whose comments were indicative of the underlying frustration felt.

(FG10 P1) It feels like it's a done deal anyway all the time.

(FG10 P4) Part 1. We just have to let them know and pretend that we are asking for their opinions but part 2 is already sorted out!

(FG10 P1) It becomes very piecemeal, very lip service, oh well; we'll ask the people at the coal face what they think but its going to go through anyway but we have to ask them.

This attitude was also evident during a brief exchange between three participants towards the end of focus group 6, who were discussing why they collected information.

(FG6 P1) You know its one thing having the knowledge. It's another thing to actually act on that knowledge and to make changes because of that knowledge ... It all feels a bit Kafkaesque sometimes ...

(FG6 P2) [Laughs.]

(FG6 P1) [Sniffs.] *A big body of information. What are you going to do with it? I don't really know! Well it's just there. It's just information!*

(FG6 P3) *Like **** said it will probably sit somewhere gathering dust.*

(FG6 P1) *... for me its about the purpose of being observed and not wishing to be paranoid in any way but if we're observed it needs to have a clear purpose ...*

What happened to the information was important. This was referenced throughout focus group 6 by participant 1.

(FG6 P1) *I think it's the more you know the less you realize is certain. And I think that's a big learning curve and I am not sure our organizations have learned that their figures might only mean one thing. They can pull these figures and it might not actually mean too much unless you put it in context or unless you talk to the people that are gathering those figures. Might their information be more valuable if they started talking to us?*

He continues.

(FG6 P1) *What's the inherent value in being observed? If there's a value to it that's quantifiable that I can see will improve practice, improve management, improve people's lot, there's a point ... It's about b**s on seats and petrol in tanks really isn't it? ... That's fine if there's a place for it, but don't just do it for the sake of collating information that just gathers dust somewhere.*

The same Band 6 nurse frequently returns to the theme.

(FG6 P1) It's a bit like VAT. It's almost like you're collecting it for a third party ... For me it's about why are you collecting, why am I collecting this information for you?

And again.

(FG6 P1) Well I don't see a point to it. I don't see any figures published. I don't see any end of year figures that say we had x amount of contacts and out of these contacts x amount of these were by x amount of professionals and ...

This is picked up in various guises in other groups as well.

(FG1 P1) I think one of the things, certainly from an individual point of view, erm, would be the observation that it doesn't always seem transparent. For example the sort of monitoring via ecpa, via Pims, erm, via those sort of computer systems ... we're not always clear why the information's being collated.

I sought clarity on this issue by asking the following question.

(GS) Do you mean actual audit trails or why you're being asked to input information in the first place?

(FG1 P1) I guess it's both, because sometimes the audit trail part of it doesn't make sense ... What's it actually measuring and what's it about?

The rapidity of organizational change was discussed in a variety of ways.

(FG3 P3) ... there is no explanation to the purpose of it. And often that's the case with all the changes I have experienced in this Trust is that a change will happen almost like you change your jumper in the morning and nobody will give you a

rationale for it ... But you are expected to know it and do it and of course with that comes the sort of resistance because of it.

This is echoed in the following remark by the same participant.

(FG3 P3) The sands do shift underneath you all the time.

Another participant described it variously as.

(FG1 P3) ... the 'next latest' thing. And they never stick at it long enough to see results. Everything shifts and another figure is plucked out of the air or another, you know, jump is put in front of them to jump. And they deviate off ... Everything they try is a five minute fix ... the constantly changing and evolving little click of the rubic cube or whatever they come up with next.

She continues.

(FG1 P3) ... I feel the poor old NHS, being a nationally owned company can't stick to its guns. It is pulled from pillar to post isn't it? And everybody else who works for it ... If you look at a [Government] White Paper and then you look at what actually happens when the wheel agonizingly and slowly turns, five years later and actually impacts, there is no resemblance to what was recommended.

The importance of being up-front and transparent was discussed in the following scenario where organizational motives were queried.

(FG8 P3) ... we recently had lots of policies to read and we had to sign to say have you read or are you up to date? Have you read all the policies? And it just seemed like we were asked to do that but you're not given two hours to read a hundred pages of policies, you're just somehow expected to do that but you must sign to say that you've done it. So is that being up-front, is that about me being

up to date, knowing what all the local Trust policies are? Is it about me managing to do my job properly or is it more important that I've signed the piece of paper so if I do anything wrong in future they will say you had the opportunity to read that policy, so it doesn't quite feel up-front sometimes.

2. Under the microscope

A second interdependent category within the theme of Scrutiny was a sense of feeling caught by the gaze of the contemporary panopticon. Staff described this as being watched, monitored and under the microscope. The word spotlight was used by 3 groups (groups 1, 7, and 10) to describe this view. Participants in group 1 said of working for the NHS:

(FG1 P3) It's a bit like Colditz. It's where the spotlight is.

The group were not referring to their working conditions but rather the sense of periodic surveillance and interest in their team. This was likened to a revolving beam of light. It rotated and occasionally settled on their area for a while. It then appeared to move randomly on to a new area of interest without ever explaining what 'it' was looking for. Staff described the anxiety and uncertainty this created.

(FG1 P3) ... we are all sitting there thinking is this it? Is the axe going to fall this time? And then it kind of drifts away again or it gets distracted and goes somewhere else [laughs].

*(FG1 P1) And then it goes to the crisis team who are thinking My G*d! We have x number of people in hospital. There are x number of people on the list. You gotta sort something out. You've gotta get people out and then it shifts to a CMHT [Community Mental Health Team] who actually needs to take these people because there are x number of people on the waiting list and ...*

I asked the group how this made them feel.

(FG1 P3) You make sure you have some wire cutters.

[Group laughter.]

(FG1 P1) To get out of the way of the barbed wire!

(FG1 P3) It's all very knee jerk!

(FG1 P1) It's got to be the quick fix. Yes! It's, you know, stick the plaster on.

Staff readily accepted the need for flexibility. They could not always appreciate why things needed to change so quickly and so frequently.

(FG1 P1) ... we need to develop services but sometimes it feels, it's change for change sake and you are actually losing a lot of richness ... and sometimes that is positive and needs embracing because it is about teams evolving to meet the service needs but it is making sure that it is about service needs rather than evolving it to meet tick box needs.

Her colleague wryly remarked.

(FG1 P3) Does the chaos come from below or above? Does it come from the clients or does it come from others?

The interpretation of national policy at local level was cited as a contributory factor.

(FG1 P1) I think we are in the spotlight. I think we are constantly in the spotlight. A lot of AOT [Assertive Outreach Team] teams up and down the country are actually being disbanded and pulled back into the CMHTs to do the long term enhanced work within CMHT settings which goes against the whole ethos of actually a team approach because you have got two workers in a sector team. You actually lose the richness.

Another example of feeling monitored and under the spotlight was discussed in group 2.

(FG2 P4) ... when we get visits from the Fraud Squad coming to talk to you as a team, you start to wonder and you start to become a little bit more suspicious about people's motives behind what's being done.

Another group participant remarked.

(FG2 P1) Checking up has a very negative sort of aura to it. You know somebody's watching somebody's checking how many hours I'm doing. How often I go and do this?

(FG2 P1) ... and then you have got all these constant changes the NHS go through and changes mean more scrutiny, because we need to know how this works and why it works in that particular way and could we change it? And so that doesn't lend itself particularly to being told, erm you know this is working really well! So keep it! It usually means. Its working alright but we need to 'tweak' it and change it because we need to shift the posts or get rid of some money or move this around or move that around ...

Humour was used by groups to deflect anxiety.

*(FG2 P2) I think there's flavours of the month isn't there? I know at bed management meetings, you know, we say, sometimes 'Oh it's your turn this week' **** [to be criticized]. And make it all open. 'You know **** have jiggered everything up! It's not us this week!'*

Another focus group participant said.

(FG9 P1) ... we're in a situation where it does feel like everything you do, 'Big brother' is watching you. It's very Orwellian.

Staff felt particularly under the spotlight when things went wrong. Three notable examples were cited. These were Sudden Untoward Incidents (SUI),⁸ independent inquiries and an undercover programme. Various NHS Trusts (including this one) had been secretly filmed by the *Dispatches* programme in October 2006⁹.

(FG5 P1) Mm. Yes I don't actually ever feel I'm under scrutiny but there are times, or there have been times when there's been SUIs. When of course you're very aware then any entry that you may or may not have made will be scrutinized.

(FG6 P1) Certainly in independent inquiry they do exactly the same. Everything. Absolutely everything that you did is put under the microscope ...

(FG2 P2) Well I was going to talk about the hidden camera because I was managing the ward at the time when Dispatches came in with a hidden camera. And you know that was a very painful time ... I guess there's a difference between being told that you are being observed and being aware of what's happening isn't there? And not being told and being aware of what you are doing.

Receiving a list of the face to face clinical activity levels undertaken within a team on a named staff basis was also seen as a way of monitoring individual

⁸ A Sudden Untoward Incident (SUI) is a serious unplanned event such as patient suicide or arson.

⁹ *Dispatches* was an undercover documentary programme produced by Channel 4. In an episode called 'Britain's Mental Health Scandal' shown on Monday 9th October 2006, commentary about three average NHS Trusts was provided by Professor Kevin Gournay of the Institute of Psychiatry at Kings College, London. In it he highlighted under-resourcing and reduced staffing levels as key issues in in-patient units.

performance and introduced an element of intra-and inter-team competitiveness which could be divisive.

(FG3 P4) They're watching us! [Laughs.]

(FG3 P3) Well that's how it felt! Talking about people watching and monitoring you. This form had got a list of every single member of staff in the team and the level of activity and unless you capture every single thing you do, whether it be a phone call, whether you have even opened a letter and written a response ...

3. Drowning in data

A third category to emerge from the data sets was the feeling of being physically overwhelmed and engulfed by the sheer amount of information collected within the organization. Once again this complements and builds on the two other categories.

(FG8 P3) I don't have a problem actually with being monitored. I think that it is necessary and in reality you have to ... I wouldn't want my mum to be looked after by a load of people who weren't accountable or monitored in any sense whatsoever, so I agree with it ... but I just think that the sheer volume of what is monitored ...

A male Band 6 nurse saw it as a missed opportunity.

(FG3 P1) ... never have we known so much information about people and all been left scratching our heads about what are we going to do about it'?

The value of nurses collecting information was also questioned.

(FG2 P1) I would like to think that in fifteen years' time ... we'll look back and say, 'And you used to spend all day taking all those stats! Gathering all that information?'

The group laugh and suggest that in fifteen years' time a robot may be used to collect the data currently collected by nurses. The same participant continues.

(FG2 P1) Actually the serious point is that maybe it will happen because we spend hours collecting all this information and sending it off which is, you know, hugely different to what we used to do, what our ward sisters used to do when we trained. You know maybe in fifteen years' time the systems will be far more robust and it will be able to be picked up centrally, and at least be correct (which it isn't at the minute) which will take time away from us having to do it and give us more clinical time back.

The hidden pressure 'behind the scenes', not captured or recorded electronically or on paper, that impacted on the quality of written entries, was discussed by a Band 6 nurse in group 3. He explained staff frequently had to multi-task, accessing information, manning a crisis line and inputting information onto a computer at the same time or in quick succession. He felt this diluted the quality of all these activities and yet staff would only be judged on what was recorded.

(FG3 P2) ... often there are big grey areas of the stuff that has gone on in between all the other stuff that is going on in the team at the time which isn't reflected in the paperwork that has come across.

The importance of taking time to establish an authentic therapeutic rapport and a working alliance with a patient over a period of time was also recognized as an important but often compromised ideal.

*(FG3 P2) And **** mentioned about token paper exercises before trying to complete all of the stuff that's on CPA ... I was thinking about how that might impact on the actual nurse patient relationship and, there may be some pressure on there to rush through an assessment and not give it time when actually an assessment might not need to take place in one session. It would be an ongoing thing that would take place over a period of time, perhaps and, you know, the pressure of having to complete the paperwork could actually force that to be rushed or, you know, handled differently as well.*

[The Care Programme Approach (CPA) was introduced in 1991. It is a term used to describe the Government's statutory mental health framework and is used to assess systematically, to plan, implement and evaluate mental health service user's needs. It is similar to ecpa already described (DOH, 2008d).]

This theme is echoed in group 8.

(FG8 P2) ... the irony is that we have less time to actually do the job that we're supposed to do, because most of the time we are being audited and having to get our notes and everything up to date so, actually the patients, we don't see much of at all ...

I have called the final category within the theme of Scrutiny Capturing the wrong data with blunt tools. There is a clear overlap with other categories.

4. Capturing the wrong data with blunt tools

Freire (1993a) highlights the importance of the problem-posing self-directed nature of education. Particular frustration was expressed by community nurses over the way their working day was being increasingly monitored. They felt it was broken down into discrete visible and measurable clinical 'contacts'. These were recorded by the mandatory use of the Trust's in-house designed Rapid Data

Entry (RDE) programme (2002). This is primarily an accounting devised system which monitors and records all community based clinical activity. Accurately recording community contacts is part of a national data requirement. The data collected is used by all NHS Trusts and by the Strategic Health Authority (SHA). This is part of a wider national strategy to capture and record caseload management and is used to shape, design, and streamline existing service provision. It identifies unmet needs and prompts the commissioning of new service initiatives.

What seemed to frustrate staff was the missed opportunity this sea change had at clinical level. It was an example of nurses beginning to see things as they could be and not as they are. The Rapid Data Entry (RDE) system requires clinicians to record all face to face contacts, telephone contacts of fifteen minutes or more and abortive contacts. (This is defined as a patient failing to attend an appointment or cancelling just prior to the appointment.) Assisted contacts (two members of staff from the same discipline seeing the same patient) can only be recorded by one staff member. Proxy contact is work done in preparation for, for example, a Mental Health Review Tribunal (MHRT) hearing, or case conference that has a direct clinical link with but does not involve the patient.

(FG3 P3) I think we are all probably old enough and long enough in the tooth to know that irrespective probably of the findings of these very blunt tools that the suspicions are always that the decisions have been made and the statistics will be made to fit those decisions [laughs]. That's a kind of notion that, certainly I share, you know, because I think these things seem such blunt tools that don't make any kind of allowances for the fact of the sophistication of the job.

This is a theme echoed in group 1.

(FG1 P3) ... you know most of the studies about nursing that I was given to believe were good, were qualitative. So I'm worried that people's ability to do their job and the quality of the job they do is being assessed in a quantitative

manner. I can't see how you can tick boxes and count numbers and decide how well people are doing or how good a service people are getting. Which is what the explanation given is ... That's the reason you are doing that, is that 'the powers that be' can check that hours have been devoted appropriately as purchased. And also it's not accurate because there are still things that you do outside of recording but which still has a positive impact on care provision and helping someone's quality of life.

The same idea is expressed in metaphor by a participant in a different group.

*(FG3 P3) ... it goes back to what **** says about the quality doesn't it? It's like I am going to give you a little Fiat Panda but I want it to perform like a top range Mercedes. You know, ... it will still get you to London and back but, you know, the journey is going to be a bit more rocky and a bit more turbulent and not very comfortable.*

Discussion on capturing data for data's sake is continued by the following example.

(FG3 P1) I could tell you that we operate at 105% bed capacity or whatever, you know, certainly it's in the high nineties or low hundreds, but that doesn't reflect the acuity of the unit. Not by any means cos I could have twenty bed blockers who basically are self caring who get up in the morning, go out and then come back. It doesn't reflect in any way, or I could have four or five particularly difficult, troublesome patients, you know, who have got a range of challenging needs ...

[To maximize use of beds (a finite NHS resource), it is common practice for bed managers in acute mental health in-patient units to use the bed of a patient on trial leave from the ward for a new patient requiring admission. Patients who are nearing discharge from hospital are often given gradually increasing home leave. This is done 'as a reality check' to make sure that they are able to manage. They

are supported by community staff in this process. In this way the patient on leave is supported (knowing there is a crisis plan in place if they need to return), and the patient requiring admission from the community is not denied access to a bed. It is a creative NHS 'cox and box' strategy.]

Focus group participants voiced increasing frustration at collecting data which they felt bore no direct relationship to what they actually did. They felt it lacked utility and purpose and represented the unwanted face of bureaucratized, McDonaldized health care, emphasizing the importance of control predictability and calculability over quality and actual patient experience. Staff recognized the importance of clear accountability but felt alienated from the very 'systems' designed to achieve this. They voiced concern that their competence as practitioners was measured and rated by quantification, their inputting of outputs (number of direct patient contacts) rather than by the quality of the interventions they used (in often difficult and challenging situations). Many staff felt overly monitored and controlled by this bean counter approach to care and expressed concern that this would lead to the inefficiency it was originally intended to manage. Some staff alluded to the limited menu of options they could select to 'process' the interventions they used. They wanted reassurance that they would be involved in the planning of future systems that would capture accurately the complexity and variety of skills they used to make this a meaningful and efficient use of their time.

(FG6 P1) We have a government that wants to measure everything that has initiatives that need to be evaluated and measured, and it's all very forward moving, and there's a lot of work magic goes on there; and I think about Phil Barker [contemporary nurse theorist] a lot when he tried to put together words to explain what we do. And what we do as mental health nurses isn't necessarily measurable [laughs].

His colleague agrees.

(FG6 P2) We don't work to a script do we? You can never predict what is going to happen. You're going to do a visit, you do a visit but, you can't predict what the outcome is going to be.

This sentiment is echoed by participant 3 in focus group 3. She talks about how it feels to be an experienced practitioner. She described being unobtrusively observed and scrutinized in her own practice by others, by the quality of the paperwork she often has to do hurriedly, to satisfy a service need, and not by the actual quality of the assessment she may have performed alone, out of sight of her colleagues' gaze. Working as part of the liaison team based in the Accident and Emergency Department of the General Hospital she is required to undertake complex front-line mental health assessments with patients presenting to A&E with problems that may (or may not) have a contributory psychological component. These individuals will often be unknown to secondary mental health services and a 'blind' assessment performed at point of referral as a single practitioner will often be undertaken without any contextual background or knowledge to inform this process.¹⁰

(FG3 P3) ... And the systems in place, for instance we work with the CPA system, you know, when we first came to the post two years ago we didn't use CPA at all on the computer, but now because other teams do, you have got almost like a pressure to 'perform', to fill in the documentation as opposed to quality in terms of your assessment. So I might see someone in A&E and there might be three people to see and I will be thinking well I've only got so many hours to do this.

(FG3 P4) Erm.

¹⁰ Specific permission was sought and obtained from this individual to include these observations and subsequent insights.

(FG3 P3) And I would much rather spend

(FG3 P4) Hmm.

(FG3 P3) a couple of hours with somebody in A&E cos, they might not have any other intervention but then the observation part is, well, how am I going to get that onto CPA? Get them followed up? Admit them to the ward, who's going to want that information, and who's going to monitor the quality of my assessment. Because what I am putting on the screen doesn't capture necessarily what I've done ...

Her colleague agrees, adding.

(FG3 P4) Because you have put it on a computer you can be observed by anyone who needs to access their notes and their files. Anyone could be looking at it. Going, this isn't the best assessment in the world or making judgments.

In focus group 1 participant 3 describes the frustration of compromising college 'ideas' with practice reality as she remarks:

(FG1 P3) ... as an in-patient nurse you can't give great tracts of time to somebody, as much as you know that's the right way to do it, and that's where your idealistic training comes in. It's what you should be able to do. In reality time constraints rob you of that and rob the client of that.

5.8 Chapter summary

This Chapter has presented themes from ten focus groups of nurses working in eight different clinical settings within the NHS. Demographic data is provided to help set the scene. Table 5.4 show the connection between focus group themes and related Freirean concepts. A simple code is devised and described to enable the reader to cross reference focus group dialogue with basic participant

characteristics (sex, grade and ethnicity). Key insights from the group collage ice-breaker exercise are discussed. Eight categories (Inviting observation, Making observation work, Practice confidence, A chance to shine, Organizational non-transparency, Under the microscope, Drowning in data, and Capturing the wrong data with blunt tools) emerged from the focus group data. They are considered in terms of two sub-themes, Learning Opportunity and Scrutiny. The term Transparency in Practice is used to describe the main overarching theme. Chapter 6 will discuss the focus group findings and implications for nursing practice. A contemporary schematic panopticon is devised to capture the systems based nature of the modern NHS.

CHAPTER 6

DISCUSSION

This Chapter discusses the collage and focus group findings presented in Chapter 5. It examines the key study themes of Learning opportunity and Scrutiny which emerged from these data sets. Metaphors, in the form of *The Rime of the Ancient Mariner* by the poet Samuel Taylor Coleridge, and the interpretative theoretical framework of Paulo Freire, are used.

I will reflect firstly on the theme of Learning opportunity and then of Scrutiny. I will then discuss my development of a contemporary and schematic systems-based panopticon which builds on the earlier work of Bentham. I acknowledge study shortfalls and undertake a brief critical examination of Freirean methodology. The value of the Johari Window model introduced in Chapters 1 and 4 follows. I conclude with a Chapter summary.

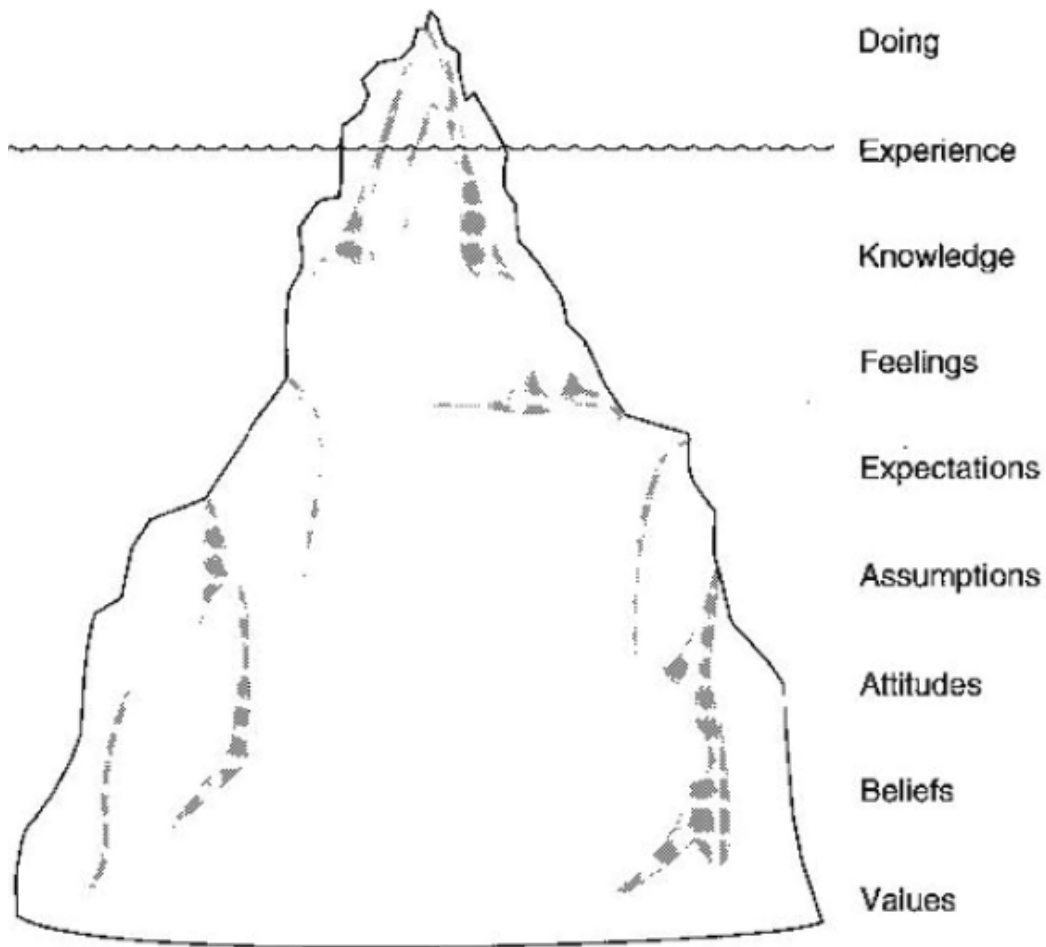
As I reflected on the themes which emerged from the focus group transcripts and began to make sense of the data I had collected, I was struck by the importance that nurses attached to workplace learning. They valued collaborative and purposeful discussion and feedback from 'helpful others' as integral to their own learning process. Informal meaningful conversation and everyday clinical encounter were used by staff as natural opportunities to share best practice with their colleagues. Learning from each other was valued highly. Participating in team meetings and case conferences and having ring-fenced time to discuss difficult and challenging clinical scenarios with others were recognized as natural opportunities to appreciate and benefit from the tacit knowledge and practice wisdom of others. Staff recognized that the context in which they learnt was influential. Being unobtrusively observed by colleagues and in-built peer review processes were positively welcomed and turned to personal advantage.

Observational learning and imitative behaviour are recognized as powerful practical teaching tools. Bandura's (1965) social learning theory model identifies the ways in which exposure to exemplary role models can influence another person's behaviour. Focus group participants commented positively on the opportunity to work collaboratively with their peers. They saw this as a way to enhance their own repertoire of skills. Constructive feedback from colleagues was valued. It was used to reflect on practice strengths and workplace weaknesses.

Several focus groups commented that the opportunity to pair up and work together was a luxury that they valued highly. However, the allocation of finite resources and competing service demands acted as prohibitive factors and so this did not happen as often as they would have liked. Clinicians expressed a keen willingness to base their practice on a philosophy that was open to scrutiny and responsive to peer feedback. In this respect they welcomed the observation of others. As staff began to engage with one another in open, honest discussion they started to 'get inside' the nature of their own and others' practice. Perry (2008) calls this process learning by 'living lessons'. It is from these insights that the focus group themes were drawn.

Fish and Coles (1998) refer to the invisible elements of practice artistry. They use the analogy of an iceberg, with beliefs, attitudes, experience and feelings hidden from the visible 'doing'. Nurses tend to share common values and assumptions and collaborative learning is recognized as a partnership based on mutual respect for one another's expertise, knowledge and skills (Pearson, 2000). Participants felt this provided colleagues with the authority to comment on one another's practice. Managers ('those upstairs') were felt to have lost this 'right' as they were perceived as having different or competing agendas which were often at variance with the shop-floor.

Figure 6.1 Iceberg model of professional practice¹¹



Taken-for-granted knowledge can be relayed through actions or words (Eraut, 2004). 'Checking out' practice uncertainties with others and building in 'room to be wrong' enables change to happen 'from the inside' (Fish and Coles, 1998). Being open and receptive to feedback and 'teachable moments' can be a powerful motivator; it can help create a shared vision. This involves a concept called craft knowledge or practice wisdom, which is described by Bierly et al. (2000, p.597) as the ability to choose effectively and apply the appropriate knowledge in a given situation.

¹¹ Taken from Fish and Coles (1998), p.306.

Skills implicit in clinical practice can be difficult to articulate or explain with certainty (Carr, 2005). 'Knowing' and 'doing' competencies are likely to be multi-faceted and a result of process rather than product. Focus group participants felt this required a variety of creative outcome measures; traditional quantitative approaches and softer focussed qualitative tools. They felt that both were needed to capture and discriminate the finer-grained nuances of human encounter. Focus group participants voiced frustration that the quality and importance of their work was measured using a 'one-size fits all' approach to care. They expressed the view that sole use of quantitative outcome measures failed to capture the hidden dimensions underpinning their nursing practice. Staff clearly valued the opportunity to talk passionately about their work and they wanted its richness and effectiveness to be measured appropriately - instead there was a feeling that the wrong data was being captured with the wrong tools.

The political direction of contemporary mental healthcare is in a constant state of change. The introduction of the 2007 Amended Mental Health Act and the Darzi Review (DOH, 2008b) are examples of this. This makes it difficult for the front-line practitioner to ever knowingly achieve total mastery over their already limited spheres of influence. Nurses are constantly asked to absorb and implement the latest policy reform, or to familiarize themselves with new 'position' papers, contemporary 'sound bites', and re-configured managerial structures as Trusts jockey towards Foundation status. This results in an inevitable surfeit of executive summaries, policy documents and top down imperatives. These need to be interpreted and implemented locally. This is time consuming. It takes nurses away from front-line care.

Learning from students as well as sharing knowledge with them was acknowledged as a mutually reciprocal process. The opportunity to share meaning and understanding with others was highly valued by focus group participants. Like many concepts it is difficult to articulate and meaningfully capture the mysteries of front-line clinical nursing in a formal classroom setting;

they are more likely to be skills-based and to demonstrate experience in the 'field' where capability and credibility are highly prized (Thompson, 2005). Insider practitioner research provides one way of contributing to this developing knowledge base and gaining a greater understanding of the complexities underpinning front-line nursing practice.

6.1 Using metaphor to explore the theme of Scrutiny

I have called the second theme to emerge from the data sets Scrutiny. Staff described feeling increasingly monitored and overseen by complex and time consuming paperwork systems which they felt lacked practical value and which impinged on the core business of nursing. They felt there was an organizational dissonance between what was requested of them as clinicians and what they in turn observed of senior staff; they wanted to hold to account those who held them to account. Increasingly, caring has become a commoditized 'product' relying on transparent outcome measures to maintain credibility and embed effective practice. Demonstrating Trust 'ward to board' openness and transparency to public scrutiny is seen as imperative. Failure to provide these assurances can "undermine the board's ability to reassure external audiences that it is a learning organization focussed on clinical quality" (Machell et al., 2009, p.2) and yet, despite this, the second part of Trust Board meetings remains closed and held in private. This gives a confused and mixed message to staff and the public and signals that perhaps the organization is not quite as open and transparent as it claims to be.

Freire (1993a) maintained that thinking occurs through dialogue when people seek to understand reality together. They become 'subjects' with other oppressed 'subjects'. Valuable insight is often portrayed by the use of novel metaphor (Martins, 2006). Shapiro (2002, p.161) comments, it is only "by thinking about how we look at the Other, and how the Other looks back at us, [that] we can learn something about who we are in relation to each other."

In *The Rime of the Ancient Mariner* (originally called *The Rime of the Ancient Marinere*) by the poet Samuel Taylor Coleridge (written in 1797-98) are found the often misquoted lines:

*Water, water, every where,
And all the boards did shrink;
Water, water, every where,
Nor any drop to drink.*

In this epic tale the Ancient Mariner shoots a beautiful albatross with his crossbow. His crew believed the bird was a good omen. It had led them to safety as the ship was drawn southwards by a dangerous storm. Coleridge called this a "rime" (a strange, icy patch of ocean). The crew is angered by the mariner when he kills the sea bird. As punishment for his sin the crew forces the mariner to wear the carcass of the dead bird around his neck. Good fortune at being rescued from ship wreck turns to bad luck and the crew gradually die from malnutrition and dehydration. Only the mariner is left. Thirsty, he finds himself surrounded by a plentiful supply of sea water. This is the inspiration behind the lines of the epic poem but he cannot drink the water because it is too salty. The metaphor of being plentiful but of little value seemed immediately analogous with the plethora of paperwork systems described by focus group participants. It seems to 'drown' contemporary nursing practice and often appears to lack practical value, utility or purpose.

Freire's concept of critical consciousness encourages us to "become aware of our awareness and critique it" (Mezirow, 1981, p.13). As I reflected on Coleridge's allegorical poem, the Christian ideals underpinning Freire's philosophy also became apparent. The albatross hung around the neck of the Ancient Mariner can be used to symbolize a cross or a crucifix that the mariner in Coleridge's seven-part verse is forced to carry with him, like a yoke, until he frees himself. I believe that nurses often carry their own 'albatross' until they recognize

and name it for what it is - oppression. They can then let it go, thus transforming their world.

Freire's literacy programme is framed by similar insights. An awareness of potentially oppressive acts being perpetuated by the oppressor 'dwelling within' is often the first step towards a liberating pedagogy. Freire's methodology is full of hope, energy and creative potential. It is optimistic and recognizes the ability to change even when oppressed by a dominant ideology that favours another way of thinking. Freire recognized the importance of transformative education and of listening to and giving a voice to those silenced and marginalized by their oppressors. Lee and Saeed (2001) agree and argue that if nurses gain a greater understanding of the concept of oppression, they will be better placed to alter the dynamic of the healthcare status quo to their own and their patients' advantage. In my opinion, Freire's approach of spending time with groups of people and encouraging them to believe in the power of change mirrors the growth process seen in acute mental health care where patients are empowered to realize that the rescue dynamic lies within themselves. This is a gradual and developmental process as problems are redefined and reframed. It requires energy, motivation and commitment. It often requires several re-admissions of the same patient before self destructive patterns of behaviour are recognized and owned for what they are and individuals are enfranchised to become their own self-change agents. Having a focussed discussion with colleagues, and reflecting on one's own practice and its impact on others, is often the first step in the realization of the same process for staff. Freire (1993a, p.38) puts it like this: "it is only the oppressed who, by freeing themselves, can free their oppressors."

Desperate for fluid to moisten his parched mouth so that he can cry for help the mariner bites his arm and sucks the blood to try to replenish his body.

*With throats unslaked, with black lips baked,
We could nor laugh nor wail;*

Through utter drought all dumb we stood!

I bit my arm, I sucked the blood,

And cried, A sail! A sail!

Coleridge comments that the sailors were imprisoned by a thirst which silences and isolates them. They are denied the ability to speak. Freire says something very similar. He comments that to empower is to give those who have been silenced the chance to speak. As staff 'unpicked' their practice with each other, they recognized 'fear of freedom' and what 'could be' as important maintaining factors. Being 'invisible' and subordinate avoids challenging the status quo and it keeps nurses in a position of powerlessness, "screaming into an echoing abyss" (Bartholomew, 2006, p.23), and yet silenced by their own 'scripted' perception things could never be any different. Nurses thus become "accomplices in their own exploitation" (Noddings, 1995, p.69). Freire (1993a) promoted the value of dialogue as a means of raising awareness and shared consciousness of this social situation. He comments "without dialogue there is no communication, and without communication there can be no true education" (Freire, 1993a, p.74).

Contrary to banking education,¹² (a traditional training philosophy) where the teacher holds all the knowledge and the student holds none, dialogical and liberating methods emphasize equality in the relationship (Heaney, 1989). This allows for the "sharing of power in everyday talk and actions" (Townsend, 1996, p.183). In this way a stance of 'equal but different' is forged and nurses can move on from the passive position of colluding in their own oppression to one where they feel empowered to change. Focus group participants in this study seemed able to challenge their peers in a way they were not able to challenge their managers because of this perceived power differential.

¹² The Banking Model of Education turns students into empty 'receptacles' that need to be 'filled' by the teacher who determines what will be taught. The Banking Model encourages students to receive, memorize, and repeat passively. It does not promote active learning.

Shor and Freire (1987, p.99) call these examples “knowing that we know” through dialogue, recognizing knowing as a social process. Freire (1993a) maintained that to transform a situation it was first necessary to understand it. In doing so political consciousness is raised and it is possible to bring about social, political and economic change. Sharing of ideas is fundamental to democracy and transformation of nursing culture most likely to occur when nurses are ‘allowed’ to voice and not suppress their own perspective and opinions. I believe that, in facilitating focus groups with nurses of similar experience, I helped them to build a safe platform to share their views, and I allowed them to be heard without fear of censure from other disciplines.

Coleridge writes that as the ancient mariner has faith to pray again the albatross falls from his neck. He is free.

*The self-same moment I could pray;
And from my neck so free
The Albatross fell off, and sank
Like lead into the sea.*

There are obvious parallels in this metaphor by Coleridge with the liberating pedagogy espoused by Freire. Using the tool of conscientization nurses can free themselves from the chains created by their own oppression. Freire calls the resulting transformation the ‘Easter Experience’.

“The educator for liberation has to die as the unilateral educator of the educatees, in order to be born again as the educator-educatee of the educatees-educators. An educator is a person who has to live in the deep significance of Easter” (Taylor, 1993, p.55).

A key observation to emerge throughout focus group discussions was a willingness by staff to work ‘with’ the system. This mirrors the principles of reciprocity discussed in the call centre research discussed in Chapter 2. Staff

appreciated the role they played as ground-floor agents and ambassadors for the Trust. They recognized the value of collecting accurate and reliable data. What appeared to frustrate them, however, were the missed opportunities to 'capture' 'distil' and to 'feedback' what they actually did. Time taken to record the information gathered can be likened to an albatross around the necks of nurses; unwanted and burdensome. It weighs them down and limits the patient contact time available to them. They were describing the well defined phenomenon of 'audit fatigue', which is not a new 'symptom' for the NHS. As Thorne duly noted in 1970, "magpie collection of statistics for no better reason than the accumulation of raw data, followed by an aimless feeding of figures into a computer, produces nothing of scientific value" (Thorne, 1970, p.16).

Caulkin (2007, p.8) describes how "of the vast quantities of information expensively pumped through corporate pipes, much gets diverted, dammed or just trickles through the cracks. What does get through is often contaminated, diluted, or otherwise unusable." In the same article Orsmond (2007) refers to 'mouse bound' rage. Nurses experience this phenomenon as they spend increasingly longer periods of time sitting in front of a computer screen inputting data they feel is meaningless, and less and less time by the side of the patient, a skill they trained for as students and expected they would use when they qualified.

Caulkin (2007, p.8) advises the following remedy: "as with physical production, it is essential to route the pipes properly, simplifying the runs and putting the right information on the screen at the right time. It is humans who work the valves and switches and, even more importantly, humans wanting their problems solved on the other end of the line." Put less eloquently than the measured words of Caulkin, staff echoed these views and expressed a willingness to help 're-plumb the system' by reviewing the Trust's audit systems alongside the senior management team to ensure that the right information is collected in the most efficient way. Fish and Coles (1998), however, caution that clinicians risk top

loading the visible parts of the iceberg causing it to capsize and sink if they take on more tasks and new roles. Balance is clearly needed. Some specific recommendations about how both can be achieved are discussed in Chapter 7.

Nurses are well versed in the guidelines required to ensure that effective records are kept. Good record keeping is a mark of the skilled and safe practitioner. Records should provide factual, current, comprehensive and consistent information about the assessment and care of patients (NMC, 2002). This is 'drilled' into every nurse at the very beginning of his or her training. The mantra 'if it isn't recorded it didn't happen', is carried around like a protective paper umbrella throughout a nurse's career; putting it into practice, however, requires inevitable compromise. This is a view supported by Dawoud and Maben's (2008) National Nursing Research Unit paper entitled *Nurses in society: starting the debate*. This research was commissioned and supported by the Department of Health (DOH, 2008c) in England. It summarizes the written evidence collected from a widely circulated questionnaire which generated two hundred and fifty seven responses from nurses, students, nursing academics, educators and managers across various practice disciplines and sectors. Information gathered over a consultation period of one month (May 2008) was used to inform the "Next Stage Review Task and Finish Group on: The role of the Nurse." Nurses commented on the tensions and challenges created by increased bureaucracy, paperwork and data collection and an emphasis on a need to "show that they are giving care rather than actually giv[ing] it" (p.21). These were seen as obstacles which interfered with delivering holistic, patient-centred and continuous care which put the patient first.

Time constraints (Anderson, 2000; Davy, 2001; Dion, 2001) and bureaucratic duplication (Owen, 2005) often impinge on this 'gold standard' ideal. This can result in a diluted retrospective record that fails to capture the hidden skills and interventions used by an individual practitioner in the assessment process. In a

culture of increased litigation and compensation claims it would seem that nurses risk being drenched by the very paper umbrella that they rely on for protection. At the end of my study I wrote to participants thanking them for their contribution and I sent them a summary of my research findings (Appendix 13). I invited staff to contact me and said that I would welcome the opportunity to discuss the study with them. No one responded. This did not surprise me and I do not think that it would have surprised Freire either. It takes time and courage to move on from a position of perceived oppression to one of perceived influence and in the busyness of the 'here and now' I appreciated staff felt they had already 'done their bit' and had now moved on to other issues.

6.2 Developing a contemporary panopticon

To try to consolidate some of my study findings and synthesize them with Bentham's earlier work, I have devised my own systems-based panopticon (Figure 6.3). As I began to consider how a modern panopticon might be represented schematically I was reminded of a classic BBC sketch that was featured in the Frost Report series, 10th May 1966 - 29th June 1967. It starred John Cleese, Ronnie Barker and Ronnie Corbett.

Figure 6.2 The Frost Report



<http://www.televisionheaven> Accessed 2nd April 2008

Satirizing the disparities embedded within the British socioeconomic class system it proved a natural source of inspiration. It paralleled some of the key concepts underpinning the 'eye' of the contemporary panopticon. Upper-class John Cleese (6ft 5in) wearing a bowler hat and suit looks down on middle-class Ronnie Barker

(5ft 8in) in his trilby, who in turn looks down on working-class Ronnie Corbett (5ft 1in) in his overalls, but up at Cleese. The juxtaposition of height and social status provided a classic and punchy sketch (Clarke, 2008).

Table 6.1 Script of the class system sketch (Clarke, 2008)

Cleese: (In bowler hat, black jacket and pinstriped trousers) I look down on him (indicates Barker) because I am upper-class.
Barker: (Pork-pie hat and raincoat) I look up to him (Cleese) because he is upper-class; but I look down on him (Corbett) because he is lower-class. I am middle-class.
Corbett: (Cloth cap and muffler) I know my place. I look up to them both. But I don't look up to him (Barker) as much as I look up to him (Cleese), because he has got innate breeding.
Cleese: I have got innate breeding, but I have not got any money. So sometimes I look up (bends knees, as he does so) to him (Barker).
Barker: I still look up to him (Cleese) because although I have money, I am vulgar. But I am not as vulgar as him (Corbett) so I still look down on him (Corbett).
Corbett: I know my place. I look up to them both; but while I am poor, I am honest, industrious and trustworthy. Had I the inclination, I could look down on them. But I don't.
Barker: We all know our place, but what do we get out of it?
Cleese: I get a feeling of superiority over them.
Barker: I get a feeling of inferiority from him (Cleese), but a feeling of superiority over him (Corbett).
Corbett: I get a pain in the back of my neck.

<http://www.televisionheaven> Accessed 2nd April 2008

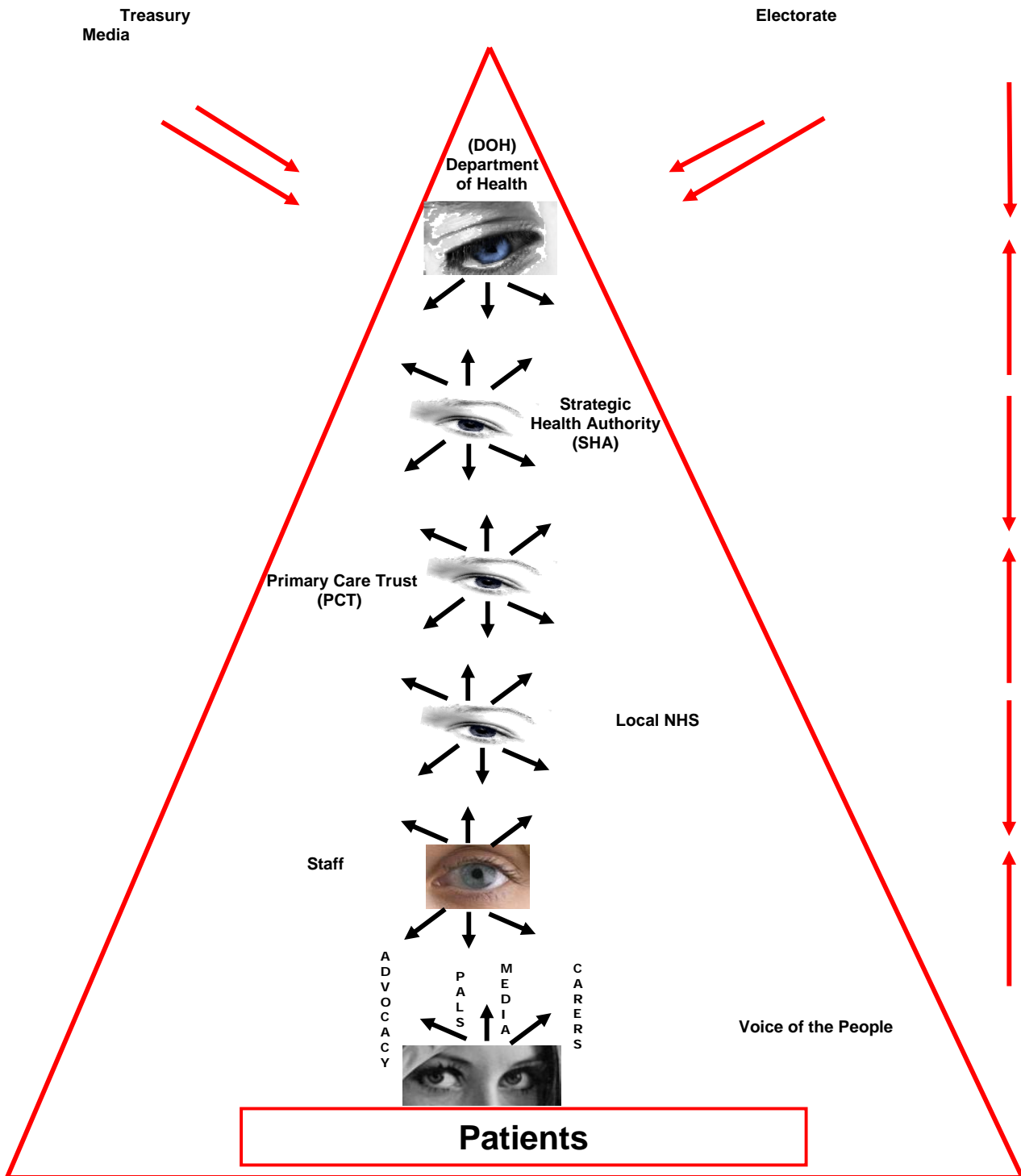
In my contemporary equivalent the Department of Health is depicted schematically as an all seeing 'eye'. It observes ten regional strategic health authorities (SHAs) for England. Strategic health authorities provide strategic leadership, and organizational and workforce development. They help Primary Care Trusts (PCTs) and NHS Trusts to put national policies into practice and to deliver the NHS Plan in their area.

The Strategic Health Authority (SHA) 'eye' looks down in glorious omniscience onto the Primary Care Trusts (PCTs). The Primary Care Trusts monitor the corporate activity of the local NHS and the local NHS monitors local delivery of commissioned services. This modern schema is depicted by two-way directional arrows. All systems watch, monitor, challenge and sometimes resist the others' performance. There are multiple stakeholders with divergent and often conflicting views. At the base of the modern panopticon are systems that monitor systems

that monitor systems (media, NHS Patient Advice and Liaison Services (PALS), and independent voluntary bodies such as Advocacy Projects). Lacking the architectonic boundaries of Bentham's original panoptic structure my contemporary equivalent is visualized as pyramidal in structure. This denotes the hierarchical characteristics typical of today's increasingly bureaucratic National Health Service and it resonates with Bentham's original system where the prisoner is watched by the guards who in turn are watched by the governor who monitors his subordinates. The prisoners spy on each other and they are all watched by the prison authorities. 'Systems' have now rapidly replaced the bricks and mortar originally required to achieve this and nurses have themselves become 'incarcerated' by paperwork that polices and makes them highly visible practitioners.

A top-down framework has been used and bi-directional arrows represent the 'driving' and 'restraining' forces originally described in Lewin's (1951) classic Force Field Analysis model. This is a model often likened to a tug-of-war that helps us to understand the dynamic balance (equilibrium) in any change between: driving forces, also known as helping forces; movement in the direction of a goal or desired outcome and restraining or blocking forces; and obstacles, real or imagined, that hinder that same process. Inward facing arrows at the top of the pyramid represent the external driving and restraining pressures on the Department of Health (DOH), from the media and Treasury Department and so on. Differences in eye shape, and lid size, and arrows radiating from each department within the triangle are used pictorially to acknowledge that power is differentially distributed. The upward arrow in the diagram is used to demonstrate schematically the importance and value of listening to the voice of the 'people'.

Figure 6.3 A contemporary schematic version of Bentham's panopticon



On 12th July 2010 The Government set out its strategy for the NHS in The White Paper 'Equity and Excellence: Liberating the NHS', proposing the phased abolition of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs). These will be replaced by GP consortiums.

6.3 Study shortfalls and alternative approaches

I am conscious of several study limitations and appreciate the impact these may have had on my findings, analysis and subsequent discussion. I remain proud of my decision to undertake a piece of work to capture the voice of local practitioners, and I understand and fully respect the reservations the ethics committee expressed about my recruiting clinicians I either worked with or with whom I had close professional contact. However, I still regret that by limiting my research study to experienced mental health nurses, I denied my junior colleagues the opportunity to contribute to some exciting discussions and the chance to become involved in creative problem solving. I am sure their voices would have enriched this study and they would have added new dimensions by offering different perspectives.

Freire proposed education as an active, participatory dialogical or conversational process involving problematization of the lived experience, "the student's actively processing an experience, modifying the experience based on past experiences, and then integrating that experience into his or her way of thinking ... such ... that the old way of thinking is changed ..." (Dolittle, 1997, p.84). I am conscious of having imposed my own 'agenda' on study participants by creating artificial groups and introducing a specific predetermined topic of inquiry that I chose and wanted to discuss. This was not negotiable although I did make the study focus clear in the Participant Information Sheet, an integral component of the recruitment process, and study participation was voluntary. In addition, I scripted question prompts, chose the selection of magazines made available for the collage exercise and acted as the self appointed time keeper for the groups, reminding staff to keep on track if I felt they deviated from the subject. I

independently analyzed the focus group transcripts, 'presented' staff with emergent themes and suggested my own solutions. This could be perceived as a disguised form of banking education where "the students are the depositories and the teacher is the depositor" (Freire, 1993a, p.53), diluting an authentic Freirean exchange and imposing my own ideas on the group rather than spending time in dialogue identifying what was meaningful and had significance for them. This may have minimized the problem-posing potential within the group. Given more time, and with the value of hindsight, I would have encouraged colleagues to build on what they had discussed and would have actively involved them in developing creative solutions to the problems they highlighted.

I had not appreciated the importance staff would attach to the ice-breaker collage exercise at the beginning of the study, and although I checked my ethics application with care (to reassure myself that I had mentioned that 'rich descriptive local data would be collected by a pre-focus group ice-breaker exercise (magazine picture collage), focus group discussion and a simple demographic questionnaire' (p.6)) to justify its use, given a second chance I would have made the value of the collage more explicit and raised the profile of this technique.

As discussed in Chapter 4, the number of participants contributing to my study groups ranged between 2 and 6 and as such they often fell below the ideal size cited in many focus group texts. However, in my experience these smaller group numbers worked well and gave staff a real opportunity to become involved in focus group discussions and to voice their ideas without feeling rushed or intimidated by the size of the group. They may also have given staff opportunities to explore and develop their ideas that larger group numbers may have prevented.

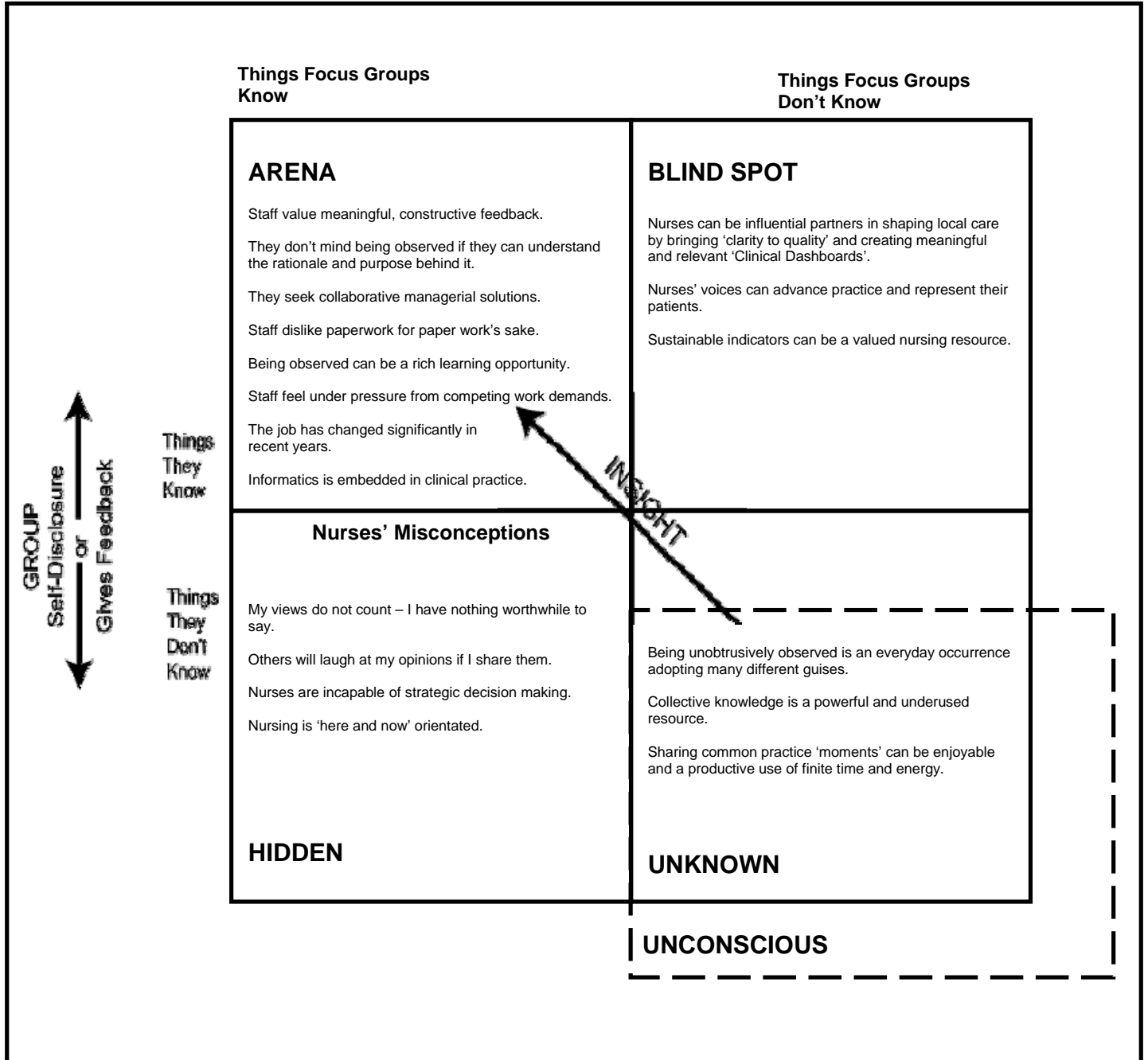
This was an initial small-scale local study, and these identified shortfalls and reflections will help to inform and shape the development of a larger and national post doctoral study that I propose to develop.

6.4 Synergies and interdependencies

In Chapter 4 the Johari Window model was introduced. It was recognized as a useful information processing tool. Figure 6.4 captures the value of the group process in developing collective understanding. Staff shared their thoughts and ideas openly and collaboratively with each other and insights were developed which may not have been recognized at an individual level. This synergy is reflected in the previously Unknown quadrant of the window.

The aim of the Johari window model is to increase collective knowledge and understanding in the Arena quadrant of the window and to facilitate safe disclosure of information in the Façade pane. Focus group facilitation sought to capture and distil information in the participants' Accessible/Will share domain. The process was used to access information in the previously Unknown domain and for focus group participants to become more aware of their own individual and group Blind spots.

Figure 6.4 Post focus group Johari Window



6.5 Conclusion

I have used this Chapter of my study to discuss focus group study findings. The allegorical ballad, *The Rime of the Ancient Mariner*, by Samuel Taylor Coleridge, is used to describe the joint concepts of oppression and liberation which underpin much of Freire's work. Nurses recognize that they are unobtrusively observed by many people and by various organizational systems. Different meanings are attached to this. Staff value being observed as a rich learning opportunity. They accept responsibility as Trust employees to provide cost-effective services. However, they felt many organizational systems failed to capture the right information at the right time and in the right way and this was perceived as a missed learning opportunity for the Trust. Study shortfalls and methodological weaknesses are recognized and the contemporary schematic version of Bentham's panopticon that I devised is explained and discussed.

Freire (1993a, p.68) comments that reflection without action is meaningless; it is "alienating blah." Punch (1994, p.194) agrees and calls this "sedentary pontificating." It does nothing to alter an oppressive position. Change occurs, however, as a consequence of being able to adapt one's beliefs and practices in response to the evidence available and to develop tolerance of ambiguity and the creative tensions that this causes. Chapter 7 will make a number of specific study recommendations that have arisen out of this research in the realization of its goals.

CHAPTER 7

CONCLUSION

The aim of this study has been to explore how experienced mental health nurses employed in an NHS setting felt about being unobtrusively observed in their everyday clinical practice. The work of Paulo Freire has been used as an interpretive theoretical framework. A contemporary schematic version of a systems based panopticon was devised to reflect the top-down nature of observation and the multi-layered gaze of an increasingly bureaucratic NHS. This model recognizes the importance of organizational systems which are not represented in Bentham's original architectonic design. This study offers important and original insights into the core values which drive and frame front-line mental health clinical practice and it gives voice and coherence to front-line nurses' views. It has helped to close a gap in nursing knowledge by developing an awareness of how nurses feel about being unobtrusively observed, an area not previously investigated. Specific study recommendations which could transform practice are proposed and now require managerial commitment.

Participants were able to recognize positive and negative consequences of being watched, and appreciated that unobtrusive observation could be a valuable learning opportunity, a chance to request colleague feedback and to discuss 'common moments' openly and honestly. They appreciated the importance of audit trails and capturing and mapping service information that could be used to organizational advantage and the need to evidence value for money in all aspects of service delivery design and implementation. Participants wanted this to be accurate, and within a systematic and sustainable framework. They wanted information to be centralized, enabling consolidation of existing audits. Staff voiced their wish to be compliant with top-down requests to assist in audit collection, but as busy practitioners they also wanted assurances that time collecting this information was being used effectively. Many staff commented that

duplication of information requests for different purposes seemed common practice. They viewed this as inefficient and a waste of limited resources.

Participants were frustrated that their effectiveness as clinicians was rated using quantitative outcome measures and standards which failed to recognize or capture the importance and richness of softer intelligence. They felt judged and scrutinized by the quality of electronic and paper trail returns which they deemed neither appropriate nor 'fit for purpose'. Staff welcomed the opportunity to engage in a constructive dialogue with the senior management team to help reconcile these practice tensions. They felt they had a useful contribution to make in the development of future performance management tools. Nurses emphasized the importance of experiential knowledge and wanted audits to capture what they actually did, rather than become involved in dysfunctional "hitting the target and missing the point" 'gaming' (Bevan, 2009, p.338) where statistics are often adjusted or corrected and outliers removed in order competitively to match national averages where nobody really benefits. Staff did not feel consulted when new systems were planned or introduced and they wanted specific, timely, meaningful and purposeful feedback on how they were performing in their local teams.

These findings are likely to be generalizable to other health care disciplines and not unique to the domain of nursing. I believe that the adoption of a Freirean focussed approach is an undervalued resource and one which has untapped potential. There is a need for it to be exploited by other practice areas so that they can also learn the benefits of this philosophy. I have identified three main research findings which arise from this study. They are the significance front-line staff attach to value-based as opposed to evidence-based practice, the importance of responding to evidence from local practice, and the need to reconcile a bottom-up horizontal and top-down practice perspective. I will now consider these in turn and will then make some specific study recommendations that should be implemented as a consequence of this study.

7.1 Shared clinical ownership

The face of modern mental health nursing should be dynamic, innovative and receptive to change (Wilmot, 1998). It should 'drive' and not be 'driven' by the change process and 'kite mark' best practice mechanisms, by empowering front-line nurses to take on a wider range of diverse clinical responsibilities (DOH, 1997, 2002, 2008c). Too often clinicians have allowed their management of the 'here and now' to cloud and distort their vision of tomorrow and to distance their involvement in the development of key national initiatives (Nicholson, 2008). The proposed devolution of power, a key theme which permeates Darzi's Next Stage Review of the health service (DOH, 2008b), provides nurses with the opportunity to have shared clinical ownership in developing local services and it tasks them with joint responsibility to drive and align the systems that influence the quality of care they aspire to deliver.

As front-line clinicians, nurses are positioned to provide the organization with an informed perspective on how audit tools and outcome measures can be used effectively and the ways in which they can be practically developed. Staff wanted the surveillance tools they used to have meaning. They also wanted them to capture the richness of their work and all its shortfalls. As knowledgeable partners in care, staff did not want their voice or those of their patients diluted by their line managers who were often perceived as distanced and removed from the real issues facing ground-floor practitioners. Instead nurses wanted to be able to devise their own practice benchmarks and to create standards that were meaningful, fair and founded on trust and reciprocity.

This practice based sentiment was eloquently expressed by President Roosevelt in a speech given in Paris, France in 1910. "It is not the critic who counts; not the man who points out how the strong man tumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood, who strives valiantly;

who errs and comes short again and again; because there is no effort without error and shortcomings ...”

As practitioners in the field participants appreciated direct constructive feedback from their peers on how they were performing. They recognized the untapped potential audit trails could have in shaping and developing effective and efficient clinical services. What they wanted to see, however, was an acknowledgement from senior managers that they were valued and had an important contribution to make. In the inclusive Patient Public and Involvement (PPI) model of the NHS, patient user, carer and public involvement are seen to be in a partnership of equals. This is often pictorially represented as an equilateral triangle where staff, patients and service providers have equal status.

In my clinical experience this is rarely the case and the triangle is more often scalene (three unequal sides) in design. This practice tension can be captured pictorially by my preferred image of an hour glass (Figure 7.1). I have represented patients at the base of the hour glass because they are often consulted in tokenistic fashion (or not at all) and they are lacking in influence and voice. To reflect practice reality nurses are metaphorically squeezed between the competing service demands of their clinical role (hands on nursing) and the restraints imposed by ‘top-down’ managerial imperatives. If the hour glass is turned upside down the situation slowly reverses and patients now assume a position of influence. They can help tailor services by feeding back what works and what requires modification. If one position is allowed to dominate over the other, decisions are made that either fail to capture the views of the patient or to reflect the latest policy steer. In both ‘either or’ examples there is a failure to deliver a needs-based service. If attention is paid to both positions simultaneously (via consultation, scrutiny committees and so on), communication is more likely to flow freely and bottleneck bureaucracies can be recognized and managed from a joint perspective. In this way, care is collaboratively influenced.

Figure 7.1 Shared clinical ownership

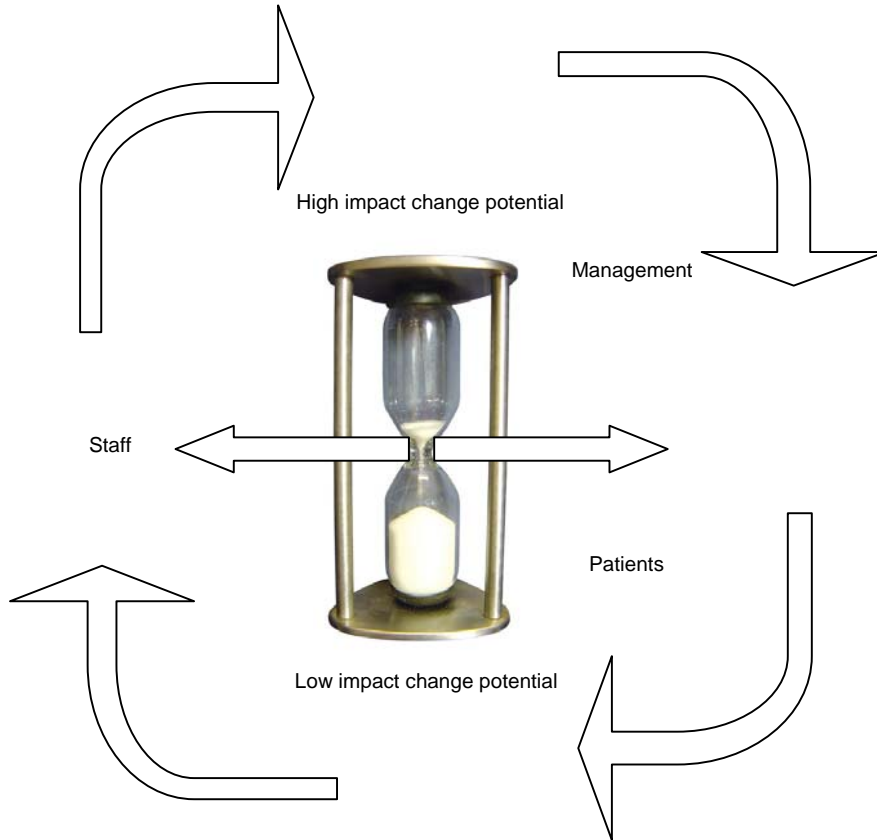


Figure 7.1 schematically represents the power imbalance experienced by patients and staff behind the public façade of equality and consultation. I have chosen to represent staff in the 'bottle neck' of this egg timer model to portray competing managerial and clinical tensions (often contradictory) and time pressure constraints. It also demonstrates pictorially the potential to act as a conduit between the two and the inevitable compromise this requires. A willingness to act and recognition that things can be different are captured by an ability to turn the 'egg timer' and to alter this position.

7.2 Evidence from practice

Front-line clinicians are in a key position to act as a natural conduit between their patients and senior managers. As 'hands on' service providers working over a twenty-four hour period, nurses are best placed to know what works and what requires modification or revision. This is unparalleled by other disciplines and practice domains. Nurses are natural ambassadors and stewards for the Trust and their views a rich source of insider information. Greater appreciation of this would enable the Trust to deliver a streamlined service which is both cost effective and efficient. Involving staff in steering group meetings and project development teams to create realistic outcome measures would be a useful way of addressing this current service shortfall. It would bring added value to the process. All too often nursing staff are involved in a limited superficial fashion, nominally represented, or consulted by email with tight unrealistic deadlines they cannot hope to meet without compromising direct patient care. Ring-fenced time to read and formulate considered views and to discuss these with colleagues is clearly required. Only then can nurses go to task and finish forums or participate in development work streams feeling really prepared and with an informed view that is credible, convincing, and has clinical impact. Failing to comment through lack of time or competing work priorities, staff are often later advised that they have been consulted and have been given the opportunity to voice their views. It is clear that staff welcome an open, inclusive, participative management style in which they feel involved and consulted about the audits with which they are expected to work.

7.3 Bottom-up processes

The contribution to knowledge of this study is its focus on issues of voice and visibility. Understanding "top-down practices and bottom-up responses", a phrase originally coined by Willis (2003, p.391), is fundamental to the future of nursing praxis. A bottom-up approach to auditing local initiatives such as peer review

may be a useful way of ensuring that quality-assurance cycles are meaningful, purposeful, and embedded in actual practice. This would ensure nurses own a process created by them that has local relevance. Staff wanted reassurance that data which they collected would not be lost or disappear into a 'black hole' in the system (Lelliot, 1995). They wanted to see centralized integrated systems in place to avoid duplication of information requests, and to have confidence and assurances that they would receive timely feedback so that they could see why they had collected the data and how it had been used.

Participants demonstrated their ability to use creative metaphor to help explain their ideas and articulate their views. The actual study process encouraged them to think and reflect critically together about their own practice. Staff commented that the study time had provided a useful reflective space. They valued the opportunity to become "active agents in their own learning" (Belenky et al., 1997, p.213) by describing not only how things were but also how they could be.

Benner (1994b) as cited in Dracup and Bryan-Brown (1998, p.250) notes a certain ease in remaining invisible, 'dancing in the margins' of healthcare, voiceless on issues that count. This resonates with the narrative of some focus group participants. Reasons behind this are likely to be complex and multi-faceted. Critical thinking can help nurses explore their own silence and the role they play in its perpetuation. Shared experiences can lead to new forms of understanding, resulting in transformative change, and situations previously seen as permanent reframed as merely limiting. Findings suggest that focus groups conducted away from the distractions of the workplace may be an underused tool. They can help nurses gain the confidence to express their views to a wider audience. Creating an environmental culture that welcomes and solicits feedback is likely to produce positive outcomes.

This research study was primarily undertaken to fulfil the requirements of a professional doctoral programme. An integral component of this course was the

value the University placed on Action Learning Sets. They mirror some of the ideas behind Freire's concept of praxis. Like the study participants I feel I have learnt many things during this process and benefited from the experience. The constant salutary reminder by the course tutors and supervisors to remain focussed, iterative, and reflexive formed a critical and pivotal mantra running throughout all stages of this inquiry. It helped me to shape, develop, and refine the form and final content of the finished product. As a self confessed 'completer finisher' by nature, the temptation to launch into premature problem definition and the urge to work towards early closure was often difficult to resist. The injunction to describe and not explain or attempt to resolve was helpful, and something I learnt to heed in the early stages of this project.

The creation of NHS Foundation Trusts ('foundation hospitals') places increasing emphasis on the devolvement of central Government decision making and strategy planning to local stakeholder organizations and communities (DOH, 2006). This provides an exciting opportunity for the innovative and creative commissioning of services which are responsive to social need and local expectation and better equipped to tackle health inequalities and disease patterns which are uniquely profiled to specific demographic areas. Foundation Trust status has inevitably meant an increased emphasis on corporate financial responsibility and a greater need to focus on the business of caring (Machell et al., 2009). Increasing emphasis is being placed on health care reform, similar to the Canadian system and its adoption of an "if you can't measure it, you can't manage it" mindset (CHSRF, 2000, p.6). The findings of this study show that nurses accept the role they play in meeting ward to board performance objectives but also want to capture accurately the emotional content of their patients' experience, a view supported by Machell et al. (2009). The nurses in this study feel current systems prevent them from doing this and, as experienced clinicians, express resentment at the erosion of traditional nursing values where the patient and not the cost of their care take priority.

Foundation status will need to be 'owned' by the community it represents (DOH, 2007). It will provide greater freedom, flexibility and independence in deciding how services are commissioned and delivered. It also carries greater responsibility, as health and social care providers will need to ensure rigorous audit trails and effective monitoring and governance systems are in place to facilitate an effective defence of the strategic decisions and plans made. Financial viability, sustainability, and accountability will be open to robust challenge and public scrutiny. An increased awareness of what works and what does not work, by being receptive to relevant small scale research, will be pivotal to underpinning this process and informing decisions around efficiency and economy. Listening to the voice of local nurses and responding to their views may result in the collection of valuable data. This will help inform practice through research and will be a rich source of community intelligence. It will help redress the lack of perceived influence front-line staff have in shaping services (Maddock, 2002). Greater attention now needs to be paid to measuring what nurses actually do and to capturing the complexities of practice reality (Rankin and Campbell, 2006).

As organizations make the transition to Foundation status and discharge their duties ethically and responsibly they will increasingly look towards front-line practitioners to inform this process. Monitoring technology can be used as a window or a one-way mirror (Simpson and Simpson, 1999) and nurses will play an important role in determining how knowledge of this position can be used to mutual advantage. Although nurses make up around 45% of the local NHS workforce and are often described as the glue and cement (Sandelowski, 2000) holding the NHS together, we remain a largely invisible workforce and lack the political impact suggested by our numbers, a challenging paradox highlighted by Leavitt (2009).

By engaging in an open and honest dialogue on how it feels to be unobtrusively observed in their everyday clinical practice, and by highlighting what helps and

hinders them in the delivery of direct patient care, nurses are in an ideal position to play a key role in helping develop and shape local neighbourhood services. If nurses feel they are valued and listened to they will be less likely to leave the profession or relocate outside the geographical area. As the workforce ages and 'baby boomer' nurses start to prepare for retirement, the recruitment and retention of experienced clinicians will assume a greater organizational priority (Zangaro and Soeken, 2007). Informed dialogue could therefore have a positive impact on the local health economy. It will also help the NHS live up to its claim to being an Investor in People by investing in its greatest asset, its staff.

As a discipline per se nursing seldom pauses from its 'busyness' to stop and critically listen to or reflect on the views of its front-line staff. Nurses rarely place their work onto a political agenda and often see this as a core distraction from their primary role as practitioners. Maslin-Prothero and Masterson (2002) contend that this position needs to change urgently so that nurses may become effective champions in debating policy issues and practice-based tensions and in influencing how the allocation of scarce and finite resources is managed amongst competing groups within a turbulent health economy. Reaffirming the role of nursing and its contribution to effective service delivery is a practice priority which has been restated by Ann Keen, MP and Parliamentary Under Secretary of State for Health, and Christine Beasley, Chief Nursing Officer (England), (DOH, 2008c) in a paper that tasks nurses with driving up the quality of their care and re-engaging with the development of initiatives that are tangible, compelling and inspirational. Drawing on the capabilities of clinicians by devolving power to front-line staff was one of the key sound bites which emerged from the Department of Health (2008b) NHS Review. This is an agenda which promises to give greater practice freedoms to shop-floor clinicians and to reaffirm the role of nursing. This will empower staff to help set and drive the direction of future health services that are sensitive to local demography. It is essential therefore that nurses make the necessary time and space for this to be realized.

7.4 Specific study recommendations

I have made three specific policy recommendations that I believe the Trust now need to implement. I have chosen to present these initiatives together to maximize their impact and ensure that they are not lost or diluted within the text. These recommendations are formed from the key messages which emerge from the focus group discussions. They are an attempt to invest in staff in a practical way and to provide meaningful feedback to senior managers that is relevant, realistic and 'fit for purpose'. They are now discussed in turn and if implemented successfully have the potential to build on the capacity and capability of the local workforce. These positive and practical suggestions will help shape the way ahead and inform the delivery of high quality nursing fit for the 21st century. The ethic of reciprocity and the spirit of dialogue and cooperation underpinning these proposals will help redress the current imbalance within the organization and ensure that the clinicians providing the service have a voice and feel in control of the services they deliver. This approach will also benefit and add clarity of purpose to those charged with managing the finite resources needed to make this a practice reality.

7.4.1 Enhancing reflexivity

Focus group participants commented positively on peer supervision, valued lifelong learning and welcomed positive problem solving meetings and the opportunity to 'check out' practice issues with their colleagues. They now need a recognized forum for this and a collaborative work-based experiential approach is suggested. In order to develop expert reflexive practice, nurses should be allocated one day per month as a continuing professional development day. In line with allied health care professionals this should be ring-fenced protected time away from the clinical area. It should be used for networking and group focussed clinical activity, private study, reflective practice, and to share and 'show case' clinical successes amongst peers.

7.4.2 Joint working

Participants valued opportunities to 'check out' their practice with others and prized highly the occasions when they were able to perform joint assessments with their nursing colleagues. Using a group focus, staff can develop critical thinking skills and become their own agents of change by keeping up to date with the latest issues, innovations, and controversies relevant to their own practice discipline. Nurses engaging in this way are less likely to become stale and more likely to remain critically questioning, reflective practitioners prepared to challenge system shortfalls and push the parameters of current practice by considering how things could be and not just accepting the way they are. I therefore recommend that staff negotiate one hour per week where they can undertake joint assessments with their peers. Social unity and collective power are fundamental prerequisites underpinning the liberating methodology favoured by Freire. By developing and expressing ideas collegially nurses would avoid merely echoing the opinions of others and would instead begin to formulate their own informed views.

7.4.3 Meaningful audits

I also recommend that a local audit policy development and impact committee is created. This should include representation from front-line clinicians, carers and service users and be used to inform and develop audits that have obvious workplace relevance, currency and immediacy. In this way audits will have meaning and purpose and reflect accurately the clinical activity of front-line nursing staff. This process will prove invaluable for managers anxious to 'square the budgetary circle' and will also ensure that the voices of all stakeholders are heard and respected.

7.5 Meaningful conversations

As my thoughts returned to Raphael's fresco *Causarum Cognitio* (previously discussed in Chapter 3) I reflected on the following: if Paulo Freire and I had

walked in dialogue together discussing this study and its implications for nursing practice, what might he have said? I imagined it would be something provocative like “ok ... good as far as it goes but where is the dialogue with your oppressors? You are still behaving as an object and not a subject reacting ‘to’ rather than in communication ‘with’ ...” Nurses need to be the midwives in their own liberation transforming limiting situations into creative ones. Freire calls this progressive struggle militant non-violence.

Like “Blackbirds singing in the dead of night isolated and sadly ignorant of how their song is part of a much larger singing in the world” (Chambers, 1991, p.354), nurses need to share their ideas and visions with a wider audience, becoming more than a familiar chorus that has ceased to be heard or to have meaning. This will require them to critique their own position and to consider the relationship they share with their perceived ‘oppressors’. It will take time and courage and be easier for some nurses to achieve than others. Having meaningful conversations with senior managers and feeding ideas into existing Trust mechanisms will help set the tone for future service direction and it will open up the way for a dialogue about the need for a diverse repertoire of creative and consensual management strategies.

This study has provided a useful platform for nurses to voice their views. It has also provided rich and original insights and an agenda of specific managerial recommendations that need now to be acted upon. It is imperative that staff maintain and sustain the momentum gathered in this study and capitalize on the dialogue they began with each other. This will enable nurses to continue to explore issues collaboratively and collegially with other allied health care disciplines and those perceived to be in positions of influence. Antrobus (1999) refers to the ‘political invisibility of nursing’. She contends the discipline exists within a political vacuum. Only by becoming part of the broader debate and by contributing to national conversations can nurses ever hope to influence change and ensure their ideas are heard, respected and acted upon. Failing to do so will

result in a missed opportunity; it will perpetuate the sedentary pontificating so abhorred by Paulo Freire and nothing will have changed.

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Appendix 1

Poster

Are you a qualified mental health nurse?

Are you interested in taking part in a research project?

As part of my Professional Doctorate in Nursing Research you are invited to participate in the completion of one short questionnaire, a group collage and a taped focus group discussion around how it feels to be observed while working in acute mental health care. This may help in the development of future mental health practice. Participation is purely voluntary. But should you agree this will take no more than two-three hours of your work time (depending on the venue). Refreshments and a relaxed setting will be provided. All travel costs will be reimbursed. If you are interested but would prefer to share your ideas on an individual basis this can be arranged.

Further details are available on request. Thank you

Gail Salisbury

Doctoral Student Researcher

University of Brighton

Local work contact Tel: [Removed]



University of Brighton



**Clinical Research Centre
For Health Professions**

Appendix 2

November 2007
Version 2

Dear Colleague (Name to be inserted),

Hopefully by now you will have seen one of the posters that I have recently displayed in the communal areas of your unit.

As part of the Professional Doctorate in nursing that I am undertaking at the University of Brighton, I am inviting you to participate in the completion of one short questionnaire, a group collage and an audio taped focus group discussion around how it feels to be observed while working in acute mental health care. This will be confidential and it may help in the development of future mental health practice. I would be happy to see you on an individual basis if you would prefer.

Participation is of course purely voluntary. Should you agree to take part, however, this will take no more than two - three hours of your work time (depending on venue). Refreshments and a relaxed setting will be provided and your travel costs, if appropriate, will be reimbursed.

If you are interested in knowing more about this project please contact me so that I can send you a comprehensive participant information sheet that provides you with full details of what this study will involve. You will be required to sign a consent form and are free to leave the focus group and group collage at any time and without explanation.

Further details are available upon request. I can be contacted at (contact details removed).

I look forward to hearing from you.

Many thanks,

Yours sincerely,

Gail Salisbury.
Doctoral Student Researcher.
University of Brighton
Local work contact: [contact details removed].



University of Brighton



**Clinical Research Centre
For Health Professions**

Appendix 3

October 2007
Version 1

Thank you for agreeing to participate in my doctoral research which seeks to understand your views on working in acute mental health care. As you will have gathered from the participant information sheet that I sent you, I am particularly interested in understanding your views on how it feels to be observed in everyday clinical practice.

Several of your colleagues have also agreed to participate and I will contact you shortly with the date and venue of our meeting. Meetings will take place in work time and travel expenses may be reclaimed by completing the Trust's mileage claim form in the usual way.

Please let me know in advance of any environmental adaptations that may need to be made.

Please feel free to contact me with any queries or concerns that you might have.

Yours sincerely,

Gail Salisbury.
Doctoral Student Researcher.
University of Brighton
Local work contact: [contact details removed].



University of Brighton



Clinical Research Centre
For health professionals

Appendix 4

October 2007
Version 1

PARTICIPANT INFORMATION SHEET

You are being invited to take part in a student research study. Before you decide whether you wish to participate, it is important that you are given the opportunity to understand why the research is being done and what it will involve. Please take time to read the following information carefully before deciding whether or not you would like to take part.

- Part 1 tells you the purpose of this study and what will happen to you if you take part.
- Part 2 gives you more detailed information about the way in which the study will be conducted.

Please don't hesitate to ask me if there is anything that is not clear or if you would like more information. Thank you for reading this.

Part 1

What is the purpose of the study? This student research study seeks to understand how qualified mental health nurses feel about being observed in their everyday clinical practice. Observation can assume many forms. It can be direct or indirect. Direct observation might consist of someone watching you perform a task. Indirect or unobtrusive forms of observation might include audit trails, computer surveillance, and managerial or clinical supervision, amongst others. The aim of this study is to identify whether nurses' views about being observed in their everyday clinical practice change as a consequence of their role, experience, unit culture, and so on.

Study aims: The aim of this study is to gain a greater understanding of qualified mental health nurses' feelings about being observed in their everyday clinical practice. It is to consider the practical implications of these findings for acute mental health services and continuing professional practice development at both an individual and organizational level.

Why have I been chosen? You have been invited to participate in this research study because you are a front-line qualified mental health nurse working in acute care.

Do I have to take part? No. It is up to you to decide whether or not you wish to take part. If you do decide to take part you will be asked to sign a consent form. You are free to withdraw from the study at any time and without giving a reason.

What will happen to me if I take part? You will be invited to complete a simple questionnaire, and to participate in a group collage and focus group discussion on how it feels to be observed in clinical practice. The focus group discussion will be audio taped. You will be clearly told when the taping is about to begin to avoid any 'out takes'. Together, these tasks will take approximately 2 hours to complete. They will be performed with colleagues of a similar grade to you. You will not be asked to compromise the safety of your service by participating when it is busy. To avoid distraction you will be asked to turn your mobile phone off.

Expenses and payments: You will not be paid to participate in this study as this will be done during work hours and not in your own time. If travelling is involved you will be able to claim a mileage allowance by completing a Trust claim form in the normal way.

Ice-breaker exercise: A magazine picture collage exercise will be used as a group ice-breaker tool. It will be used as a natural opportunity to get you talking, sharing ideas and relaxing together in preparation for the focus group discussion that follows. You will be asked to create a group collage using a selection of glossy 'waiting room' magazines. These will have a high pictorial content to help generate ideas. You will be asked to cut or tear out pictures, images and slogans that reflect how it feels to be observed in clinical practice. A female holding a child, being seen as either supportive or nurturing or conversely parental and controlling (depending on how the image is perceived by you), is a practical working example. This example is obviously based on extreme polarities. You can approach the task in whatever way you choose. Titles and word cuttings (text, for example) can all be used on the final collage. It is not a competitive exercise. There are no right or wrong answers. You will have about forty-five minutes to complete the task and will be given a time prompt at the thirty minute mark. Free refreshments will be made available during this time.

Focus group: This session will last for about one hour. You will see a co-moderator taking written field notes of the main discussion points made during the focus group. He will sit outside the group to avoid distraction. There will be up to seven other people in the group. You will be asked to give your opinions, and not to try to convince other people. There will be no right or wrong answers, just your views. These will be equally important. You are not there to reach a consensual view. It is important to give everyone an opportunity to talk. You may

be asked to stop if the discussion is going 'off track'. Please don't be offended if this happens.

You will also be asked to complete a simple factual questionnaire (age, gender, and ethnicity), and to state your work grade and how long you have been in this grade. You are under no obligation to provide this information, simply leave the sections blank that you do not wish to answer. If you wear glasses or contact lenses for reading, please do so to help you complete the questionnaire. Please let me know in advance of any other environmental adaptations that may need to be made. You will be given the opportunity to agree a set of ground rules with those participating in the study.

If you would like to share further thoughts with the researcher after the focus group discussion, you will also have this option.

What are the possible benefits of taking part? There will be no obvious initial direct benefit to you as an individual. It will, however, give you an opportunity to share your thoughts and feelings about some aspects of contemporary and local acute mental health care with other qualified mental health nurses.

Will my taking part in this study be kept confidential? Yes. This research will follow ethical and legal good practice guidelines and all information about you will be handled in confidence. The details are included in Part 2.

Contact details: For further information on this study I can be contacted at [contact details removed.]

This completes Part 1 of the information sheet. If the Information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study? You are free to withdraw from this study at any stage. The results will simply state how many people chose to withdraw and at what stage in the data collection process they did this. If you leave midway through the focus group discussion you will need to decide whether you give permission for your contribution to be used as part of the main analysis.

What if there is a problem? If a problem arises as a result of participation, for whatever reason, once the project is up and running, please contact (name removed), clinical psychologist, who has agreed that he can be accessed independently for support. If you remain unhappy with the response and wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained from the unit that you work on at the hospital. As an NHS

employee you also have access to the occupational health department and Counselling in Confidence (CIC) resource free of charge.

Will my taking part in this study be kept confidential? Yes. All the information gathered throughout this study will be treated in the strictest confidence. Although you will possibly recognize and be recognized by other qualified staff working within the Trust who may also agree to take part in this study, you will not be identifiable in the findings. Only the researcher, two academic supervisors and course leader (constituting the 'expert' panel) will have access to the collected data and the field notes. These will be transferred onto and stored on a password-protected database within a locked environment, secure against unauthorized access. Interviews will be tape recorded and later transcribed for analysis after which the tapes will be destroyed. Group participants will be requested to commit to and honour each other's right to privacy and asked not to share focus group content outside the group setting. Any data collected will be specific to this research study. It will not be used or given to any other researcher for future studies. The results and the recommendations from the research will be made available for you to read following completion of the project. For ease of reading they will be summarized onto two A4 pages. You will, however, be able to read the report in full if you wish.

What will happen to the results of the research study? The results from this study will form part of my final two year Professional Doctorate in Health and Social Care thesis that will be submitted to the University of Brighton in September 2010-2011. If the results of this study are published the Trust and the units participating in this research will not be recognizable.

Who is organizing and funding the research? This research forms part of a Professional Doctorate in Health and Social Care project being undertaken at the University of Brighton. (Trust name removed) is funding this research via the personal study day contract it has negotiated with the University.

Who has reviewed the study? The University of Brighton Health Professions Faculty Research Ethics and Governance Committee (FREGC); East Sussex NHS Research Ethics Committee (REC), managed by the Central Office for Research Ethics Committees (COREC) within the National Patient Safety Agency; NHS Research Governance via the local Sussex Consortium's Research Approval and Monitoring Committee (RAMC); (Name removed) Associate Director of Nursing (Adult Mental Health); (name removed), Modern Matron, Adult Mental Health (In-Patient Services); and (name removed) Academic Supervisor, University of Brighton, have reviewed and approved this research study.

What do I do now? Please sign the attached form to show that you have read, understood and give your informed, written consent to take part in this research. If you wish to withdraw from the study, you may do so at any time without giving

a reason. You will be given a copy of the information sheet and a copy of the signed consent form (on the day) to keep.

If you have any queries, please do not hesitate to speak to me.

Thank you for taking time to read this sheet and for considering taking part.

Contacts for further information. The following individuals have agreed to act as additional local contacts for this research study:

[Contact details removed.]



University of Brighton



Clinical Research Centre
For Health Professions

Appendix 5

Centre Number:
Version 1
Study Number 1
Date: October 2007
Subject Identification Number: 1

CONSENT FORM

Study title: How do qualified mental health nurses working in acute mental health care feel about being observed in their everyday clinical practice?

Name of Researcher: Gail Salisbury. Doctoral Student Researcher.

Please initial box

1. I confirm that I have read and I understand the information sheet dated October 2007 (version 1) for the above study and I have had the opportunity to consider the information and ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
3. I agree to take part in the above mentioned group collage, focus group study and questionnaire.
4. I understand that the focus group will be audio recorded. This will be only for the purposes of this research. It will not be used for commercial purposes, or any other research project.
5. I understand that the use of anonymous quotes will form part of this study.
6. I agree to take part in the above study.

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of researcher	Date	Signature
Copy to be kept by participant and researcher.		



Appendix 6

Demographic Questionnaire Version 1 October 2007

Please take a few minutes to answer the following questions. Thank you.

Are you

Male Female (Please tick)

Age

Band: 5 6 7 8 Bank Agency (Please tick)

How long have you worked in acute mental health care? years months

Please indicate your ethnicity

- | | |
|---|--------------------------|
| White (British) | <input type="checkbox"/> |
| White (Irish) | <input type="checkbox"/> |
| White (Any other White background) | <input type="checkbox"/> |
| Mixed (White and Black Caribbean) | <input type="checkbox"/> |
| Mixed (White and Black African) | <input type="checkbox"/> |
| Mixed (White and Asian) | <input type="checkbox"/> |
| Mixed (Any other mixed background) | <input type="checkbox"/> |
| Asian or British Asian (Indian) | <input type="checkbox"/> |
| Asian or British Asian (Pakistani) | <input type="checkbox"/> |
| Asian or British Asian (Bangladeshi) | <input type="checkbox"/> |
| Asian or British Asian (Any other Asian background) | <input type="checkbox"/> |
| Black or Black British (Caribbean) | <input type="checkbox"/> |
| Black or Black British (African) | <input type="checkbox"/> |
| Black or Black British (Any other Black background) | <input type="checkbox"/> |
| Other ethnic groups (Chinese) | <input type="checkbox"/> |
| Other ethnic groups (Any other ethnic group) | <input type="checkbox"/> |
| Participant declined | <input type="checkbox"/> |



University of Brighton



**Clinical Research Centre
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Appendix 7

FACILITATOR'S DISCUSSION GUIDE (Version 1 – October 2007)

Adapted from Levine and Ligenza (2002)

Materials

Paper/pencils

Scissors

Glue

A1-size sheets of black card

Informed consent forms

Demographic questionnaires

Audio equipment

Two sets of contemporary issues (approximately the same throughout the focus group sessions) of glossy magazines.

Welcome

Thank you for coming.

I appreciate your help.

Briefly describe the project

Goal: How do qualified mental health nurses working in acute mental health care feel about being observed in their clinical practice?

Required forms to be filled out

Distribute copies of signed informed consent forms for participants to keep.

Complete demographic questionnaire.

Any questions?

Collect forms.

Make introductions

Introduce group collage.

Stress that this is a non-competitive group exercise designed to get people talking in a relaxed non-threatening setting.

Explain that there are no right or wrong answers and that the magazines are there to inspire ideas.

Explain that they are not there to reach consensus.

Advise that the collage will be taken at face value and not be used to analyze, for example, group motives.

Agree time frame.

Focus group

Set ground rules adapted from Levine and Ligenza (2002)

Describe and implement focus group discussion.

Thank you

Thank you for your participation.



University of Brighton



**Clinical Research Centre
For Health Professions**

Appendix 8

Focus group ground rules

Adapted from Levine and Ligenza (2002)

Version 2
November 2007

- There are no right or wrong answers. Just your views.
- We are not here to reach a consensual view.
- I want to hear from everyone.
- Just give your opinions, don't try to convince other people.
- I want to give everyone an opportunity to talk so please be brief.
- I may ask you to stop if we need to get back on focus to get through the topics. Don't be offended.
- We need to end promptly at – (time will be stated on the day. This may vary from focus group to focus group).
- The discussion is being audio taped so that I don't have to take lots of notes.
- As we are taping, you need to speak loudly and clearly one person at a time.

- Try not to make noises that will distort the sound quality of the tape.
- The discussion group is anonymous. This means that I won't be using your name in the research write-up.
- Please respect that this discussion is confidential and should not be shared with anyone outside this room.
- Usually people enjoy these groups as an opportunity to talk with others. Please relax and be as open and honest as possible.
- Please give examples where you can to illustrate your answers.
- I would be happy to make time to see people after the focus group if there are concerns that arise as a consequence of this session.

If you think of anything you forgot to mention, or did not want to say during the focus group, or anything else worthy of note over the next couple of days, I can be contacted on the following email address: (contact details removed).

Are there any other ground rules that you would like to negotiate?

Thank you.



Appendix 9

Version 1

October 2007

Outline of collage and focus group questioning route and protocol

Opening comments:

As front-line mental health nurses working with a high risk and challenging patient group we spend a lot of our working day directly and indirectly observing the patients in our care. My research focus, however, lies in exploring and understanding the feelings of qualified nurses being observed in their own clinical practice.

Before we begin our discussion, it might be useful to define the term observation. Observation can assume many forms. It can be direct or indirect. An example of direct observation might be someone watching you perform a task. Examples of indirect observation can include, audit trails, computer surveillance (logging on and logging off times), and managerial and clinical supervision.

Opening questions:

What do you understand by the term direct observation in a work setting?

Can you give some practical examples?

In what ways do you think nurses are indirectly observed in their work practice?

Is this the same for all nurses?

How does this make you feel?

Are some qualified staff more observed in their practice than others?

Key questions:

Are you conscious of being indirectly observed?

Does being indirectly observed have an impact on your day-to-day practice?

Do you think that your feelings about being observed in practice have changed?

Do you think that nursing grade influences indirect work based observation?

Do you think that indirect observation might serve an organizational function?

What are the positive consequences of being indirectly observed in practice?

What are the negative consequences of being indirectly observed in practice?

Ending question:

Is there anything about your feelings concerning workplace observation of practice that we haven't talked about that you would like to raise before we leave?

Appendix 10

Gantt chart project time line stage 1

Stage 1 Tasks	2006				2007					
	Sept	Oct	Nov	Dec	Jan	Feb	March	May	July	Nov
Design a clear, credible, robust, ethical, transparent and plausible research protocol addressing the following research issue: In-patient nurses' views on work-based observation.	X									
Complete NHS 'Central Office for Research Ethics Committee's' (COREC) Application Form.	X									
Proof read and make editorial revisions to both protocol and Ethics Application Form.		X								
Email draft protocol to independent colleague for comments.			X							
Make suggested editorial revisions.			X							
Submit first draft to (name removed), Personal Tutor, University of Brighton.				X						
Make editorial revisions and continue to design the protocol and amend the ethics application form.				X						
Present 'work in progress' to senior staff team colleagues.				X						
Obtain written managerial approval.					X					
Submit Protocol for East Sussex 'Central Office for Research Ethics Committees' (COREC) Approval.						X				
Attend Ethics Committee meeting with Supervisor, 8 th March 2007 13.30hrs.							X			
Present to junior staff team colleagues, 28 th March 2007.							X			
Build in anticipated Ethics revisions and resubmit.								X		
1 st May 2007, email draft research protocol to independent colleague for further comments.								X		
Make final editorial revisions.								X		
25 th May 2007, submit final bound proof read 12,000 words Research protocol (Assignment 3) to University of Brighton.								X		
18 th July - 25 th 2007, present at Research Students Work-in-Progress presentations and Monitoring meetings (University of Brighton Peers at Monitoring and Presentation day).									X	
Resubmit Ethics Application with minor amendments for chair's approval.										X

X = proposed month of completion

Projected project Gantt chart time line

Stage 2 Tasks	2007		2008						2009									
	Sept	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	Nov	Jan	Feb	April	June	July	Sep
Submit thesis outline approval to Thesis Panel, University of Brighton to proceed to Stage 2.		X																
January 2008, study recruitment. Send out invitation letters and flyers etc.			X															
Perform pilot study.				X														
Pilot data collection.				X														
Present Work at Senior Nurses' Forum, 25 th April 2008.						X												
Pilot data analysis.					X	X												
Present at Research Students' Work-in-Progress presentations and Monitoring meetings (University of Brighton Peers at Monitoring and Presentation day).									X									
Build in project design revisions.				X														
Main data collection.						X	X											
Main data analysis.							X	X	X	X								
Literature search to augment research findings.										X	X							
Present Academic Poster at Trust nurses' Conference 19 th September 2008.											X							

Stage 2 Tasks	Sept	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	Nov	Jan	Feb	April	June	July	Sep	Nov
Present findings at Suade Conference, 17 th April 2009.															X				
Invite participant feedback from data collection findings.												X							
Write up project.										X	X	X	X	X	X	X	X	X	
Write the research abstract and the conclusion.														X	X				
Proof read and make editorial revisions.														X	X	X	X	X	
External colleague to read.																X	X	X	
Proof read and final editorial revisions.																X	X	X	
Bind thesis.																			X
Submit final bound thesis.																			X

Appendix 11

Actual Gantt chart project time line stage 2

2007

2008

2009

Stage 2 Tasks	May	Aug	Nov	Dec	Jan	Feb	March	April	July	Aug	Oct	Nov	Jan	Feb	June	July	Aug	Sep	Nov
Submit Faculty of Health Research Ethics and Governance (FREGH) application.	X																		
Submit Ethics application.		X																	
Unfavourable response to Ethics application received.		X																	
Resubmission of Ethics application.			X																
Submit thesis outline approval to Thesis Panel, University of Brighton to proceed to Stage Two.				X															
Ethics Approval resubmission confirmed.				X															
Sussex NHS Research Consortium approval confirmed 9 th January 2008.					X														
Study recruitment. Send out invitation letters and flyers etc.					X														
Perform pilot study.						X													
Pilot data collection.						X													

Stage 2 Tasks	May	Aug	Nov	Dec	Jan	Feb	March	April	July	Aug	Oct	Nov	Jan	Feb	June	July	Aug	Sep	Jan
Pilot data analysis.						X													
Present at Research Students' Work-in-Progress presentations (University of Brighton).																X			
Build in project design revisions.						X	X												
Main data collection.						X	X	X	X	X									
Main data analysis.									X	X	X								
Literature search to augment research findings.											X	X							
Obtain project participant feedback.												X							
Write up the research.											X	X	X	X	X	X			
'Proof read' and editorial revisions. Ongoing.																X	X		
External proof read.																			X
Editorial revisions.																			X
Bind and submit thesis.																			X



Appendix 13

November 2008

Dear Colleague,

Re: University of Brighton Professional Doctorate Study Feedback

Thank you for participating in my professional doctorate focus group study looking at how experienced mental health nurses feel about being unobtrusively observed in their everyday clinical practice. Your contribution was appreciated and I thought you might be interested in receiving some feedback about the study findings.

Ten focus groups involving eight different local teams were facilitated over a five month period between February and July 2008. Participants ranged in group size from 2-6 with a total of 35 participants.

The following key themes emerged:

1. Inviting observation
2. Making observation work for you
3. Practice confidence
4. A chance to shine
5. Organizational non-transparency
6. Under the microscope
7. Drowning in data

8. Capturing the wrong data with blunt tools

I have attached the thematic analysis of your focus group and would be pleased to make a copy of the transcript and/or digitally photographed collage available to you. Themes represent an overview of all the groups.

I would welcome feedback and would be happy to explain how I arrived at these themes. I am now writing up the study and its implications for clinical practice.

Yours sincerely,

Gail Salisbury
Doctoral Student Researcher

Appendix 14

How do qualified mental health nurses feel about being observed in their everyday clinical practice?

Panopticon, Greek for "all seeing", is often used as a contemporary social metaphor to describe the multi faceted power potential inherent in the National Health Service (NHS).



Nurses work in a growing 'panoptic' culture. Their work and their clinical activity are increasingly visible, overseen, monitored, controlled and subject to a rigorous auditing cycle (Epling et al., 2003). Monitoring technology can be used as a window or a one-way mirror (Simpson and Simpson, 1999) and nurses play an important role in deciding how this can be used to mutual advantage.



Author
Gail Salisbury
Professional Doctorate Student
University of Brighton
June 2008

This research study aims to:

Capture the voice of frontline mental health nurses working in adult mental health services.

Gain a greater understanding of qualified mental health nurses' feelings about being observed in their everyday clinical practice.

Nurses have three things in common: "experience, knowledge and opinions. These traits can't be bought, they can't be sold, but they can be shared" (NMC 2008, p. 5). This view sits comfortably with the dialogical approach adopted by Paulo Freire (1921-1997) whose work theoretically underpins this study.

A magazine picture collage exercise (theme board technique) is being used as a group ice breaker tool and semi structured focus groups are being facilitated to capture the thoughts and feelings of those participating. Thematic content analysis will be used to



analyze the focus group data and to identify the major issues discussed.



Implications for practice

The creation of NHS Foundation Trusts (foundation hospitals) places increasing emphasis on the devolvement of central Government decision making and strategy planning to local stakeholder organisations and communities (DOH, 2006). This provides an exciting opportunity for the innovative and creative commissioning of services, which are responsive to social need, local expectation and better equipped



to tackle health inequalities and disease patterns uniquely profiled to spe-

cific demographic areas.

'Capturing the voice' of local nurses by listening and responding to their views of reality may result in the collection of valuable data that helps inform practice through research. This could be a rich source of community intelligence and help redress the lack of perceived influence frontline staff have in shaping services (Maddock, 2002). This could be used to help streamline cost effective monitoring mechanisms and inform clinical governance structures.

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Sussex Partnership 
NHS Trust

Transparency in Practice Some observations about observation

Surveillance has become a pervasive feature of contemporary mental health care and audit trails, CCTV and electronic 'footprints' are common place. Being monitored in a work place setting is largely taken-for-granted and rarely do we stop to consider its wider implications.



To understand how experienced mental health nurses felt about being unobtrusively observed in their every clinical practice thirty five (band 5-7) staff from eight local mental health teams participated in a group collage and semi-structured focus group discussion.

The work of Paulo Freire was used as an interpretive theoretical framework and informed study findings.

Using thematic analysis the following themes emerged:



Monitoring technology can be used as a window or a one-way mirror (Simpson and Simpson, 1999) and nurses play an important role in determining how this can be put to mutual benefit.

Like "Blackbirds singing in the dead of night isolated and sadly ignorant of how their song is part of a much larger singing in the world" (Chambers, 1991, p. 354), nurses need to share their ideas and visions with a wider audience, becoming more than a familiar chorus that has ceased to be heard or to have meaning.

References

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