Innovation and change in a rehabilitation unit for the elderly: Through action research.

Lucienne J. R. Hoogwerf

Cover: Paul Crommentuyn

CIP-DATA KONINKLIJKE BIBLIOTHEEK, DEN HAAG

Innovation and change in a rehabilitation unit for the elderly:
Through action research/Lucienne J. R. Hoogwerf

Thesis University of Utrecht – With references – With a summary in Dutch

Lucienne J. R. Hoogwerf
Faculty, Division of Nursing Science, University Medical Centre Utrecht
Postbus 80036
3508 TA Utrecht
The Netherlands
Email: L.Hoogwerf@fontys.nl

Published by: Wetenschappelijke uitgeverij Academia Press, Gent Belgium
Published in the series: Studies in Nursing Science/Verplegingswetenschappelijke studies

Innovation and change in a rehabilitation unit for the elderly: Through action research.

Innovatie en verandering op een revalidatieafdeling voor oudere patiënten
doormiddel van actieonderzoek

(Met een samenvatting in het Nederlands)

PROEFSCHRIFT

Proefschrift er verkrijging van de graad van doctor aan de Universiteit Utrecht op
gezag van de Rector Magnificus, Prof. dr. W.H. Gispen in gevolge het besluit van het
College voor Promoties in het openbaar te verdedigen
op dinsdag 17 december des middags te 12.45 uur.

door

Lucienne Josepha Rosalia Hoogwerf
Geboren op 27 juni 1958, te Rotterdam

Promotor	Mw. prof. dr. M.H.F. Grypdonck
Co-promotor	dr. Cor van Dijkum

The study described in this thesis was partially supported by a grant from the New Zealand Nursing Association and Auckland Healthcare New Zealand.

The publication of this thesis was supported financially by the Executive Board of Fontys Hogescholen, Eindhoven, The Netherlands.

For those who accompanied my journey

He aha te mea nui o tenei ao?
Māku e kii atu
He Tangata He Tangata
He Tangata.

(Traditional Maori Saying, cited in Ministerial Taskforce on Nursing, 1998)

What is the greatest treasure in the world?
I could only reply
'Tis people, 'Tis people,
'Tis people.

This report describes an eighteen-month action research project in an assessment, treatment and rehabilitation ward for older people in a large metropolitan hospital in New Zealand. The study aimed at developing participative care and the clinical nurse consultant role, and advancing nursing practice. Initially, nurses and patients worked together towards establishing a relationship in which patients were viewed as valid members of the interdisciplinary team. In the reconnaissance phase, nursing practice was critically examined. One-to-one guided interviews with nurses, patients and their families, and group discussions were used to develop an understanding of current nursing practice. This led to the transformative action in which action plans, based on the feedback from patients, nurses and allied health workers, were implemented and reflected upon. The action plans consisted of environmental changes, alteration of the admission procedure, implementation of group (patient) education sessions, and patient guided care plans. The positive outcome of this phase was the impetus for the interdisciplinary phase, in which patients became active participants in interdisciplinary participative goal-setting meetings. Interdisciplinary assessment forms and care plans were also piloted at this stage. The qualitative evaluation suggests that patient participation in the planning and evaluation of care came to be regarded as valuable by patients and health professionals. In conclusion, by critically examining nursing practice, the nurses were able to gain an insight into their practice, take informed action to transform practice, and initiate change in a ward environment.

List of textboxes

List of tables

List of figures

Acknowledgements

In undertaking this study I have been fortunate to work with some very special people. My first thoughts are to the older rehabilitation patients, in particular Tom Cowley, who assured me that it was "OK" to mention his name. As he said, he was a co-researcher. Tom, I enjoyed our conversations and have learned from the insight you gave me during our lengthy yarns, as you called our interviews. Tom, and all the other patients, thank you for your involvement in and commitment to the study. The health professionals on Kauri Ward, who had the courage to critically examine their own practice and were prepared to walk the extra mile to accommodate the practice changes: we certainly had ups and downs during the study but thanks to your belief in me, and the commitment from many of you, we have been able to make a difference. The clinical director, Roger Harris, I would like to thank for the opportunity he created for nurses within the Aged Care Services. Margaret Tolley, the wise woman, you would patiently listen to me and engage in a reflective dialogue with me at 7.00 in the morning when we were both supposed to start work! Margaret, you kept me sane! I am thankful to Martha Forbes. Your advice on bicultural issues during the study was invaluable. You were able to provide me with insights into the Maori culture. Thank you for trusting me. A very special thank you to the action research group members. They said whole-heartedly, "Yes," to the study. I do admire their enthusiasm, commitment, and their willingness to work through all the issues with me. Donna Frost, I came to know you as co-researcher and later as friend. Your support through the final write-up has been tremendous. I did not only enjoy our discussions during it but also the memories it brought back! Blair Turner, thank you for your critical comments on the earlier drafts. Cheryle Moss, and later also Penny Cash, your critical comments and your patience during the early stages of the study and the write up have contributed to my professional learning. Your critical discussions during PhD school at the Department of Nursing and Midwifery of Victoria University of Wellington, New Zealand take a special place. I feel fortunate to have lived, and conducted this study, in Aotearoa.

I owe a great deal to my parents, Joop Hoogwerf and Ans Hoogwerf-Jespers, for their profound influence on my early years of education.

My supervisors, Prof. Dr. Mieke Gryponck and Dr. Cor van Dijkum, require special mention. Their sustained interest, commitment and direction have made final completion possible. Saskia van der Lyke, thank you for advising and listening to me during the final stages of this journey.

Finally, Henk Kasius, despite my preoccupation with this thesis you did start a relationship with me. You often "drew your own plan," as you called it, when I needed to work during the weekends and you quietly went your own way. Last year I dedicated my summer holiday to continue writing this thesis. The phone calls I received from France were very supportive. You gave me the space to do what I needed to do.

This journey has come to an end! Once more I thank all the people who accompanied me.

1: Introduction

1.1: The clinical setting where the study was undertaken

The study presented here was undertaken in an in-patient department of the Aged Care Service, an assessment, treatment, and rehabilitation unit for the elderly, located in a large metropolitan hospital (Tui[1] Hospital) in New Zealand. The Aged Care Service is a subdivision of a larger health care organisation. The Aged Care Service provides a service for patients aged 65 years and over - 10.5% of the population in this region (Walker, 1998). The service is publicly funded and is one of three geriatric services operating within the city. The demand for the service is high within the hospital; this is reflected in both consultations per month (30 nursing and 50 medical), and occupancy (100%). The study took place over a period of eighteen months (late 1996-1998).

1.2: The context of the study

The following developments influenced this study: the clinical review and the move toward participative care. The clinical review of Tui Hospital, conducted by the Ministry of Health in 1994, was an important factor in the initiation of this study. The inadequate staffing, in particular the lack of experienced nurses, led reviewers to conclude that the hospital was clinically unsafe. In order to improve the quality of care and attract new staff members the nursing department felt that new nursing roles were necessary. Tui Hospital, like many other hospitals within New Zealand, introduced a clinical career pathway to address the issues raised by the clinical review, but also to provide new graduates with a structure to enable them to integrate theory into practice. It was anticipated that the introduction of bachelor prepared nurses to the health care setting would lead to a new emphasis on evidence based practice and reflectively practicing nursing, helping to close the theory-practice gap. At Tui Hospital the clinical career pathway was based on Benner's (1984) work, and supported the progression of nurses as they moved from novice to expert practitioners. The clinical career pathway recognised four levels of practice within the clinical setting, rewarding attainment of higher levels with both peer recognition and increased remuneration[2]. The organisation expected that nurses would continue practising at level two, as a minimum, throughout their employment. However, nurses were encouraged to develop their skills and confidence until they became recognised as proficient practitioners, known as level three nurses. This tended to occur over the next one to three years, and was dependent on an individual's motivation and length of time spent in a particular area of practice. For a nurse to achieve level four, that of expert nurse, s/he had to have been practising for at least four years and be working towards a speciality qualification.

Although the clinical career pathway had attracted nurses (both experienced and new graduates) the desired transfer of research into practice did not occur. International

---

[1] The names of Tui and Fantail hospital are fictitious.

[2] New graduate bachelor prepared nurses began at level one, as novice nurses, and were supported (and expected) to attain the necessary skills to be practising as competent practitioners (level two) by the end of their first six months in the workplace.

research clearly indicates that advanced practice roles contribute to practice development and the transfer of research into practice within organisations (Koperski, Rogers & Drennan,1997; Shamian, 1997). Consequently, hospital management decided to employ advanced practitioners throughout the hospital to support the new structure. These roles were new to the organisation and the advanced practitioners needed to articulate their place in the hospital's structure and to gain greater sense and meaning regarding the potential strength of their own role. How the advanced practice role was developed in relation to the advancement of nursing practice in Aged Care Services utilising a participative method is described in this report.

The need to develop participative care within the Aged Care Service also shaped this study. This was influenced by both the Treaty of Waitangi[3] and consumer movements which increasingly demand inclusion and participation in all aspects of health care for patients and service users (Jansen, Harrison, Richmond, Suckling & Nixon, 1997; Thorne, 1993). The shift in focus that this required would have a significant influence on how its services were delivered. Aged Care Services aimed to facilitate consultation and promotion of choice for a range of health care options. It was anticipated that both health professionals and patients in this project would develop strategies to enable them to communicate and discuss concerns, in an environment of understanding and respect for each other's knowledge and situation. This accords with the current national and international political emphasis on patients as consumers. In addition, there has been a growing body of research evidence to suggest that active patient participation leads to improved patient outcomes and better adjustment (for example see Payton, Ozer & Nelson (1990)).

It was thought that action research, in particular emancipatory action research as described by Grundy (1982) and Kemmis and McTaggart (1988), was a suitable methodology with which to encourage health professionals to become involved with their practice and to stimulate patients to participate in their care. This lead to the research questions:

- Is emancipatory research suitable to advance nursing practice by developing the clinical nurse consultant role within the service?
- Can we develop participative care in collaboration with older rehabilitation patients based upon their feedback?

1.3: Overview

With the rationale for the study being presented above, the chapters that comprise the thesis are presented in this section.

Chapter 2 introduces the background of the study and aims to provide the reader with an understanding of the context of this study. This includes a description of the

---

[3] An agreement, signed in 1860, between the indigenous people of New Zealand and the British Crown.

clinical nurse consultant role, the rationale for the chosen methodology, and the development of a research culture prior to commencement of the study.

Chapter 3 provides an overview of the historical development of action research. The various types of action research and its contemporary use are explained. The actual methodology for this study, that is, Kemmis and McTaggart's (1988) action research framework, is introduced. The discussion then turns towards the scientific underpinnings of action research. Ethical considerations within action research are discussed in the final section of this chapter.

Chapter 4 outlines the work plan of the study. The study was designed in two phases. Phase I, stage I, was planned as the health professional reconnaissance and the aim here was to develop an understanding of current practice. The following stage (II) was planned as a response to stage I, thus involving action plans and changes in practice. Phase I, stage III, was concerned with patients' perceptions of current practice and was intended to explore the possibility of participative care. Phase II, stage I, describes the development of participative care, which was facilitated by goal-setting. The data gathering methods and analysis are also described in the final section of this chapter.

Chapter 5 reports the literature study that was utilised to aid the participants' understanding in relation to participative care and goal-setting within the health care setting.

Chapter 6 describes Phase I, stage I of the study, the health professional reconnaissance, in which the aim was to develop an understanding of the research ward. Insights into the ward's environment, beliefs about gerontological rehabilitation nursing, the nurse patient relationship, and the feelings towards the research project on the ward were developed. This enabled the action research group to take strategic action.

Chapter 7 describes stage II of Phase I of the study, and begins with the introduction of the action research group members. This is followed by a discussion of the action research group's concerns resulting from reflections from stage I. In the next section the action research group members' feelings in relation to conducting patient interviews are described, as are the action plans that evolved from stage I. The final section documents the reflection on stage II.

Chapter 8 presents stage III of the first phase of the study, the patient reconnaissance. During this stage the action research members explored patients' perceptions of current practice and their interest in participative care. The patients' concerns formed the basis for a series of action plans that transformed practice and provided the base for multidisciplinary goal-setting. My reflections, as the clinical nurse consultant/researcher, are presented in the final section of the chapter.

Chapter 9 describes the multidisciplinary phase of the study, Phase II, stage I, which consisted of several action cycles. In the first section of the chapter the focus is on the development of a framework for participative goal-setting. In the second section the concerns voiced by the participants were acted upon by adjusting the action plans. The three types of goal-setting meetings that developed from this study - participative, assisted and non-participative - are presented in the following section. The final section is concerned with both patients' and health professionals' reflections on participative care.

Chapter 10 shares with the reader some reflections on the methodology. Further, the outcomes of the study are presented and some suggestions for using participative research and participative care are made. The thesis concludes with a summary **(Chapter 11)** in English and in Dutch.

2: Introducing Aged Care Services: the research setting

This chapter provides the reader with the background to the study. I was introduced to the Aged Care Service by means of my appointment as clinical nurse consultant for Aged Care Services at Tui Hospital. I was invited to join the senior management team as researcher and lead nurse[4] and to conduct a research project that aimed at the advancement of nursing practice. In my function as a clinical nurse consultant I conducted this study in collaboration with other health professionals within the unit.

In the first section of this chapter I describe Aged Care Services. This is followed by a description of how the clinical nurse consultant role was developed within the hospital. I then turn towards my interpretation of the role and my thoughts about operationalising it.

2.1: Aged Care Services at the beginning of the study

The Aged Care Services management team (Appendix 2A) consisted of a service manager, a business manager, a clinical director, and a lead nurse. The senior nursing team comprised four clinical charge nurse managers, two gerontology nurse practitioners, a clinical nurse educator, and myself the clinical nurse consultant. The nursing staff consisted of registered nurses, enrolled nurses and nurse aids. The line manager was the business manager.

At the time of the study, Aged Care Services at Tui Hospital was yet again under review. Suggestions included a possible relocation back to Fantail Hospital, causing renewed distress among staff members in Aged Care Services. The proposal involved a split of the Assessment, Treatment and Rehabilitation Unit, with 60 beds to be at Tui Hospital and 60 beds in Fantail Hospital. There was a degree of scepticism and distrust among the senior nursing staff within the unit regarding any change. I was very much aware of this and needed to take it into account in my work as clinical nurse consultant. The unit's senior nurses decided, during strategic planning meetings, that conducting a research project within the service would raise the status of gerontological nursing within the hospital, and at the same time aid practice development.

Prior to commencing such a project, some preparation was necessary to create an environment receptive to research. The following sections describe the steps taken to develop that environment.

2.1.1: The clinical nurse consultant role

The role of the clinical nurse consultant was new within the hospital. It was created as a response to the clinical review conducted by the Ministry of Health in 1994. The review mandated a structured investment into the nursing service at the hospital to address issues of patient safety, resource and resource-utilisation, low morale, and inability to recruit and retain staff. The new infrastructure implemented by the Tui

---

[4] The lead nurse was the member of the senior nursing team elected by them to represent nursing within the management team.

Hospital nurse adviser and senior management team was aimed at supporting three areas: research, education, and practice. The nurse adviser at the time believed that, to respond to the report, experienced well-prepared nurses needed to be attracted to the hospital. Consequently, several new nursing roles were created in each service: clinical nurse consultant, clinical nurse educator, clinical charge nurse manager, nurse practitioners and clinical nurse specialists. These advanced practice roles were aimed at providing clinical support to the staff nurses.

The clinical nurse consultant role was developed based on literature supporting the contributions of advanced nursing practice. The exact nature of advanced practice was unclear to the people commencing the roles when the positions were created, and remained so by the beginning of this study. According to Manley (1996) there are two main views of advanced nursing practice. The first view represents the medicalisation of nursing roles, and stands in contrast to the second: the advancement of *nursing* practice. In the former the development of new clinical roles at the nursing-medicine interface is promoted. In this model nurses develop skills and competencies in order to take over some of the medical tasks previously performed by medical staff. In contrast, in the latter view the focus is on the development of expertise within nursing practice. Here the advanced nurse practitioner integrates the roles of researcher, educator and consultant, and aims to develop clinical nursing and lift nursing to strategic and policy levels.

Within Tui Hospital there was a need to develop and advance nursing practice[6], and there appeared to be agreement within the literature that clinical practice, education, consultation, change management, and research are components of advanced practice (Hickey, Ouimette & Venegoni, 1996). Consequently, the senior nursing team developed a job description (Table 1), in which the key accountabilities focused on advancing nursing practice through developing clinical expertise, rather than on the development of purely medical expertise.

---

[6] Clinical roles at the nursing-medicine interface were addressed later.

	Indicator description
1	Provide a consultation service for staff
2	Provide professional leadership to nursing
3	Contribute to continuous improvement of care through quality initiatives
4	Undertake and utilise research to enhance the quality and development of care delivery
5	Participate with the senior nursing team in planning and development of education and professional development opportunities

Table 2: Job description for Clinical Nurse Consultant at Tui Hospital, 1996.

At the time, I interpreted the job description as encompassing direct (indicator 1) and indirect nursing practice (indicators 2-5). The first indicator enabled me to actively work on the wards. I case-managed patients and their families with complex nursing needs. The other four indicators provided the opportunity to work with staff in planning patient care, for example, holding nursing rounds once a week to discuss and review nursing care (professional leadership and consultation), development and implementation of evidence based practice protocols[7] (research and quality improvement), and the facilitation of guided reflection (practice improvement). I also needed to create a culture in which staff felt safe to reflect on their practice and act upon their reflections.

Through working in clinical practice I was able to role-model, and share my skills and competencies with the staff. Furthermore, the staff nurses were able to share their knowledge with me. This reciprocal relationship enabled me to build trust and credibility, which made it easier to engage with staff in practice development and introduction of change. Moreover, direct practice also enabled me to remain connected with the realities of the practice environment in which development was to occur.

After I had been in the unit for one month I consulted with the senior nursing team and invited them to discuss their expectations of the clinical nurse consultant role with me. They thought it appropriate to further develop participative care, commence a research project, and develop the nursing role within the unit (multidisciplinary team). Their ideas were congruent with mine. I will briefly describe how my ideas were shaped.

2.2: Kemmis and McTaggart's (1988) framework

As a clinical nurse consultant, I needed a framework to develop my role and advance nursing practice within the unit. Given the move towards participative care, my priority was to advance nursing practice together with the nurses and the consumers within the service.

---

[7] Evidence based practice was beginning to play an important role within the hospital and was seen as instrumental for establishing effectiveness and efficiency within nursing practice.

I had been introduced to action research while studying for a Masters degree in nursing, in Australia. The idea of participative research appealed to me since it encourages participant involvement. The positive experience in my previous study (Frey-Hoogwerf, 1996) showed that a shift from a directive care model towards a participative model of care could be beneficial to both health professional and patient. In that study I utilised Kemmis and McTaggart's (1988)[8] action research framework to guide the development of active consumer involvement in care. It enabled me to develop an understanding of the feelings and reactions of the consumers. Moreover, an egalitarian relationship between the women participants (the clients) and myself (the nurse) was able to develop. This meant that neither the nurse-client relationship nor the research process were entirely controlled, planned or dominated by me. It was a democratic and collaborative joint (ad)venture. Using action research enabled me to value the participants' experiences, provided the participants with an opportunity to take informed action to improve their situation, and also advanced my own practice. These positive outcomes provided an impetus to investigate whether action research could be used to advance nursing practice in collaboration with patients, and encourage patient participation in decision making regarding their care, in a hospital setting. The experience with Kemmis and McTaggart's (1988) framework of participatory research suggested that it could be used to facilitate practice development. It provided a framework for patient participation, guided nursing practice, and assisted in the development of practical knowledge.

Based upon the assumption that an action research project should bring about practice improvement, innovation and change, and should aid practitioners to a better understanding of their practice (Zuber-Skerritt, 1996), I chose Kemmis and McTaggart's (1988) framework again.

2.2.1: Use of Kemmis and McTaggart's framework in the development of the clinical nurse consultant role

Action research actively seeks the involvement of nurses in all aspects of the research process. Action research investigates practice-related problems, making it a suitable approach for health professionals wanting to look closely at their daily experiences and social constraints, and to determine ways in which to overcome these constraints (Lewin, 1946). In my role as the clinical nurse consultant, I was directly and immediately involved with the nurses in the practice setting, working together in resolving and improving clinical issues. I could see that action research provided a framework to role-model those actions that were encouraged by the senior nursing team, such as critiquing nursing practice, engaging in reflective practice, and identifying practice issues. It would allow, in collaboration with the nurses, the introduction of new concepts into local practice; thereby aiding professional development and continuing the improvement of nursing care delivery based on research. This could generate a culture where staff could become learners themselves.

---

[8] For a description of Kemmis and McTaggart's (1988) framework see section 3.3.3.3.

Using an action research framework in the nurse consultant role could also lead to the development of other skills for the clinical nurse consultant: increased understanding of project management, dealing with group dynamics, change management, and continuous development of technical, practical and emancipatory knowledge. Thus, the position of clinical nurse consultant offered me an opportunity to further develop my own practice in an advanced role, and consequently contribute to advancing nursing practice in an aged care setting. Because the unit intended to move towards a participative model of care, I was able to broaden my knowledge and experience with this type of service delivery. To be more precise, I was able to continue with my work on the development of participatory care.

Prior to using action research within the Assessment, Treatment and Rehabilitation Unit at Tui Hospital, the nurses needed to be introduced to some of the following concepts: research (conducting and utilising), reflective practice, and patient participation in care. The consequent creation of several small groups was an important step towards the development of interest, in research and practice development, in a number of nurses in the Aged Care Services. Each group had a different focus because I felt that it was important to be guided by the nurses' interests.

2.3: The groups prior to the action research study

Several groups were formed to accommodate the nurses' interests, such as the reflective practice group, journal group, nursing focus group, and the documentation group.

The reflective practice group aimed to develop reflective practice within the unit. The group consisted of six members, both new graduates and experienced nurses, meeting on a weekly basis. The nurses kept a reflective diary or journal in which they described their nursing practice. In the meeting the practice stories were shared and reflected upon. Early entries in the journals were written in a style described by Hickson (1990) as uncritical and pre-reflective. In other words, group members were just accepting their practice, beliefs, and social relationships as they were. Later in the year some group members were able to move away from pure description, and started to be able to identify some current themes and issues in their writing. Reflection also involved critical conversations between myself, the clinical nurse consultant, and the participants. Moreover, some of the group members were ready to enter the next stage, that is, to explore the historical, social, cultural and political forces that influenced nursing practice. This stage was the beginning of a move towards critical reflection (see Textbox 1 for an explanation of reflection).

Reflection is an important aspect of action research, making a brief explanation of reflective practice appropriate at this point. A vast amount of literature has been published regarding reflection in relation to nursing. How reflection is understood and defined depends largely on the author's perspective. Habermas (1974) writes that history of species is a self-formative process based on the emancipatory power of critical self-reflection. Habermas (1974) links self-reflection to an understanding of both psychoanalysis and the therapeutic relationship. It can be conceived as the internalisation of therapeutic discourse (Habermas, 1971). The therapeutic dialogue is based on the analyst assisting the analysed to see the ways in which their understandings are based on self deceptions. Habermas (1971) assumes that the person being analysed comes to realise that self deception has prevented their achievement of personal freedom. The development of "false consciousness" is prevented when self-reflections are shared with others.

Within nursing the interpretation of reflection is based on values and assumptions, which are influenced by a number of factors (personal, practical, and intellectual experiences). Important components of reflection are thought, learning, action and transformation. Schön (1983), an educationalist, was one of the first to describe and develop reflective practice. He developed some of his ideas in two books: *The Reflective practitioner* (1983) and *Educating the reflective practitioner* (1987). Schön believes that by observing and reflecting on our actions we can learn to describe the knowledge we have but do not openly express (tacit knowing). This is a type of knowing that we cannot express in words, or the knowledge we use but do not consciously think about.

The types of reflection described by Schön are reflection-on-action and reflection-in-action. Reflection-on-action refers to reflection that occurs retrospectively. The practitioner analyses and interprets the information recalled in the event and tries to uncover the knowledge used in the event. Reflection-in-action refers to the practitioner's ability to recognise or identify a problem and think about it while working (Lumby, 1991*).* Reflection is a course requirement in many nursing degree programmes in Australia and New Zealand. Students are required to maintain a reflective diary throughout the course.

Schön's (1983, 1987) work is concerned with the practitioner's ability to identify practical problems and develop strategies for improvement, but does not challenge the current situation. Critical reflection, on the other hand, originates from the critical paradigm. Street (1990) describes it as reflection that "can uncover the historical and traditional constraints that shape nursing practice and can identify social and political interests that have been served by the maintenance of these practices" (p.29). Practice is challenged and forces that maintain the status quo or constrain practice improvements are identified and, if possible, removed. Argyris and Schön (1974) state that "professional competence requires the development of one's own continuing theory of practice" (p.172). In other words, critical reflection leads to continuous improvement of nursing practice.

Textbox 1: Explanation of reflection.

The aim of the second group, the journal group, was to develop skills in the critical appraisal of nursing research articles. I assisted others in the group with critiquing research. The results were passed on to the nursing focus group (a quality improvement group). The members of the journal group wanted only to develop critiquing skills and were not especially interested in implementation. The journal group consisted of ten members.

The nursing focus group was an existing group within the service, which aimed to improve quality within the unit. The staff nurses within this group did not, at this stage, have the skills to evaluate research and its suitability for application in the unit. At the start of this project, therefore, research findings were not incorporated into hospital or unit protocols. In fact a large amount of data was routinely collected within the unit but not utilised. One of the aims of the group was to develop audit tools or use those already identified within the literature. It became evident that there were large knowledge differences among the group members. Accordingly, we spent the first half of the year exploring the concepts of utilising and conducting research. Halfway through the year the group was ready to start small projects. The nursing focus group implemented, and evaluated the implementation of, urinary continence and constipation practice guidelines (Johanna Briggs Institute for Evidence Based Nursing, see http://www.joannabriggs.edu.au). The results were presented at two national conferences in New Zealand. The group had ten members.

The multidisciplinary documentation group was also an existing group within the unit. Within the unit a multidisciplinary approach to patient care was advocated, but the documentation, although integrated, did not reflect multidisciplinary care planning. Therefore, the aim of the multidisciplinary documentation group was to develop multidisciplinary documentation within the unit. The group met on a fortnightly basis. The link between the documentation group and the action research group was the clinical nurse consultant, who also became the facilitator for the documentation group. The multidisciplinary assessment package with a new documentation system was to be developed over a two-year period utilising action research. It became evident, even at an early stage, that joint learning occurred within the group. Through this process the group members were starting to develop a beginning understanding of each other's problems in relation to documentation. I anticipated that this process would continue throughout the project. The group consisted of one physician, two occupational therapists, two physiotherapists, one speech language therapist, and four nurses.

The groups within the unit, except for the multidisciplinary documentation group, worked under my guidance. I tried to develop a learning environment for the staff nurses relevant to practice.

2.4: Positive experience in the six months prior to the start of the action research study

The groups contributed to a developing research culture within the ward. Nurses were now engaged in utilising, interpreting, and evaluating research in various groups. The focus group was involved in developing research-based protocols for quality assurance and educational purposes, and engaged in the conduction of applied research. With the initiation of the groups I had set the scene for practice development inspired by the key accountabilities. It became clear that clinical leadership was going to be important throughout the planned action research study. Furthermore, the areas that I intended to target in this study were facilitation of consumer participation (moving from direct care towards guidance), and the role of nursing within the multidisciplinary team. From working with the groups and the discussions with staff members it became clear that a participatory research method suited the environment. Working with the groups helped develop the collegial support necessary for a successful action research project.

I was encouraged by the small changes that had occurred during the previous six months of my employment. It became evident that we were beginning to create a supportive environment in which learning and practice development took place. This preparation time prior to the project was important because it set the scene for the study, and helped clarify my role as the clinical nurse consultant in relation to my practice and as a research facilitator. It also enabled me to identify themes (such as practice development, participative care, role of the nurse within the multidisciplinary team, and shared learning) that were important to the research project.

The unit's Heads of Departments (medicine, nursing, physiotherapy, occupational therapy, speech and language therapy, finance, and the research unit) welcomed the idea of an action research study, particularly if it addressed issues raised by the Ministry of Health's review (patient safety and research utilisation), and those raised by Tui Hospital's senior management (advancement of nursing practice, development of the clinical nurse consultant role, and the implementation of participative care). After careful consultation and discussion the Heads of the Departments agreed to put Kauri Ward forward as the location for the study.

2.5: Some concerns

The senior nurses and the management team expected the clinical nurse consultant to initiate a project on Kauri Ward without compromising the other wards. This created blurred boundaries between the research project and the clinical nurse consultant's day-to-day activities. From my limited working experience within the unit I knew that I needed to work carefully, spending an equal amount of time on each ward. It was apparent that the study had the potential to create friction within the senior nursing team, and confusion between wards. It was clear to me that, in the role of researcher, I would be more involved in the Kauri Ward, especially during the data gathering process of the study. I hoped that the start of the nursing rounds on the other two wards would be one way of ameliorating this.

2.6: Summary

The clinical nurse consultant role for Aged Care Services was one of the new senior roles within Tui Hospital. Although there were certain expectations of the role, the actual development of it was largely left to the individual in the role. This allowed me to bring several of my ideas (research-guided practice, reflective practice, and participative care) into practice, all of which seemed to be congruent with the unit's expectations of the clinical nurse consultant role. Having some insight into the history of Aged Care Services and its organisational structure assisted me in the facilitation of practice development and allowed for identification of possible barriers to change. The six-month preparation phase was necessary to develop a receptive audience for the project. The tasks and skills achieved by the various groups can be described as laying the foundations for the project. Some concerns regarding the study and the role of the clinical nurse consultant/researcher were identified. After ethical and organisational approval was obtained, the project officially started. Before I describe how I went about planning the study, I will introduce the methodology to the reader.

3: Approaches to collaborative research

3.1: Introduction

Action research is a generic term for a number of different approaches to collaborative research. The trend towards the utilisation of participative methods of inquiry within the discipline of nursing has increased over the last two decades. Many scholars view it as a method that offers practice advancement, organisational change, facilitation of best practice and the development of learning organisations. In order to develop an insight into participatory research and its conceptual similarity with practice development, organisational development and change management, a brief historical overview is provided. This is followed by an outline of the different approaches of action research within organisational development. Subsequently, other emerging forms of action research are discussed. Finally, the discussion turns towards rigour, ethical considerations, and general criticisms in relation to collaborative research.

3.2: Historical background and influences

Action research has been an accepted research method in various parts of the world for the last 20 years, particularly the United Kingdom, the United States of America, Scandinavia, Spain and developing countries. It has been established as an appropriate method for educational, professional, managerial, and organisational development (Zuber-Skerritt, 1996). Action research can be traced back to two people: John Collier (1945), a British Commissioner of Indian Affairs, and Kurt Lewin (1946), a social psychologist.

Collier (1945), in his role as Commissioner, was concerned with the improvement of race relations. Through his work it became evident that improvement could only occur when strategies were developed collaboratively with all parties concerned, which meant the involvement of administrators, researchers and lay people. He called this way of working and researching, action research. Independent of Collier, Lewin (1946), a refugee from Nazi Germany, developed a similar form of research. The influence of these people, Lewin in particular, led to the development of the classical model of action research, which can be viewed as the foundation from which several variations have emerged, each with its own methodological and theoretical assumptions. In addition, Lewin’s work has been very influential in the field of planned change management.

Kurt Lewin was director of the Centre for Group Dynamics. The influence of cognitive learning theories on the centre’s work is evident. Learning was seen as a group process in which individuals develop an insight into the consequences of their behaviour, and that of others, on the group. As a group, individuals develop skills in diagnosing problems, which in turn enables them to take informed and effective interpersonal and group action which will lead to change, (Burnes, 1996; Hendry, 1998). The work of the centre was focused on group work, interaction between group members, and democratic decision-making.

One of Lewin's (1946) main concerns was the carrying out of experimental studies in the laboratory setting. He argued that the findings obtained in experimental settings were too far removed from the practical setting, and therefore difficult to implement. He suggested that these experiments needed to take place in the actual work setting, especially when it concerned social change programmes. For Lewin, action research was the link between experimentation and application, and between academics and practitioners.

Lewin (1946) believed that action research, because of its nature, would address several issues simultaneously. These included the development of an understanding of the laws of social change, collaboration and joint inquiry between scientists and practitioners, provision of data about problems in the workplace setting, increased possibility of finding relevant and workable solutions to problems, and discovery of general laws explaining social phenomena. Consequently, Lewin argued that there were two types of action research: the investigation of general laws and the identification of specific situations or problems. Contemporary definitions of action research reflect these early philosophical tenets. For example French and Bell (1995), two contemporary action researchers, offer the following definitions of action research.

> A sequence of events and activities within each iteration (data collection, feedback and working with the data, and taking action based on the data); and it is a cycle of iterations of these activities, sometimes treating the same problem through several cycles (French & Bell, 1995, p.139).
>
> The application of the scientific method of fact finding and experimentation to practical problems requiring action solutions and involving the collaboration and co-operation of scientists, practitioners and lay people (French & Bell, 1995, p.140)

Both definitions imply that action research is research conducted with people about the social phenomena in their environment. People act within their environment and reflect upon their actions (outcomes). They may relate their actions and resulting outcomes to previous research situations, and by doing this they are able to make some inferences that in turn may aid theory development.

These definitions indicate that action research can be viewed as both a scientific method and a problem solving approach. The action research cycle as described by Lewin (1946) is utilised in both approaches. He applied action research to several different situations, such as facilitation of training, organisational learning, encouragement of worker participation in decision-making, and inter-group relations (Lewin, 1948, 1958). He pointed out that the important feature within action research is the collaboration between people within the organisational setting and the outside researcher/change agent.

Lewin's conception of action research (planning, action/observation and evaluation) is influenced by Dewey's (1933) work. (See Figure 1 for an overview of the models.) Dewey developed a model for reflective thinking that consisted of five stages:

suggestion, intellectualisation, hypothesising, reasoning, and testing the hypothesis by action.

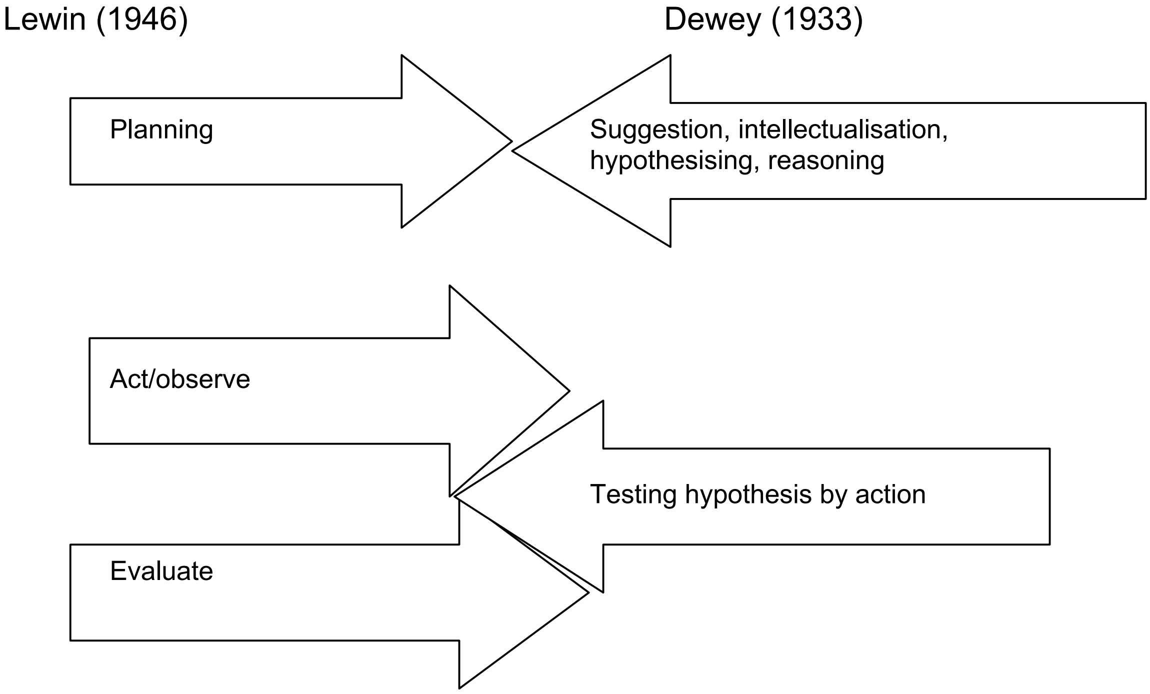


Figure 1: Lewin (1946) and Dewey's (1933) models.

Lewin's planning stage is comparable to Dewey's first four stages. It involves the identification of a problem about which people are concerned enough to want to initiate change. As a consequence, they think about the situation and explore possible solutions. This equals Dewey's hypothesising and reasoning stage in which the group thinks about possible actions and consequent outcomes. In both models the action/observation stage consists of testing and analysing the suggested solution under careful observation. Lewin completes the cycle with an evaluation phase in which the solution is re-tested and verified, whereas Dewey includes this in his fifth stage, testing the hypothesis by action.

At the heart of both processes is learning from experience. The major differences are that both early and contemporary action research have a stronger emphasis upon rigor and interpretation of data, than does Dewey's model of reflective thinking, and there is a requirement to work collaboratively with others. With action research one is not only seeking personal generalisations, but also the development of local theories grounded in the data of the fieldwork.

Lewin, as director of Centre for Group Dynamics, had a significant influence on his staff members Marian Radke, Leon Festinger, and Ronald Lipitt, who in turn were influential in various areas of organisational development (French & Bell, 1995). The fact that Lewin had a large number of followers resulted in the development of several approaches to action research, each with its own method, unit of analysis, and underlying assumptions.

In the late forties Chien, Cook and Harding (1948) published an influential paper with regard to action research. Like Lewin (1946, 1948, 1958) they emphasised the importance of the interaction between social research and practice problems. They identified four different types of action research: diagnostic, participant, empirical, and experimental.

Diagnostic action research is very much researcher oriented. The researcher is invited into the organisation, often in the capacity of consultant. (S)he diagnoses the problem and makes some suggestions for improvement without engaging in an action research cycle. This means that there is neither collaborative problem identification nor evaluation. Consequently, the recommendations are frequently not implemented by the organisation (Porter-O'Grady, 1996).

The emphasis in *participant action research* is on the development of a collaborative relationship between researcher and practitioners. The researcher and the practitioners are involved in the whole research and action process, from problem identification to the evaluation of actions. The outcome of such a project is that the solutions to the problems are relevant and workable for the practitioners. Consequently, practitioners are more likely to continue when the researcher withdraws from the setting (Porter-O'Grady, 1996).

In *empirical action research*, the researcher keeps a meticulous record of the effectiveness of the actions and makes comparisons to previous situations. This is seen as problematic because the situation under study might be unique and therefore no generalisations could be made. However, the next situation under study might be similar and the findings could be used as a starting point.

Experimental action research is described as research on action. In experimental action research the effects of different solutions to one problem and their consequent action are studied. The process is aimed at determining which solution is most effective. Chien *et al.* (1948) suggested that this form of action research would make the largest contribution to the advancement of knowledge. However, the conditions required to create the necessary environment are difficult to achieve. Working under experimental conditions is time consuming and often expensive.

3.3: Collaborative research in contemporary organisational development

Since the 1950s action research has had an organisational and work-life focus. For example, action research initiated by The Tavistock Institute in the United Kingdom focused on the relationship between the individual and larger scale social problems (Rapoport, 1970). The institute worked together with the Leadership, Organisation and Co-determination (LOM) group in Norway (Gustavsen, 1996). This group was developed between 1985 and 1990. It involved 150 public and private organisations and sixty researchers. The aim of their programme was to assist organisations in their development. It was thought that one way of achieving this was to bring (action) research into the work place. Action researchers in the LOM programme refer to action research as developmental research.

3.3.1: Developmental research

Developmental research can focus on individuals, groups, or wider society. Toulmin and Gustavsen (1996) point out that it aims at practical effects, not at theoretical rigour. It seeks the type of knowledge that Aristotle termed practical wisdom, over *esteme* (theoretical grasp) (Toulmin & Gustavsen, 1996). The researchers associated with the LOM group argue that people in organisations have particular knowledge, insight, and skills. These are operational only at certain times and need to become explicit. This could possibly be compared to the type of knowledge that Fals-Borda and Rahman (1991) refer to as people's knowledge.

The focus of developmental research is on the exposure of existing knowledge rather than on the creation of new knowledge. In time, organisational knowledge needs to change and the advantage of a dialogue-based approach is that knowledge and action are the result of scientists and members of the organisation working together. Consequently, the organisation becomes able to implement and maintain the outcomes of changes in practice (Philips & Rehnström, 1996). In other words, organisational members are active participants in action and inquiry. The action initiation will come from thoughtful practitioners or from practical theorists. Accordingly, the success of an action research study is judged by its effects on practice. The results in turn form a basis for theoretical issues that arise from practice. The LOM programme has demonstrated that action research can be used successfully in a variety of settings (Fricke & Hofmaier, 1996; Philips & Rehnström, 1996).

The LOM group, like other European researchers, has been influenced by critical theory. They argue that critical theory could provide the foundation for action/developmental research, given the similarities between the two. According to Gustavsen (1996), both question the so-called objectivity of language and the disinterested observer. The recognition of the significance of language in the development of theory is due to Adorno's (1976, as cited in Gustavsen, 1996) influence on critical theory. Everyday language is seen as sets of instruments that enable individuals to deal with reality. Each word is a collection of signs and sounds with the meaning determined by the way it is used. The role of research then becomes to restructure the language in order to create new theory or extend existing theory. To do this the practice associated with the relevant language needs to be transformed. In other words, restructuring communication can be an effective approach to changes in practice.

An important concept within the theory of communication is democratic dialogue, which can be regarded as a modified version of Habermas's communicative competence (Gustavsen, 1996). This involves the development of open, honest dialogue, with the exclusion of power and manipulation, leading to a mutual understanding between all parties. Again Gustavsen (1996) suggests that future extensions of critical theory are shifting increasingly towards democracy as a frame of reference for critical standard formulation. This could strengthen the basis for a relationship between developmental research and critical theory. According to Gustavsen, the role of communication has become a core issue in all participatory research approaches.

It should be pointed out, however, that one cannot assume democratic communication. Argyris and Schön (1974) alert action researchers to the tacit theories-in-use of the participants, as they may hinder open communication. If unidentified and unchecked they distort discoveries of action/developmental research and disrupt the development of plans for action flowing from it.

3.3.2: Action science

Argyris and Schön's (1974) work has made a significant contribution to both participative research and planned change. Action science is concerned with actions that influence organisational change. Argyris (1982) differentiates between Model I and Model II learning. Learning is defined as “a detection and correction of error” (Argyris, 1982, p. 48).

Learning in Model I is described as single-loop learning and is aimed at solving presenting problems without questioning the underlying assumptions, values and beliefs about the current situation. Action strategies associated with Model I - such as suppression of negative feelings, lack of flexibility (which is seen as a weakness) and covering up - limit learning and inquiry. The author believes that defensive behaviour is the outcome of professionals’ strong preference for single-loop learning, which is acquired through years of training and practice. Using Argyris’ words, “because many professionals are almost always successful at what they do, they rarely experience failure. And because they have rarely failed, they never have learned how to learn from failure” (Argyris, 1991, p. 100). This creates a situation in which professionals are enthusiastic about change programmes but at the same time unconsciously act in ways that limit the success of a programme. Argyris (1991) explains that Model I reasoning processes inhibit the exchange of relevant information, reduce sensitivity to feedback and consequently make double-loop learning impossible in interpersonal exchanges. He believes that the ‘actors’ need to be made aware of these actions through careful reflection. If the actor fails to do so the consequences are miscommunication, distortion, sabotage, and ‘escalating error’, all of which lead to a reduction in efficiency and effectiveness.

These errors can be corrected if governing values are changed. This involves moving towards a new theory-in-use (the actual rules people use to manage their life and beliefs). In other words, to move from an espoused-theory (a set of values and beliefs people say they use to manage their life) (Argyris, 1991) to a theory-in-use, which is facilitated by reflection and action maps. The author suggests that theories-in-use are ‘the master programmes’ which enable individuals to be in control. Double-loop learning, Model II, involves questioning and changing underlying assumptions, values and beliefs. According to Argyris (1991), professionals are reluctant to engage in the critical reflection on their own behaviour that is necessary for double-loop learning to occur. He proposes that for double-loop learning to occur individuals need to transform to Model II, which is governed by variables such as valuing information and questioning. This leads to actions that actively seek and evaluate information and participation from others. Consequently, the person is capable of making an informed and free choice in which (s)he can set his/her own objectives and determine how to achieve these. This in turn leads to increased commitment because the action is intrinsically satisfying and not dependent on the reward. In other words, the person acting in Model II is in control, which leads to greater effectiveness (Argyris, 1991).

The researcher working in an action science framework works with the organisation's members to assist them in understanding that their own theories-in-use inhibit learning. The researcher develops action maps with the members of the organisation. Argyris (1985) uses an action map to demonstrate that the individuals who adhere to their theories-in-use are causing their social systems to malfunction, which in turn influences behaviour and theories-in-use. They are asked to present cases that demonstrate the strategies they use in working through a problem (Argyris, 1985). Through working and analysing them together they discover the discrepancy between espoused theory and theory-in-use. This collective learning process leads to new organisational strategies in which double-loop learning is applied to problems as they arise.

According to Argyris (1985), organisational members are frequently pleased to work with a skilled researcher, but experience some frustration when working towards Model II. The role of the researcher or change agent is to facilitate the transition from Model I to Model II learning. In doing so the organisation is able to engage in strategies that support the new theories-in-use developed during the process.

It therefore appears that Argyris' earlier work, often in collaboration with Schön, has been relevant to the disciplines of nursing and education, particularly in relation to reflective practice. Action science aims to expose the discrepancy between theories-in-use and espoused-theories. To minimise unsatisfactory outcomes of any participative research project or planned change programme, researchers need to be aware of the local theories-in-use and resulting actions. It is thus suggested that an understanding of action science is useful when conducting a participative research study, especially in an organisational context.

3.3.3: Praxis research in nursing

The approaches described below are termed praxis research because the relationship between theory, practice and empowerment is central to them all. Comstock (1982) introduced facilitated praxis as a form of democratic and critical research. The concept of praxis involves the integration of theory into practice, combining reflection and action to work with people to cause change (Senge, 1990). It implies that practitioners become self reflective, self-critical researchers as a commitment to developing their disciplines, as well as bridging the gap between theory and practice. The goal is neither prediction nor understanding but emancipation and social change. It involves research into the practitioner's own practice. Professionals engaged in praxis research are involved in developing and advancing practice. Action research methodologies, as described below, are in line with the praxis view as they aim to transform the practice world of the practitioner.

During the 1980's the advantages of action research were rediscovered and recognised by nursing. This form of research made visible the close relationship between theories-in use, the practice of nursing and the possibility one had to transform practice. Handling those three important aspects required praxis research; that is, a type of research in which one understood what should be done in practical situations (Carr & Kemmis, 1986). Inspiration for this kind of research was found in participatory research as described by Kemmis and McTaggart (1988) and Grundy (1982), and participatory action research as described by Fals-Borda and Rahman (1991).

3.3.3.1: Participatory action research

At the beginning, participatory action research was most often practiced in community settings and in third world countries. It tended to be initiated and guided by researchers who were highly educated. The Society for Participatory Action Research in Asia states that, “participatory research implies an effort on the part of people to understand the role of knowledge as a significant instrument of power and control”, (as cited in Reason, 1994, p. 328). Fals-Borda and Rahman (1991) view participatory action research as a combination of research, adult education, and socio-political actions. Together they combine into an ‘experiential methodology’. The first aim for a participatory action research project is to develop knowledge through research, education, and social-political action. This leads to the second aim, which is directed towards empowerment for changing the immediate environment. This is achieved through collective self-inquiry and reflection (Fals-Borda & Rahman, 1991).

In developed countries the participatory action research approach has been utilised by academics with a desire to implement their institutions’ responsibility for community work (Fals-Borda & Rahman, 1991). Areas in which dominant knowledge is a force of control appear to be appropriate settings for participatory action research. Dominance is often maintained because there is no representation for oppressed groups within the dominant ‘elite knowledge’ group. This is very relevant to the health care setting where consumers’ knowledge is often seen as less valid than, and is dominated by, that of health professionals’. This occurs particularly when the health professionals adhere to a traditional model of care delivery.

Consequently, three aspects of participatory action research have developed, namely, reappropriation of knowledge, development of the people’s knowledge, and participation in social production of knowledge.

The *reappropriation of knowledge* involves developing strategies that are directed at making knowledge accessible to ordinary people. According to Fals-Borda and Rahman (1991) there is a vast amount of knowledge available in developed countries. However, due to certain characteristics of a knowledge-based society (privatisation, secrecy, and professionalism), it becomes difficult for certain groups of people to access the information that affects them. The worker-based research movement asserts that people have the right to access information, in particular when it affects them. Training manuals have been developed and groups taught to develop skills that enable them to reappropriate knowledge from the knowledge elite.

This type of movement is prominent in Scandinavian countries. Scientists and lay people work together in controlled research centres. However, the aim is to go even further, to actively involve the people who are affected by the research, leading to a *social production of knowledge*. All participate in the decision making regarding the research topic, the production of new knowledge, and how the results are to be used.

The participants, both experts and lay people, are conscious of their own limitations. The social knowledge resulting from this approach should be more relevant, humane, rational and democratic than the traditionally generated knowledge, which is generated by a few specialists (Fals-Borda & Rahman, 1991)[10].

Developing people's knowledge, or common-sense knowledge, is concerned with valuing knowledge that has been suppressed by the dominant culture. It is the type of knowledge that is culture specific, has enabled people to survive and work for centuries, and which is more appropriate to a population's needs than that imposed by an outside group. For example, pre-industrialised societies' folk knowledge was more appropriate to them than imposed modernised knowledge. According to Fals-Borda and Rahman (1991) knowledge of this type needs to be retrieved to provide non-dominant groups with an identity and a 'more authentic future' (Fals-Borda & Rahman, 1991). In addition, valuing and using common-sense knowledge in our western society enables people to gain strength. It may lead people to develop an improved insight into their own situation, allowing them to examine the political context in which they live and, as a result, challenge the dominant ideas.

3.3.3.2: Critical action research

Action research , in particular emancipatory action research as described by Grundy (1982) and Kemmis and McTaggart (1988), is becoming increasingly popular within the Australian and New Zealand health care settings. The Australian community of action researchers had a significant influence on the development and application of critical action research in nursing. Like the LOM group they link action research to the critical theory of Habermas (1972, as cited in Carr & Kemmis, 1986). According to Habermas (1974) knowledge is derived from three spheres of human interest: technical, practical, and emancipatory interests.

Technical knowledge is derived from the empirico-analytical paradigm and generates procedural knowledge. Practical knowledge is generated from the interpretive paradigm. It enables one to form an interpretive understanding which can inform and guide practical judgement. Emancipatory knowledge arises from the critical paradigm and is driven by emancipatory interests. Through critical reflection people are able to identify and overcome ideological distortions. In other words, emancipatory interest serves as a foundation for the critique of ideology and for the knowledge that informs fundamental social change (Comstock, 1982).

Accordingly, Grundy (1982) identifies three modes of action research, namely the technical, the practical, and the emancipatory modes. In *technical action research*, the Aristotelian notion of *techne* is regarded as the craftsperson's art or skill. The actions that result from *techne* are described as *poietike* (making action). Accordingly, the researcher forms an idea (*eidos*) of the finished product/outcome s/he would like to create/achieve. Through repeating the skill over time, the craftsperson or researcher may become more skilled or develop a greater understanding of his/her work (Carr & Kemmis, 1986). Thus in this mode of action research the researcher identifies the problem, develops the action plan and implements it.

---

[10] This is very much the approach the LOM group takes in their developmental research.

Important to this form of action research is the improvement of efficiency and effectiveness. It is often an outside researcher encouraging the participants to evaluate and incorporate external research into their practice setting. Consequently, the aim of this research becomes the verification of previous research. The knowledge obtained is not reflexive and does not, therefore, "change the framework of tradition and expectations within which it operates", (Carr & Kemmis, 1986, p. 33). It is not surprising then, that when the researcher withdraws from the setting, practitioners often return to their previous routines and habits. However, the authors point out that the participants may be encouraged to engage in critical reflection and consequently move towards emancipatory action research.

According to Grundy's (1982) view, the practical mode of action research is based on the Aristotelian notion of *phronesis*: "the prudent understanding of what should be done in practical situations" (Carr & Kemmis, 1986, p. 132). The authors propose that *phronesis* (the knowing why) informs and guides praxis. Praxis in turn is based on the assumption that through informed action and reflection the knowledge that informs that action is constantly reviewed, aiming to reconstruct the "fundamental structure of the social setting" (Carr & Kemmis, 1986, p. 32). The authors point out that this type of research develops the practical reasoning of practitioners.

In practical action research the researcher, together with the practitioners, identifies potential problems, and together they develop and implement the action plan. As a consequence, the group develops a common language and understanding of the problem. The role of the researcher is to facilitate and guide the reflective learning process. Depending on the learning and trust within the group, one or more of the group members could take responsibility for guiding the group in its collaborative self reflection, thereby facilitating the transition towards emancipatory action research.

Use of the third mode, *critical-emancipatory action research,* is intended to promote emancipatory praxis in those participants who are practitioners (Grundy, 1987). In doing so a critical consciousness is created which shows itself in political, as well as practical, action to initiate change. According to Habermas (1974), "it is through the development of critique that the mediation of theory and practice is possible" (as cited in Grundy, 1987, p. 29).

An important outcome of the process of critique is that through the development of critical theorems people may develop an understanding of how their history shapes their reality (Habermas, 1974). Critical theorems form the basis for enlightenment, (a process whereby the practitioners learn to see their world/problem in a different way). This can be regarded as a learning process within a particular group, in which critical theorems are examined by means of reflection, enabling the group to select the theories that are considered to be the fairest, most just, and most emancipatory (Carr & Kemmis, 1986). Accordingly, the preferred theory will guide the actions that need to be taken to intervene in and change social processes that constrain reconstruction of a given situation (Comstock, 1982).

Carr and Kemmis (1986) point out that each of the three elements of critical social science (the formulation of critical theorems, the process of enlightenment, and the organisation of strategic action), are evaluated according to certain criteria. Formation of critical theorems requires freedom of discourse. The criterion for the process of enlightenment, which is a social and political activity, is that individuals be committed to unrestrained and democratic communication. They need to develop a common orientation towards action in order to reach decisions that are acceptable to everyone. The criterion by which strategic action is judged is that it should be just, and takes both the present and the past into consideration.

In other words, critical social science requires researchers and participants to actively (re)construct both theory and practice. Coercion and deception are sought to be overcome by a process of rational discussion and democratic political action based on free commitment to social action. The process of critique, the interest in emancipating those groups that experience some form of oppression, and the political nature of this approach distinguish it from conventional theories of social sciences and make it a science of praxis (Comstock, 1982). Critical research can be regarded as a re-educative or self-critical approach to social problems and practices that arise from, and are embedded in, a social context. It deals with the participants' self-confidence about their ability to create local theories grounded in either the data emerged from fieldwork or from experience and practice (Zuber-Skerritt, 1996). Any member of a group can facilitate the process of reflection. Carr and Kemmis (1986) point out that an outsider may assist in the development of a self-reflective group but should withdraw as soon as this is established. Otherwise the outsider undermines the responsibility of the group for its own self-reflection.

3.3.3.3: Kemmis and McTaggart's framework

The critically self-reflective developments of educational research in Australia have spanned twenty years now. Action research, particularly as developed by Kemmis and McTaggart (1988) for the critique and transformation of educational practice, is one of the forms of research as praxis. They define action research as:

> A form of collective self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own social or educational practices, as well as their understanding of these practices (Kemmis and McTaggart, 1988, p.5).

In this self-reflective enquiry, in which understanding guides transformation of social or educational practices, research becomes praxis. It is seen as a medium to facilitate change in practice, through reflection and action. Kemmis and McTaggart (1988) provide explicit guidelines for conducting action research based on emancipatory principles. In the explanation that follows I have drawn on their material, in particular their action research planner (Kemmis & McTaggart, 1988).

The action research process starts with the 'reconnaissance' phase. This begins with the identification of a thematic concern, which relates to the practitioner's recognition of a problem within his/her area of practice. The practitioner shares this concern with colleagues and invites them to participate in an action research project. The thematic concern that was addressed in this study related to the level of patient involvement in rehabilitation.

Kemmis and McTaggart (1988) suggest that all participants reflect on the current situation, to be certain that they view the thematic concern in a similar way. In this phase the participants will gather information about the situation, taking both past and present influences into consideration. Subsequently, the findings are discussed and a strategic action plan is formulated.

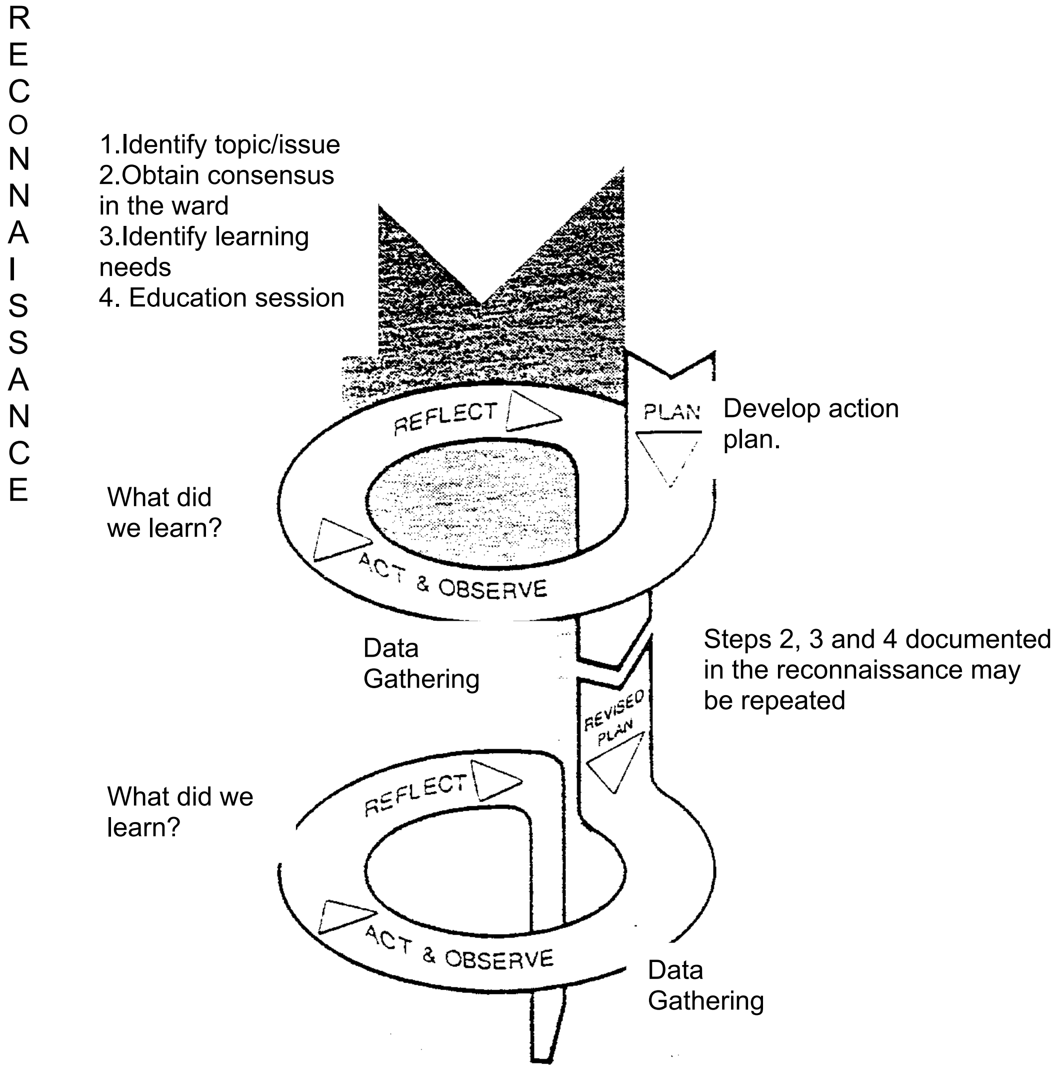


Figure 2: The Action Research Spiral (Kemmis & McTaggart, 1988).

The action research spiral described in the action research planner provides the framework for the research process. Following the action research planner, the next step is to establish how the effects of the action plans in the practice setting will be observed. Suggested techniques for monitoring are anecdotal records, field notes, ecological behavioural description, document analysis, diaries, logs, item sampling cards, portfolio, questionnaires, interviews, sociometric methods, interaction schedules and checklists, tape recordings, video recordings, photographs, slides, and tests of participant performance. Once an appropriate method is established, the group is ready to implement and observe the action plan. A realistic time frame then needs to be set for the implementation phase. This includes (as can be seen from Figure 2) an evaluation of the practitioners' knowledge and the consequent development of an education programme prior to implementation of the action plan.

When the implementation is completed the group meets again for the reflection phase. The obtained information is critically examined and incorporated into a reconstruction of the action plan, which then starts a second action research cycle.

According to Kemmis and McTaggart (1988, pp16-17, 55-64) it is hoped that changes occur in (a) the use of language and discourse, (b) in activities, practices and social relationships, and (c) in the way the social environment is organised. The changes that are observed are entered in the research register. Observations are mapped to these three dimensions as described below.

The language and discourse used by the participants in describing the issues surrounding the area concerned reflects their knowledge and understanding of the thematic concern. Action research enables them to expose their existing knowledge and critically evaluate it. Through dialogue with colleagues and experts, and exploration of the literature, they may change their language. Consequently, communication becomes the vehicle for change, as knowledge and action are informed by the language used by the practitioners (Philips & Rehnström, 1996).

Changes in activities and practices describe the learning experience of the participants. In the process, alternatives to current activities are explored and barriers to implementation are identified. The resulting actions and the learning involved are documented.

Finally, social relations are formed within organisations and influence the way practice is organised. The action research group may influence these relationships through negotiating planned actions with key people in the organisation. This in turn could influence the formal structures within the setting. Moreover, the relationship between group members may also be affected. The focus on social change remains, as in Lewin's (1946, 1948, 1958) work. One of the main differences between emancipatory research and Lewin's work is that the former is inspired by Habermas' (1974) critical theory[11], and the latter by cognitive learning theories (Gouldner, 1976, as cited in McTaggart, 1991).

Participative research teaches (nursing) professionals to engage in systematic, regular and rigorous review of their practice, in such a way that they are able to advance their practice based on both *phronesis* and *episteme*. This may result in theory verification and the development of a new local theory. Moreover, according to Senge (1990), stimulation of practical wisdom within organisations contributes to the development of learning organisations. He describes these as places where workers can continually learn how to create and change their reality through discussion, dialogue and reflection. Senge (1990) and Zuber-Skerritt (1996) regard participative research methods as ideally suited to the creation of this type of organisation. Thus, changes in practice are based on the insights of practitioners, rather than being imposed upon them as happens in many change management projects.

3.3.3.4: Feelings associated with the change process

Changes in organisational structure and process require the development of new behaviours, values, skills and competencies (Hendry, 1998). The author points out

---

[11] In particular, Habermas' work on communicative competence which involves the development of open, honest dialogue with the exclusion of power and manipulation (Gustavsen, 1996). This in turn leads to an authentic shared understanding of a social action or situation. This link seems justified as both emphasise the important of democratic dialogue.

that to make a new practice acceptable and efficient, sufficient time should be given to the development of skills and competence. In other words, change is less likely to occur if the rate of change exceeds the rate of learning (Garratt, 1991).

Another important aspect in relation to change is the feelings participants may experience during the process. According to Bridges (1991) individuals pass through three stages (endings, transition and beginnings) when experiencing change.

The first stage, *endings*, is described as the time when individuals need to let go of their familiar ways of working, (which happens in the exploration phase of the action research process). They try to hold on to the past as they are expected to move out of their safe and stable practice environment. As a consequence, individuals can experience feelings of loss, loss of meaning, and negative emotional receptions to change. At this point they neither belong to the old or to the new. Trust and feelings of security are difficult to develop if people do not understand the reasons for 'ending', which may lead to decreased commitment and morale (Gilmore, Shea & Useem, 1997). Communication appears to be vital in successful change (Gustavsen, 1996; Quirke, 1996). It is suggested that open communication will aid successful ending, enabling people to let go of the past and begin to move on.

The *transition* (evident in the planning and action phase of the research cycle) is a time of uncertainty, and can last for weeks or even months. During this phase people need to move from the old to the new. In doing so, they are searching for a new identity and meaning. It is a time of redefining vision and values, and reviewing systems and processes. This brings feelings of excitement for some and anxiety for others. According to Schein (1993) there are two types of anxiety that are interacting, namely, worries about changing, and worries about not changing when indications are there that one should. Consequently individuals may question their own, and others', competence, especially if new practices create unforeseen problems. Individuals' confidence in themselves, colleagues, managers, and at times the entire organisation, may be affected (Gilmore *et al.*, 1997), and this needs resolution before a person can move into the final phase, termed *new beginning*.

Once a majority of people within an organisation accept and are committed to the new practice, the integration phase ends. In the next and final phase (new beginning) the majority of the people are positive about current and future opportunities. However, some may still be fearful because the end is now real, and they may be grieving for what has been lost. This group may be in need of additional support or counselling. The feelings and emotions associated with change can negatively influence acceptance if the researcher fails to recognise them during the research process. Moreover, I believe that awareness and providing time and support for those who experience difficulties will create a positive and secure environment for change.

3.4: Action research and science

Bunning (1992) suggests that action research addresses the whole system and provides a holistic framework for the social situation under study. According to the author, researchers attempt to influence the situation under study during the action research process. This is based on the assumption that the real nature of the social systems or suitability of theories are more likely to become evident when changed and studied in practice. The research design is emergent, meaning it evolves during the process, influenced by the events that take place during the project and the ongoing interpretation and analysis. This does not mean, however, that action research does not adhere to scientific rigour within its design (McTaggart, 1997).

In the tradition of scientific academic research, rigour is associated with validity and reliability. However, several researchers have questioned the suitability of these traditional measures for qualitative research (Lather, 1986; Lincoln, 1985; McTaggart, 1997; Melrose,1996; Sandelowski, 1993; Zeichner & Noffle, 1998), and support a shift towards indicators considered to be more suitable for evaluating the research quality.

For example, Guba and Lincoln (1989) propose the concept of ‘trustworthiness’. Criteria for trustworthiness are credibility, transferability, dependability and conformability. According to the authors a study gains *credibility* when the researcher provides a detailed, faithful, written account of the study that is recognised by co-researchers and those involved. Suggested ways to ensure credibility include the keeping of research journals in which the details of interactions and changes are described. They in turn provide the basis for reflection. Because the practitioners are involved in the entire process, the outcome will more readily reflect reality (Melrose, 1996).

Transferability, the second criterion, relates to the degree of similarity between two situations or contexts. In other words, strategies that are found to be effective with a particular group of individuals allow for the formulation of similar approaches, which may be equally effective with other groups. However, the original situation must be described in great detail in order to decide if the outcome of the study fits the situation the reader has in mind.

Dependability relates to the auditability of the research. The audit trail should show a detailed account of the reasoning and decision making processes used by the researcher. This would enable other researchers to duplicate the study (Sandelowski, 1993). It is suggested that by adhering to the action research process the researcher provides an audit trail and is constantly validating the findings.

Reflexive critique relates to the ability to actively seek other views in order to develop a holistic understanding of a situation. In other words one should regularly step back and question one’s own presuppositions, values and implicit paradigms to examine how they are influencing one’s interpretation of a situation and choice of actions. Reflexivity affects how one conceptualises and reports on phenomenon under discussion. Reflexive practice works on the basis that one’s own account of a phenomenon is a representation of a reality. It is never regarded as the truth about that reality.

In addition to the criteria described above by Guba and Lincoln (1989) and Sandelowski (1993), Lather (1986) proposes that validity and reliability may be achieved by incorporating the following elements into the research design: triangulation, construct validity, catalytic validity, face validity, and reciprocity.

Denzin (1994) identified four basic types of *triangulation*. The use of different data gathering methods is one form of validation (for example, audiotape recordings of one-to-one interviews and group discussion meetings, journal entries and anecdotal evidence). Investigator triangulation involves the use of several different researchers, and theory triangulation uses multiple perspectives to interpret the research data. Finally, methodological triangulation makes use of multiple methods to study a problem.

Construct validity is established by documentation of how an *a priori* theory has been affected by the logic of the data. It is anticipated that the participants' beliefs about their practice and participative care will be influenced through learning and reflection throughout the project.

The researcher establishes *catalytic validity* by documenting the extent to which the research process has provided the participants with insights into their situation and then stimulated them to change it. This type of validity will become evident during the discussion of the data, where examples of newly developed insights influencing participants' actions are presented.

Face validity is established by making the preliminary interpretations and conclusion available to the participants. The participants are then asked to comment on the content. These comments are then used for further interpretation, influencing both the direction of the study and theory building. Greenwood (1984) points out that face validity in action research ensures that the researcher’s interpretation of informants’ accounts of the local situation is a true representation of their reality. The reliability can be checked by comparing the researcher's interpretation of the interviews to that of the participants. In my view this also assists in increasing the credibility described by Guba and Lincoln (1989). It may well be that several informants perceive the reality, or describe the phenomenon under study, differently. It is important to theorise the identified differences and provide an account of how a common understanding may develop.

Finally, Lather (1986) proposes that strategies of reciprocity should be included into the research process. Reciprocity can be achieved when the researcher is willing to share their feelings and thoughts about the research topic and process with the other participants. In other words, the researcher engages in self-disclosure. Furthermore, (s)he encourages the participants to move from what they know about the research topic to thinking about it.

Some action researchers argue that it might not be necessary to demonstrate rigour in an action research project, as long as the researcher acts ethically and responsively towards their community (Melrose, 1996). According to Melrose the level of rigour is very much associated with the audience and resulting dissemination of the outcome of the research. The audience in her action research project included the participants in the group, the organisation and community, and the scientific community. With this view, Melrose (1996) introduces a weak form of action research, with which I disagree. Such a view leaves action research open to criticism as a romanticised form of research (Reason, 1994). Action research, like any other form of research, needs to adhere to scientific principles in order to be recognised as rigorous within the scientific community.

3.4.1: Criticism

Action research is heavily criticised, largely because the presumed lack of validity, researcher detachment and control groups produces results that are not generalisable. I would counter that the discovery of strategies that are found to be effective within a particular group of individuals allow the use, of similar, possibly equally effective, approaches with other groups. Although each group of researchers would have to evaluate the efficacy of a particular strategy in their group-specific context before implementation, the expectation that similar strategies would turn out to be effective is a view supported by other researchers (for example Greenwood, 1984; Toulmin & Gustavsen, 1996).

Criticism in this area may have led to the emphasis placed by some practitioner-researchers on generalisation in action research. In doing so they often follow Corey’s (1953) recommendations, namely, the careful recording of actions taken, and the accumulation of evidence to determine the degree to which the goal has been achieved. This allows for generalisations to be made regarding the relationship of the actions and the desired goal, and allows continual repeating, or testing, of these generalisations in action situations (Corey, 1953).

A further criticism is that action research is non-academic. This view is taken for two reasons. First, it is conducted in the practical, not university, setting, and is therefore seen as more practical than theoretical (Gustavsen, 1996). That the focus is on *phronesis* rather than on *episteme* is not, however, viewed negatively by Toulmin (1996), who argues that the majority of participative approaches are aimed in the first instance at practical effects and less at theoretical rigour.

The involvement of practitioners in creating scientific knowledge is viewed with some scepticism because practitioners often lack the education that would enable them to produce scientific results. This view indicates that the knowledge of the scientific community is considered superior to that of lay people, although scientific knowledge too remains the knowledge of a small group of people and is possibly only useful to this group. In the action research process there is frequently an exchange of knowledge between the researcher and participants, which may lead to new practice.

The question of whether action research is really research will remain, as it stands in the middle of two opposite views of research methodology (Toulmin, 1996). How that question is answered depends on the prior experience and expectations of the audience. In particular it depends on the audience’s paradigm of research.

3.4.2: Ethical considerations in action research

There are several ethical concerns in relation to the participants. The participants are often in a vulnerable position. Any action plan results in actions that will have an effect on practitioners not involved in the research or, in extreme cases, require a more radical change. This is not always appreciated by colleagues and those in leadership positions. The danger is that the participants may be seen as whistle blowers and their positions may be threatened. The action researcher needs to be aware of this possibility and have strategies in place to work through the issues should they arise.

Meyer (1993) raises the issues of confidentiality, informed consent, and group cohesiveness in action research. Confidentiality in action research is difficult to maintain. She argues that although fictitious names are used, readers may still identify participants since it is setting-specific. Action researchers need to point this out to the participants prior to commencement of any action research project. In addition, it is difficult to completely inform the participants since one can only plan the first step of an action research process. I would like to emphasise here that informed consent can only be given to the extent of entering an interactive research situation. As long as it is made clear to participants that this is the case, unforeseen developments automatically become something that are open to negotiation within the group. I suggest that, given the nature of action research, informed consent should be obtained prior to the commencement of a new action cycle and should be formally incorporated into the method.

Cohesion within the group will develop as the action research project progresses. It may become difficult for any of the participants to withdraw from the research at a later stage, since they may feel that this would let the group down. They may therefore continue to participate regardless of their own feelings. In my view it is up to the researcher to make sure that the participants do arrive at a good understanding of the process, and that withdrawal from the study is understood to be entirely acceptable.

The complexity of participative research is, in my view, not well addressed in the literature. It requires an understanding of group dynamics, group facilitation, reflective practice, negotiation, and change management. It is not surprising that Argyris and Schön (1987) recommend a good understanding of the action research method before commencing a project. This includes a good understanding of group dynamics and experience in working with small groups. Moreover, researchers (depending on the context and type of participative research) can easily become emotionally involved, and need to be prepared to deal with a number of unexpected issues (Greenwood, Whyte & Harkavy, 1993). It is therefore important that a novice action researcher has an experienced mentor to provide the necessary guidance.

Winter (1996) has attempted to develop a set of ethical principles. These are reflective of the concerns outlined above and are useful in the development of an action research study.

- Make sure that the relevant persons, committees and authorities have been consulted and that the principles guiding the work are accepted in advance by all.
- All participants must be allowed to influence the work, and the wishes of those who do not wish to participate must be respected.
- The development of the work must remain visible and open to suggestions from others.
- Permission must be obtained before making observations or examining documents produced for other purposes.
- Description of others' work and points of view must be negotiated with those concerned before being published.
- The researcher must accept responsibility for maintaining confidentiality. (Winter, 1996, p. 14)

3.4.3: Data collection

Accurate and thorough collection of data plays an important part in establishing rigour. Data is collected during the action and observation phases of the cycles. The method and criteria for collection are negotiated with the group members prior to commencement.

According to McTaggart (1997) the observations, and reporting of the observations, is mostly an individual activity. On the other hand, interpreting and gaining confirmation is always a collective activity. However, it is common that some participants may lose interest in interpretation, theory building and reporting during the various cycles. It is important that they are not coerced into continuing with the project if they wish to withdraw.

Ideally all group members maintain a research journal. The research journal is important in the perceiving, describing and critiquing of those actions and preconceptions of members' that influenced the research. The participants reflect on their own journal entries by means of narratives and group sharing. The advantage of group reflection is that it increases the validity of the knowledge derived from it. Action research, like any other form of research, is concerned with protecting the rights of the research participants and those affected by it.

3.5: Summary

There is overall agreement that Lewin's (1946, 1948, 1958) work was the precursor for a post-war movement that led to a new direction in human social science, in which humanistic, participative and democratic values were advocated. Action research is an umbrella term for a number of different approaches with different philosophical underpinnings. Participative research has had a strong following within organisational development. This resulted in the collaboration of several international institutions. It can be seen that from an organisational development perspective, action research is often regarded as a problem solving method and as such is linked to processes of planned change and development. The level of participant involvement in an organisational action research study ranges from nil or little involvement to that of co-researcher (involvement in the actual design and analysis).

The Australian assimilation of action research as a self-reflective enquiry in which understanding guides the transformation of social or educational practices was described in this chapter. Other forms of participative research such as participatory action research, action science, and critical action research were discussed and some commonalties and differences were outlined. This was followed by a discussion of rigour and ethical concerns with respect to participative methods. It was suggested that participative methods have a significant role to play in the minimisation of the theory practice gap, because the majority of participative approaches are aimed, in the first instance, at practical effects and less at generalisable theoretical development. The emerging local theories are grounded in the local data. These are developed from the interaction between researcher and participant (a bottom-up approach of knowledge development).

In conclusion, this type of research is guided by the desire to solve real world problems, to be honest, and to be liberating while dealing with local contingencies. However, transferring these ideals into the practice setting is a challenge. Given careful consideration of the forms of action research and given my familiarity with Kemmis and McTaggart's (1988) framework, I chose to use their approach in responding to the challenge. If it became evident that this method didn't suit a given situation or context, it may have been necessary to incorporate other forms of the discussed participative methods. Having outlined the overall framework of the study, I would like to share with the reader how I went about planning the project.

4: Planning phase one of the study: taking steps to promote practice advancement

4.1: Introduction

This chapter begins with an introduction to Quirke's (1996) communication framework. As communication plays a vital role in any action research and change project, a guide for communication was needed. Quirke's (1996) model was adopted for this study because he and Kemmis and McTaggart (1988) all advocate open communication. Moreover, the language used in his model, such as 'raising awareness', is similar to that used in Kemmis and McTaggart's (1988) framework. It functioned as a background communication tool to guide the steps needed to establish an audit trail. It aided us (the researcher and the action research group members) in taking the steps within the research spiral, where the provision of constant feedback, reflection, and discussions with the informants (patients, family members, and ward staff) are crucial for a positive outcome. This is followed by a work plan for the intended study. This plan gave the organisation an impression of the form the research could take for the first six months. In addition, the method of data analysis and the software package used throughout the study are addressed.

4.2: Communication framework

Quirke's (1996) 'communication escalator' consists of five steps: awareness, understanding, support, involvement, and commitment. At each step various communication strategies are employed. These differ depending on the environment and the issue concerned.

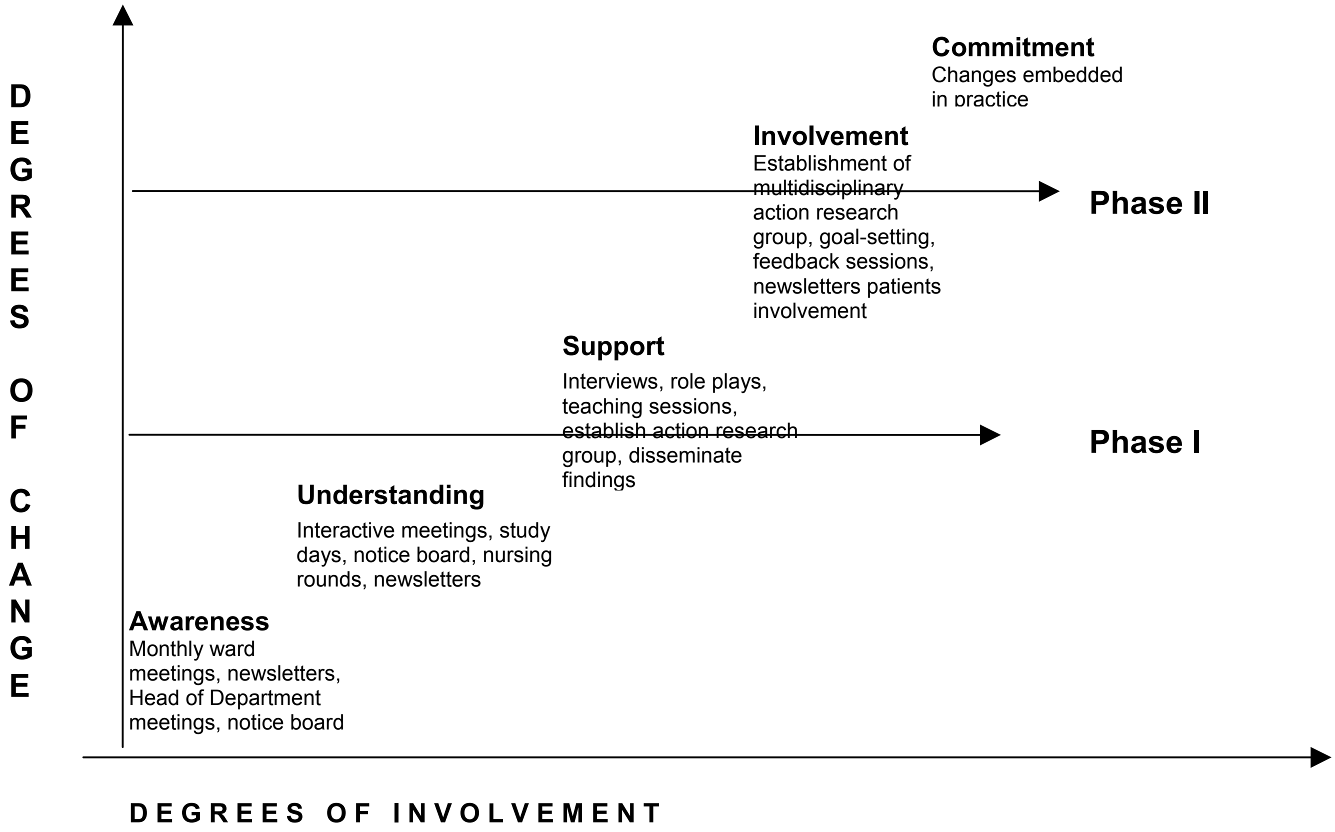


Figure 3: Quirke's (1996) communication framework, with the anticipated means of communication shown inside the boxes.

Raising awareness involves communicating the impending change to all the people involved, explaining what they can expect and what is expected of them during the change process. The aim is to reach as many staff members as possible using various methods of communication. In the present study it was planned to utilise newsletters, electronic mail, notice boards, and departmental meetings.

During the next stage[12] the aim is the development of an understanding, among the people affected, of the intended actions and impending changes. Consequently, more interactive communication is desired. There are several ways to facilitate this, including meetings, presentations, question and answer sessions, and newsletters. The aim was to provide a rationale for the impending change, and to obtain feedback from staff members regarding their understanding and points they wanted clarified.

Once people understand what is expected and what the implications of the proposed changes are, the next step can be pursued, namely, obtaining support. It remains important to explain the rationale and provide education sessions for the staff.

---

[12] It should be noted that these stages are not linear. It may well be that future action cycles have to begin again at the 'raising awareness' step.

Clinical teaching sessions were planned, along with seminars, lectures, role-play and nursing rounds.

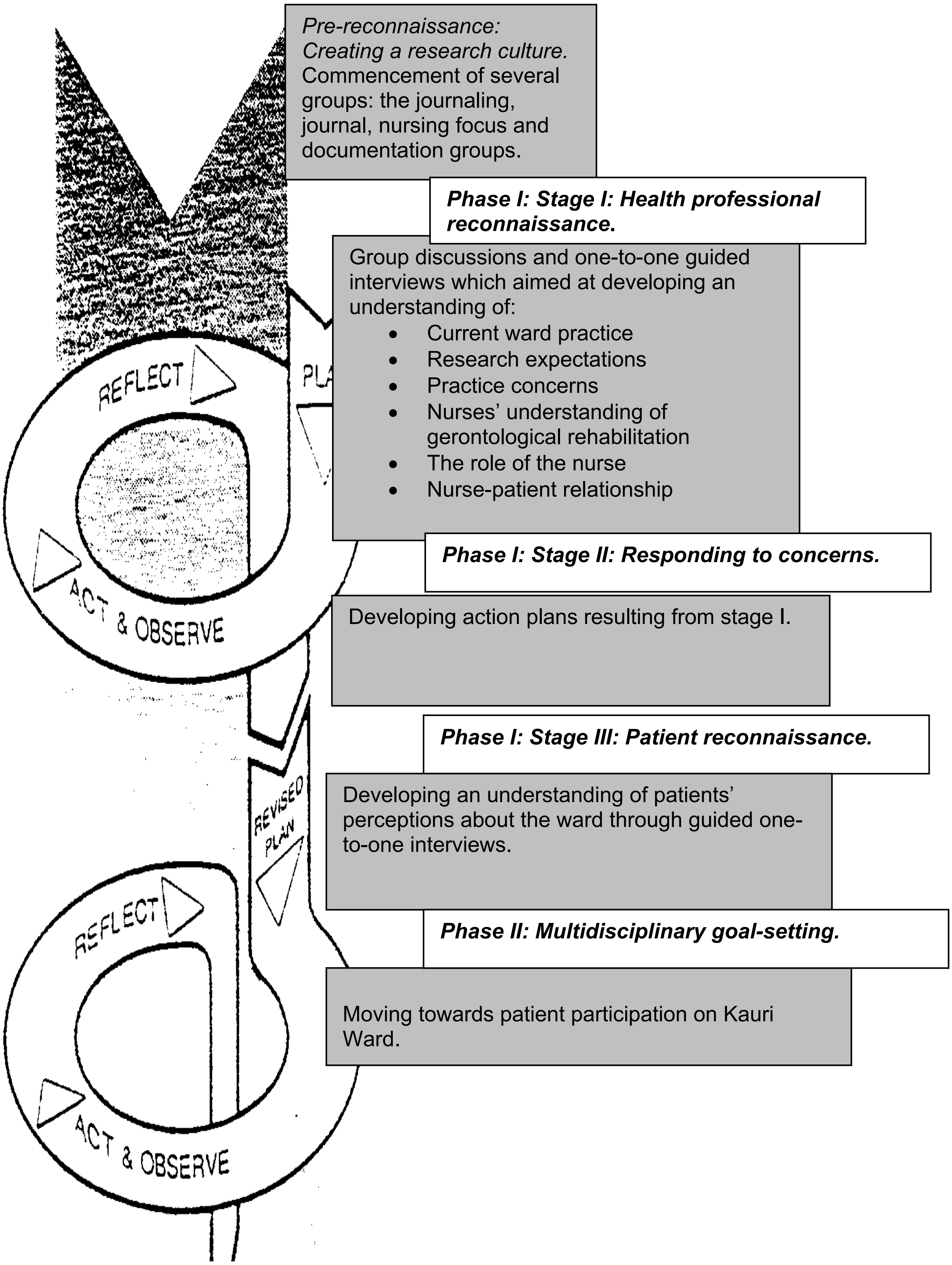
The next step is to involve as many people as possible. Inviting staff members to engage in dialogue regarding the anticipated changes will facilitate this. They will be encouraged to voice their concerns, critique and explore alternatives, exchange ideas, and find suitable methods of implementation. Quirke (1996) recommends team meetings, cross-functional project teams, feedback forums, and speak-up programmes, all of which are potentially useful within the current project. Support may result in commitment, the final step on the escalator. Quirke (1996) points out that “commitment comes from a sense of ownership” (p.132) which is developed through participation in the development of the strategy and solution. It involves a high level of participation and interaction, ensuring that everybody has the opportunity to participate. The parameters for contribution should be explicit and in this study update sessions are planned on a monthly basis, across the disciplines, to disseminate information.

4.3: Anticipated work plan

In this section the intended study plan is described, in terms of phases, stages and action cycles (see Figure 4)[13]. Each of the action cycles includes the planning, implementation, observation and evaluation described previously (see section 3.3.3.3: Kemmis & McTaggart’s framework). Phase I will consist of three stages, namely the health professional reconnaissance (stage I), with the resulting action plans (stage II) and the patient reconnaissance (stage III). Within each of these will be a number of action cycles, which are determined once the study is underway. The phases following phase I can only be planned once this phase is completed. Nevertheless, it is anticipated that the following phases will involve the multidisciplinary team and the community. These would be labelled phase II and III respectively. Figure 4 depicts the intended phases of the study. Each box presents a phase within the study. The white box prior to each chapter informs the reader of the phase within the study. The grey box depicts the intended actions. As the account of the study progresses the intended actions, described in the boxes prior to each chapter, will change and be presented in result boxes, which will have a dark grey colour.

---

[13] For a time-line and summary of data gathering methods see Appendix 4A.



Pre-reconnaissance: Creating a research culture. Commencement of several groups: the journaling, journal, nursing focus and documentation groups.

Phase I: Stage I: Health professional reconnaissance.

Group discussions and one-to-one guided interviews which aimed at developing an understanding of:

- Current ward practice
- Research expectations
- Practice concerns
- Nurses' understanding of gerontological rehabilitation
- The role of the nurse
- Nurse-patient relationship

Phase I: Stage II: Responding to concerns.

Developing action plans resulting from stage I.

Phase I: Stage III: Patient reconnaissance.

Developing an understanding of patients' perceptions about the ward through guided one-to-one interviews.

Phase II: Multidisciplinary goal-setting.

Moving towards patient participation on Kauri Ward.

Figure 4: Action research spiral. Note that each text box represents a phase of the study which will be highlighted at the beginning of each chapter.

4.3.1: Phase I: Stage I: Understanding current practice: health professional reconnaissance

Ethical clearance will be required prior to active participant involvement. Phase I will be initiated while waiting for ethics approval, because the activities prior to participant involvement are concerned with providing the potential participants with sufficient information to enable informed consent. It seems logical to begin phase I with the health professional reconnaissance stage, as unless this stage is worked through, the others will not be achieved. The reconnaissance aims at developing a shared understanding regarding participative care. The focus will be on nursing practice, exposing and discussing the issues confronting nurses in practice, and their understanding of participative care.

4.3.1.1: Pre-ethics approval: raising awareness

The aims will be to (a) raise awareness and develop understanding of action research amongst staff on Kauri Ward, (b) develop an understanding of the past experiences of the staff on the ward, (c) develop an understanding of the present situation (a baseline) and (d) expose and discuss the issues confronting the potential participants in relation to the introduction of participative care.

Nine study days will be negotiated. The study days will be aimed at enabling the ward staff to gain some insight into the nature of action research and participative care. During the study days they will have the opportunity to discuss the material and any concerns regarding these topics with their colleagues, enabling them to make an informed decision regarding participation in the study. The study days will be conducted with three groups of nurses each attending a block of three days. The content of the study days will not vary between groups (Appendix 4B). Once the study days are completed, the nursing staff will be invited to participate as active participants in the study. Those who do not wish to become a part of the action research group will be asked if they would consent to being interviewed.

Base-line measures will be derived from a documentation audit and a review of the clinical records, including care plans, in relation to integrated documentation, patient centeredness, and participative care. It s is anticipated that the audits will provide an insight into ‘theories-in-use’. The results could be compared to the interview data where it is anticipated that the interviewees will generally discuss their ’espoused theories’. Clinical notes and nursing care plans will be audited again, after the action research has taken place. Clinical documentation is thought to be reflective of changes in clinical practice in relation to participative care. Of special interest will be evidence of participative care in the care plans and the visibility of nursing within the clinical notes. Because the hospital is preparing for accreditation, existing audit tools could be utilised (documentation is a component of the audit). It should be noted that once the action research group is established that the data gathering methods will be discussed with the group.

4.3.1.2: Post-ethics approval: staff involvement

The aims are to (a) develop an understanding of the current situation, (b) develop an insight into the nurses’ perceptions of ward practice, practice concerns, gerontological rehabilitation, the role of the nurse, the nurse-patient relationship and their expectations of the research, (c) establish the action research group, and (d) discuss the literature review on participative care.

The actions during this step will consist of interviewing, analysis of the interviews, feedback sessions regarding the interview results, and development of the action research group. Prior to conducting interviews consent will be sought. The nurses will be given a plain language statement and asked to sign a consent form (Appendix 4C). Following this the interview rounds will commence.

4.3.2: Phase I: Stage II: The beginning of practice advancement: action plans based on the perspectives of the health professionals

The action plans in this second stage will be made in response to the information obtained from analysis of the stage I data.

4.3.3: Phase I: Stage III: Seeking patients' feedback: patient reconnaissance

In order to advance nursing in relation to participative care it is important to understand the needs of the client group receiving the care. Consequently this phase aims to (a) examine patients' and their families/significant others' opinion of current practice and their need for participative care, (b) compare patients' understanding of the perceived ward practice to that of the ward staff, and (c) compare the literature to the research findings so far.

The actions during this step will consist of interviewing, analysis of the interviews, and feedback sessions regarding the interview results.

Prior to any actions the informants (patients and significant others) have to consent to the planned interviews and participation in the study (see Appendix 4D for consent form). Following this the interview rounds with the patients will commence. All patients with a Mini Mental State Examination Score (Appendix 4E) of 26 and higher will be invited to participate in a guided, one-to-one, open-ended interview as described by Patton (1990). According to Fontana and Frey (1994) the use of such a framework for the interviews enables participants to express themselves more freely and have a greater voice in both the research process and the research report. It is anticipated that each nurse in the action research group will interview two patients at the beginning of the patient reconnaissance, and then follow the patient from admission to discharge. Given the resources and the type of study it is not feasible to include more patients. With the permission of the participants the sessions will be video and/or audio taped.

Any action plans commenced in stage II will continue throughout this stage, and new action plans will be initiated concurrently with the patient interviews.

4.3.4: Phase II: Can we develop participative care with older patients based upon their feedback?

The introduction of participative care to Kauri ward will necessitate the involvement of other health professionals, and it is therefore anticipated that part of the work of phase II will be preparing for this occurrence.

4.3.5: Phase III: Possible extension into the community

Once the amalgamation of Aged Care Services and Community Services is completed the project may be extended to include that setting. Issues that could be explored are the possibilities of (a) primary nurses conducting home visits after discharge, (b) family members as case managers, and (c) the development of seamless care.

4.4: Development of the action research group

It is anticipated that a beginning level of involvement and commitment (Quirke, 1996) from the ward staff will occur after the study days and interviews are completed. After completion of the study days the registered nurses will be invited to form an action research group. The core of the group would consist initially of registered nurses from the Kauri ward, including the clinical nurse consultant and charge nurse manager. It is hoped that membership of the action research group will be extended to include patients and their significant others[14], and other members of the multidisciplinary team. Membership of the action research group will be flexible. Thus the research process will accommodate both people joining the action research group for several cycles and then taking time out, and the inclusion of new members at a later date. It is hoped that the resulting practice changes will encourage others to become actively involved.

4.5: Data gathering and analysis

4.5.1: Journals

All members of the action research group will be asked to keep a research diary, either written or audio taped. These reflective diaries should track the development of insights and the changes in relation to practice, language and discourse, and social structures. With permission the participants' entries will be used in the data analysis.

4.5.2: Action research group meetings

With the permission of the action research group members, meetings will be audio taped and relevant discussions included in the analysis.

4.5.3: Interviews

All the nurses on Kauri ward will be invited to participate in a one-to-one, open ended, guided interview, as described by Patton (1990). It is intended that all nursing staff (n=26) will be interviewed and, with their permission, that the sessions will be video or audio taped. Working with the groups (in particular the reflective practice and journal group) in the pre-reconnaissance phase, showed that the use of

---

[14] An information programme will be developed prior to the start of the study for the client and significant other participants, in order to obtain informed consent. They will be invited to join the group after they have read the information and participated in the interviews. A plain language statement will also be given to the participants (Appendix 4D).

spontaneously worded, rather than structured, questions elicited a more in-depth conversation in which feelings and thoughts were easily shared. Combining this technique with the use of an interview guide (Patton, 1990) allows the preparation of a list of topics and issues perceived to be important (Appendix 4F). The guide will ensure that the same topics are addressed during each of the interviews, although the order of questions is up to the interviewer.

A similar procedure will be developed for the patients (see Appendix 4D for plain language statement and consent form), the main difference being that the action research group members will conduct the interviews.

4.5.4: Analysis of the data

The interviews will be verbatim transcribed by a secretary. A descriptive analytical framework is to be used for analysis (Patton, 1990). That is, the responses will be grouped by topics according to the interview guide. Any themes occurring are to be ordered according to the registers recommended by Kemmis and McTaggart (1988): practice, language and discourse, and social structures. In addition, Non-Numerical Unstructured Data - Indexing Searching and Theorizing, version 4 (NUD.IST 4) will be utilised for the thematic analysis. NUD.IST 4 is a software programme developed by Richards and Richards (1994) at LaTrobe University in Melbourne. It is a code and retrieval system. One of the positive features of this package is that it can be used to manage large amounts of data, both documents and ideas. It consists of a document system that contains textual level data about documents, which may consist of on line-documents or even off-line data such as books, tapes or anything else that needs coding. The documents are coded and kept in an index system. The index system enables the researcher to develop nodes, which consist of concepts, and store emerging themes. The nodes may also hold information about cases, data, and settings. These nodes are organised into trees, which show the organisation of the concepts into themes and sub-themes. The nodes within the tree can be linked to represent the linkages between the concepts. The nodes can be used at textual level (to code documents), and at conceptual level (to record and code thoughts).

It should be noted that data from participant journals, action research group discussions and evaluation meetings will also be entered into NUD.IST 4.

4.5.5: Feedback of information

Feedback sessions are planned to inform the ward staff and keep them up-to-date with the study. It is hoped that this will assist in the development of support for the study and aid the action research group's understanding of current practice. The feedback sessions will also help validate the researchers' interpretation of the interview data (face-validity).

It is anticipated that throughout the study the ward meetings and the research journals will provide important information. There are several monthly meetings already conducted on Kauri ward. The multidisciplinary 'rehabilitation meeting' has a focus on rehabilitation issues, while the 'ward meeting' tends to deal with nursing care issues and day to day running of the ward. The multidisciplinary 'quality meeting' focuses on quality issues. All meetings could be used to exchange ideas, discuss progress, and critique the action plans. Relevant minutes could be used, with permission of the meeting participants, in the analysis.

4.6: Summary

Communication is important in action research. Quirke's (1996) communication framework was used to provide guidance in the development of a communication plan for the study, and this is explained. There follows a description of the intended study, which has been designed in phases and stages. The first phase has three stages in it, beginning with stage I, the health professional reconnaissance, which aims to develop an understanding of the current situation. Stage II is designed to act on any information gained, or concerns raised, in stage I. Stage III, the patient reconnaissance, aims to examine patients' and their families /significant others' perceptions of current practice. The second phase, the multidisciplinary phase, may take place if there is an indication that participative care is supported by both patients and health professionals. Phase III may eventuate when the unit amalgamates with the community services.

The following section described the plan to establish the action research group. The data gathering methods such as study days, documentation audit, review of the clinical records, one-to-one guided interviews with health professionals and patients, research journals and action research group meetings, were described. The intended data analysis utilising a computer software package (NUD.IST 4) was outlined.

5: The literature that informed the study days and the first action research meeting (1996 - 1997)

5.1: Introduction

Senior staff in Aged Care Services were keen to implement participative care within the unit, and felt that goal-setting could be considered as a method of facilitating such a transition. A literature search was undertaken, therefore, in relation to the meaning of participation, and with respect to the advantages of and concerns about participative care. A search was also made for information regarding goal-setting.

5.2: Participative care

Since the 1980's the population has been ageing, with numbers of those aged 85 and over growing the most quickly. It is predicted that the size of this group will increase more than six-fold in New Zealand by 2050 (Jansen *et al.*, 1997). Because of the high incidence of disabling conditions in patients of this age, they must frequently be assessed for rehabilitation services (Ramsdell, 1990). Their rehabilitation needs often differ significantly from those in the younger age group in that they are long lasting and associated with an increase in health-care expenditure. The Ministry of Health has predicted an average of 1.2% per annum growth in health-care expenditure up to 2050, because of the demographic changes (Jansen *et al.*, 1997). The effective delivery of services is dependent on a good relationship between the community, community and hospital care, and the Departments of Health and Social Services (Swift, 1996). Given the prediction that the demand for geriatric services will increase and that expectations of healthcare will change, for example with the move towards consumerism within NZ, it becomes important to involve prospective and current clients in the development of rehabilitation services.

At the time of the reconnaissance there was no evidence of consumer consultation or participation in the development of services. This left some uncertainty regarding the appropriateness of the services - from both the elderly consumers' and the primary care providers' point of view. Some work was in progress to rectify this situation, as consumer consultation was perceived to influence patient outcomes positively (Naylor, Brooten, Jones, Lavizzo-Mourey & Pauly, 1994; Richmond, Baskett, Bonita & Melding, 1995; Seltzer, Ivry & Litchfield, 1987; Seltzer, Litchfield, Kaphurst & Mayer, 1992).

The World Health Organisation (1986) stated that patients have both the right and responsibility to be involved in their own health care. Since then the popularity of the concept of patient participation has increased, evidenced by the vast amount of published nursing literature on this topic. In reviewing the literature it was seen that the words 'involvement', 'consultation' and 'sharing' were used in the definition or description of participation (Appendix 5A, Table 1). What this seems to indicate is that participation may mean any of the following: sharing information with consumers, consumers being involved in decision making, involvement of consumers in implementation and evaluation of care, or consumers taking part in physical care

(Clark & Latter, 1990). The words ‘participation’, ‘involvement’, ‘collaboration’, and ‘partnership’ are also interrelated in the literature, and the definitions in the *Concise Oxford Dictionary* (1991) would support this (Appendix 5A, Table 2). The nature of the understanding of the terms, as well as the commitment of individual practitioners and organisations to these concepts, will influence clinical practice[15].

Arnstein’s (1972) model attempts to determine the meaning and level of involvement. The model is represented in the form of a ladder in which three levels of participation are identified, namely, *non-participation, degrees of tokenism*, and *degrees of citizen power* (Figure 5).

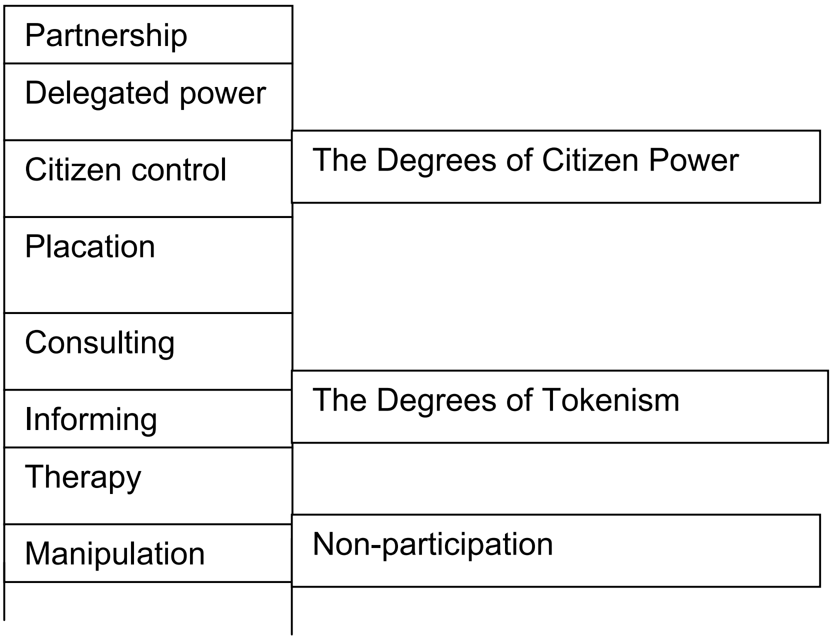


Figure 5: Arnstein’s model, adapted from Arnstein (1972, p. 177).

The lower rung, non-participation, consists of manipulation and therapy. Manipulation occurs when those in authority are engaging in activities that create the impression that individuals are participating, however, there is no delegation of power. Therapy is described as “any activities to distract from the issues by those in authority” (Arnstein, 1972, p. 178).

The degrees of tokenism comprise the following three ‘sub-rungs’: informing, consulting, and placation. Informing and consulting are considered two important steps towards participation. However, according to Arnstein, at the informing rung, the information flow is frequently top down. That is, from those in authority to those with less, or no, authority, for example, from management to staff or from health professionals to patients. For the staff or patients there is neither a channel for feedback nor power to negotiate. If those in authority desire proper participation, the information giver needs to ensure that in-depth information is provided at an early

---

[15] The understanding of, or level of commitment to, participative care is also culturally dependent, as demonstrated in an international study (Kim *et al.*, 1993).

stage in an intervention and that proper feedback channels are in place. At the next rung, consultation, individuals are asked to identify their needs, and voice their opinions and concerns. This is a legitimate step towards full participation. However, at this point, no effort is made to involve individuals in the actual decision-making. Consequently, there is no guarantee that the information obtained via consultation is taken into consideration in the decision making process. At the rung termed placation, some degrees of tokenism remain. These can be avoided when those in authority allow individuals to be placated, by providing them with the necessary level of professional assistance to enable them to articulate their needs and priorities.

Partnership, delegated power, and citizen control are the final three rungs of the ladder, and together make up the degrees of citizen power. Citizen control occurs when power is delegated to local policy makers, who then have the authority to engage in operational activities. At the delegated power rung, individuals will have control and decision making power over resources. Partnership is established when individuals, in this case citizens, are full members of policy boards and are active participants in decision making.

It was possible for Arnstein's (1972) model to be used as a guide for the action research group. It is suggested that at the time of the study patient participation was non-existent. Some consultation occurred but findings were not implemented accordingly. In other words, the nurses on Kauri Ward practiced at a non-participatory level. In the event of the study it was anticipated that practice would move up the ladder and reach the last three rungs (the degrees of citizen power). Suggested forums where (ex)-patients could participate were multidisciplinary team meetings, quality meetings and possibly, in the future, the management team. Factors that could influence the transition from non-participation to participative care are described below.

5.2.1: Factors influencing participative care

Consumerism forms the central tenet of a new nursing paradigm and stands in sharp contrast to the bio-medical model (Salvage, 1992). From the literature it becomes evident that nurses generally support the concept of participation but that there appears to be incongruence between espoused theories and theories-in-use.

Studies investigating nurses' willingness to engage in participative care found several factors that contribute to their difficulties in doing so (Baynton-Lees, 1992; Saunders, 1995). To begin with, patients are still viewed as passive recipients of care with little or no control over that care. This is reflected in nurse-patient interactions, as demonstrated by Gibb (1990). The author analysed conversations between nurses and patients and found that nurses exercise control over both physical and verbal activities of their patients. Hewison's (1995) work mirrors this finding. The power differential within the nurse-patient relationship creates a barrier to a reciprocal relationship and participation in care. Eisenthal, Koopman and Lazare (1993) suggest that nurses are reluctant to involve patients, and resign control or power to them, because they do not trust the judgement of the patient. A possible explanation for these attitudes is the impact of the bio-medical model, which strongly dominated health care for over 50 years and retains an influence today. The model advocates a reductionist view of healthcare (Ehrenreich, 1978), and within it the relationship between health professionals and patients is paternalistic, directive (Veatch, 1981).

Additionally, nurses are yet to develop an understanding of participative care and its use in practice. Wright (1995) points out that nurses traditionally, like other health professionals, have been responsible for the planning rather than the facilitation of care, and that therefore a knowledge deficit exists within the profession as a whole. This is affirmed by Leutz, Sciegaj, and Capitman (1997), who conducted a nation wide survey in the United States of programmes providing aged care. The findings indicated that case managers participating in the study received little education and did not have systems in place to promote client/patient autonomy. This lack of education and consequent understanding of expected roles may lead to role conflict and role confusion (Clayton, 1988). It is important, therefore, to accurately determine what patient participation entails and what the expectations are of both the health professionals and the patients.

Jewel (1994) acknowledges that certain patients (for example, those with cognitive impairment or experiencing acute illness) may lack the ability to participate in decision making and implementing the resulting care. However, the author also points out that the misconception that older people have neither the ability nor the desire to participate in care is still present amongst some health professionals. This may be related to the common, but erroneous, belief that ageing is always accompanied by cognitive decline (Gibb, 1990). These misconceptions foster dependency and may force the older person into a submissive role, in which they are made vulnerable and seen as incapacitated. Consequently, the older person becomes, without choice, the passive receiver of care. In fact, psychological theories of ageing and current research indicate that older people are capable of adjusting and should be provided with the opportunity to engage in participative care (Gibb, 1990).

It must be noted that the assumption that the majority of patients are eager to participate is challenged by Biley (1992). The author asserts that some patients prefer the submissive passive (recipient of care) relationship, in which decisions are left to the nurse. Others suggest that expecting patients to participate can be stressful for the patient, with those accustomed to traditional care delivery having difficulties adjusting to a more participatory role (Waterworth & Lucker, 1990). However, true patient participation would ensure that individual preferences and abilities are respected, and cultural differences taken into account.

Other obstacles to participative care include bureaucratic organisational structures and a lack of available resources. Like many other human service agencies, the health care organisation that ran Tui Hospital embraced the bureaucratic (mechanistic) organisational structure (Wess & Page, 1995). Such institutions are characterised by a hierarchical organisational structure, in which sub-units are controlled by a decentralised style of management that employs impersonal control mechanisms, such as rules, policies, procedures and regulations, to maintain uniformity (Burnes, 1996). These organisations are suited to functioning efficiently in static situations that are routine and predictable (Aston Group, 1996, as cited in

Burnes, 1996). Their lack of flexibility makes them unsuited to managing rapid and unexpected change.

Working in such an institution may have an influence on feelings of frustration, powerlessness and helplessness for both health professionals and patients (Wess & Page, 1995). Health professionals may find that policies, procedures and job descriptions are not conducive to participative models of care delivery (Burnes, 1996). Changes in practice resulting from this study, for example, could be blocked by organisational policies and procedures that have created an environment not accommodating change.

The level of commitment of senior management to consumer involvement and consequent shared decision-making will have an impact on an organisation. Role modelling by senior or experienced staff, and modification of relevant policies and procedures, will assist in bringing about a culture change (Burnes, 1996). Participation proper will create a challenge not only for health care providers but also for consumers, as it requires a major change in roles. Examples of participation are present in the literature, and some of these are outlined below.

5.2.2: Examples from practice

The Comex Valley Nursing Centre delivers their services to the community based on the principles of collaboration, as described by Clark and Mass (1998)[16]. The nursing centre was developed in close consultation with the community. Consequently, a reciprocal relationship with the patients was developed, in which planning and decision-making were seen as a shared responsibility.

In their paper, Seltzer *et al.* (1992) describe a successful case management program where family members were trained to share in case management with social workers. Noack (1995) describes, together with a consumer, the partnership that exists between nurses and health care consumers in Broadmoor Hospital. The clinical nursing units in Burwood and Oxford, described by Pearson (1983), also demonstrate a reciprocal relationship between nurses and patients.

The success of client or patient participation, as presented in the literature, is largely related to the way information is conveyed to the participants. This was demonstrated by an analysis of consumer participation in the planning of acute and community health services, conducted by O'Neill (1992). Although some organisations did provide consumers with a seat on their executive boards, the consumers had not been able to make an impact. According to the author this may be related to the generally small number of consumers on the board and the way that information was conveyed, that is, the inappropriate use of professional jargon.

It appears that information is the key ingredient if involvement, collaboration, participation, or partnership is to occur. Without appropriate information the consumer is not able to be involved in decision making. It is up to the health

---

[16] This article was added to the review after the study days as it was found to be relevant by the action research group members.

professional to volunteer the information that will benefit patients and their families/significant others, in order for meaningful interaction to occur. In fact, the majority of information provided by health professionals is difficult to understand for the majority of the population (Campbell, 1995). Participant feedback in other studies indicates that information must be clear, concise and in language understandable for the patient (Frey-Hoogwerf, 1996). Only then are patients able to obtain, process and evaluate the information in a way that enables them to make informed decisions.

5.2.3: Benefits of patient participation

With the increasing focus on evidence-based health care and evidence-based practice it is not surprising that health professionals are increasingly asked to provide evidence in support of a particular health care practice. It has been widely recognised that patient participation is advantageous for patients, clinicians, and organisations. Muir-Gray (1997) points out that participation in decision-making increases patient satisfaction. The author cites the ‘friendly dentist’ trial. In the treatment group patients were involved in decision making, as opposed to those in the control group, who were not. The outcome suggests that the so-called ‘friendly’ dentists obtained better outcomes. This finding was mirrored by a large survey conducted amongst 7730 patients from practices of 300 physicians (Borowsky & Kravitz, 1995, as cited in Muir-Gray, 1997). Patients appreciated the longer participative consultations, which led to increased patient satisfaction. Participative consultations were regarded as cost effective in the long term.

Haddock (1994) and Naylor *et al.* (1994) describe findings that suggest that patient involvement in discharge planning increased patient satisfaction, while length of stay and re-admission rates decreased. Studies examining the effects of education programmes report positive outcomes, such as enhanced knowledge (Brown, 1988). Folden’s (1993) quasi-experimental study suggests that education had a positive effect on older people’s ability to make decisions regarding their self-care goals. Gerdner, Richards-Hall and Buckwalter (1996) utilised a stress threshold model in dementia care, which encourages ongoing information and education for family and patients, and this proved to be positive. The authors developed an in-home family caregiver training protocol, which is in the process of evaluation in a four year controlled trial. According to the authors, anecdotal evidence so far from caregivers suggests a positive outcome. Harvath *et al.* (1994) cite several cases demonstrating how nurse specialists and caregivers working closely together, valuing each other’s knowledge and experience, has led to increased confidence of caregivers in their own ability. Consequently, the caregivers were able to manage care giving more effectively[17].

Seltzer *et al.* (1987, 1992) found that caregiver training in case management resulted in appropriate utilisation of support services that suited the needs of both patient and caregiver. Moreover, there was no increase in the level of subjective or objective caregiver burden. The programme was perceived as cost effective and at the same time empowering, and it was perceived to have improved the quality of life of the caregivers. This finding was supported by Macias, Kinney, Farley, Jackson and Vos

---

[17] This study did not address the issue of caregiver burden.

(1994). They obtained feedback from patients, family members, and health professionals one-year post-implementation of a team case management model, in which they worked closely with patients and family members. The experimental group reported an increased quality of life due to improved mental health, as they felt less burdened. This is an important factor for successful client outcomes. Richmond *et al.* (1995) observed that caregivers and voluntary agencies complain that they are frequently not consulted. As a consequence they are ill prepared for caring for the older person concerned. In combination with poor communication and poorly resourced services, this results in increased numbers of unplanned re-admissions to inpatient settings.

Education or access to information is often associated with increased compliance with therapy or medication. However, Tettersell (1993) found that this is not always the case and points out that compliance is a multidimensional concept. It appears that education, in combination with involvement in care and decision-making, results in concordance[18] and positive outcomes. Payton, Ozer and Nelson (1990) assert that patients are prepared to follow guidelines if treatment is directed to alleviate signs and symptoms that are of concern to them. Furthermore, if discharge goals are set jointly, patients are more likely to continue with the program post-discharge. Because they were involved in the goal-setting and agreed upon the goals they were more likely to follow the program through. If, for some reason, patients fail to continue the program, they are aware that they may jeopardise their health.

Some critics argue that participation is a cost cutting measure (Brearly, 1990; Wilson, 1987), advantageous only to the organisation. However, Seltzer *et al.* (1987) demonstrated in their study that they were able to develop a programme, in response to cost cutting measures introduced by funding authorities, that was not only cost effective but also empowered the caregivers. Empowerment occurred because health professionals were acting in what Wright (1995) describes as the role of non-directive facilitators, supporting the patients' choices. Patient participation in this context served the emancipatory interest of the patient as well as the technical (financial) interests of the organisation.

To call upon the patient to change the socio-political forces that shape health care settings may be viewed as a diversion of responsibility. Health professionals, patient interest groups, and patients could share this responsibility together.

5.2.4: Patient participation in relation to the present study

It is suggested that patient participation can be described as a generic term covering a number of understandings and concepts resulting in various descriptions and definitions. The resulting interpretation of participative care influences the relationship between nurse and patient.

---

[18] It is interesting to compare the two words compliance and concordance. Compliance is described as the act of complying: obedience to a request or command, and it has a power connotation (*Concise Oxford Dictionary*, 1991). Concordance is defined simply as agreement indicating an arrangement between individuals. The latter fits in with the concept of empowerment important to this study.

Through participative care the patients' individual needs are appropriately addressed. An older patient with a chronic disease brings years of lived experience to the team: speaking with Fals-Borda and Rahman's (1991) words, common sense knowledge to the health care setting. On the other hand health professionals bring clinical experience and general discipline specific knowledge to the relationship. The developmental dialogue (sharing of and valuing each other's knowledge) could potentially lead to a relationship in which joint learning, planning and decision-making can occur. Such a relationship between health professional and patient can be viewed as mutually beneficial. Empowerment strategies can remove the feeling of powerlessness and turn it into a feeling of power and hopefulness (Wess & Page, 1995). Empowerment can also be beneficial to the organisation in terms of reduced absenteeism (Swift & Levin, 1987, as cited in Wess & Page, 1995), higher job satisfaction (Rodriquez, 1988), and improvement of staff attitudes to patients (Cherniss, 1980). The transition towards participative care requires time, investment and commitment from all involved. The combination of strategies used in this research project may facilitate a step in the direction of an empowered health care agency.

5.3: Goal-setting theory

Goal-Setting Theory as originated by Locke (1968, as cited in Locke & Latham, 1990), states that goals are immediate regulators of human behaviour, and is classified as a motivational theory. Evidence drawn from over 400 studies in organisational settings has shown that goal-setting has a positive effect on individual (Locke & Latham, 1990), as well as group, motivation and performance (O'Leary-Kelly, Martocchio & Frink, 1994).

Locke and Latham (1990) view a goal as an intention to behave. Goal-Setting Theory is concerned with conscious goal directed actions and assumes that human action is directed by conscious goals and intentions. Locke (1969, as cited in Locke & Latham, 1990) acknowledges that some human actions are taken subconsciously.

Locke and Latham (1990) point out that once a conscious goal is identified it is not constantly present in the individual's mind. For example, a patient's ultimate goal in a rehabilitation program might be to return home. Yet the patient's immediate focus will be on the sub-goals, even though the ultimate goal can be called into awareness at any time. In fact, according to the authors, an exclusive focus on the end goal can have a negative effect on the person's performance. It can distract the individual from taking actions, in particular those actions that involve new learning, to attain it. Generally, once an end goal is accepted and understood it remains in the background of consciousness and serves as a reference point only. It provides guidance and will give meaning to the mental and physical actions that lead to the attainment of the sub goals, which in turn contribute to achieving the final goal. Locke (1968, as cited in Locke & Latham, 1990) also points out, however, that under certain circumstances conscious goal directed actions do not facilitate a positive outcome. This may be related to insufficient knowledge, illness, change in circumstances, or other external factors.

Several components constitute Goal-Setting Theory. At the first level Goal-Setting Theory addresses the relationship between goals and action (task performance), and the cognitive factors influencing this relationship (in particular feedback and expectancy/self efficacy). At the second level it deals with the factors that affect goal choice and commitment to the goal. In addition, Goal-Setting Theory suggests that for people to be motivated, goals must be clear, specific, attainable but challenging, and (preferably) quantifiable.

Goal specificity refers to clarity, or the degree to which a goal is precisely formulated and understood. It encourages the breaking down of large and extremely complex tasks into a series of smaller, more manageable ones. Setting a specific goal is claimed to be more effective in terms of motivating performance. Moreover, clear and specific goals establish a minimum acceptable performance level. In other words clear and specific goals enhance performance. Ambiguous or vague goals, such as ‘do your best’, do not provide a clear indication of the performance level required, and are often perceived to indicate that a whole range of performance levels (including those that are sub-standard) are acceptable.

Goal difficulty is regarded as a critical issue. Research findings show a relationship between goal difficulty and performance. Difficult goals, if accepted by the individual, lead to greater effort and persistence. It must be noted that this only occurs when the goal does not exceed the person’s ability. Studies have shown that the ‘goal difficulty effect’ function levels off when the participants in the study reach the limits of their perceived ability (see ‘self-efficacy’ below) This is of importance for rehabilitation, specifically when a person is said to have plateaued.

Goal complexity refers to task complexity, or the number of sub-processes involved on the way to goal attainment. Research has shown that the effectiveness of the previous two categories may depend on the complexity of the task. Wood, Mento and Locke (1987) reviewed 125 studies and found that specific and difficult goals led to a higher performance in relatively simple tasks than in complex ones.

Goal conflict occurs when several goals are set and achieving one goal interferes with the successful performance of another. This influences motivation and eventually performance. The potential for goal conflict to occur in the rehabilitation setting is present when goals are set independently by each discipline. Effective communication between multidisciplinary team members and the patient is necessary to prevent this.

Goal strength (or intensity) refers to the amount of effort an individual is willing to put into achieving a goal. This is established early in the process, at the stage where goals are established and planned, and co-determines the degree of commitment to that goal.

One of the *social factors* impacting on goal commitment is the degree to which the goal-setting procedure is public. A publicly set goal typically leads to greater commitment than a privately set one (Hollenbeck, Williams, & Klein, 1988, as cited in Locke & Latham, 1990). Consequently, when a goal is set jointly in a goal-setting meeting in the rehabilitation setting, both the patient and the multidisciplinary team are more likely to be committed to the goal, thereby increasing the chances of goal attainment. Commitment is also strengthened via peer influences. In the rehabilitation context peer support groups, such as The Stroke Foundation, or introduction to a stroke survivor as a role-model, may validate the goal for the patient.

Goals can be set in three different ways: self-set, assigned and participative. The way in which goals are set appears to have little influence on commitment to the goals. The majority of studies have focussed on the effects of assigned goals. Assigned goals provide the person with normative information in that they specify the level of performance an individual is expected to achieve. They can improve performance because they positively affect a person's beliefs about how well s/he can perform an action (self-efficacy) (Bandura, 1982). Consequently, self-efficacy plays a major role in Goal-Setting Theory. Modelling, persuasion, physiological feedback and the individual's cognitive processing of all of these, influences self-efficacy. The effects of role-modelling are well documented (Earley & Kanfer, 1985; Payne, 1993; Rakestraw & Weiss, 1981). It is evident that after observing a high performing role-model, individuals set higher personal goals compared to those who have observed a low performing role-model. The former condition led to higher commitment (perhaps via increased competition), ultimately resulting in higher performance. It is suggested that modelling is also important in the rehabilitation context. The literature regarding patient support groups reports supporting findings (Frey-Hoogwerf, 1996).

People tend to take action after evaluating whether their behaviour is likely to lead to a certain desirable result (outcome expectation), and when they are reasonably sure that they have the ability to engage in such behaviour (self-efficacy). In this manner, a person entering a rehabilitation programme will evaluate if the pain and frustration of participating in the programme is worth the effort. In other words, self-efficacy encompasses a complete assessment and consequent judgement of performance capability (past and present), and consideration of all relevant information (capacity to coordinate skills, find solutions, cope with stress). Such assessment may be attainable for patients who have lived with their disability or chronic disease for some time and have reached a certain level of acceptance. It is, however, important to keep in mind that those who have just been diagnosed with a chronic disease, or suffered a stroke, may not be able to judge from experience and complete the necessary assessments. More than others, they rely on the information they can gather from sources such as health professionals, support groups, libraries, and the internet.

Locke and Latham (1990) point out that the terms goal acceptance and goal commitment are often used interchangeably. In an earlier paper Locke (1968b, as cited in Locke & Latham, 1990) refers to acceptance as the initial agreement with a goal, whereas commitment is related to the person's level of reluctance to change the goal at a later stage. However, Locke and Latham now view commitment in a slightly different light: commitment encompasses the person's determination to attain a goal, whereas acceptance indicates the level of commitment one feels to an assigned goal.

Goal commitment depends on the information given to the individual and, in the case of assigned goals, on whether the person assigning the goals is in a position of authority or a perceived expert. Mento and Locke (1989) and Salinck (1977) suggest that having an authority figure or an expert assign the goal may positively affect self-efficacy or confidence, because it is implied that the recipient is thought to be capable of attaining the goal.

Self-set goals are thought to provide the individual with choice and control, which might be expected to positively influence performance. However, empirical evidence suggests that self-set goals are no more efficient in this respect than any other form of goal-setting (Locke & Latham, 1990). Bandura (1986) points out that setting one's own goals may be quite stressful in the absence of self-efficacy, as it involves confronting a situation that may seem too difficult to deal with overall. On the other hand, participation enables the individual to discuss the issues related to the goal and assists in the clarification of expectations. Wagner and Gooding (1987) argue that this process provides the individual with a better understanding of the task, which in turn may positively affect performance. Locke and Schweiger (1979) and Tjosvold (1989) would agree, having suggested that participative goal-setting and decision making might affect performance cognitively.

In combination, the reviewed evidence suggests that the cognitive benefits of participation are greater than its motivational effects. For this and other reasons (empowerment and concordance with therapy), health professionals should seek to encourage patient participation in their care. The process of participation in the goal-setting process may itself lead to the development of realistic goals, as patients recognise their inability to achieve unrealistic goals (Young & Chesson, 1997) in their own time. To diminish hope at an early stage in the rehabilitation process may lead to depression, apathy and failure to respond to treatment (Hohman, 1975). The feeling of being in control has an influence on the individual's well being (Schulz, 1975; Thompson, 1981), as it has been shown to assist in adjusting to living with a chronic illness (Bandura, 1977; Thompson, 1981). In addition, Herbert and Powel (1989) demonstrated that people who were optimistic and had positive expectations made better progress than those who had low expectations.

Feedback, or knowledge of results, has long been thought to be important in goal attainment (Locke & Latham, 1990). However, meta-analyses (Mento, Cartledge & Locke, 1980; Tubbs, 1986, as cited in Locke & Latham, 1990) have failed to show consistent evidence for the interdependence of goals and feedback. The exact relationship between the two is complex and feedback does not always improve performance. Feedback seems to have a positive influence on performance when it results in a cognitive appraisal of progress and coincides with a value appraisal in the form of a relevant response (Locke, 1979, as cited in Locke & Latham, 1990).

Other evidence indicates that Goal-Setting Theory is also directly applicable to groups/teams. Recent reviews - both quantitative (O'Leary-Kelly *et al.*, 1994), and qualitative (Locke & Latham, 1990) - have shown that Goal-Setting Theory can be successful in both motivating groups and increasing their effectiveness and productivity. Group goals in addition to individual goals led to higher commitment to the individual (sub)goals (Matsui, Kakuyama & Onglatco, 1987).

5.3.1: Goal-setting in the health care setting

The demonstrated beneficial motivational effects of goal-setting, and the known importance of motivation in areas such as rehabilitation, provided the impetus to apply the principles of Goal-Setting Theory within the clinical setting. The value of goal-setting as a therapeutic strategy was recognised by Glaser (1965, as cited in Godfrey & Smith, 1996). The Goal Attainment Scale, developed by Kiresuk and Sherman (1968), was the first instrument that provided health professionals and families/patients with guidance when engaging in the goal-setting process. These authors suggest that goals are intended to reflect the patient's concerns.

Within the Goal Attainment Scale five possible outcome levels are determined for each goal. The expected outcome provides a behavioural description of the patient's most desired status after completion of the treatment. Accordingly, the goal attainment score provides an indication of the patient's relative success in achieving his/her individually set goals. The Goal Attainment Scale has been found effective for both individualisation of goals and the quantification of summary outcomes for the participants in the programs (Smith, 1981). It has been utilised in a variety of contexts with a range of small patient populations, such as family therapy (Houts & Scott, 1976; Woodward, Santa-Barbara, Levin & Levin, 1978), mental health rehabilitation (Willer & Miller, 1976), physical rehabilitation (Clark & Caudrey, 1983), traumatic brain injuries (Godfrey & Smith, 1996; Prigatano, 1986), counselling (Egan, 1994), psychiatric nursing (Stanley, 1984), and residential care settings (Blair, 1995).

A similar scale, The Canadian Occupational Performance Measure, was developed by Law, Baptiste, McColl, Polatajko and Polock (1991), and is described by the authors as fostering a client centred approach. In the Canadian Occupational Performance Measure scale goals are generated from problems identified by the patient and therapist. Subsequently, the problems are weighted, that is, the patient is asked which problem is the most pressing. Following this the patient is asked to score how well s/he thinks s/he is performing the activity at present, and how well s/he would like to perform the activity in the future. The re-assessment is conducted using the same process.

Payton *et al.* (1990) also developed a goal-setting procedure. The process adopted by these authors is similar to the Canadian Occupational Performance Measure, with the omission of the performance score. Instead, the level of patient involvement is recorded as part of the goal-setting process and reflects the value the authors' place on patient participation. This score provides an indication of the patient's capability and readiness to participate. Neither the Canadian Occupational Performance Measure nor Payton *et al.*'s (1990) work have been utilised as extensively as the Goal Attainment Scale.

King (1981) views nursing as "a process of action, reaction, and interaction whereby nurse and client share information about their perceptions in the nursing situation" (p.2). The emphasis is on shared problem identification and planning of interventions to meet the goal. She points out that communication between the various disciplines is necessary to identify the discipline specific goals and those that are overlapping.

King (1981) advocates the utilisation of the Goal Oriented Nursing Record as an extension to the Problem Orientated Medical Record, developed by Weed (1969, as cited in King, 1981), as a single patient record. Responses to interventions are then recorded in the progress notes.

The Goal Oriented Nursing Record consists of five components: a database, problem list, goal list, a plan, and progress notes (King, 1981). It provides a record of the goals, and the means and process used to achieve them, allowing an insight into the processes and outcomes of nursing situations. There are several nursing studies that demonstrate the effectiveness of King's approach to goal-setting in nursing practice. Her goal attainment theory has been utilised in several settings including curriculum development, teaching and clinical practice. Its effectiveness in terms of its therapeutic value has been demonstrated in a number of case studies. For example King (1983) applied her theory with an elderly patient who suffered a CVA, and a patient in the end stage of renal disease (King, 1984). Husband (1988) utilised goal-setting with a patient group suffering from diabetes, and Blair (1995) showed that mutual goal-setting improved self-care behaviours among residents in a nursing home. Woods (1994) also used goal-setting with a group of older women in a nursing home, which resulted in several behavioural changes.

What becomes apparent from the work of Kiresuk and Sherman (1968), King (1981) Law *et al.* (1991) and Payton *et al.* (1990), is that they all support and encourage patient participation in decision making, as well as the patient's right to accept or reject health care. Given that all three approaches emphasise the importance of patient participation in care in the form of goal-setting, it is surprising that none of the authors refer to formal Goal-Setting Theory (Locke, 1960, as cited in Locke & Latham, 1990), or to the motivational effects of goal-setting on performance. In this way they fail to acknowledge the complexity of the goal-setting process, and the way in which it is influenced by factors such as commitment, goal specificity, self-efficacy, and feedback (Locke & Latham, 1990).

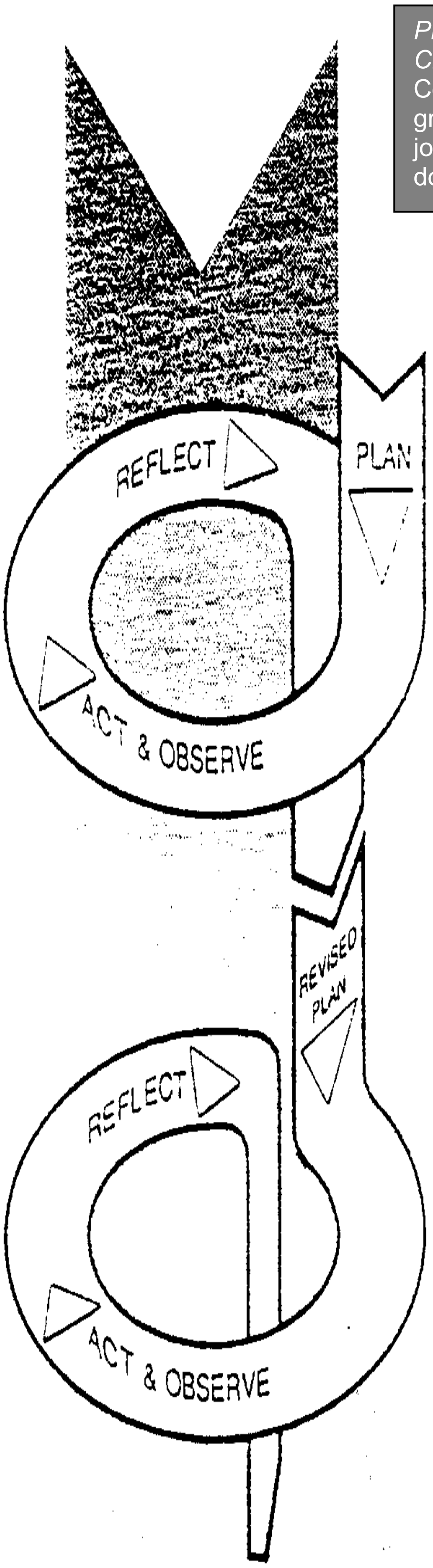
5.3.2: Choosing a goal-setting framework for use on Kauri Ward

Payton *et al.* (1990) describe the goal-setting process in detail and therefore provide an easy-to-follow guide for the beginning practitioner. King (1981) does not provide much detail regarding the steps involved in the goal-setting process. However, the Goal Oriented Nursing Record illuminates the process and outcomes in nursing situations, because the goals, means to attain them, and process used to achieve them are documented (King, 1981). Achieved goals can be seen as an outcome and measure of effectiveness. Documentation of the means and processes involved provides the opportunity for practice evaluation and exposes the contribution of each of the disciplines involved in care delivery. It must be noted that although this integrates nursing and medicine's documentation it excludes the allied health professionals. After some debate it was decided to begin by using King's (1981) Goal Oriented Nursing Record and Payton *et al.*'s (1990) work as a base, and make adjustments to suit the needs of the ward. Payton et al's work was also chosen because their documentation was developed from an allied health perspective.

5.4: Summary

The material presented above began by clarifying the meaning of the concepts of involvement, collaboration, participation and partnership. Arnstein’s model was useful in describing the depth and level of involvement in the relationship between health professional and patient. It was suggested that it could also provide guidance in the development of strategies, policies and procedures that facilitate a consumer focused health care organisation. The present lack of organisational commitment to consumer driven health care was briefly discussed and the influence of the bio-medical model on nursing practice was identified. The advantages of an increase in patient participation for patients, health professionals, and organisations were discussed and some concerns were raised. The literature also suggests that participative care may result in benefits such as increased patient satisfaction, quality of life and empowerment. The literature on goal-setting suggests that the setting of specific, difficult to attain, non-conflicting goals leads to increased motivation. Goals can be assigned, participatory, or self set, and there is no evidence to suggest that any one way is superior with respect to motivation and performance. However, participative goal-setting appears to have an influence on cognitive processes and is thus thought to result in better strategies for goal attainment. Other influences on goal attainment, such as commitment, self-efficacy, feedback and social influences have also been discussed. In conclusion, it appeared that goal-setting could be an appropriate vehicle with which to approach patient participation in care. The use of goal-setting within a multidisciplinary team context could contribute to team synergy and assist in the development of trust and respect for each others’ competence. Finally, goal-setting is a step in the direction of an outcomes focused rehabilitation programme that incorporates the views of both patients and health professionals. The material presented above, in combination with the literature in relation to action research presented in chapter two, was discussed in the study days and the first action research meeting.

6: Phase 1: Stage 1: Understanding current practice: health professional reconnaissance



Pre-reconnaissance: Creating a research culture.
Commencement of several groups: the journaling, journal, nursing focus and documentation groups.

Chapter 6

Phase I: Stage I: Health professional reconnaissance.
Group discussions and one-to-one guided interviews aimed at developing an understanding of:

- Current ward practice
- Research expectations
- Practice concerns
- Nurses' understanding of gerontological rehabilitation
- The role of the nurse
- Nurse-patient relationship

Chapter 7

Phase I: Stage II: Responding to concerns raised in stage I.
Addressing concerns (change resulting from action plans).

Chapter 8

Phase I: stage III: Patient reconnaissance.

- One-to-one guided interviews with patients aimed at developing an understanding of patients' perception of the ward.
- Development of action plans in response to the interviews.

Chapter 9

Phase II: Introduction of multidisciplinary goal-setting.

Chapter 10

Conclusion

6.1: Introduction

This chapter presents stage I, understanding current practice: health professional reconnaissance. The first section describes the study days in which the nurses were given information about the action research study to enable them to make an informed decision regarding active participation in the study. During the study days the nurses shared their concerns regarding the current nursing care delivery system and the preceptorship model. They also discussed their expectations and concerns regarding participation in an action research study. The next section describes the outcome of the one-to-one guided interviews. These provided a valuable insight into the nurses' perceptions of gerontological rehabilitation nursing, the nursing role, the nurse-patient relationship, the communication processes within the unit, workload, and ward environment. The subsequent section discusses actions and questions arising from information provided by the nurses so far. The final section presents some decision points for the next stage of the health professionals' reconnaissance. Data collection tools included group discussions, note taking during meetings, one-to-one interviews, and also a documentation audit conducted by the hospital.

6.2: The development of an understanding of action research on the ward

Three study days were organised for each member of the nursing staff, (n=26), to provide them with the necessary information[19] to enable informed decision-making regarding participation in the study. As can be seen from the content of the study days (Appendix 4B) the intent was to a) inform the potential participants about action research and their role within it, b) discuss their expectations and beliefs about reflective practice and participative care, and c) practice interview skills. I facilitated the study days which were interactive and mono-disciplinary (nursing only). The nursing staff was divided into three groups (two of nine and one of eight), and all were able to attend the study days. Permission was granted to audiotape the discussion sessions that occurred, and to use these tapes as a data source.

The morning sessions of the first study day, for each of the three groups, were not as interactive as planned. The nurses listened and asked clarifying questions, but it wasn't until the last session of the day, entitled 'The current care delivery model', that they voiced any concerns. These were regarding the current nursing care delivery system and preceptorship[20], and the discussion occurred because they were asked to describe their current practice.

The second study day involved a session on journal writing and reflective practice. During the sessions two members of the reflective practice group[21] shared their experiences with the participants of the study days (all three groups). The study day participants then discussed their expectations of the research and reflective practice. The topic for the final session of the day was goal-setting, using the work of Payton *et al.* (1990).

---

[19] See also the consent forms (Appendix 4C)

[20] This occurred in two of the three groups.

[21] See prior description of this group in section 2.3 (pp.17-19)

On the third day, during the interview practice session, the nurses again shared their thoughts with each other. They were asked to work in pairs, taking turns in being the interviewer and interviewee. During the interviews they discussed their expectations of the study, voiced concerns, and mentioned the communication processes on the ward.

6.2.1: Outcome of the study days

The tapes of the study day discussions were transcribed verbatim by a secretary, and I carried out the analysis utilising NUD.IST 4. (An example of a text-search and corresponding nodes is presented in Appendix 6A.) The analysis involved extracting any commonalties of meaning attached by the nurses to events, experiences or situations they had encountered while practicing on the ward. These meanings were then condensed into themes and entered into the register under the headings of language and discourse, practice, and social structures, as suggested by Kemmis and McTaggart (1988). The emerging themes were discussed with nurses during two ward meetings. From the analysis it became clear that the nursing care delivery system (primary nursing) in Kauri ward was important to the nursing staff. This was evident in how they responded to the question: *Could you describe the current nursing care delivery system to me?* It appeared so important to them that they kept returning to discussing it. The major concern for the senior nurses was their feeling that the movement toward and enthusiasm for primary nursing had lost momentum.

The issue was further explored by asking the question: *Why do you think it has lost its momentum?* According to the senior nurses this was related to several issues, beginning with the opening of two new acute gerontology wards. They felt that the subsequent redeployment of experienced staff had left a vacuum on Kauri ward. Six new graduates (level I nurses) were then employed, which highlighted another problem: the lack of adequate role modelling for Level I and II nurses (see section 1.2, p. 9). Due to the shortage of senior nurses as role-models and to provide clinical guidance, the beliefs and values held by previous staff members, and the few remaining senior nurses, were not necessarily becoming incorporated into the junior nurses' practice. They in turn, due to a lack of awareness, were not able to transfer the beliefs and values intended to underpin nursing practice in the ward to subsequent new staff members. The importance of primary nursing within the ward culture was therefore lost.

The following quote is representative of the general perception of both the senior and junior nurses in Kauri Ward.

> We have lost the tradition of primary nursing now. Maybe if we had [senior nurse] preceptors for a new graduate, if they had been with a senior you get a snowball effect (GD, G1, p 9)[22].

This extract also highlights another factor identified by the nurses as problematic: the hospital's policy on preceptorship. Hospital management assumed that junior nurses

---

[22] Entries from the transcript notes are coded as follows. 'GD G' (group discussion, group number), T (one-to-one guided interview), tu (text unit), ARGM (action research group meeting), Journal (journal entries of the research group participants), followed by a number, where relevant, corresponding to that interview or excerpt's numerical identifier in the data record.

were more suitable as preceptors to new graduates than senior nurses, because they were seen to have greater empathy with the needs of new graduates. The junior nurses clearly disagreed, demonstrated by the following comment.

> The way she [a senior nurse] assessed on a minute-to-minute basis. She would pick up things that pass me by and that was because she was experienced. I knew the basic techniques of doing a dressing and the basic stages of wound healing. What I did not know was how to bring it all together and that is what an experienced nurse can show you. I found working with a senior nurse valuable (GD, G1, p 6).

It was felt by all involved in the study days that it would be beneficial to the new graduates and junior nurses to have senior nurses as preceptors. The junior nurses felt that if senior nurses had this role, new staff members would be more effectively socialised into the existing culture. The new graduates found working under the guidance of the senior nurses more beneficial for the development of their competencies.

The question: *How do you feel about an action research project on the ward?* revealed that the majority of the nurses were positive towards the action research study. The following excerpt is representative of the general feeling

> I did a research paper. We did discuss action research. It is so exciting to actually be involved (GD, G2, p 7).

Five of the 26 nurses had concerns regarding the reflective component of the project. They mentioned, in particular, that problematising practice and consequent reflection could be daunting.

> A lot of my practice is, quite frankly, automatic and I have been doing nursing for so long that a lot of what I do, I do without thinking. Like I do like when I am driving, changing gear or how fast I should press the clutch. A lot of what I do is automatic and I do not question it. The thought of questioning it and the possibility of questioning a lot of my practice is scary (GD, G2, p 7).

Eight voiced concerns in relation to the possibility of an increased workload.

> I guess time is my only thing - of when it's all going to happen. How are we going to fit extra things into the busy-ness of the shift? In any case that's - yeah, that's where my concerns would be (GD, G2, tu 32).

Neither intra- nor inter-disciplinary communication processes were optimal on Kauri Ward, and communication was discussed by nearly all the participants during the training interviews. They felt that the inability to provide accurate feedback to each other led to ongoing communication difficulties on the ward, and they had not been able to change this situation.

> We are all good nurses but we are different people and we need to improve that communication. We are not in the habit of discussing things. Maybe a room meeting once a month [to discuss] where we are going, look at things that we could have done better. That is all done on an ad-hoc basis at the moment. That may be a way to improve the communication (GD, G2, p 6).

6.2.2: Discussion

Prior to the group discussions the group was convinced that they were engaged in individualised and participative care, and group members felt that primary nursing facilitated this. Its use as a care delivery model was valued on the ward. During the discussions, however, reflections on actual practice made evident that the nurses' theories-in-use differed from their espoused theories.

An espoused theory common to all the nurses was their preference for individualised care. Some authors do argue that individualised care maximises contact between nurse and patient (Egan, 1994; Frey-Hoogwerf, 1996). It facilitates continuity of care and - if consultation with the patient occurs - care tailored to patients' needs and wants. Although primary nursing is certainly not a panacea, it is suggested that it can be an important stepping-stone to the further development of participative care. It seemed, then, that the nurses on Kauri ward preferred this style of nursing, even if at this stage it was more in principle than in action.

The study day participants put forward some reasons for this discrepancy, and tended to agree that the lack of senior nurse involvement in the preceptorship of new and junior nurses had led to a loss of commitment to the primary nursing ethos. The explanation given by the nurses for the apparent demise of primary nursing on Kauri ward had implications for the action research study. According to the junior nurses, senior nurses were able to provide clinical guidance, effective role modelling, and an overall ward picture. New graduates stated that they found working under the guidance of the senior nurses more beneficial for the development of their competencies, than working most closely with junior nurses, who tended to be more skill and resource orientated. These preferences needed to be taken into account in the development of the action plans. The skills necessary for effective preceptorship would also be valuable during the action cycles.

Given their experience with both preceptorship and primary nursing, nurses had the potential to take the leading role in promoting participative care in rehabilitation within the unit. The possible amalgamation with community services could see a participative model of primary nursing developing into care-ordination. This in turn would enable nurses to cross boundaries and begin to facilitate the development of seamless care. This is not an unrealistic expectation, since nurses are expected to play a central role in rehabilitation (Ramsdell, 1990). However, the discussions that occurred during the study days indicated that there was quite some development needed before that transition could be contemplated.

It was also felt that communication between all health professionals on the ward was, in general, poor. This issue would need addressing, as effective communication is a key aspect of an action research study. This was something that needed to be discussed with the clinical charge nurse manager.

The findings from the study days were reported back to the nurses in the form of a presentation. They were asked to comment. This was important as it reassured me that my findings were representative of the practice reality of the nurses.

6.3: The one-to-one guided interviews

After completion of the study days six of the 26 nurses volunteered to become active action research group members. The majority of nurses (n=17, including the six just mentioned) agreed to be interviewed further, while the remaining nine felt that they had provided sufficient information during the study days.

The one-to-one guided interviews held after the study days were aimed at developing some insights into the nurses' views on gerontological rehabilitation, the role of the nurse in the multidisciplinary team, and the nurse and patient relationship. During the interviews the nurses also mentioned communication processes, environment, and workload. The interviews were conducted with the aid of an interview guide (Appendix 4F). The tapes were transcribed and the analysis carried out, using NUD.IST 4, as outlined previously. Thereafter the emerging themes were discussed with the individual nurses.

6.3.1: Gerontological rehabilitation and the role of the nurse

Fifteen of the seventeen nurses interviewed described gerontological rehabilitation in terms of restoration of function.

> We are, we're supposed to be specialised with stroke people. And we're dealing with their physical disabilities, to [help the patient] get back to the best of their physical abilities, to the best they can, you know - able to cope (T20, tu 130).

The nurses were taken aback when asked to describe their role in gerontological rehabilitation, and found it difficult to do so. The following excerpts demonstrate nurses' descriptions of the various components such as teaching, maintenance, bringing reality, advocacy, and the multiplicity of the nursing role.

Ten nurses regarded the teaching role to be closely related to fostering independence.

> There is the teaching role. You have to make them feel that they can do things for themselves (T10, tu 237).

Seven perceived the facilitation of independence and maintaining physical well-being (for example bathing and feeding) as the maintenance role. This can be seen from the following excerpt.

> There are quite a lot of different roles, and not only that…you have to make sure that they feed and they eat properly. Whether they can feed themselves or not. If not, the nurse has to actually sit down and feed the patient (T2, tu 95).

The comforting component was also seen by four in relation to the maintenance role, whereas ten described it as a stand-alone component.

> Some will even just want to hold your hand. And sometimes you want to do things, but they hold your hand. It is just quite comforting for them (T2, tu 288).

Creating a supportive environment through the provision of hope was also seen as a responsibility.

> Nurses are the ones that give patients hope. They do that through trust. I would say that that's the biggest thing and they do give them [the patients] hope (T14, tu 180).

The supporting and guiding component was perceived to be an element in gerontological rehabilitation nursing, as demonstrated by the following excerpt.

> You are there with or along-side the patient when they are going through something, which might be quite difficult for them. They are going through a change of health and in gerontology, well in rehabilitation nursing, they are going through learning things in a new way (T7, tu 100).

The diverse elements of the coordinator role were mentioned by only four nurses, but its complexity in terms of role variety was described well by one of them.

> I tend to think that the role of the gerontology nurse is not just providing the care. It is almost like the conductor of an orchestra. Because there's so many different roles built into it (T1, tu 60).

Bringing reality to the situation is described as a continuation of therapy in the absence of occupational therapists and physiotherapists. This included activities such as dressing, undressing and mobility.

> When I hear a physiotherapist talking or I hear an occupational therapist talking, I think the role of the nurse is really to bring to that meeting what the reality is of what they're saying. If the person is dressing well for the occupational therapist, then it's my role to get across to those people whether they are actually following that through in the real situation, which is the bedside situation, or when they go to the toilet (T13, tu 230).

All the nurses saw advocacy as one of the more important roles especially outside the unit.

> I think in general for gerontology nursing and rehabilitation nursing, the biggest thing has always been advocacy. Older people have got a weak voice in the community anyhow, but when they actually get sick, they've got an even weaker voice, so that has always been the number one priority. Before even getting people to become independent, or restoring their independence, you know, advocating for them, with the rest of the team and with their families. Those are things that I feel are quite unique to general gerontology nursing - and getting these people back to a normal environment (T8, tu 200).

In addition to the role components, the nurses also identified the following necessary competency to function as a gerontological rehabilitation nurse: an understanding of multiplicity.

> The older adults we get in come in with multiple problems as I said, and a lot of them are a lot sicker and they've got more medical problems so that the focus is on getting them over that crisis, or over that acute phase, so that you can then help them move into the rehabilitation phase (T1, tu 79).

It is interesting, given the recognition of the multiple problems confronting their patients, that none of the nurses mentioned the counselling or the specialist component of the nursing role.

6.3.2: The nurse-patient relationship

The focus of the study was to examine the possibility of involving patients in decision-making regarding their health care. The relationship between health professionals and patients plays the most important role in creating an environment where the patients feel safe to provide feedback and to participate. It was therefore of interest to explore how the nurses viewed their relationship with patients. The nurses found it easier to discuss the nurse-patient relationship than they did the role of the nurse in gerontological rehabilitation. Trust, honesty, friendship and openness were seen as important components in the development of the nurse-patient relationship, which was frequently described in terms of a partnership.

The nurses indicated that they believed trust and openness to be the key components in the development of the nurse-patient relationship, and in the development of partnership between the nurse and the patient.

> I think at times both the patient and yourself need a settling-in period to get to know each other...that's what partnership is all about; it's developing that trust relationship, that rapport (T1, tu 104).
>
> I think it is important to have openness and trust between the patient and the nurse - so that the patient understands [and] trusts you - so that when you say you are going to do something you will do it (T13, tu 55).

According to the nurses, empathy facilitates openness and trust.

> I had to give someone an enema today and I did not really have to stay with her for the full twenty minutes till it was working, but I did, because for her it was really embarrassing. She thought that visitors were going to arrive and that they would want to see her and that there was no one to tell them to go away (T7, tu 72).

Three out of seventeen nurses felt that because of trust and openness developing, a special relationship evolved which could lead to friendship.

> I have another...patient, oh she has left months ago and I still go to visit her every week. I think there has to be something between that particular patient and the nurse. I don't think it's going to happen with every patient (T10, tu 170, 213).

Therapeutic communication was also seen as contributing to the development of the nurse-patient relationship.

> Even silence sometimes. They have the feeling you're just there (T7, tu 91).

6.3.3: Role of the nurse in the multi-disciplinary team

Four nurses expressed feelings of inequality and of not being valued by the multidisciplinary team. Nurses' opinions about the way in which other team members perceived nursing's contribution varied.

> I think they always think that they [allied health] are more important than us [nurses], and that we nurses are only there to have the patient nice and clean and dressed (T10, tu 255).

Four also believed that lack of respect and credibility was associated with the lack of competence of some nurses.

> If you build up your reputation as a nurse, all health professionals respect and then [accept] your opinion, but not if nursing is so much as crawling somewhere in a little corner (T12, tu 476).

Communication between team members and nurses was seen as an issue. The communication difficulties were mentioned in the group discussions and in the one-to-one interviews. The fact that some nurses were not able to express themselves adequately to convey their patients' needs was mentioned several times and was a concern to me, and fourteen of the nurses interviewed. Additionally, nurses were concerned about people's inability or unwillingness to provide feedback to each other.

> I wonder if people were open in giving feedback to other people about things...I [would] consider going to the other person and talking to her. You and I know that this way is better. Like sometimes if you've got friction going on, you actually go to the other person and talk, even though it's really incredibly hard sometimes. If you are not there then communication is not happening (T12, p 4).

Other noteworthy statements made during the interviews referred to the supportive and pleasant ward environment, the senior nurses enjoying working with the new graduates and that they enjoyed exchanging experiences, which created an environment for joint learning. Joint learning became important throughout the study. Moreover, all the nurses on Kauri Ward worked there because they enjoyed working with the older patient.

6.3.4: Discussion of interview data

The interviews revealed that the majority of nurses held a medicalised view of rehabilitation, which became evident from their description of rehabilitation in terms of restoration of function. This was understandable given the location of the unit in the acute setting, with a large input from medicine, where the emphasis was placed on cure. Certainly, medicine fulfils an important role in treatment of primary illness and prevention of secondary illness. The importance of psychosocial factors within chronicity, however, such as illness behaviour, coping strategies, and support networks, was largely neglected within the ward. In this respect, Kauri Ward was not dissimilar to the majority of rehabilitation wards (Nolan, Nolan & Booth, 1997; Renwick, Brown & Nagler, 1996).

According to Nolan *et al.* (1997), despite the call for a holistic approach to rehabilitation, at present the focus remains very much on illness, disability, and restoration of function. They point out that this is appropriate for patients who are expected to have a full recovery, but less appropriate for those who may have permanent disabilities - often the case in the frail elderly (Nolan *et al.,* 1997). Renwick *et al.* (1996) have also criticised this approach and are advocating a shift to a health and wellness model for rehabilitation. This advice has been followed with the development of rehabilitation nursing standards in the United Kingdom (Bell *et al.*, 1994).

This is an important shift, especially since ageing is associated with an increase in prevalence of chronic disease and disabilities, such as stroke, arthritis, cancer, dementia, and osteoporosis (Swift, 1996), and so the need for rehabilitation of the older adult can reasonably be expected to increase. Rehabilitation needs for this group are long lasting and issues such as quality of life, coping mechanisms, and adjustment to chronic disease become more important. Significant changes in health professionals' understandings and attitudes need to occur to shift the focus from a disability to a wellness orientated approach. Such a change would have a significant influence on how rehabilitation is conducted, which would, in turn, influence the nursing role within rehabilitation.

As mentioned before, the nurses had difficulties describing the nursing role, although they were able to describe components of the role. The components they described were education/teaching, maintenance, carry-on, advocacy, and multiplicity. As can be seen from Table 2, these were consistent with those described within the literature (Brillhart & Sills, 1989; Corbin & Straus, 1996; Hoeman, 1996; Nolan *et al.*, 1997; O'Connor, 1993; Waters, 1987).

Nursing roles described in the literature	**Nursing roles described by the participants**
Education/teaching	Teaching
Maintenance	Maintenance
Carry-on	Bringing reality to the situation
Advocacy	Advocacy
Multiplicity	Complexity (meaning multiple pathologies)
Coordinator	
Specialist	

Table 2: Comparison of the nursing roles from the literature to those described by the participants.

O'Connor (1993) conducted a literature review of 312 journal articles, to examine the role of the nurse in stroke rehabilitation. Only seven percent of these articles were based on research. She concluded that the nature of the role remained vague. A similar conclusion was drawn by Nolan *et al.* (1997) who conducted a systematic review of over 3000 articles pertaining to a variety of rehabilitation settings (stroke, myocardial infarction, spinal injuries, arthritis, and multiple sclerosis). Given the findings of both O'Connor (1993) and Nolan *et al.* (1997), it was not surprising that the nurses had difficulties describing their role.

The majority of authors (Brillhart & Sills, 1989; Corbin & Strauss, 1996; Hoeman, 1996; Waters & Luker, 1996) clearly describe the educative component of the nursing role. Brillhart and Sills (1989) and Hoeman (1996) all perceive it to be one of the core competencies of rehabilitation nurses, and suggest that rehabilitation nurses should be able to conduct education from admission to discharge, thereby involving all multidisciplinary team members.

The teaching role was felt by some nurses to be closely related to fostering independence. Waters (1987) describes facilitation of independence, maintaining physical well being, and comfort care as the maintenance role. Andrews (1987) and Baggerly, Belmosto, Drinkwater and Master (1995) suggest that the maintenance role is nursing's major contribution to rehabilitation. According to the nurses in this study, this was also a view held by the majority of the multidisciplinary team members working on Kauri Ward.

Other authors (Brillhart & Sills, 1989; Corbin & Strauss, 1996; Gale & Gaylard, 1996) also mention the comforting element as part of the maintenance role. Although the nurses in this study did not mention comforting in that context, they perceived it as a separate role very much like Nolan *et al.* (1997) describe it. According to Nolan *et al.* comforting consists of creating and maintaining an environment for rehabilitation that "facilitates the identification of the patients' motivation, hopes and aspirations and their active participation in rehabilitation" (p. 90). They describe comforting as a nursing responsibility, and it was recognised as such by the nurses on Kauri Ward. The supporting and guiding component is identified by Hymovich and Hagopian (1992, as cited in Nolan *et al.*, 1997) in relation to paediatric rehabilitation, but is also clearly present in gerontological rehabilitation. It is suggested that providing support and guidance can also be regarded as necessary components for creating and maintaining an environment for rehabilitation.

Only four nurses mentioned the coordinator role. The importance of care co-ordination is, however, well recognised within the literature (Brillhart & Sills, 1989; Corbin & Straus, 1996; Kemp, 1993; Waters, 1987). Beardshaw (1988) and Thorne (1993) argue that this role is often neglected in health care for the older person or those with chronic illness. It became evident from Thorne's (1993) study that patients and their families often found the input from nurses helpful, and Beardshaw (1988) recognised fifteen years ago that nurses could fulfil the role of coordinator. The developments since that time have been positive. Advanced nursing roles such as nurse specialist and nurse consultant are good examples of the development of this aspect of nursing. It was hoped that the primary nurses, in particular the senior nurses, would move towards a care co-ordinator role during the study.

The carry-on role was described as a continuation of therapy in the absence of an occupational or physiotherapist. The nurses described it in terms of 'bringing reality to the situation', and felt that it involved more then simply carrying on with activities when the therapists were not present. The nurses pointed out that the other members of the multidisciplinary team did not observe a patient at the end of the day when they were tired and when, for example, their ability to perform activities of daily living, or to transfer from chair to bed, may have significantly deteriorated. It was up to the nurse to motivate, guide, and support the patient through this often frustrating time. The nurses felt that this was not well understood within the team. Therefore some nurses felt that they also had an advocacy role both within the team and outside the ward as well.

Hoeman (1996) describes patient advocacy as an aspect of gerontological rehabilitation nursing, and the nurses on Kauri Ward saw this as one of their more important roles, especially outside the unit. The advocacy role in terms of education and ward consultations was also an important aspect of the gerontological clinical nurse educator and clinical nurse consultant role.

The roles and activities described by the nurses are congruent with the discourse on the role of the gerontological rehabilitation nursing in the literature. Being able to describe only components of the nursing role in gerontological rehabilitation nursing occurs both nationally and internationally (Nolan *et al.*, 1997). The inability to articulate what constitutes the nursing role as a whole may well be related to the complexity of that role, since a variety of skills and competencies are needed in different situations. In addition, like the nurses in Waters' (1996) study, the nurses in this study did describe the specialist contribution they made to the multidisciplinary team.

In Waters' study the nurses' contributions were often described by other health professionals in terms of wound, skin and continence care. However, as in Waters' study, the nurses themselves did not mention these specialist roles. Waters (1996) feels that this is because nurses frequently lack the interest and knowledge required to assess and manage continence and tissue viability appropriately, and goes so far as to argue that nurses lack the knowledge and skills needed to fulfil their responsibilities within the general rehabilitation context. If this is true, it could be an explanation for the nurses' lack of confidence within the multidisciplinary team, and their perception that they are not valued by other members of that team. Nurses stated that they felt neither respected nor credible during discussions with other members of the multidisciplinary team.

Communication did appear problematic at multidisciplinary team meetings[23]. Unfortunately, prior to commencement of the study, many members of the multidisciplinary team rotated in and out of the area[24]. It was perhaps not surprising, therefore, to find confusion about the nursing role(s) in the multidisciplinary team. It may also have contributed to the nurses' feelings of inequality, because they believed that time and again they had to prove their skills and competence to therapists and house surgeons who were often not familiar with nursing's[25] participation in multidisciplinary team meetings. It has been suggested that for teams to work collaboratively the members need to understand each other's roles (Qualls & Czirr, 1988). Lack of understanding may influence the level of trust and respect for each team member's competence. Moreover, lack of trust will obstruct collaboration between members, and result in the team becoming dysfunctional, which may have a negative influence on the provision of care (Alder, Bryk, Cesta & McEachen, 1995). Ideally, team building should occur to build trust and confidence in each other's skills.

According to the nurses on Kauri Ward, poor communication processes may have contributed to some of the perceived difficulties within the multidisciplinary team. As mentioned before, communication is a key aspect of an action research study. Therefore, the communication processes became an issue for the study and needed to be discussed with the clinical charge nurse manager.

Communication within the unit occurred via Heads of Department Meetings. Each discipline was represented at these meetings. A decision was simply communicated down, without checking how it was received or perceived. Quirke (1996) suggests

---

[23] This was also the case at ward meetings and nurses found it generally problematic to provide feedback to each other.

[24] Physiotherapy and occupational therapy departments rotated their staff on a three monthly basis. Medicine rotated the house surgeons on a three and registrars on a six monthly basis. Dieticians, social workers and speech and language therapists tended to remain allocated longer.

[25] The majority of nurses pointed out that they had never attended a session on the purpose and expected outcomes of multidisciplinary team meetings, so they may not have been clear themselves about what was expected of them.

that if you do not know how your staff perceives your communication then you are not in control of it. This was frequently the case within Kauri Ward where a communication book was used. The entries in this book were often misinterpreted, which led to tension between staff members. It concerned me both as the clinical nurse consultant, and as researcher, that the unit engaged mainly in top down communication. A communication strategy suitable to the study would be two-way, horizontal, and open.

Finally, moving towards a participative model of care also influenced the nurse-patient relationship. The fact that the nurses valued and espoused working in partnership was encouraging. However, their actions were not supporting their espoused theories. As mentioned below, there was no evidence of patient consultation or involvement in care in the nursing or multidisciplinary documentation.

6.3.5: Documentation audit

Independently to and concurrently with the interviews a pre-accreditation documentation audit was conducted hospital wide. This audit showed that documentation was not up to the accreditation standards and there were no entries indicative of patient involvement in care. The audit investigated the level of physical, psychological, and social assessment made by all the disciplines. The ability to translate the assessment into a client centred care plan was also audited.

Consequently, a documentation working party was appointed within the hospital. Aged Care Services was exempted because they indicated that they wanted to develop multidisciplinary documentation during the study.

6.4: Insights Gained

The insights gained during the health professional reconnaissance are described in this section. In some instances possible actions are suggested and in others questions are raised. However, this section does not address the action plans nor does it answer the questions, as both are addressed in subsequent chapters.

It became clear from the literature review, and the health professional reconnaissance, that to create participation proper would require a major organisational culture change throughout the unit. This shift, if it occurred, would be dependent on the willingness of health professionals, the desire and readiness of the patients, and the flexibility of the organisational environment.

The health professional reconnaissance provided insights into the nurses' perceptions of gerontological nursing, the nurse-patient relationship, the nursing role within the multidisciplinary team, and the ward culture. It was interesting to note that some nurses were convinced that they were engaged in participative care, while others realised that the move from directive towards participative care would require a shift in focus. The former group consisted of those nurses who did not participate in the one-to-one interviews and who worked mainly evening duties. They had created their own practice culture and were indifferent to practice innovation. The second group consisted of nurses who were interested in research and practice development. There was, therefore, the potential for a ‘them’ and ‘us’ situation to develop. Grundy and Kemmis (1981) describe this as a distinction between the ‘knowers’ (who incorporate theory into their personal knowledge), and the “doers” (those who unreflectively work with the changes). As they point out, for knowledge to be empowering the non-action research group members must make it their own. If they are able to do so, then knowledge does become empowering. However, if for some reason they choose not to do so, any changes produced may be superficial and unauthentic. Moreover, it may be perceived as if the change was coerced. This would be the complete antithesis of the spirit of this research project.

It became clear that to work closely with the nurses, reflecting with them and carefully exposing their theory-in-use, was required. As the group discussion revealed that all the nurses valued primary nursing and agreed that it needed to be reinstated, it was seen as a good starting point and vehicle with which to facilitate patient involvement. An understanding of what was expected and the development of necessary competencies would be required before any move could be made toward a participatory model of care delivery. It was anticipated that this model would involve the whole multidisciplinary team[26]; therefore prior to any action being taken in relation to participative care, multidisciplinary team functioning needed to be addressed. The issues of leadership and rotation were particularly pertinent.

Within the unit, physicians, including house surgeons, automatically assume the chair function within the multidisciplinary team meetings, regardless of facilitation skills. This is congruent with research that indicates that the leading role is frequently taken by the senior medical member in the team (Thurgood, 1990). The assumed leadership role may be related to the team’s adherence to a tradition in which physicians have employed authority over treatment decisions without consulting other disciplines. This, if combined with an authoritarian leadership style, may disempower other health professionals, as was the case with some of the nurses on Kauri Ward.

Team rotation is problematic because it leads to the disruption of an often well functioning team, and creates the need for the development of a new team – which requires time and commitment. Trust, knowledge, effective communication skills, and the ability to collaborate are all thought to be essential ingredients for effective team functioning (Harrison, 1987). According to Harrison, role sharing and trusting colleagues is difficult for novice practitioners as they are often not clear about their own role within the team. As Øvretveit (1990) points out, a team needs to be planned, developed, nurtured, and regularly reviewed. However, none of this took place on Kauri Ward or any of the other wards in the unit. Once rotation occurred, the new team members came together and started working together. There was no introduction, or discussion regarding the model of care. This had the potential to lead to misunderstanding and feelings of not being valued, as some of the nurses had expressed.

It was also of concern from a managerial perspective. Nursing, as a discipline within the hospital, had to justify an all registered work force. Moreover, the charge nurse

---

[26] This was discussed and agreed upon at the Head of Department Meeting.

managers of our wards were repeatedly asked to justify their staffing levels. How could this challenge be met if nurses themselves were not able to articulate the nursing contribution to the multidisciplinary team? It was necessary to develop strategies that enabled the nurses to be confident and able to articulate their contribution to the multidisciplinary team.

The medicalised view of rehabilitation in the ward indicated that rehabilitation was still dominated by an acute simple disease model (Pawlson, 1994), which implied that rehabilitation was delivered from a short-term rather than a long-term rehabilitation perspective (Nolan *et al.*, 1997; Robinson, 1988). It appeared that the discourse on the ward espoused the value of the long-term model, which is patient oriented, whilst simultaneously working with the short-term model, which is technique orientated. The discovery that the discourse of both rehabilitation and the nurse-patient relationship was contradictory to actual practice and activities on the ward, was concerning to all. It was decided to include some sessions on partnership and rehabilitation in the in-service education programmes. It was hoped that through reflection on both practice and theory the nurses might develop insights into their practice and respond critically. This is a process described by Freire (1970) as conscientization.

The shift towards participative care was recognised as necessary by all the Department Heads. To facilitate such a transition a good communication process was needed. However, the communication process within the unit was described as problematic. Communication (including feedback) is important in any change process. A clear strategy was developed prior to commencement of the action cycles. This entailed implementing a communication model, a ward-specific orientation programme for new staff members, and improving the staff ability to provide feedback. The latter was an issue for many working on the ward.

Although the issues described above were of concern, the majority of the staff nurses enjoyed working on Kauri Ward. This was demonstrated by the comments the nurses made during the interviews. It was surprising to find therefore, from observations and the interviews, that the ward was hierarchical and bureaucratically controlled. Although some nurses tended to resolve nursing related issues independently, in general, they did not tend to solve interpersonal or process related problems themselves. If any of these occurred they turned (often without consulting the person involved) towards the clinical charge nurse manager. This created a dependency of the nurses on the clinical charge nurse manager.

The interpersonal relationships on the ward were pleasant at first glance and people were made welcome. During the interviews it became evident that the interpersonal relationships between staff members tended to be pleasant on a superficial level only. Nurses did not feel comfortable with providing feedback to each other or critiquing each other's practice. Instead they adhered to particular routines on the ward in an attempt to maintain the status quo. This became evident when observing several ward meetings. There was very little, if any, disagreement or expression of ideas and opinions by the majority of nurses in the ward meetings. For example, in one meeting the nurses were challenged regarding their practice. They were unable to respond or discuss the matter. It appeared that they were uncomfortable with expressing opinions or providing feedback in the group. They tended to avoid uneasy situations and challenging each other. Instead they chose to discuss the issues privately with the clinical charge nurse manager. This created, at times, a very uneasy atmosphere between some staff nurses. So much so that two nurses utilised part of the research project interviews to discuss some of their problems. Another two nurses wanted to be interviewed together. They felt safe sharing their concerns because the interviews were confidential, but it made it nearly impossible to discuss issues raised with the clinical charge nurse manager and the other people involved.

In general, the situation was concerning from the point of view of both ward functioning and the action research project. How would the nurses respond to change resulting from the action plans? Would they discuss it, challenge it, obstruct passively, or just passively accept it and comply? These questions were addressed within the senior nursing team and I stressed again that action research involved action and change. The clinical charge nurse manager of Kauri Ward indicated that she viewed the study as practice development and innovation, which she saw as the domain of the clinical nurse consultant. She described her role in the study as accommodating the initiatives arising from the reconnaissance and the subsequent action plans.

The issues in relation to multidisciplinary team development and participative care were discussed at the Head of Department meeting. After some discussion they formed the opinion that the study would facilitate team building, and might assist in finding ways to develop practice from an interdisciplinary rather then a multidisciplinary perspective. The Heads of Departments believed that the existing professional competitiveness was related to different training philosophies and a lack of communication, which had combined to create a ‘them’ and ‘us’ situation. It was hoped that collaboration between disciplines would foster joint learning and decrease this feeling.

Given the trust and support of management and the majority of the nursing staff, it was justifiable to continue with the patient reconnaissance, but some actions in response to the health professional reconnaissance were needed. They are briefly described in the next section and were regarded as decision points.

6.5: Decision Points

Several decisions needed to be made to set the scene for participative practice. After consultations within the unit it was decided that several actions needed to be taken with respect to multidisciplinary team structure and functioning, confidence building among the nursing staff, learning of feedback skills, reinstating primary nursing, and the incongruence between espoused theories and theories-in-use in relation to participative care.

From my attendance and observation at multidisciplinary team meetings, the lack of nurse involvement was clear. The manner in which the meetings were conducted contributed to the nurses’ lack of participation. Other contributing factors included length of attendance and seating arrangements. All disciplines except nursing attended the meeting from beginning to end. The nurses only attended when primary patients in their care were discussed. They were seated at the only available chair, close to the door. Nurses were continuously interrupted when they discussed patient issues particularly when they disagreed with the other team members in relation to discharge planning. It is understandable that this created a feeling of inequality or 'not being valued' amongst the nurses. More specifically, some nurses felt that some therapists were under the impression that nurse's should work under the direction of the other disciplines. Finally, the meetings were always chaired by one of the physicians regardless of their facilitation skills.

Ways to improve multidisciplinary team functioning needed to be explored. Ideally, the team's goals, objectives and plans should be reviewed when new team members entered the team. These goals and objectives need to be stated in functional terms and must clearly address the desired outcome (Schmidt, 1995), so that new team members understand them and are able to integrate them into their discipline specific work. For a team to become outcome focussed, or result driven, it needs to have a common purpose and an agreed process to achieve that purpose. In addition, competence of team members within their own area of practice is thought to have a positive effect on team outcomes (Alder *et al.*, 1995; Hastings, 1996; Schmidt, 1995). Some interdisciplinary teams work closely with, or have as a permanent team member, a case manager or care co-ordinator. It is suggested that case management and care co-ordination enhances the effectiveness of the team (Alder *et al.*, 1995; Øvretveit, 1990; Tahan, 1998). Whatever form it takes, leadership within the team should be clearly defined and the person in this position should have the skills necessary for the role (Øvretveit, 1990).

Before strategies were employed directly within the multidisciplinary team, however, it seemed important to take action that would build nurses' confidence in themselves and in the value of their contribution. To become confident members of the multidisciplinary team, nurses needed to be able to articulate their contribution to the rehabilitation process and demonstrate their competence. It was obvious that the nurses who did demonstrate their competence were respected and made valid contributions to the overall plan of care. It was thus important to help the nurses to develop the skills necessary to be able to articulate patients' nursing needs and to actively participate in or facilitate the meetings. I therefore decided, as the clinical nurse consultant/researcher, to work mono-disciplinarily in the first action cycles of stage II, to enable nursing specific issues to be addressed. It remained important to keep the other disciplines informed, which meant that a communication plan needed to be in place prior to commencement of the action cycles.

There were some concerns regarding some senior nurses' perceptions of their practice in relation to participative care, and their inability to role model, communicate and provide clinical supervision. Although the transfer of senior staff to the newly opened wards had had an effect on Kauri ward, it was difficult to understand why the remaining senior nurses had not been able to role model. This was an issue because role-modelling, communication and clinical teaching were not only necessary for the development and growth of junior staff, but were also necessary for the management of the anticipated changes throughout the study. It was beneficial to all involved to explore the concepts of clinical supervision, teaching, and role modelling and, more importantly, to implement them in the clinical setting. This was a hospital wide issue and plan. The newly developed career pathway programme was intended to address this and was implemented throughout the hospital during the course of the study.

Primary nursing was seen as a vehicle through which participative care could be achieved. It was a concern held close to the heart of the senior nurses and the clinical charge nurse manager. They had implemented this system some years ago and believed that they were able, in co-operation with the primary nursing project co-ordinator[27] and the clinical nurse consultant, to reinstate primary nursing on Kauri Ward.

Following the group discussions and interviews, the enthusiasm of the majority was evident, but so was the apprehension of others. The latter were a small group of staff nurses who did not want to participate in the interviews or the project. They believed that they were already engaged in participative care. I discussed this with the clinical charge nurse manager and it was decided to conduct some workshops about patient participation in care and individualised care planning. At the end of the workshops these nurses agreed to participate in the study as observer participants but were not happy to be interviewed.

Their decision was respected, but I remained concerned about their lack of trust. It seemed very likely that they participated because they did not want to disappoint the senior nurses, for whom they had great respect. I considered working some evening shifts with them but other senior staff advised against it. They felt that this group might perceive such an action as ‘checking on them’. It was decided to wait for an opportunity for me to volunteer for a replacement evening shift (an extra shift due to sickness), where my role as the clinical nurse consultant would justify my presence. It became obvious that there was potential for actions associated with the study to be confused with the responsibilities associated with the clinical nurse consultant role.

Finally, the planning of the patient reconnaissance began in this stage, based on the enthusiasm of the majority of the staff nurses and support of the senior management team. It was planned that the new co-researchers (the action group members) would participate in interviewing the patients. This meant establishing the action research group, developing interview skills among the group members, studying the literature, and adjusting the duty roster to accommodate the action research group members. These actions were undertaken simultaneously with the patient reconnaissance phase of the study.

6.6: Summary

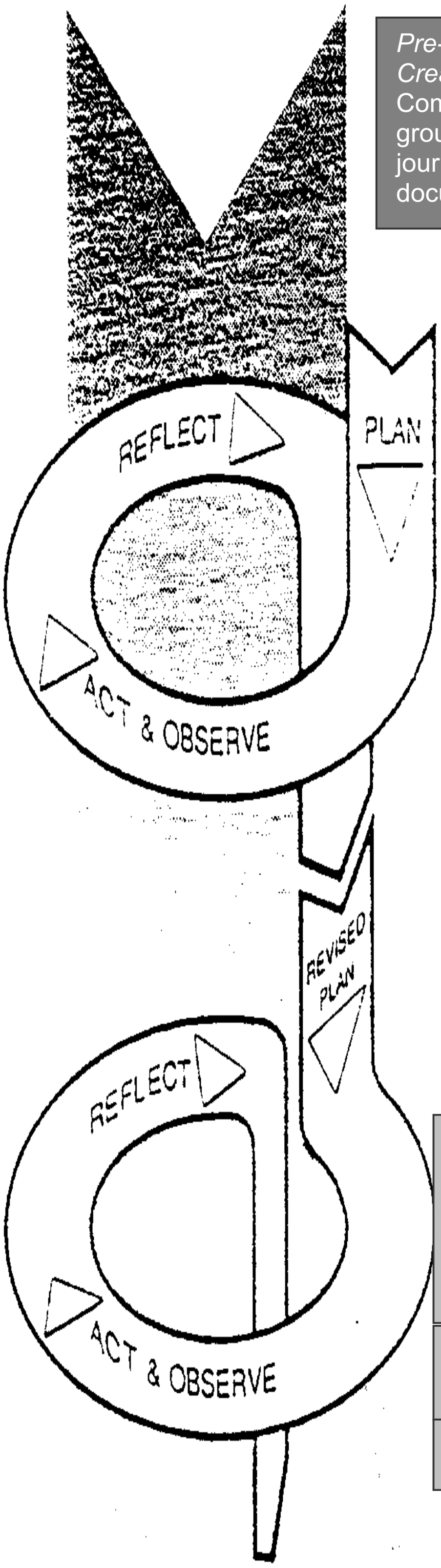
From the first stage of the reconnaissance it became clear that there was an incongruity between language/discourse and activities/ practice. In other words, the group discussion, the documentation audit, one-to-one interviews and practice observations revealed that the theories-in-use differed from espoused theories. The research project on the ward was generally perceived as positive. It was possible that this was because the clinical charge nurse manager, clinical nurse consultant,

---

[27] The project to implement nursing care delivery models was hospital wide. Primary nursing was one of these.

and senior nurses were very enthusiastic about the project. On the other hand action research, in order to be successful, does require the support from all involved, including those at a senior level. The first stage of the health professional reconnaissance helped concentrate the focus of the project with respect to day to day care delivery on the ward, so that participants could decide individually and collectively on how to change the current way of practice. Prior to patient involvement, and based on the findings so far, the action research group decided to work towards creating a supportive environment for participative care. This was done in consultation with the rest of the ward, and resulted in the procedural action plans described in the stage two of the health professional reconnaissance.

7: Phase 1: Stage II: The beginning of practice advancement: action plans based on the perspective of the health professionals



Pre-reconnaissance: Creating a research culture.
Commencement of several groups: the journaling, journal, nursing focus and documentation groups.

Chapter 6

Phase I: Stage I: Health professional reconnaissance.
Group discussions and one-to-one guided interviews which aimed at developing an understanding of:

- Current ward practice
- Research expectations
- Practice concerns
- Nurses' understanding of gerontological rehabilitation
- The role of the nurse
- Nurse-patient relationship

Chapter 7

Phase I: Stage II: Responding to concerns raised in stage I.
The action plans resulting from stage I:

- Develop action research group
- Preparing for patient interviews
- 'A foot in the door'
- Introduction of the FIM
- Information/activities board
- Orientation information

Chapter 8

Phase I: Stage III: Patient reconnaissance.

- One-to-one guided interviews aim to develop an understanding of patient perception of the ward.
- Developing action plans in response to stage III.

Chapter 9

Multidisciplinary goal setting

Conclusion **Chapter 10**

7.1: Introduction

This chapter presents stage II of the health professional reconnaissance. The first section introduces the action research group members. It then turns towards a description of the first action research meeting. During this meeting the action research group members reflected on the reconnaissance so far, and voiced their concerns in relation to participative care and practice changes resulting from the action plans. The subsequent section describes the group members' experiences of interviewing patients and comments on the perceived therapeutic effects. This is followed by a description of the procedural action plans ('a foot in the door', reintroduction of the Functional Independence Measure, information/activity boards, and the orientation programme). Finally, my thoughts and concerns, as the clinical nurse consultant/researcher, regarding this stage are discussed. Data was gathered by means of research journals and audio taping research meetings.

7.2: The participants: action research group members

After completion of the study days six nurses, who ranged from novice to expert practitioners, out of the 26 on Kauri Ward, volunteered to join the action research group. They were joined, at a later stage, by a seventh nurse volunteer. The action research group decided, in consultation with the clinical charge nurse manager, to meet weekly and to participate in a study day on a six weekly basis. The staff nurse volunteers in the action research group were given the following research names: Joc, Stef, Irmgard, Ann, Gemma, Yolanda and Betty. I used my own name (Lucienne) in the group and for the rest of the study. Members of the research group were asked to keep a research journal in which they reflected on their feelings in relation to the research project and made practice observations between meetings (see Appendix 7A for guidelines on journaling). Some group members felt uncomfortable keeping a journal and so shared their reflections in the group or on audiotape. The journal entries and the practice stories were utilised during the group meetings for reflections on action(s). Minutes were kept of all meetings, as well as having them audio taped[28]. Some tapes were transcribed verbatim, after the group gave consent, if it was felt that the discussion added value to the group's understanding and knowledge development. These tapes were transcribed and analysed, as described previously.

The format of the meetings was based on that described by Wheeler and Chinn (1989). All meetings started with a 'check-in process' in which each member was given at least five minutes to share with the group what they felt was important and concerned them. Once a group member indicated that s/he had finished the next person would 'check-in'. During the meeting the group members agreed that they would allow each person time and space to voice their concerns. No one would interrupt while a group member was speaking, but would instead indicate when s/he would like to enter into the discussion. At the end of the meeting each person was given the opportunity to evaluate the usefulness of the meeting, and 'check out'.

---

[28] It should be noted that the tape-recorder was turned off if requested.

During ‘check in’ and ‘check out’ time a group member could pass[29] if they felt this was appropriate for them.

The sharing of feelings and concerns, in relation to their practice and the experience of being an active participant, was confidential[30]. It was intended that the meetings would provide a safe environment for the group members, where they could safely give and receive feedback and critique. General progress, discussion outcomes, and progress with the action plans were discussed with the other nurses on Kauri Ward during ward meetings.

Those nurses outside the action research group requested an extra ward meeting to discuss their role in the study. They explained that they wanted to be involved, but in a less intensive manner. For various reasons they were not able to commit themselves to the work required at the beginning of the study, but felt they would like to participate at a later stage. They opted to critique and provide feedback on the action plans and agreed to be named ‘observer participants’. They were reassured that full participation was possible at any stage in the study. The observer participants developed a strategy, together with the active participants, for their involvement in the research process. This consisted of the following steps (Figure 6).

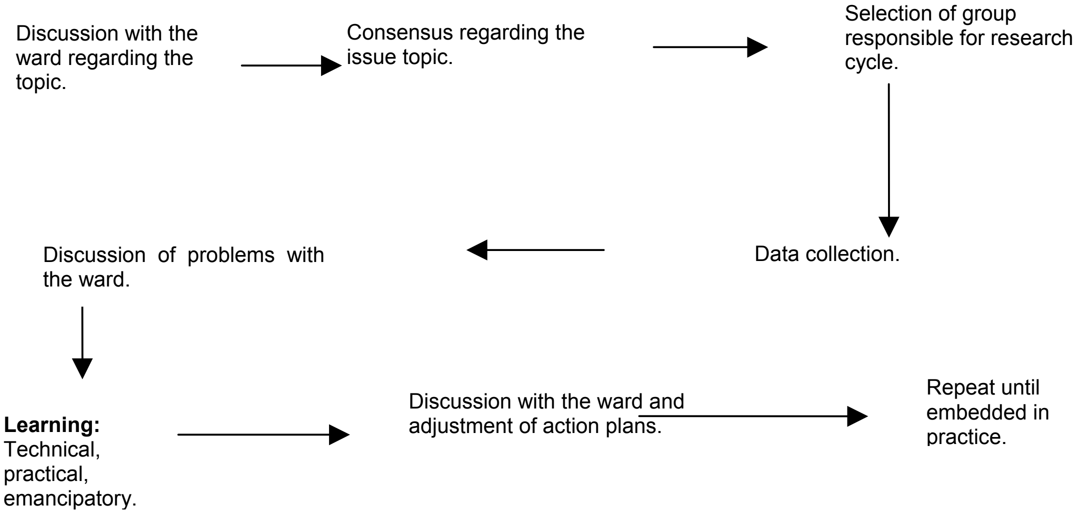


Figure 6: The planning framework utilised in the study.

The action research group (active participants) was seen as the core from which ideas were put forward to the ward (observer participants) for critique. It was explained to all staff members that they could participate and withdraw from the action research group at any stage. This was essential, as informed consent and willingness to participate were important features of this study. Initially, the action

---

[29] A pass meant that a group member did not want to share his/her feelings or thoughts. They did not need to provide an explanation for this decision.

[30] The transcriptions from the meetings were only given to the members of the action research group. They were asked to trust each other and to keep confidential all discussions held within the group.

research group consisted of six nurses but a seventh nurse joined later, and it became multidisciplinary during the course of the study.

7.3: Starting the research process: the action research meetings prior to patient interviews

During the 'check-in' at the first meeting of the action research group, the group members all commented on the study days and the discussions that had followed on the ward. The group members went on to discuss the value of reflection and their concerns regarding the introduction of participative care, and expressed their feelings about the first action research meeting.

The study days had already proved to be valuable. The action research group members reported that they had sparked a lively discussion on the ward. Moreover, five nurses had joined the reflective practice group. The comment made by Irmgard during the meeting was representative of those made during the discussions on the ward (Appendix 7B, Table 3).

> I want to move my nursing practice closer to what I think it should be. I want to be able to incorporate the reflection into what I'm doing everyday while I'm doing it. So that I can see what could be better and change it. And see what's worked really well and carry on with that while I'm working. So that all the patients you work with get the benefit of your reflection rather than just the ones that you work with after you've failed with a couple of others (laughter) (Irmgard, ARGM1, p 19).

Using reflection the group members discussed their practice and began to engage in practice development. For example, the discovery during the study days that nursing was invisible in the clinical notes was a concern to many. So much so that two senior nurses, both action research group members, had discussed the problem with their nursing team and developed a strategy that resulted in a practice change. The following excerpt illustrates this.

> That wee discovery you know? [Concerning the invisibility of nursing within the clinical record]. We started changing our headings for writing up our notes in room 40. Rather than just 'ADLs and mobility', we're writing down 'walking practice'. Well now she [the nurse] is actively involved with the patients. We're actually engaging in walking practice or dressing practice. It is a thing between the nurse and the patient, and we're doing that at the moment in room 40 (Stef, ARGM1, p 17).

Consequently, the nurses in this team headed each entry in the clinical notes with 'nursing' and described their nursing actions.

During the second meeting of the action research group, the group members expressed concerns about making changes when implementing action plans. Given the ward's history and the way change was perceived to have been managed in the past, this was understandable. Change had not always been seen as beneficial for the patient and had been implemented with a top down approach.

> We have all been through a time of change when things were negative. The environment was really quite negative in lots of different ways. When I hear you talking about the change, I think it is positive.

> It depends on the environment we're in as to whether the changes are positive or they're negative (Irmgard, ARGM2, p 5).

Ann's response to Irmgard's concern was representative of the general feeling in the group.

> If you remember, the seven or eight years we have been here we've changed general managers several times. We had to change everything [each time]. They are not here any more but we are. I am not talking about if it was good or bad. It's a constant change and it's not, it's not always related to the patient needs (Ann, ARGM2, p 6).

Two members of the action research group were sceptical about change and anticipated a negative attitude on the ward towards any changes resulting from this study. However, other action research members pointed out that the change evolving from this project was based on patient feedback, and would be initiated by nurses working in the ward setting. Moreover, as the action research group was aware of the potential for anxiety among ward staff, they could ensure that adequate information, and the opportunity to be involved in the development of the action plans, was provided. Of course, it remained up to the individual nurses as to how much they wanted to be involved.

Through reflective writing Stef identified a concern in relation to patient safety regarding the implementation of participative care.

> Over the past week I have been thinking. As I say I have always been committed to the idea that it's patients' needs that come first and not what other people say. Implementing that could present a danger to some patients. We tell them 'you have got the right to plan your care, or to participate in the planning of your care'. Then the reality that they may actually face on the ward from the other disciplines is that they don't have that right (Stef, ARGM2, p 9).

This sparked a lively discussion as several action research group members and observer participants had similar thoughts. I had undertaken several discussions with the senior multidisciplinary team members and senior management team, in which they expressed support for the project. They too were aware of the benefits involved in patient participation in therapy planning, and all had agreed to a multidisciplinary study day prior to commencement of patient participation.

During 'check out' at the end of the second action research meeting, all group members commented that they felt safe within the group. They were able to share their concerns freely[31].

> I think that there is rapport within the group and we are starting to share and trust. I have said things that I would not have said in the first meeting [reconnaissance]. I think it was important that we did not stick to the program. Thank you for the day we shared. It was important (Ann, ARGM2, p 53).

The development of trust within the group was crucial if the members were to feel safe. Sharing practice stories and practitioners learning from each other were perceived as valuable aspects of the meetings and study days (see Appendix 7B, table 5).

---

[31] See also Appendix 7B, Table 4.

7.3.1: Preparing for the interviews and sharing the interview experience

The first action plan consisted of planning and conducting one-to-one, guided, patient interviews. The action research group members had received reading material and participated in educational practice interviews in order to prepare for the patient interviews. The patient interviews were scheduled as soon as the individual members of the group completed their educational sessions and had contacted a patient willing to participate in the interview. The next four action research meetings were therefore focused on this topic. The group members' excitement about the interviews is best summarised by Yolanda's comment.

> That is the way that we are going to find out what the patients think about our practice. That's the way we might be able to improve our practice. Knowing what they think and say, not what we nurses have to say about nursing practice (Yolanda, ARGM3, p 1).

By the fourth meeting all the action research group members had conducted, or were planning to conduct, an interview with a patient. This meeting was concerned with sharing the action research participants' experiences of the interview process. All admitted to some degree of nervousness prior to the interview. The entry in Joc's journal, which she shared with the group, represents the general feelings of the group (see also Appendix 7B, table 6).

> Crunch day tomorrow, I'm interviewing Mr S. I'm really nervous about the whole interview thing. I'm worried that I'm not going to be able to get everything to flow. It's good that Lucienne is going to be there so I'll be able to see if I'm doing things properly (Joc, Journal, 1997).

The action research group members recognised the importance of supporting one another in gaining confidence with interview skills[32]. Once the interviews (17, see chapter 8) were conducted they were transcribed and the group reflected on each other's transcripts.

Irmgard had been confronted with an issue that affected a patient's safety.

> Some problems have come up with the interviewing of patients. That is what happens when they bring up some details about my colleagues, which I find difficult to actually face up to. I have to confront this situation and hopefully it can be resolved (Irmgard, ARGM4, p 67).

She felt very uncomfortable about this and sought the opinion of the group. Although patient confidentiality was pivotal in the interview, the incident shared by the patient did concern the group. This particular incident compromised the patient's safety and needed to be brought to the attention of the nurse involved and the clinical charge nurse manager. The group felt that I, as a member of the senior nursing team, was the appropriate person to discuss the incident with the clinical charge nurse manager and the nurse involved. As discussed by Munhall (1988), in cases of conflict the 'therapeutic imperative', in this case safety, takes priority over the 'research imperative'.

---

[32] To support the action research group, I offered to sit in on the first interviews.

Members of the group all noted how the interviews influenced their relationship with the patient, demonstrated in Gemma's comment.

> I have noticed, especially over the last two weeks, that since performing the interview with Mr T, that he has been more responsive to me. If he has any queries or would like to talk, it seems as though it is me that he would approach - even though I do not work in his room. Just with passing in the corridor, there is almost an instant 'connection' as such, as if that interview had lasted a lifetime and we were old friends that had not seen each other for a while. There was definitely a sense of trust developed in that hour-long interview. This was also a trust and nurse-client relationship that I had not come across previously, especially in such a short meeting, and considering I probably have only worked with this client for approximately 24 hours (Gemma, ARGM4, p 124).

Yolanda described another therapeutic effect of interviewing.

> I had a very interesting interview with Mr Z. He said a couple of things that were quite positive. He said, "Those trays [given to him after the first interview] behind the bed make me really independent. I know I have got all my stuff here and I know that I do not have to wait to call someone. I can get everything for myself". I thought well that is positive and maybe we should get more in the ward and I went and discussed it with the charge nurse manager (Yolanda, ARGM4, tu 12).

With the exception of the incident described by Irmgard, the action research group members felt that the patient interviews were a positive experience for all involved. The interviews were perceived as therapeutic since they provided the patients with the opportunity to describe their experiences, and discuss and clarify concerns. All group members experienced how the flow of the interview switched from sharing of information, to patient education, to expression of thoughts and feelings, and back to the nurse-patient relationship. Consequently, the time spent with the patient was perceived as positive.

According to Hutchinson, Wilson, and Skodol-Wilson (1994) the in-depth interview process (listening and responding) enables the interviewer and the participant to connect and may provide the participant with a sense of purpose and self-awareness. Moreover, the feeling of being heard can be empowering for participants. Through the interview the participant is given a voice that is heard and acted upon by the interviewer. Yolanda's excerpt, above, provided an example of this. The patient involved had been functionally dependent. His lack of independence caused him severe distress and he had expressed his concern during the interview. Yolanda listened and took action that enabled the patient to be more functionally independent.

It is obvious now that the conduction of the interviews was the beginning step towards participative care, as this was the first time that the nurses consciously listened to the patients and worked with the patients' concerns. The members of the action research group were stepping away from tokenism towards involvement (Arnstein, 1972). The intention was to utilise the information received from the patients to develop action plans that would increase patient participation in their care, and then to evaluate these with health professionals and patients. This will be discussed in the next chapter.

7.4: The first series of action plans in relation to practice advancement

Before direct patient involvement could occur, the group needed to create procedural action plans. In the development of the procedural action plans the group looked closely at both objective conditions (availability of resources), and subjective conditions (opportunities and constraints in terms of what people think now, exceptions, and existing patterns of formal and informal relationships) (Kemmis & McTaggart, 1988). Information was given to the ward staff in the form of newsletters, meetings, presentations, and feedback sessions (See Appendix 7C for examples of the newsletters). Actions taken to develop and change nursing practice had the potential to impact on the rest of the multidisciplinary team. The action research group members identified collaborators in each of the other disciplines and these people were instrumental in the implementation of the action plans[33].

The first set of action plans, some involving only the action research group, and others including the allied health professionals, are summarised in Table 3.

Action Plans
1. ‘A foot in the door’
2. The Functional Independence Measure
3. Information/Activities board
4. Orientation information

Table 3: Action plans resulting from the health professional reconnaissance.

7.4.1: Action plan one: a foot in the door

The appearance of the ward was regarded as inappropriate for gerontological rehabilitation, in terms of layout and colour scheme. It was uniform and drab, and as a result all the rooms looked similar which made it difficult for both patients and visitors to find their way around the ward. Many patients and visitors to the ward failed to recognise their surroundings because of the similarity of the rooms, and the fact that all the doors were the same colour. A change in the colour scheme was something that could be resolved within a reasonable time frame, and that could be managed with the resources available. All staff and patients on the ward were invited to participate in designing the colour scheme, and, after some lengthy negotiations, it was decided to give the door to each patient room a different colour.

The reflection step showed that the plan had been successful, as positive comments were received from patients, visitors, and visiting staff. Moreover, everyone started to use the colour of the doors to refer to the location of rooms.

> I was taking her back to the room after a shower and I asked her what room she was in. She replied that it was the one with the yellow door, which I thought, that was pretty cool. Since then I've had another lady say the same (Joc, Journal, 1997).

---

[33] They were subsequently invited to join the action research group in the second phase of the study.

Following the advent of coloured doors, neither visitors nor patients had difficulties identifying the rooms. This functional action step facilitated a non-threatening introduction towards action research. It allowed various disciplines and patients (volunteers) to work together, was a good starting point for further changes and yielded a valuable early success.

7.4.2: Action plan two: reintroduction of the Functional Independence Measure

The management team had already voiced concern regarding the lack of outcome measures in use within Aged Care Services. They had been under considerable pressure from general management to justify the need for an assessment and rehabilitation unit within the hospital. Outcome measures cannot be ignored in today's environment with its focus on efficiency and effectiveness. Traditionally, rehabilitation services for the older population have been conducted in acute hospitals in New Zealand[34]. They were evaluated according to clinical measures appropriate to an acute setting. Outcome measures such as length of stay, throughput, and readmission are important to the acute environment, but are less appropriate to the rehabilitation field, where measures such as quality of life, discharge destination, functional independence measures, and un-planned readmission are regarded to be more appropriate (Nolan *et al.*, 1997).

Before reintroducing the Functional Independence Measure[35], I consulted with the ward nurses about suitable times to conduct the teaching sessions. They suggested the weekends and evenings, as they tended to complete the care-plan evaluations at these times. This also provided an opportunity to discuss practice and research related issues directly with the nurses, and assisted with the development of professional relationships.

Two action research members conducted one-to-one teaching sessions with the nurses on the ward. The Functional Independence Measure was reintroduced in May and subsequently utilised during the goal-setting meetings. The majority of staff appreciated working with the Functional Independence Measure as it decreased the time spent writing the progress notes. The feedback from patients (discussed in the next chapter) indicates that they too found it useful.

7.4.3: Action plan three: introduction of information/activities boards

The third action plan, the introduction of information boards, was an immediate response to the patients' confusion regarding appointment times, the lack of communication between health professionals on the ward, and suggestions made by family members during the first patient interviews. Double booking of patient appointments frequently occurred, causing confusion amongst the patients, and frustration for therapists.

Within two short action cycles (a total of 3 weeks), the information boards were finalised. Using an A3 format plastic board, the names of the multidisciplinary team

---

[34] In the last few years, however, they have been relocated to the sub-acute care setting. Kauri Ward was now quite unique.

[35] See Appendix 7D for an explanation of the Functional Independence Measure.

members involved with the patient, and their admission date, were recorded. A section of the board was used to communicate the date, day and time of any activities or therapy sessions for which the patient was scheduled. The boards were immediately useful to patients, their families, and the multidisciplinary team. Keeping the information on them current was important but did not prove to be a problem: the nurses agreed to keep the information section up to date, while the activity section was updated by whoever was responsible for an activity. The boards were hung at the end of the bed or behind it on the wall, depending on patient preference.

7.4.4: Action plan four: multidisciplinary team orientation

Because the multidisciplinary team members had worked together on the activity/information board action plan, it provided a good starting point for the next action plan, the multidisciplinary team orientation. Multidisciplinary team functioning and orientation were concerns shared by all. Team building, to a reasonable extent, needed to occur in the unit. It was realised that it was impossible to follow the stages of team development (forming, storming, norming, and performing) described by Bion (1968), due to the frequent rotation of multidisciplinary team members. The action research group felt that to help gain some clarity around expectations and roles it would be helpful to conduct orientations for all new multidisciplinary team members. The planned orientation programme was seen as the first step towards multidisciplinary team team-building and collaboration. The aim was to adequately inform new multidisciplinary team members. It consisted of a self-learning package, an orientation sheet, and a multidisciplinary study day every three months. The themes of the study days, for the first year, were communication, participative care and the role of the health professional within it, and facilitation of multidisciplinary team meetings. The development of the orientation programme was completed within two action cycles, and it was to be implemented during the next rotation.

7.4.5: Reaction to the action plans

All the action plans described above were directed at the improvement of processes and had an impact on practice. They did not, however, require a change to any of the ward practice routines. This may have contributed to their positive reception on the ward. The action research group anticipated some anxiety among the observer participants once the actions resulting from action plans affected the ward routines. So far the project was received positively within the unit and several actions were helpful in the move towards new practice.

7.5: Reflections in relation to social interaction, roles and changes

7.5.1: Social interaction

Painting the doors proved to be a good initial exercise for further changes, and yielded a valuable early success. In addition, the choice of colours and the associated discussions created a good atmosphere on the ward. All staff members mixed during breaks, which was unusual as staff members often had their breaks separately. It appeared that it had been a non-threatening way to introduce the action research study to the ward. However, this was slightly overshadowed by an incident resulting from poor communication. The incident, outlined below, created some uncertainty and led to mistrust.

A respected senior nurse's entry in the communication book[36], in relation to ward practice, had caused distress on the ward. The entry included the phrase "the research has shown". Actually, there had been no data distributed or discussed simply because there was none at this stage. This nurse had used the study to communicate a point, resulting in a 'them and us' situation and the creation of some distrust towards the action research group members. I addressed the issue directly with the nurse concerned. She was clearly embarrassed and had not foreseen the impact of her comments. She had wanted to get her view across and had used the study as a vehicle. A ward meeting was arranged where the situation was discussed. To avoid future misunderstandings it was agreed that the newsletter and ward meetings were the only media for dissemination of research findings. An important aspect of the action taken as the clinical nurse consultant/researcher was that it role-modelled a method, previously unknown to the nursing staff, of dealing with the situation. Instead of involving the clinical charge nurse manager, the issue was addressed directly with the person involved.

Feedback was used during the one-to-one Functional Independence Measure teaching sessions, and appeared to be received positively. The observer participants also appreciated the fact that the active participants had asked them about the best time to conduct the sessions. Several nurses commented that prior to the teaching sessions "they thought that changes only impacted on *their* practice but not on that of management" (Journal, Lucienne). Some also mentioned that their first thought was that the clinical nurse consultant was "checking up on them" (Journal, Lucienne). This concern about 'being checked up on' is related to the way practice audits had been conducted in the past, when receiving the results was associated with a 'telling-off' session. In contrast, the two Functional Independence Measure trainers were generally able to use the teaching sessions to reinforce their regard for and affirm the clinical assessment skills of the nurses. The group of observer participants that tended to work the evening shifts participated in the Functional Independence Measure teaching sessions, but they did not transfer the new information into practice. It wasn't clear if this was a language or a competence issue.

During the Functional Independence Measure teaching sessions, the trainers noted both anticipation and anxiety regarding the changes about to take place on Kauri Ward. Additionally, several observer participants had approached me for clinical teaching sessions in relation to an assessment, and it became apparent at the time that, for some nurses, the ending stage had begun (Bridges, 1991, see section 3.3.3.4, pp. 35-36). They were eager to explore the opportunities provided by the implementation of the action plans. In contrast, other observer participants (largely the group of nurses working the evening duties) were holding on to the past. They felt secure in their known practice world and were anxious about any changes. Further time was scheduled with this group to discuss their concerns. It was important to do this because trust and feelings of security are difficult to develop if

---

[36] The communication book was a forum in which staff members could write their opinions in relation to ward issues and practice.

people do not understand the reasons for ending something, resulting in a situation which may lead to decreased commitment (Gilmore *et al.,* 1997).

7.5.2: Role of the researcher

In the role of the researcher, I centred on guidance, facilitation of processes, and teaching the action research group at this early stage. The observer participants experienced difficulties distinguishing between my role as a clinical nurse consultant and that of the researcher. Both roles were associated with practice development, innovation and change. At this early stage it was not too concerning. Maybe it was the beginning of a transition from technical to practical action research?

7.5.3: Group process

The action research group members enjoyed each other's company. There was a lot of laughter and sharing of practice stories. The relationship between the group members was in some cases based on trust and respect. According to Govier (1993) trust is important in the development of relationships. She defines trust as "an attitude based on beliefs and feelings and implying expectations and dispositions" (p.104). The group had worked together and shared stories in a way they had not done before in their time as nurses.

However, there was a slight difference between the junior and senior nurses. The junior nurses were asking practice-related questions and shared practice-related stories, whereas the senior nurses were more concerned with the impact of the study on both other health professionals and the patients. The action research group also began to talk about action plans with some sense of urgency. I explained the importance of not rushing into any actions without addressing the needs of those experiencing anxiety associated with the possible changes (the endings of old practice). A smooth transition could only occur when the majority of ward staff were committed to the problem, recognised that existing knowledge (practice) may block the development of new knowledge, and felt supported (Bridges, 1991). The ward needed to keep up with any developments. A rate of change should never exceed the rate of individual learning: if the rate of learning is slower, no organisational change will occur (Garratt, 1991).

7.5.4: Action research group process

At this stage the action research group needed to evaluate the communication strategies set in place at the beginning of the study. Raising awareness had involved several ward meetings and Head of Department meetings, which were held in an informal setting. Newsletters were also distributed to all Head of Departments, the nurse advisor, clinical director, and clinical charge nurse managers across the hospital.

The study days described in the previous chapter were intended to help the development, on Kauri Ward, of understanding about the research itself and participative caring.

The action research group anticipated that providing staff with the opportunity to critique the action plans and to see their suggestions incorporated into those plans, would enhance commitment to the study. With the action research group now providing the ward with both written and verbal communication regarding the intended action plans, it was hoped that misunderstandings, such as that described earlier, would be avoided.

7.5.5: Practice advancement

It was interesting to observe that the language used in the clinical documentation was changing. Within two of the nursing teams, written language and practices began to correspond. The nurses’ entries in the clinical progress notes were detailed and accurately documented their actions. They made nursing actions visible to the rest of the multidisciplinary team. This was an early indication that nurses were beginning to share nursing practice with other health professionals. This in turn could assist other disciplines in developing an understanding of the nursing role (Parker & Gardner, 1991).

The Functional Independence Measure was introduced after multidisciplinary team rotation. One of the allied health professionals objected to its introduction and, in particular, to the fact that nurses administered the Functional Independence Measure. This health professional felt that the nurses were not the appropriate people to use this tool, and so tended to ignore the Functional Independence Measure scores during the meetings. In response, a nurse from the action research group used the reporting of patient Functional Independence Measure scores in the multidisciplinary team meeting as a teaching opportunity. The nurse put the scores on a transparency and presented them using the overhead projector. The nurse also explained the value of using the Functional Independence Measure in patient evaluations. As a consequence the new multidisciplinary team member had to take notice of the tool and the scores. Furthermore, other members of the multidisciplinary team volunteered to participate in the Functional Independence Measure training sessions.

This action by the research group participant made nurses and nursing visible. Moreover, it was the first example of the nurses becoming informed autonomous practitioners without seeking approval or permission from the clinical charge nurse manager.

The action research group members could see progress in the way the multidisciplinary team meetings were conducted. Nurses were now present throughout the meeting and they did contribute during the discussions. But the issue of not being valued was still present. After some discussion, the group decided to describe a day of their practice and identify therapeutic aspects within their practice. It was anticipated that this would assist them to become aware of their own practice, value it, and consequently be more able to articulate the nursing contribution to the team. These practice stories were shared in the action research group.

7.6: Summary

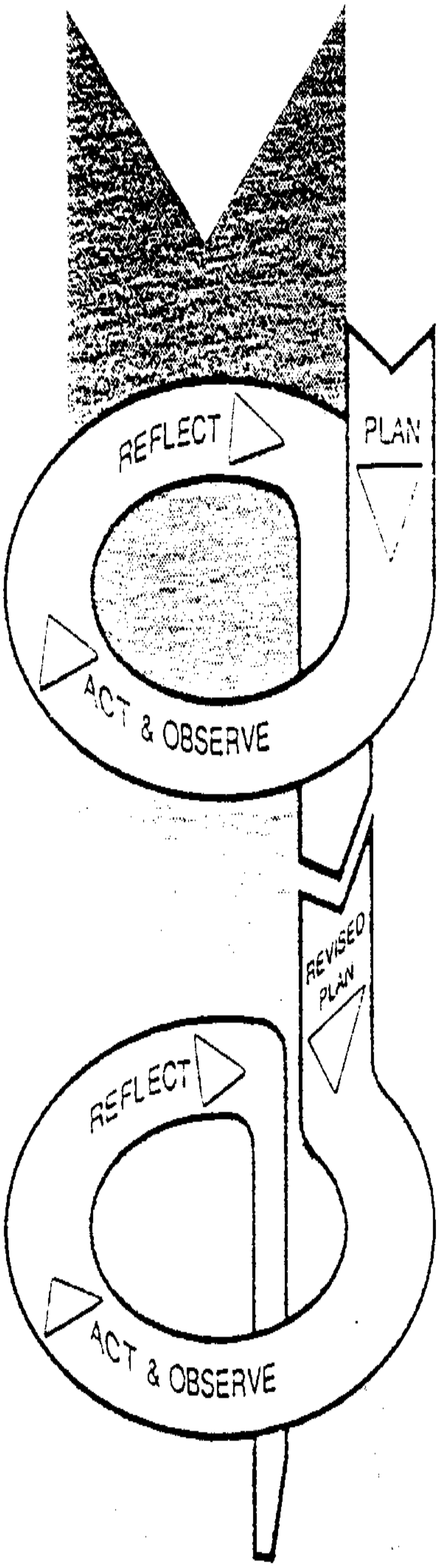
This chapter described the formation of the action research group, which consisted of six staff nurses with varying levels of experience and myself (the clinical nurse consultant/researcher), and the processes used within the meetings. During the first meeting time and space was created for the group members to share their concerns.

This was perceived to be valuable and set the scene for subsequent meetings. Before action plans were developed and implemented the action research group discussed the literature, and the potential impact of the action plans on practice.

The patient interviews appeared to be mutually beneficial, to the extent that the interview process came to be viewed as therapeutic. The first action plans dealt with the ward environment, reintroduction of the Functional Independence Measure, communication in the form of an information/activity board, and a multidisciplinary orientation programme.

Finally, some of my thoughts and concerns were shared. In conclusion, this stage can be seen as one in which practice structures were developed to facilitate participative care. It also demonstrates the flexibility of the action research process. During this stage some patient feedback was received, and planning for the future goal-setting intensified. The feedback from the patient interviews and the resulting action plans are presented in the next chapter.

8: Phase 1: Stage III: Seeking patients' feedback: patient reconnaissance



Pre-reconnaissance: Creating a research culture.
Commencement of several groups: the journaling, journal, nursing focus and documentation groups.

Chapter 6

Phase I: Stage I: Health professional reconnaissance.
Group discussions and one-to-one guided interviews which aimed at developing an understanding of:

- Current ward practice
- Research expectations
- Practice concerns
- Nurses' understanding of gerontological rehabilitation
- The role of the nurse
- Nurse-patient relationship

Chapter 7

Phase I: Stage II: Responding to concerns raised in stage I.
The action plans resulting from stage I:

- Develop action research group
- Prepare for patient interviews
- 'A foot in the door'
- Introduction of the FIM
- Information/activities board
- 0rientation information

Chapter 8

Phase I: Stage III: Patient reconnaissance.
Identified themes from one-to-one guided interviews:

- Lack of information regarding the ward
- Wanting to receive information
- Lack of stimulation
- Lack of privacy
- Continuity of care
- Environment from patients' perspective
- The nurse-patient relationship.

Developing action plans in response to stage III

Chapter 9

Multidisciplinary goal setting

Discussion **Chapter 10**

8.1: Introduction

This chapter describes stage III of the reconnaissance. In this stage the action research group members set out to explore patients' opinions of current practice and patients' interest in participative care. The first section of this chapter discusses the twenty guided interviews conducted by the members of the action research group. The patients' concerns regarding privacy, lack of knowledge regarding the ward, lack of education/information, and lack of stimulation were the central ideas that guided the action plans during this stage. The discussion then turns toward the impact of the action plans on nursing practice. Implementation of the action plans led to ward staff raising two concerns: being taken for granted, and the increased workload. My thoughts and observations in relation to social interaction, roles and the concerns of the nursing staff are presented in the next section. Finally, a working definition of participative care for this study, developed by the action research group, is presented.

8.2: Seeking feedback on current practice

The actions during this cycle consisted of patient interviews, analysis, and feedback sessions regarding the interview results. In order to obtain the necessary information the action research group members conducted interviews with twenty patients over a period of six weeks. Twenty appeared enough as no new information was obtained after the fifteenth interview[37]. Those patients with a Minimental State Examination (Folstein, Folstein & McHugh, 1975) score[38] of 26 and higher were invited to participate in a guided interview as described by Patton (1990). Each staff nurse member of the action research group conducted two interviews with hospitalised patients (see Appendix 8A for interview topics). I conducted seven interviews. The average age of the participants was 78 years (60 - 97 years).

With permission from the participants the sessions were audio taped and verbatim transcribed by a secretary. The transcripts were analysed as previously described. This involved extracting commonalties of meaning attached by the informants to the experience of being a patient, the value of participative care, the need for information, the perception of the ward, and the nurse patient relationship. These meanings were then condensed into themes. The occurring themes were ordered according to the registers recommended by Kemmis and McTaggart (1988). Two members of the action research group conducted the analysis utilising NUD.IST 4 (see section 4.5.4, p. 50 and section 6.2.1, pp. 68-70).

The information provided the group with some insights regarding the patients' perceptions of the ward. The themes identified from the interviews were:

- Lack of information regarding the ward before admission
- Wanting to receive information about one's care
- Lack of stimulation
- Lack of privacy
- Continuity of care

---

[37] The other five interviews were carried out despite this, as appointments with patients were already made, and patients wanted the opportunity to discuss their concerns.

[38] See Appendix 4E for a copy of the Minimental State Examination.

- Environment from the patients' perspective
- The relationship between nurse and patient

8.2.1: Lack of information regarding the ward

Patients were frequently admitted to Kauri Ward from other wards in the hospital, having been placed on a waiting list prior to transfer. The interviews revealed that while on the waiting list patients received little information regarding Kauri Ward. Consequently, they expressed distress and disappointment on admission (Appendix 8B, Table 7).

> The problem was I didn't know what to expect in rehabilitation. I didn't know what type of patient was going to be up here or anything. When they brought me up and put me into room X ... there were a lot of stroke patients and different things and it was a bit of a shock to the system. It really was. And my husband was quite upset about it. He kept saying, 'Is this for you?' (PI 3, tu 308)[39].

The information indicated that the majority of patients were very concerned about being admitted to a rehabilitation unit for the elderly. It appeared that they perceived it to be for 'old' people, a group with which they were reluctant to be identified themselves. In the interviews with most patients (fifteen) it became evident that they associated old age with cognitive decline rather than physical impairment (Appendix 8B, Table 8).

> I thought, 'What am I here for?' and all the other patients were all lying around, not exactly 'with it', and very sick, poor dears, and I thought what have I come into? (PI 4, tu 53-54).

8.2.2: Wanting to receive information about treatment

Patients and significant others indicated that information regarding medication and disease process or treatment was also desired (Appendix 8B, Table 9).

> I do feel I could have a little bit more, quite honestly, a bit more information. I know that they will send all the medication information tomorrow when we go home but that is one area where I feel I could have had a session perhaps with somebody (FM 18, tu 320).

8.2.3: Lack of stimulation on the ward

Fifteen of the twenty patients interviewed indicated that they would appreciate more involvement in their care although the others were comfortable with a less active role. Twelve patients mentioned the general lack of stimulation on the ward and that they experienced boredom (Appendix 8B, Table 10).

> You're bored and you can't see what's going on, you know, just lying there, with nothing to do. Well there was only the radio that I could listen to and the talking book. It's the talk-news that is played up in the

---

[39] (Entries from the transcript notes are coded as follows. 'PI' (patient interview), 'tu' (text unit), and 'FM' (family member), each followed by a number corresponding to that interview or excerpt's numerical identifier in the data record.)

> hospital, so I never really bothered about it after a while (PI 12, tu 333).

Ten patients had expected more activities once they were admitted to the rehabilitation ward. On average, patients attended one to two therapy sessions a day during the week, and none at the weekends. At present there were no activities available other than the therapy sessions.

8.2.4: Lack of privacy

The majority of patients were admitted to one of the six-bed rooms, in which both the medical and nursing assessment took place[40]. Moreover, nursing and medical investigations or interventions were conducted in this same room behind closed curtains. The resulting lack of privacy was a real concern to ten patients (Appendix 8B, and Table 11).

> The lack of, you know, confidentiality ... asking personal questions about how you feel, if you don't want to die ... sort of stuff, you know it's very difficult for people to answer with the room knowing what's happening. You have got an audience. Everybody wants to know what's going on for you (PI 6, tu 6).

The concern about privacy was one that came up spontaneously during the interviews. This was taken to indicate that privacy was as an important issue for the patients, and their family members, as it was for the nurses.

8.2.5: Continuity of care

Continuity of care, on the other hand, was a topic raised in the interviews by the action research group members. The patients generally valued the continuity of care provided by the nurses on Kauri Ward. The dependent patients certainly preferred continuity of care (Appendix 8B, Table 12).

> Well as far as I am concerned I do not like different nurses. I get used to them. I could not wipe my backside or anything and if I'd had a different nurse every day I'd have to go through the same sort of embarrassment and humiliation every day, I think (PI 12, tu 39).

Interestingly, the more independent patients did not appear as concerned with this aspect of their hospitalisation, (Appendix 8B, Table 13).

> I have to be honest that it doesn't really matter so long as I am being looked after. That is all. But when you get used to one person, then another one comes and you think here we go again [repeating information] (PI 13, tu 432).

However, patients' general appreciation of continuity affirmed for the nurses that primary nursing suited the needs of the patients. Furthermore, it is suggested that continuity of care influences the consistency of information provided to the patient and fosters the development of the relationship between nurse and patient.

---

[40] The ward consisted of three six-bed rooms and three single rooms.

8.2.6: The nurse-patient relationship

It became evident that patients valued the relationship that they developed with the nurses. Important aspects in this development, from the patient's point of view, were trust, honesty and respect. These were often mentioned in the same context as continuity of care (Appendix 8B, Table 14).

> Tolerance, but on the whole I think that they respect the dignity of the patient very well. She always did it with enormous respect for the dignity of everybody (PI 8, tu 85).

In addition, confidence in the nurse and encouragement given by the nurses were thought to be important aspects to the relationship (Appendix 8B Table 15).

> I think it's just their manner and the way they go about things. I think if they approach something with, you know, approach it with confidence, you've got confidence back in them (PI 3, tu 376).

Clearly, dimensions of continuity also involved the patients feeling that they were supported. They greatly appreciated this (Appendix 8B, Table 16).

> I will tell you a little incident. The other day, I went for the biopsy and the doctor came up after. He came and saw me and they found that the prostate gland had cancer. He said to me there are four options [options explained]. So anyway he left and then A, one of the nurses, he must have heard the doctor talking. I said, 'You heard X did you?' and he said, 'Yes' and he said, 'If you want someone to have a yarn to, just tell me and we can go and have a yarn'. Then there was B, C and D, three of them came to me on the same thing. So I said, 'If I do feel the need I will'. I got support there straight away. That was great (PI 12, tu 315).

The nurses also mentioned, during their interviews, that the giving of support was an important aspect of their role.

Other issues mentioned during the patient interviews were related to the environment, such as the nurses' workload, the ward routine, and location of the ward.

Patients' commented frequently on the nurses' workload during the interviews. They indicated that at times they did not approach nurses simply because they believed the nurses were under a considerable amount of pressure (Appendix 8B, Table 17).

> They seem to be able to handle the things and the pressures that they are under. I found it very hard to ask for anything that perhaps in some ways I can cope with myself. For the simple reason that I see their stress at times and then they never show it (PI 5, tu 68).

It became apparent that some patients adjusted their needs according to the nurses' workload and ward routine. Some patients even went as far as changing their toilet patterns (Appendix 8B, Table 18).

> I have got into a routine and I have sorted something out in the ward. Before dinner at night, after 4pm, not later than 20 past 4pm, I must go to the toilet. I am training myself because when it gets around to 10 minutes to 5pm, right on tea time, people [nurses] don't have time. I have tried to organise my own self to go to the toilet before 5pm (PI 5, tu 565).

The lack of toilets was an issue that caused distress among both the older patients and nurses.

8.3: Reflections on patient feedback

The feedback from the patients indicated that admission to Kauri Ward caused distress. This appeared to be related to not knowing what to expect. A logical conclusion seemed that the information available to patients and their families/significant others about Aged Care Services was not sufficient.

Patients also indicated that they wanted to be informed about and more involved in their care. The extent to which patients wanted to be involved differed from person to person. Not wanting a high level of participation could be due to several factors. Some patients simply prefer the submissive passive (recipient of care) relationship in which decisions are left to the health professional (Biley, 1992). The stage of the disease process also influences whether patients decide to participate or not (Corbin & Strauss, 1996; Morse, 1991). Alternatively, some may be uncertain regarding their ability to participate and therefore remain passive (Bandura, 1982). The action research group members felt that if patients express their readiness to participate, they should be given that opportunity. In other words, it was important to create an environment conducive to participation.

Patients indicated that they were disappointed with the lack of activities on the ward. According to Locke and Latham (1990) a lack of stimulating activities could adversely affect patients' motivation. Activities should be educational and relaxing. The importance of education and information in the context of participative care has been demonstrated by Brown (1988), Folden (1993) and Frey-Hoogwerf (1996). Therefore, in the development of the action plans in relation to the lack of information and stimulation, it was decided that ward activities should have an educational intent.

Given the feedback from the patients, the action researchers needed to bear in mind that information and education, depending on the topic or issue, needed to take place in privacy. In general, the female patients found the lack of privacy distressing, whereas the male patients did not, or if they did it was not mentioned. Similar findings were reported by Parrott, Burgoon, Burgoon and LePoire, (1989). Males felt there was less violation of privacy than their female counterparts. All the patients, however, indicated that they preferred to discuss health-related issues in private. This was important to the patients in Bäck and Wickbald's (1998) study. A similar finding was obtained by Arciero (1993, as cited in Bäck & Wickbald, 1998).

It is suggested that the environment in which the interaction between nurse and patient occurs plays an important role in the development of their relationship. Trust was regarded as essential for the development of a relationship, for both the nurses and patient. Trusting each other was necessary if patients were to build confidence in the nurses, and for the nurse to support patients outside the therapy session. The nurses described giving this support as bringing reality to the situation (equal to the carry-on role described by Nolan *et al.,* 1998).

The patients also commented on the nurses' workload, which influenced when and how they approached the nurses. This, in turn, influenced the patients' own routines.

Some even suffered functional urinary incontinence, which caused embarrassment for all involved. The two issues that led to this situation were the workload and lack of toilets, and they were issues that also concerned the nurses. Fortunately, the action research group was able to plan around the workload concern, but the toilet shortage could not be solved in the immediate future. Details such as these were passed on to the architectural planning committee who were in the process of developing plans for a new hospital.

To summarise, patient feedback indicated that action was needed on the admission procedure, the rehabilitation activities, privacy issues, and the workload. Up to now, the ward had not actively encouraged patient participation. To implement patient involvement required the creation of an environment that would facilitate it. In the development of such an environment the feedback received from patients needed to be taken seriously, and this is reflected in the action plans.

8.4: The action plans made in response to patient interviews

The study was now at a stage where support and commitment from all involved in patient care was necessary. In order to obtain this the action research group invited all the disciplines to feedback sessions in which the interview results were presented. During those sessions potential action plans were discussed. Weekly interactive meetings were conducted on the ward in an effort to reach all staff. In addition, the outcomes of both the interviews and discussions were placed in the monthly newsletter (Appendix 7C).

All action plans were developed according to the framework described in the planning chapter. Unlike the action plans developed from the health professional reconnaissance, the action plans developed from patient feedback were expected to have an impact on the practice of both nurses and other health professionals. The patients' concerns regarding privacy, lack of knowledge regarding the ward, lack of education/information, and lack of stimulation were the central ideas that guided the formation of the action plans at this stage (Table 4).

Action Plans
1. Information prior to admission
2. Admission procedure
3. Evaluating nursing care with the patients
4. Education and lack of stimulation
5. Activities

Table 4: Action plans resulting from the patient reconnaissance.

8.4.1: Action plan one: providing information prior to admission

The feedback from patients indicated that a process for providing information to patients prior to and during admission needed to be developed. The action research group felt that this issue should take priority, as minimising the distress of patients on arrival might help their progress throughout the rest of their admission.

Patients were admitted to Kauri Ward in one of two ways: either via a waiting list, or through direct referral and admission from the community. Those on the waiting list were inpatients on the acute wards waiting for transfer to one of the Aged Care Services wards. At present the geriatric consultant visited these patients once to assign them to one of the three wards.

After consultation with the medical director the action research group developed the first action plan. The actions in this plan consisted of:

- The primary or associate nurse visiting those patients who were waiting to come to Kauri Ward, while they were still on the acute wards, to introduce themselves.
- During the visit the nurse explained what the patient could expect on the Aged Care Services ward. Written information was left with the patient to share with their family.
- Once on the ward, patients received more general information about how the ward was organised and the staff they would meet[41]. All the written materials were kept in the patient's bedside folder so they had the opportunity to refer to them as required.

In the reflection step of the cycle it became evident that patients and families appreciated the visit by the nurses as well as the information they provided (Appendix 8C, Table 19).

> When she first met me, I was miserable, down in the dumps. I'd just had a stroke; no not a stroke, a heart attack, and I just didn't feel I had anything worth living for. I lost faith in myself. She explained about the ward and she talked me into coming up here. I have no regrets (PI 20, tu 17).

It seemed to reduce a lot of the uncertainty generated by the transfer to the ward. Moreover, on arrival to the ward, patients were immediately able to see a familiar face. During the first action cycle it became evident that the primary and associated nurses did not always have the time to conduct the visits. It was decided to adjust the action plan, and have the clinical charge nurse manager or myself (as the clinical nurse consultant) make the visit, if the other nurses were pressured for time. By completion of the second cycle it was apparent that the clinical charge nurse manager and I conducted the majority of the visits. It was decided that I should incorporate the visits into the gerontological nursing rounds already held on the other wards. Patients had the opportunity to discuss their expectations with me, and a care-plan was commenced that was transferred with the patient to the ward. Once admitted to Kauri Ward the primary or associate nurse continued the nursing assessment.

8.4.2: Action plan two: providing privacy during the admission procedure

Although it was viewed as important that patients be at ease during the admission (clinical) interview, traditionally both the interview and the physical examination were conducted in a six-bed room. Being cognisant of patients' feedback in terms of the lack of privacy, the action research group explored the possibility of conducting this procedure in a private room.

---

[41] Patients who were admitted directly to the ward were given the same information.

The first cycle of this action plan consisted of creating a private atmosphere for both patients and nurses. The action research group decided that the Bellbird room (a multi-purpose room) was the only available option, and thus it became the interview area for patients admitted by members of the research group. During the reflection step it was obvious that the increased level of privacy was received positively by both patients and health professionals. Nurses felt more at ease with asking personal questions, and medical staff - although not always compliant with the new admission procedure - reported similar advantages (Appendix 8C, Table 20).

> The Psychiatrist was going to come to see her and he looked really surprised when I told him about our new assessment procedure, and I said, 'Well I am sorry if this is inconvenient for you but I prefer if she is in here.' 'Oh no,' he says, 'I think that is marvellous.' (Yolanda, Journal, 1997).

The patients' comments were also positive (Appendix 8C, Table 21).

> It was a new experience. I have been in hospital several times, but yes, it is a good idea because there are no distractions there (PI 16, tu 18).

Nurses, medical staff, and patients perceived the private surroundings as valuable. After two action cycles, which included consultation with the ward staff, the admission procedure became ward practice. From this success the idea to involve patients in the weekly evaluation of nursing care began to take shape.

8.4.3: Action plan three: involving patients in the evaluation of nursing care

This action plan was in response to patients' need for privacy and information. It was also a starting point towards encouraging patients to become active participants in their care. In step one of the cycle, the nurses tried to establish a nursing goal with their patients during the admission in the Bellbird room. A week post-admission the nurse and the patient took approximately ten to fifteen minutes to evaluate this goal. As with the admission process, the evaluation took place in privacy in the Bellbird room. These sessions, depending on patients' needs, could be educational, fact finding, evaluative, or a sharing of experiences. Often there was a mixture of all components in one session[42]. Care planning in a private setting enabled the nurses to concentrate and give attention and time to the patient without being interrupted, and it was generally perceived as positive by the action research group members (Appendix 8C, Table 21).

> This idea of taking patients out of the room once every week or once every two weeks to listen to what they want to say is proving not only enlightening for me, but it is also - I think - a way for the patient to get rid of the frustration and perhaps the anger that they are feeling towards their stroke and towards the system. Having said that, [patients] are now very free and open on the ward as well. (Journal Stef).

The reflection step of the first cycle revealed that the patients who were exposed to the new practice were more likely to raise their concerns. However, the group members also felt that it was very time consuming. Moreover, it placed pressure on

---

[42] Five sessions were audio-taped. This was not possible with all of them as some patients and nurses were uncomfortable being audio taped.

the colleague working with this nurse. S/he had to take over a part of the shared workload. Given these comments, it was necessary to achieve some sort of compromise. In the planning for the second cycle it was agreed that the nursing evaluation with the patient should take place during the weekend, when time permitted. In the reflection step it was decided that the interdisciplinary goal-setting was now at a stage were it could be introduced to the ward. The group members felt that their attending both nursing and interdisciplinary team evaluations was not an effective use of resources. As a result the action research group members, together with some allied health professionals, started the conversation on participative goal-setting (presented in chapter 9).

During the previous action plans the action researchers had seen the value and experienced the effects of providing information to the patients. The fourth action plan was directed at combating patients' reported boredom.

8.4.4: Action plan four: activities

In step one of the first cycle, the action research group explored ways of alleviating boredom with the development of meaningful education sessions and activities. It was hoped that these would help patients to better understand their current situation, and perhaps continue with therapy plans. It was felt that education sessions and activities needed to take place at the weekend, when staff had more time available, and these activities were planned in consultation with the patients. For those patients who felt the need to socialise, access to the activities organised by the Day Ward was negotiated, again providing that nurses' workloads allowed it.

The reflection step indicated that these interventions were appreciated. The weekend sessions were organised by a registered nurse on a Saturday morning. The patients almost always chose bingo (housie) or a music session.

> Well we went up there, we had a woman talking and we played all these old tunes, you know? All those World War I songs. And we did various different exercises. Clapping hands and the ones that couldn't clap hands were stamping their feet. And moving their heads. There was a head exercise, and arm exercises, waving your arm up and down like this. See, it's all a bit of exercise, and, yeah, mobility and that, there was a bit of fun, and a bit of relaxation - that was good (PI 12, tu 91).

Both were hourly sessions followed by lunch. These sessions provided the patients with the opportunity to socialise with each other and share their experiences. The activities were perceived as valuable and incorporated into practice after two cycles.

Yolanda shared with the action research group an enjoyable experience. Inspired by the success of the activities so far, she had taken all six of the patients in her room to the kitchen on the Day Ward, where they had made pikelets[43] for afternoon tea.

> It was the getting together and being social. It is good for cognitive functioning to have normal social communication. I thought that was the best thing of it. It would be different if it were for therapy then it would be on a one-to-one basis, then it would be therapeutic for the

---

[43] A pikelet is a small pancake.

> hand. When they are only doing one stir each, I did it to keep them occupied. I found it tremendously therapeutic to have them all cognitively busy. We got conversations happening that do not happen in the room. Conversations about their life, their history, their children the way they voiced their opinions about things. Rather than things like, ‘Oh my bowels have moved you can put the flag up.’ (ARGM15, tu 371).

Given that this was a positive experience, Yolanda planned to repeat it and make it a regular occurrence in her working day.

8.4.5: Action plan five: education for patients and significant others about stroke rehabilitation

If patients and their families/significant others were to make decisions about care, they needed to be provided with information and the chance to have questions heard and answered. During the fifth action plan the research group hoped to help meet this need by providing education sessions.

Step one involved planning the first of these sessions. As Kauri Ward specialised in stroke rehabilitation, the group felt it was appropriate to start with this topic. It was perceived to be important to invite families and carers, and make the sessions accessible to them, as family dynamics often change as a result of stroke (Baskett, 1996). The impact on relationships and family functioning is significant, and issues such as physical loss, cognitive and perceptual disorders, language impairment, and effects on sexuality, could all be addressed in education sessions.

The reflection step showed that this change in practice had indeed been useful to the patients.

> Watching that video the other day, I enjoyed that. Listening to those people, they all had strokes, and they were all talking about how they gradually clawed their way back. It feels like that. I thought it was very good. I am at the stage where I think it will never end, so to have a look at something like that and you know what people have done and got there, and you can say, ‘I can do that.’ (PI 13, tu 212-213).

The sharing of information encouraged patients to directly address some concerns not previously dealt with by the multidisciplinary team. Moreover, the sessions created a supportive environment during which issues and dilemmas were discussed. Families/significant others, patients and nurses all found the sessions rewarding. Families/significant others, however, indicated that evenings were not a suitable time for them to attend. During the second action cycle, therefore, different times were trailed. In the end, the weekends were the preferred option because family members were more likely to attend, and the workload was less hectic.

In consultation with the ward, both the education sessions and activities became permanent features in the weekends and one evening per week.

8.5: Reflections in relation to social interaction and roles

8.5.1: Social interaction

Attending the weekly action research meetings, and spending time working on the action research plans, meant that the staff nurse members of the research group were reliant on the support of the observer participant nurses. The latter group had to ensure the safety and comfort of the researchers' patients while these nurses were off the ward. Provision of this support seemed to depend very much on which nurses were on duty, and the people in the action research group noted comments and actions that suggested resentment at their involvement in the project was building among the observer participants on the ward.

> I start beginning to feel that people will not work with me any more because I am always going off somewhere (Irmgard, ARGM20, tu 46).

The situation meant that the members of the action research group were reluctant to ask for help, had difficulty getting to the meetings on time, and were generally feeling stressed when they got there. They were also worried that care of their patients might be compromised by their absence to attend research activities. Yolanda shared a negative experience, and other group members agreed that they had had similar ones.

> People who are incontinent would not have been incontinent if other people had been there to help them to the toilet, or wash another person for you (Yolanda, ARGM20, tu 38).

I was very mindful of the fact that the project had created two groups on the ward, namely, the action research group and the ward staff. This could result in a 'them' and 'us' situation, and the issues outlined above suggested a rift of this sort could be developing. It was important for safe ward functioning, as well as for the research project, that such a situation be avoided. It needed to be addressed with the staff on the ward.

Consequently, I scheduled my breaks with those of the observer participants who appeared apprehensive, and also organised a ward meeting which was attended by the clinical charge nurse manager, the members of the action research group, and the majority of the ward staff. The ward staff were concerned about being taken for granted, not being valued, and the extra work the study created, although they said they supported the study in **principle.** In the meeting the ward staff voiced frustration about having to 'take over' when the action researchers were developing action plans. They felt that it was just an expectation, held by the active participants, that the observer participants would manage both their own patient load and that of the action research group members while they (the researchers) were absent. The observer participants pointed out that they felt their input was just taken for granted and not seen to be important. These concerns needed to be addressed.

It was decided that the action research group members would negotiate the workload in the morning with the other ward staff at handover. I tried to schedule activities in such a way that I could work on the ward during the action research meeting days. Additionally, the action research group members agreed to try and support each other better, especially during the days when meetings were scheduled.

At the same time as these concerns were being discussed, interventions within the action plans were starting to have an impact on the observer participant nurses' practice. Whilst sensing that familiar ways of working were being challenged or altered, they were reluctant to move out of their safe and stable practice world[44]. According to Bridges (1991) it is important for staff in such a situation to understand the rationale for change. Without this understanding, trust and feelings of security are difficult to develop or maintain, while a reduction in commitment and morale are common (Gilmore *et al.*, 1997). Bridges (1991) points out that the development of anxiety is also a common feeling, and this was becoming apparent at this stage among staff on Kauri Ward. However, the fact that the majority of the observer participants were willing to discuss their feelings directly was positive, as this had not occurred before. It appeared that the communication strategies employed throughout the project had helped create enough trust for the staff members to voice their concerns in a meeting.

8.5.2: Action research group process

Learning and problem solving together, and the use of group and individual reflective processes, had led to the development of trust and respect between the group members. They felt safe sharing their practice experiences and feelings with each other, and this helped some group members build the confidence required to transfer that reflective process into their practice environment. Reflecting on practice in and outside the meetings was a positive development in their practice. This is demonstrated by a passage from Gemma's diary:

> The study I believe has enabled, certainly myself, but generally those that are participating, to bring these qualities out of the unconscious and to the forefront, reflecting on them - good or bad, and 'improving' or developing them. This research group I think has also enabled discussion of personal events that have occurred while on the ward. The good events of these, which are never really brought forward and rightfully praised, something which I believe we all deserve and need at times. The 'bad' events are usually withheld, maybe due to the thought of being embarrassed or looked down upon. However with the mutual understanding that is within the group at the moment, there is, I feel, an understanding amongst us, whereby I know for myself, that I feel that I am able to discuss issues with the others and know that this latter situation would not occur – if anything, understanding and encouragement has been the result. This does not necessarily have to occur when we are at the 'meetings', these people that are participating; I feel that I am able to discuss anything with them, with confidence (Journal, Gemma).

The action research group members were able to address issues, to a certain extent, with each other while functioning on the ward. They still had difficulties doing this with the observer participants. The fact that they felt comfortable doing so with other researchers was related to the supportive culture within the group. The challenge ahead of the action research group members (including myself as the clinical nurse

---

[44] The group of nurses that worked the evening shifts had created a particularly strong culture, and were very reluctant to make changes to their practice.

consultant/researcher), was to create a similarly trusting environment while working with the staff on the ward.

Although implementation of the action plans had in some ways created tension on Kauri Ward, whether because of the time involved or due to the challenge it presented to current practice, one of the action plans helped alter attitudes towards the research, among the observer participants who were previously the most negative. A staff nurse in this group was impressed by the move to provide activities and education sessions during the weekends. She felt that these sessions were appropriate for her and the people she cared for, and she began to take responsibility for the organisation of them. Her enthusiasm and commitment for this aspect of the study influenced her attitude to the rest of the project. She had been able to transform some of her practice based on patients' experience, and she began seeing the benefit of being prepared to leave the old and try new practices. Her support and commitment in the form of her leadership was very valuable in enabling the action research group members to communicate more effectively with this group.

8.5.3: Role of the researcher

An important aspect of this role was helping to build trust and rapport amongst the members of the action research group, and also between the group and the ward. This emerged slowly, as illustrated above, through ongoing dialogue and informal interactions. During the reconnaissance, the action research group members also needed guidance with regards to the conduction of interviews, data interpretation and the research process. At this time my role as researcher within the group was more hierarchical because I directed the learning process, and, in order to safeguard the research process, was responsible for making the major decisions. However, during this process I tried to enable the group to become more self-directing.

Providing clinical leadership was an important part of the role during this stage. For example, being able to coach the action research group members in the clinical setting during the implementation and evaluation of the action plans. I found this rewarding, and that it sometimes highlighted difficulties that the group, or members of the group, were having in applying in practice the principles discussed in the action research group meetings.

8.5.3.1: Practice observation in relation to incongruence between espoused theories and theories-in-use

The journal extract described in the textbox is an example of the difficulties encountered when translating research into practice.

X, an action research group member, was helping patients up for breakfast. One patient wanted to stay in bed because he enjoyed his breakfast in bed. X addressed the patient as follows, “You have to get up dear because I need to shower you before nine a.m.” The patient replied that it was agreed in his goal-setting meeting to shower at night. The nurse told him that they always showered two people before breakfast. I was a little surprised by this comment. I checked if the patient had an early appointment, which he did not. I approached her later during the day and asked her about the incident. I pointed out that this particular patient preferred a shower at night. She acknowledged this but said it was not common practice to shower patients at night. Moreover, she always showered two patients before breakfast. I asked her why this happened. She explained that it was ward practice to have everybody up for breakfast because this was the rehabilitation ward. It was often perceived, although not openly discussed, that the ‘done to’ needed to be completed in the morning. Moreover, she added, “This is real practice” meaning that participative care was not realistic. This comment was rather upsetting as it demonstrated that espoused theory developed during the action research meeting was not her/their theory in action. This in turn led to incongruence between her espoused theory and theory in use.

Textbox 2: Journal entry: Lucienne. Context: working on Kauri Ward.

We in the action research group reflected on and worked through the following questions:

- Did the ward routines and the social pressure associated with the workload result in her action?
- Was it because she had not yet incorporated the newly acquired knowledge into practice and was still in the process of becoming a knower?
- Was it possible that one reverts back to old practice when work pressure leads to stress?

8.6: Discussion

The action plans based on health professionals’ feedback were well received by the ward. The action plans based on patients’ feedback were initially well received but it became clear, as time progressed, that the associated changes interfered with ward routines. It was interesting to see that although nurses acknowledged the feedback from patients and families, some were reluctant to act on it. It was clear that some practitioners experienced difficulties with letting go of familiar ways of working. Perhaps, as Bridges (1991) suggests, they held onto the past in an attempt to retain their safe and stable practice environment. This became evident with comments such as: “But why change? This is fine,” “We have always worked this way,” and “What is the evidence?”

Attitudes like this are understandable given that Kauri Ward had been through two major reorganisations in five years, due to changes in general management. It appeared that, at this stage, nurses were experiencing feelings of loss and emotional responses to change. Given the emerging feelings, the number of feedback sessions was increased. Although a time of uncertainty for some, Bridges (1991) points out that the transition phase, when planning and action occurs, is exciting for others. In moving from the old to the new, and trying to make sense of the new practices, the nurses needed to establish whether these practices fitted with their practice philosophy. Some nurses, in particular the action research members, had already moved into this new beginning.

Based on patient feedback, other nurses and allied health professionals indicated that they would like to participate but were uncertain about the skills they needed. Role-plays and teaching sessions were conducted to address this situation. By the end of this phase of the research, the majority of the staff members were enthusiastic about current and future opportunities, and ready to engage in the discussions regarding goal-setting.

The action research group, after discussing the literature and completion of the reconnaissance, suggested developing a working definition of participative care for the study. The nurse participants agreed on the following statement of their understanding of participation, and this was presented to the ward.

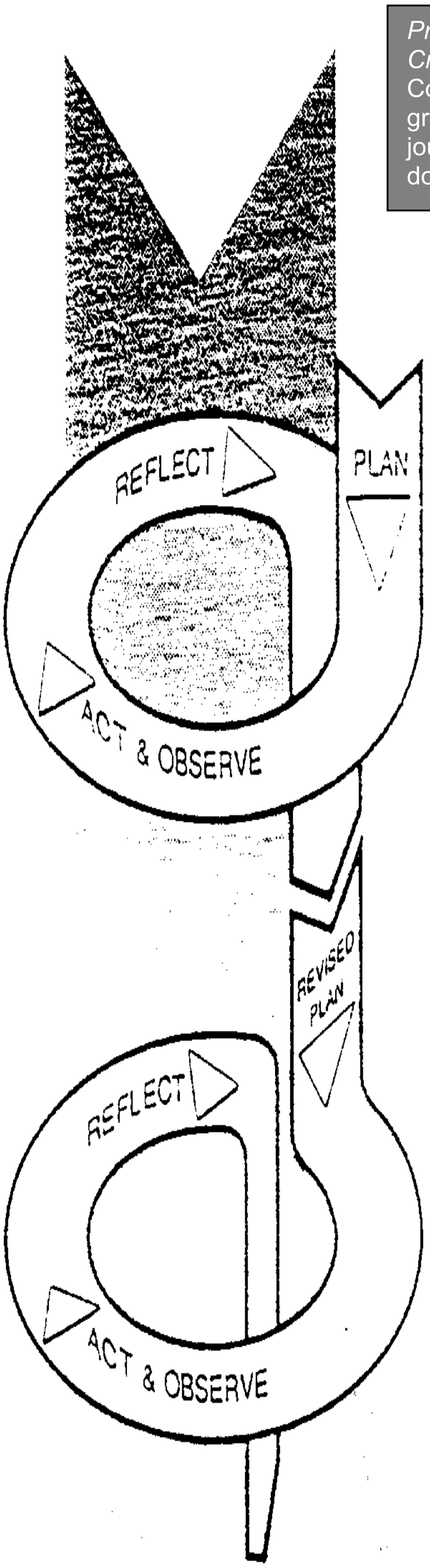
> *Participation is about the creation of an environment that provides patients and health professionals with the opportunity to engage in a relationship that is mutually beneficial. This involves the sharing of information, and bringing together knowledge from health professionals and patients/families, allowing both to engage in a joint learning process.*

8.7: Summary

The feedback received from the patients during the interviews led the action research group to develop action plans addressing the reported lack of knowledge regarding the ward, lack of privacy, lack of education/information, and lack of stimulation. The impact of the action plans became apparent as the study progressed. For example, the information provided to patients prior to admission to Kauri Ward minimised their admission stress. The nurses no longer admitted patients in a six-bedded room but in the Bellbird room, and this addressed some of the concerns with regards to privacy. In addition, the education sessions and the activities organised to address the lack of stimulation appeared to be advantageous to the patients.

The feedback received from the group discussions with the nurses and other health professionals assisted in procedural changes, and helped develop more effective communication processes among staff on the ward. By the end of the patient reconnaissance, both the action researchers and the observer participants had experienced how the use of action research had the potential to involve nurses in critical examination of nursing practice, and moreover, in the subsequent locally driven improvement of nursing care delivery. Through the action research process the group developed a beginning understanding of the patients' needs and developed new practices based upon the patient feedback. The ward staff generally supported the idea of participative care. Their support and the patient evaluations provided the impetus for the final multidisciplinary phase of the study.

9: Phase II: Can we develop participative care in collaboration with older patients based upon their feedback?



Pre-reconnaissance: Creating a research culture.
Commencement of several groups: the journaling, journal, nursing focus and documentation groups.

Chapter 6

Phase I: Stage I: Health professional reconnaissance.
Group discussions and one-to-one guided interviews which aimed at developing an understanding of:

- Current ward practice
- Research expectations
- Practice concerns
- Nurses' understanding of gerontological rehabilitation
- The role of the nurse
- Nurse-patient relationship

Chapter 7

Phase I: Stage II: Responding to concerns.
The action plans resulting from stage I:

- Develop action research group
- Prepare for patient interviews
- 'A foot in the door'
- Introduction of the FIM
- Information/activities board
- Orientation information

Chapter 8

Phase I: Stage III: Patient reconnaissance.
Identified themes from one-to-one guided interviews:

- Lack of information regarding the ward
- Wanting to receive information
- Lack of stimulation
- Lack of privacy
- Continuity of care
- Environment from patients' perspective
- The nurse-patient relationship

Introducing participation to the ward.

- Information prior to admission
- Evaluating nursing care with patient
- Education and lack of stimulation
- Activities

Chapter 9

Phase II: Multidisciplinary goal-setting
Developing goal setting on Kauri Ward.

Discussion **Chapter 10**

9.1: Introduction

In accordance with the feedback received from patients, goal-setting was introduced to Kauri Ward. The involvement of the multidisciplinary team began Phase II: the multidisciplinary goal-setting phase. The first section of this chapter describes the development of the goal-setting process, which consisted of eight action steps. In the next section of this chapter the participants' reflections on goal-setting development are presented. The reflections indicated that the nurses were advancing their practice role, while improving their relationships within the multidisciplinary team, and that goal-setting was perceived to be beneficial for both health professionals and patients. The subsequent section deals with the implementation of goal-setting on the ward. Following this, the insights gained through the action cycles, such as the development of three types of goal-setting meetings, are described. The final section presents my thoughts and practice observations. All action plans in this phase were aimed at achieving the objectives of the study: that is, the development of participative care and the advancement of nursing practice.

9.2: Introducing goal-setting: the emergence of a local theory

The action research group now comprised five staff nurses, a physiotherapist, an occupational therapist, a speech and language therapist,[45] and myself (the clinical nurse consultant/researcher). The aim at this point of the study was to develop a structure and process for goal-setting meetings to enable their effective use with rehabilitation patients on Kauri Ward.

9.2.1: Action step one: preparation of the action researchers

At the start of this step, the action research group developed initial goal-setting instructions and an evaluation procedure (Appendix 9A). The goal-setting process was influenced by the work of King (1981), Kiresuk and Sherman (1968), Law *et al.* (1991), Locke and Latham (1990) and Payton *et al.* (1990). The content was discussed with the senior multidisciplinary team members and presented in the senior management meeting.

Members of the action research group practiced goal-setting meetings with the use of role-play. Senior clinicians were invited to take the roles of the patients[46]. The group asked the 'patients' to voice their concerns, and then used this information to develop goals and care plans. They tried to create goals based on the wishes of the 'patients', as well as on treatment and rehabilitation aims.

Once the team members felt comfortable about the procedure a goal-setting meeting, for which a real patient volunteered, was organised[47]. When reflecting on this meeting, it became evident that the prior practice had been helpful.

---

[45] At this stage no physicians were present. **The outcomes of goal setting meetings were discussed in the multidisciplinary team meetings.**

[46] Inviting the senior clinicians was also intended to create awareness and gain support at this level.

[47] The patient was an 80 year old active councillor of Life-Line.

As can be seen from the following excerpt, the health professionals and patient all perceived the meeting as useful.

> First of all I asked Mrs L, two days beforehand, if she would be agreeable to it. She thought development of the goal-setting meeting was a brilliant idea. I also asked her to think of some sort of goals that she might have as well. Then I went and saw her again on the day, probably about two hours before we went in. It didn't really sound as though she had thought about it too much but [she] had a few ideas. Prior to the meeting I met with the occupational therapist, the physiotherapist and the clinical nurse consultant and talked about the approach. It was the physiotherapist that had the best relationship with Mrs L. So she was the one that sort of took control of it [the meeting] through the goals she [Mrs L] made with each discipline and also some that she thought of previously. With me being there and being able to listen to the other therapies, as to what is actually happening when the patient has to go off the ward; that was quite good. Then also being able to say what we [nurses] can do to implement [therapy into daily routines]! With everyone sitting there and with Mrs L understanding that a lot of work needed to be done [with] her rehabilitation (Gemma, ARGM27).

The goal-setting meeting had been a positive and enjoyable experience for all involved. The fact that Mrs L was not clear about her role, however, indicated that she might not have received all of the information she needed before the meeting.

> I evaluated the goal-setting meeting with Mrs L. Although her response was positive, Mrs L indicated that she did not quite understand what her role was. But she enjoyed the quality time with the team (Lucienne, Journal).

This reinforces the importance of thoroughly explaining and discussing the intent of the goal-setting process with patients. Moreover, it highlights that health professionals often erroneously assume that a patient has understood an explanation. The above incident reminded the members of the action research group to make a conscious attempt to avoid misunderstandings. In addition, the action research group members became aware that unnecessary jargon was used during the goal-setting meeting, which made the meeting difficult to follow for the patient. In the next goal setting meetings, group members took more care to avoid jargon, and tried to ensure sufficient time was available for the patient to state their goals and ask questions.

The guidelines developed by the group prior to the session had proved useful, but needed further work. Other concerns raised by this first goal-setting meeting included its long duration and the ill-suited documentation forms. On reflection, the length of the meeting was attributed to the novelty of the process and was anticipated to decline as the action researchers gained more experience. It was also decided to devote a separate action step to addressing the documentation of the goal-setting meetings. The positive reactions to the meeting provided the impetus to continue and further explore goal-setting.

9.2.2: Action step two: refining the goal-setting process and deciding which patients to include

The goal-setting process and criteria needed to be finalised as soon as possible because the busy winter months had arrived, bringing the usual increase in patient acuity and workload. This would influence the number of goal-setting meetings that could reasonably be conducted on the ward.

Because Kauri Ward's focus was stroke rehabilitation, it was decided that only patients who had suffered a CVA, had complex needs, and who required the involvement of three or more disciplines, would be invited to participate. In addition, they needed a Mini Mental State Examination score of 24 or greater. This meant that only six of the present patients were able to participate. They had been inpatients for less than a week, which meant that they could be followed from admission to discharge.

From this point the action research group decided to invite every newly admitted patient, who fitted the criteria, to participate in the goal-setting process. (This resulted in a total of fifteen patients being included in the next action step.) It was also planned to ask the patients to participate in the reflection steps, if they wished. Both the goal-setting meetings and reflection sessions would be audio-taped as aids to feedback and learning.

9.2.3: Action step three: conducting goal-setting meetings in practice

During this step fifteen goal-setting meetings were undertaken and evaluated by the action researchers. With the permission of all the participants I observed and audio-taped each goal-setting meeting. The tapes were played back in the action research group meetings where they were used as a starting point for discussion, and as an aid to reflection, evaluation and feedback. Reasonably early in this step (after five goal-setting meetings), the group members identified process related concerns. These included lack of preparation of both patients and health professionals, and problems with the scheduling of the meetings. Further action steps were initiated to address these concerns.

9.2.4: Action step four: establishing ice-breaking

It became evident that the level of information given to patients before the goal-setting meeting took place had an influence on the success of that meeting. This process and time spent with the patient to explain and discuss participative goal-setting became known as 'ice-breaking'. It informed the patient, and their significant others, about the principles of participative goal-setting and why it was felt to be valuable, and gave them a chance to prepare for their part in the meeting.

> A brand new thing [the goal-setting meetings]. An innovation but I found them very helpful - my wife and I always discussed that in our own time and before we came in [to the goal-setting evaluation meetings]. It is good to be able to meet everybody together and just to find out where you were going, and for Julie [wife] as well (PI 20, tu 20).
>
> The ice breaking seemed to be really important, spending the time in the days leading up [to the goal-setting meeting] rather than going in directly. Explaining seems to be paramount to the success of any goal-setting meeting (ARGM31 tu 21).

When the ice-breaking did not occur, or when it was done poorly, the duration of the meeting increased (an issue in terms of cost effectiveness), and patients and their significant others were less likely to take an active role in the meeting. Ice-breaking came to be seen as an essential part of the goal-setting process. It was felt, by the allied health professionals, that the nurses were in the best position to provide the patient with this initial information, as the nurses carried out the admission procedure and were more readily available on the ward.

Later in the action research project, one of the patients suggested the development of a booklet explaining the goal-setting meetings. A first draft was developed by one of the action research group members. The multidisciplinary team members and four discharged patients, who had participated in the goal-setting meetings, reviewed the content. The booklet helped formalise patient preparation and education for the goal-setting meeting (see Appendix 9B for a summary of the information given in the booklet).

9.2.5: Action step five: improving facilitation and scheduling of the goal-setting meetings

It seemed logical, in most instances, for the role of ice-breaker to be carried through to the goal-setting meetings where this person could then act as facilitator. Members of the allied health professions felt that the nurse was generally the most appropriate person for this job.

> It is the nurse's role to facilitate, although we think it is a partnership and we need to be supportive. The nurses are there 24 hours for [the patients'] care and they see the whole person. With the nurses facilitating, it will be good. We know that it is their role and we are supportive (ARGM35, tu 48).

Initially, the nurses were uneasy taking on the responsibility of organising and facilitating the meetings. Their main concern was the amount of time involved, but they were also lacking in confidence, to a certain degree (see Appendix 9C, Table 22 for comments made by nurses as their confidence improved). The use of role-plays, in which the nurses practiced facilitation under the guidance of the Aged Care Service's organisational psychologist, was again useful. It became evident that the nurses had, during the previous action cycles, developed a clear process for the goal-setting meetings, and this is described below.

After patient consultation, the nurse invited the family to the ice breaking session and ensured that they and the patient received written and verbal information regarding the purpose of the upcoming meeting. This allowed the patient time to discuss any issues of concern with either family or health professionals prior to the goal-setting meeting. The health professional participants also got together briefly (workload permitting) to check they were adequately prepared for the session.

In the goal-setting meeting, the facilitator (the nurse) asked the multidisciplinary members to introduce themselves and explain their role in the team, before inviting the patient to share their concerns. Subsequently, the nurse asked each discipline to discuss their input with the patient, and then checked the patient's understanding of any goal and proposed action. The next step was the discussion of the Functional Independence Measure, which was followed, in some meetings, by goal prioritisation. Finally, the nurse summarised the goals, negotiated a date for the evaluation meeting, and checked that all participants were satisfied with the outcome. After the meeting the multidisciplinary team and patients would complete a quick practice audit (Appendix 9D)[48].

I observed that the action research group nurses facilitated well. They generally ensured adequate preparation of the patient prior to the meeting and created a safe environment within the meeting once it had started. Obviously, for the meetings to be successful, all participants needed to feel comfortable. In general, patient feedback was positive in this respect.

> She [the nurse] graded you on marks [talking about the Functional Independence Measure score], how you had improved or whatever the case and then it made you feel good if you had improved. We just discussed ... points to work on, you know, practice; you know what was needed to be improved on and that sort of thing. Like transfers or something like that (PI 26, tu 135).
>
> I thought that it was done pretty well. I always had at least a weeks notice - so I had time to think and reflect (PI 30, tu 79).
>
> I thought you did well, you made me feel as though I was part of the group too, not an outsider (PI 30, tu 187).

It is important to note that future evaluation interviews with patients and their families did reveal two occasions when patients had not felt listened to or safe within the goal-setting meeting. These incidents are discussed later in this chapter.

It became evident that the timing of the meetings had an impact in terms of patient preparation and readiness to participate, and also with respect to the availability of all the health professional participants. Firstly, the appropriate interval between admission and the initial goal-setting meeting differed for each person. The following patient was too ill to engage in participative care on arrival to the ward.

> I wouldn't even be sure of how many days, but I would say three or four days ... were a complete loss, and then I 'came to' in that room. I started to settle down a bit then. From that time on, you were ready to get information and ready to start your rehabilitation programme (PI 21, tu 180).

In contrast, feedback from other patients indicated that they expected rehabilitation to commence earlier than it did.

> I was told when I was on the other ward that I was coming to a rehabilitation ward. I had to wait for three days before I saw that team, you know, the ones that ask you about what you want (PI 24, tu 10).

Not surprisingly, each patient had different needs and expectations. Their readiness to receive information and participate actively in rehabilitation was dependent on the factors described by Morse (1991) and Corbin and Strauss (1996): willingness, stage in illness trajectory, and coping mechanisms. The multidisciplinary team attempted to be flexible, and to accommodate and respect those as much as possible. At the same time it was beneficial if each discipline had had the opportunity to conduct an assessment prior to the goal-setting meeting, and important that the nurse had sufficient time to provide the patient with the necessary information. Consequently, it

---

[48] Patients did their evaluation separately from the multidisciplinary team.

was decided to try and conduct the first meeting within three to five days of admission, explaining the reasons for the timing to patients as required.

Timing of evaluation meetings was, on occasion, problematic. Early in the rehabilitation process it was useful to have weekly evaluation meetings, but the workload made it difficult for all multidisciplinary team members to be present at each of these. While agreeing that all team members would attend the evaluations where possible, the action research group members accepted the suggestion, made by one of the group, that evaluation of goals could occur across the disciplines.

> The goals are really set so that the patient can understand them. So everyone in the team should be able to understand them as well and do some sort of evaluation. There might be some things that you can't, but we could deal with that. The whole thing with the goal-setting is an enhanced communication - we probably [now] know a lot more about what the occupational therapist is doing anyway. So we are better equipped to do the evaluation [than we would have been in the past] (ARGM42, tu 33).

9.2.6: Action step six: documentation of the goal-setting meetings

The documentation of the meetings needed to meet a number of criteria. The goals and resulting actions needed to be written in language understandable to patients and their families. Additionally they needed to be clinically useful across the disciplines, while avoiding duplication. At the time of this project, the multidisciplinary quality team was developing an interdisciplinary care/therapy plan, which was intended to be patient focused, and to draw all the clinical records together (Appendix 9E). It was hoped that the package would be in a format that could be left at the bedside if the patient wished, and it seemed appropriate to include in this document the record of the goal-setting meetings.

For nursing this involved a complete change of documentation. The existing nursing care plans were to be replaced by an outcome orientated care/therapy plan. Instead of being kept in separate folders not readily accessible to patients or other disciplines, they would be visible and accessible to all.

This change was anticipated to be difficult to implement initially, not only among the nurses. Members of the medical profession were very reluctant to have their interventions documented in the patient care/therapy plan. This meant they would be unlikely to read the plan and would therefore remain unaware of the goal-setting progress. They suggested summarising the goal-setting meeting in the progress notes. However, this meant duplication and a digression from patient centred documentation. A compromise was made by photocopying the goals and placing them in the progress notes[49]. Goal attainment would be documented in the achievement section of the care/therapy plan. Although this solution was not optimal, it meant that the patient and all multidisciplinary team members had access to the goals, the care/therapy plan was patient-friendly and could be left at the bedside, and the patients had direct access to a record of their progress and the plan for their care.

---

[49] The ward clerk was consulted as the photocopying became her responsibility.

Examples of patients using the documentation to direct their own care began to appear.

> Patient reading from care/therapy plan to an agency nurse: "In my care/therapy plan it states that my nebuliser is to be administered before lunch, not after. I would appreciate it if you could give it to me." (Betty, Journal).

Additionally, the change to integrated care/therapy plans, and inclusion of weekly nursing evaluations in the progress notes, made nursing considerably more visible to the other disciplines. This, in turn, influenced the quality of the nursing documentation.

During the development of the new documentation, only the action research group members worked with it in practice. After the format of the care/therapy plan was revised, and it had been evaluated by the multidisciplinary team on the two acute gerontology wards, the day ward, and community teams, its use by all the staff on Kauri ward was piloted. After final adjustments were made, the new documentation forms were submitted to the hospital's Records Committee and were approved for use in practice.

During the long process of development and adjustment, the action research group and the documentation group worked closely together. This was another point at which respect and understanding was fostered between the disciplines. Moreover, working together on the documentation resulted in the increased interest of two geriatricians in the goal-setting process. They subsequently volunteered to discuss goal-setting during the orientation day provided for the registrars and house surgeons.

9.2.7: Action step seven: medical involvement in the goal-setting process

Despite geriatrician support of the project, there had been no direct medical input in the goal-setting meetings up to this point. As well as being confusing for the patients, it created the potential for goal conflict - where several goals are set and the pursuit of one goal interferes with successful attainment of another (Locke & Latham, 1990). Goal conflict influences motivation and eventually performance. Due to all the other disciplines being present at the goal-setting meetings, and medical staff being informed at multidisciplinary team meetings about progress, major problems had been avoided. However, the absence of medical representation in the goal-setting was creating conflict among the multidisciplinary team, and the geriatricians were beginning to question this lack of involvement.

The two registrars who had been involved in the documentation action step volunteered to become active members of the action research group during this time, and they were invited to observe goal-setting meetings. In the meantime the two house surgeons (junior doctors) on the ward attended an educational session on goal-setting conducted by the physiotherapist and myself. After time spent as observers, these physicians became actively involved in the goal-setting meetings.

On reflection, it was noted that the participation of the medical staff still very much depended on the individual registrar or house surgeon and needed to be further discussed with the rehabilitation committee and the clinical director[50]. Eventually the geriatricians indicated that either they or their registrar would be present at future goal-setting meetings, as they believed the value of the meetings in the rehabilitation process had been demonstrated. Physician participation was appreciated by other members of the team.

> I just remember one [goal-setting meeting] with Mr. P, when they were talking about his knee. It was one of the most important things at the time for that meeting. He just wanted to take it all in and so it was quite good that the doctor was there. She was explaining things to him, as everyone [else] didn't really know what was happening with the knee. It was important for where we were going to go. I think that was quite good for him, and that he was able to have that time just to take it all in. She did explain it really well, he didn't really need to ask any questions, so I think it depends on what stage they are at as to who does do the talking (ARGM36, tu 50).

The registrars also commented on the advantages of goal-setting.

> At the end of the day it saves time, actually. Because otherwise you end up wasting that time on ward rounds or you approach the nurse in between and they are not always available (ARGM36, tu 151).

Once the process related concerns were addressed the action research group began looking at content related concerns.

9.2.8: Action step eight: dealing with unrealistic goal-setting

The action researchers had noticed, among some patients, a tendency toward the setting of unrealistic goals.

> Unrealistic goals always come up in the goal-setting meetings of the patient. One of the purposes of goal-setting is educating the patient as to where they're heading, what is realistic, and what is unrealistic. Educating other team members [about] what's realistic and what's unrealistic [is also important], because you might have found something, or felt something, that you don't really think is heading in the appropriate direction. It's a good place to bring those things up to the patient, where you've actually got the support of your colleagues. I don't mean that we've got each other's support so that we can threaten the patient. But it's where we can support each other and explain things and be backed up by little examples of things (ARGM49, tu 160).

At this stage the group members consulted the literature. It became evident that although the setting of unrealistic goals was of concern, it could also be viewed as a stage on the way toward more realistic goal-setting. Moreover, to diminish hope at an early stage in the rehabilitation process may lead to depression, apathy and failure to respond to treatment (Hohman, 1975). The feeling of being in control has an influence on the individual's well being (Schulz, 1975; Thompson, 1981), and it has been shown to assist in adjusting to chronic illness (Bandura, 1977; Thompson, 1981). Herbert and Powel (1989) demonstrated that people who were optimistic and had positive expectations made better progress than those who had low expectations. Furthermore, patients may need some time to understand their

---

[50] It should be noted that one of the registrars remained an active member of the action research. She attended as many meetings as she could.

disability, its limitations and their potential. Participation in the goal-setting process may, in itself, help with this understanding, and lead to the development of realistic goals (Wade, 1992; Young & Chesson, 1997).

On the other hand, rather than being unrealistic, the goals may simply conflict with the interests of the multidisciplinary team. Both of these possibilities were openly discussed in both action research and goal-setting audit meetings. An example of conflict between the goals set by the patients and that of the team is described in section 9.4 (pp. 127 - 130). According to Haas (1993), conflict in goal identification may well be resolved with clear and open communication, and our experience found this to be valid. Locke and Latham's (1990) work in relation to goal specificity was found to be useful in this area. Goal specificity refers to the clarity or the degree to which a goal is precisely conceptualised. The setting of a specific goal is claimed to be more effective in terms of motivating performance, and the group found that it could help expose an unrealistic goal while still acknowledging the achievements made in the pursuit of that goal. For example, the patients in the study generally wanted to go home. However, they needed intensive rehabilitation in order to be able to function safely at home. So the large and extremely complex task was broken down into a series of smaller, more manageable ones.

> All the little goals [sub goals] actually adding up to the big one - that's been cool. It helps the team immensely and I think in that way, doubly and indirectly helps the patient as well. So it is definitely patient centred, but directive (ARGM42, tu 125).
>
> There was a time when I had begun to see it was out of the question for me to go back home, as things were anyhow … but I was not at all at sea. It is a question of what was the best thing to do. No, I [knew] I wouldn't be able to go home at that stage (PE28, tu 23).

Clear and specific goals establish a minimum acceptable performance, and make explicit the progress that is required to meet the larger overall goal.

9.2.9: Summary of the action steps

The action research group had, in the development of the goal-setting meetings, addressed process and content related concerns that had evolved from practice or shown up in feedback from patients. This had resulted in several action steps (Table 5) being consciously undertaken.

Action Steps In Relation to Goal-setting
1. Preparation of the action researchers
2. Refining the process and deciding which patients to include
3. Conducting goal-setting meetings in practice
4. Establishing ice-breaking
5. Improving facilitation and scheduling
6. Documentation
7. Medical involvement
8. Dealing with unrealistic goal-setting

Table 5*:* Actions steps in relation to goal-setting.

The action research group had developed the process to a stage where they felt confident using it in their practice. Goal-Setting Theory, as developed by Locke and Latham (1990), had been translated into a local healthcare setting. During the process, adjustments initiated through the research resulted in a local theory of goal-setting suited to this group of patients and health care professionals. The theory had been operationalised in the form of a guideline, documentation (multidisciplinary careplan), audit sheets and an information booklet for patients and their families. It could now be utilised in practice by the observer participants on Kauri Ward. Prior to this, however, time was set aside to reflect on and learn from the steps taken so far.

9.3: Reflection on developing goal-setting

The process of incorporating goal-setting meetings into the practice of the action research group members resulted in a number of changes in their relationships, and had an impact on their patients and the observer participant nurses on Kauri Ward. Probably the most obvious effect was the way in which the relationship between the nurses and the allied health professionals had changed during the time they had worked together. Mutual learning and giving of support had led to the development of interdisciplinary trust, which was previously absent. Trust is thought to be an essential ingredient for effective team functioning (Hastings, 1996; Øvretveit, 1990; Schmidt, 1995).

As trust was developing, so too was a better understanding of each others' roles, which helped address the issue of nurses feeling 'invisible' in the rehabilitation process. For example, the allied health professionals became more interested in what were previously viewed as nursing issues only, such as continence and wound management. As a result, continence was now recognised as an important factor influencing progress in therapy.

> One of the positive things is that the other disciplines are aware of issues that we have identified as a problem for the patient. Continence may not have been a big thing for the occupational therapist and physiotherapist, but now they are asking what their [patient's] continence management is (ARGM50, tu 756).

Physiotherapists invited the nurses to conduct an in-service session on incontinence. Whereas previously a therapist would have asked the nurses to toilet the patient prior to a session in the gym, whenever it was occurring, they would now take the bladder-retraining programme into account when scheduling therapy.

In the same way, the nurses participated in therapy sessions when workload permitted.

> The physiotherapist invited me over to the gym one time to watch O [patient] and to show me what he was doing. I went back and I wrote it as nursing notes what would be good for the nurses [to know]. The physiotherapist had a look at it to make sure it was still the same way and it worked (ARGM50, tu 97).

The action research group felt that they were truly working together towards common goals, and not in conflict with each other. Consequently, recognition of each other's achievements occurred. From the nurses' perspective it certainly addressed the concern of inequality in the multidisciplinary team. The nurses were recognised for their leadership role in the introduction and development of the goal-setting process.

> I heard one of the physiotherapists talking to one of her students saying that the nurses have started this goal-setting. The way she described it, I thought it was good to see. They thought it was a really good idea (ARGM52, tu 73-73).

As professional trust and respect grew, members of the action research group began to support each other's professional and role development. For example, it was the encouragement and support from the allied health professionals that assisted nurse members of the research group to take on the role of goal-setting meeting facilitator. The relationship helped the nurses develop confidence and self-efficacy.

> The facilitation of the goal-setting meetings - the ones I've been to - has been pretty well co-ordinated and I felt really supported. Everyone is supporting each other as well as the patient (ARGM49, tu 10).

The relationship between the professionals in the action research group became that of equals, and an atmosphere of collegiality and camaraderie developed.

> There has been a lot of laughter and a lot of giggling … and it lightens up quite a bit. I don't know if the others have a lot of laughter and humour. One of the things that X [PT] said to me before she went off on Friday was that [during] the evaluation of our goal-setting, the patient was telling everyone how wonderful it was and how she felt good about it, although the patient didn't actually say it to me (ARGM48, tu 1155).
>
> It just makes everything a lot more focused, and one of our physiotherapists actually called it synergy between everyone! It's not quiet that yet, but that's what we're aiming for, between everyone, between the team members and the patient, that everyone [works] towards common goals (ARGM47, tu 167).
>
> I think that even though this is all patient directed or patient focused, it was a good team thing that came out; educating other disciplines about what we do and how we help ... with each other. I think that's really good. So it enhances communication (ARGM49, tu 43).

As mentioned in the excerpts above, multidisciplinary team communication had improved noticeably. This was not confined to the action research or goal-setting meetings, but carried over into the real working relationships, so that when problems occurred in between meetings, team members addressed them immediately.

> Yesterday there was a good opportunity to find out what was happening. It was a good time to sit down. The other therapist came and we had a mini-conference (ARGM51, tu 10).

The good relationship between action research group team members also improved continuity of care, as the multidisciplinary members of the group continued with the therapy or management programmes of each other.

> What I find really good about them is knowing where the patient wants to go, what everyone else is working on. So we can all take each other's work into account. Often [the conversation] focused on the stuff but translating the physiotherapy into the home environment is something else. I never realised that the nurses are doing that (ARGM52, tu 305-307).

In addition to the improvement of relationships within the multidisciplinary team, the action research group members had been excited to note the increase in motivation amongst their patients once they had begun the goal-setting process. It became evident that goal-setting, even when it was assigned and not participative in nature, had the potential to motivate the patients when conducted carefully.

> They [patients] give you a goal and you [break it down into] small parts, it is almost like you have taken their goal away from them and made it yours. But so long as they are aware of the process of going from their big goal to what it takes to reach that goal by the little small goals they seem to be a lot more accepting. Then in my experience they then work towards those smaller goals with a lot more motivation (ARGM53, tu 65).

As shown above, the willingness to share experiences and learn from each other enhances teamwork (Barr, 1997). Working and learning in a multidisciplinary team context created a very positive atmosphere amongst the people involved. This is essential for the development of shared understandings (Barr, 1997; Cott, 1998; Hackman, 1990).

9.4: Feedback from patient and family evaluation interviews

Reflection on the progress made until this point was aided by the conduction of patient evaluation interviews. Ten interviews were undertaken, with patients and families who had participated in the goal-setting development. Conducted during hospitalisation and post-discharge, the interviews concentrated on feedback with respect to the goal-setting process, and were analysed in the manner described previously.

Members of the action research group often said that they felt that patients' motivation improved with goal-setting. Patients and family members appeared to agree with this experiential account. A woman whose partner was involved in the goal-setting meetings pointed out that his behaviour changed after participation in the process.

> I think from Wednesday last week, I think he has really taken a more positive stand in himself, because we are seeing a lot of nice changes taking place. Whereas before he was getting so depressed because

> he just wasn't willing to participate in getting himself better or improving from what the amputation situation was - and he just wasn't ... had no interest on improving on that whatsoever - but lately, there has been a vast difference, a big difference (FMI 2, tu 26, 83).

Patients themselves seemed to agree with this interpretation.

> I don't know whether I would have had the motivation by myself - it was the team yes, encouraging all the time (PE 30, tu 395).
>
> Z [partner] was in on the meeting; I don't think he really agrees with what they [multidisciplinary team] said. But I think the meetings were helpful, it makes you determined to improve your health and get out. (PE 25, tu 142).

One of the social factors with an impact on goal commitment is the degree to which the goal-setting procedure is public. A publicly set goal typically leads to greater commitment than a privately set one (Hollenbeck, Williams & Klein, 1988, as cited in (Locke & Latham, 1990). Consequently, when a goal is set jointly in a goal-setting meeting, both the patient and the multidisciplinary team are more likely to be committed to the goal, thereby increasing the chances of goal attainment. Commitment is also strengthened via peer influences. In the rehabilitation context peer support groups such as the stroke foundation or introduction to a stroke survivor as a role-model may validate the goal for the patient. The effect of role modelling on motivation was mentioned by one of the patients.

> Well it gave me a goal to live for- you know, participating, and I think even the physiotherapist, I said to her, 'You see girls [I am] struggling'. [She said] 'Three months ago you were worse than that.' And I would say, 'But how about this fellow here, I mean he is walking you know, trying to hop.' I said, 'Do you think I will ever become like that?' And she said, 'Oh yes.' That boosted me up and helped give me goals (PE 26, tu 214).

The action research group had expressed earlier that the goal-setting meetings were educational for both the team and the patient, and assisted in the development of patients' insights about their situations and what they could realistically expect to achieve through their rehabilitation. For this learning and reflection to occur among the patients and their families, the multidisciplinary team had needed to create a safe and comfortable environment in which the patients felt they could voice their concerns, be heard and listened to. As outlined previously, feedback from the patients and their families during these evaluation interviews, and also informally on the ward, indicated that generally they did feel safe with the team members (Appendix 9F, Table 23).

There were two occasions, however, where patients indicated that they did not feel listened to in the process. It was important for the action research group members to discuss and reflect on these occurrences, so that they could be learned from, and so that practice could be improved.

The first of these patients, and his partner, shared during the evaluation discussion that his goals had conflicted with those of the health professionals. This man wanted to be baptised, and so his goal was to be able to walk the short distance that would be required during the ceremony. His recent limb amputation and severe congestive heart failure meant that standing was very difficult and the effort of rising from sitting to standing made him very breathless. He was under the impression that he needed to stand and be tilted backwards in the river in order to be baptised, and so he was determined to stand.

> We didn't talk about it as such, but we thought about going in and how are we going to get that leg into the wheelchair, but we got around that actually. I always thought that baptism, they had to insert you in the bath or whatever and I didn't realise that you would go down to the beach to do so. You do it in the water and you're basically covered from head to toe. I was really ready to be baptised ... in the old tradition (PE 28, tu 338).

This man did not feel comfortable sharing his goal or plan with the multidisciplinary team, and so they were not aware of the reasons for his frustration and acute sense of disappointment and failure when he was unable to achieve this goal. If he had been able to share his goal with the multidisciplinary team, a religious minister could have been invited to the participatory goal-setting meeting, where he could have discussed alternative options with this patient. In other words, an alternative - achievable - sub-goal could have been established to enable this man to achieve his main goal of being baptised.

Similarly, the second patient felt unable to share her overall goal with the team, which was to drive the car on her farm. She felt that they did not understand the complexity of her situation or the strength of her desire to return to her previous living situation - a remote farm on an island - where she had lived most of her life. The multidisciplinary team was concerned about her safety and ability to cope in such an environment, and made this quite clear. She, therefore, did not share with them her plans or goals. Instead, both the patient and her partner felt that they just needed to work without the multidisciplinary team to attain their goal, which they quietly did.

> I did find it difficult because they did not quite understand it all, but X [partner] would tell them, 'Look, this woman has been sitting at the table preparing her meals for years and doing preserving, doing hundreds of bottles of fruit and pickles and all that.' I always had the strength - I even cut kindling wood you know. He has got a pile there for me to cut. When I went back there, I drove my car (PE 28, tu 383).

In those two instances it became evident that the team was not acting in a supportive empowering manner. The excerpts below show examples of this breakdown in communication.

> (Patient)
>
> I felt she wasn't seeing me; she was using her ideas of what I should be or should do. Now all right, I want to be listened to, I want to say these things and then have it explained in as nice a way as possible, that look, that is not really quite the best idea. If it were diplomatically put, I would have listened. But when it is not diplomatically put, I feel that I am not being listened to - I know I am difficult, I said that all the way through, I know that, because of what I turned into I suppose (PE 23, tu 270).

> (Health professional)
>
> The good thing is that it is their initiative, their meeting, and it is low key, quite informal and it is no big deal and it gives them a chance to see what they can achieve, they are setting the goals, therefore they own them. I am not setting them or anyone else, which was the case with Mrs K, why we took so long. Mrs K objected to the PT setting the goal and expecting her to meet the goal. I think that having said to Mrs K. from the word Go that we would be setting goals, that it would be her goals - not anyone else's, she had it in her mind then, it is her [Mrs K's] goal, she should be setting [it] up and not the physiotherapist. It was like a red rag to a bull (ARGM49, tu 210).

Some of the health professionals present during the goal-setting meetings concerned were tending to be more directive than was the intent. This may have been due to several factors. The health professionals used a paternalistic approach to care giving, where the experience and knowledge of the patient is not taken into consideration and their right to self-determination is frequently compromised. Moreover, the meeting occurred shortly after multidisciplinary rotation, and the new staff had not received any orientation to the ward or information regarding goal-setting. They were therefore present in the meetings without knowing what was expected of them, resulting in confusion for them and the patient. These incidents emphasised the importance of orientation and education of the new members of the multidisciplinary team. It was decided that new team members would have information about the goal-setting process included in their orientation package, and that they would be given an information sheet. In addition to ensuring that the health professionals were well prepared for the meeting, it was vital that the patients were also well informed, as discussed in section 9.2.4 (pp. 118-119). The patients themselves were generally cognisant of this and often responded to the suggestion of a goal setting meeting, in the first instance, by saying that they would like to participate but did not have the knowledge. According to Arnstein (1972), provision of information that is understandable to the person concerned, and checking that the person understands that information, is one of the first steps towards participation. Giving information coincided with consultation and feedback on progress. By this stage in the development of the goal-setting, great care was taken with the language used during these processes. The action research members tried to avoid the use of controlling language. For example, use of first names, pluralisation of the patient as 'we', and reference to the patient as a passive object were avoided.

The environment in which the meetings took place was also thought to have an influence on the outcome of the meetings. They were held in a private room (the previously mentioned Bellbird room) in which participants were seated at a round table. The patient came with their primary nurse to the meeting, and all other health professionals entered and were seated once the patient was in the room. Finally, patients were encouraged to dress in day clothes rather then attend the goal-setting meeting in pyjamas. This also minimised the dependent patient role.

9.5: Implementation of goal-setting in the ward

Given that there was general agreement that goal-setting enriched practice, it was decided to incorporate it into the ward's daily practice. As in the reconnaissance phase the ward staff had requested to be kept informed and had been providing feedback. Some participant observer nurses had been particularly interested in the process and had already participated in the goal-setting education sessions and role-plays, and had observed a meeting. From their own experience, the action research group had found that observing the goal-setting meetings was a good learning experience. Other health professionals (with permission of the patient) had also had the chance to observe meetings and participate in the education sessions.

At the beginning of this action step, therefore, the majority of staff members (allied health and nursing) had become actively involved in goal-setting. Most of the other participant observers were happy to observe a goal-setting meeting, and this was their first introduction to the actual practice of goal-setting. These staff members were enthusiastic after the feedback from the action research group and the participating patients. Once a critical mass of primary nurses were ready to facilitate their first goal-setting meeting, I or another nursing member of the action research group participated in the goal-setting meeting, in order to provide feedback. The action research group tried to have at least two experienced health professionals in each meeting, in order to guide the process. They also assisted in the formulation of the goals when necessary.

It was sometimes difficult to get staff on the ward to provide feedback, in the ward meetings, in relation to the goal-setting and their role in it. Consequently, one of the primary nurses in the research group decided to ask her nursing colleagues for written feedback, and she provided the action research group members with the results. The comments indicated that they had mixed feelings about the process, but were generally supportive (Table 6).

I think goal-setting is unrealistic.
Goal-setting is a very valuable part of the nursing process often overlooked in other wards. It is good to see it in practice. In my opinion it is something other wards could learn from.
I think goal-setting is something most nurses engage in a more real way, i.e., interacting with family and patients as part of their normal nursing practice.
The format could have a more formalised pattern so that all members would feel that they could contribute equally. But the process is very helpful.

Table 6: Feedback from some observer participants.

Until this point in the project, some nurses saw the goal-setting meetings as merely a research activity, involving only the action research group, physiotherapy, speech and language therapy, and occupational therapy. As such, it had not had an impact on their nursing practice. However, now they were asked to adopt a new form of practice, and many felt they did not have the skills necessary; this made them feel insecure. When the action research group asked them what they thought they needed, they again requested education sessions, role-plays, and chances to observe goal-setting meetings. These opportunities were provided as time allowed. The move toward participative care was received with mixed feelings by the nurses. Some opposed changing their daily routines, but others welcomed the idea and found creative solutions to facilitate participative goal-setting.

9.6: Kauri Ward's local goal-setting theory

Three types of goal-setting meetings developed during this study: participative goal-setting, assigned goal-setting, and non-participative goal-setting. The first two include the patients in the goal-setting process, whereas the latter involves the families of cognitively impaired patients[51]. The difference between the two patient inclusion meetings is that in the participative method the patient initiates the goals, whereas in the assigned meeting the goals are initiated by the multidisciplinary team.

9.6.1: Participatory goal-setting

In participatory goal-setting patients brought their concerns to the meetings, and interacted well with all multidisciplinary team members. Some of the participatory goal-setting meetings also had a fact-finding component and were informative for both the multidisciplinary team and the patient. The team was able to develop valuable insights as a result of a discussion with the patient, and consequently set rehabilitation goals according to the patient's needs. These meetings were reminiscent of the participative goal-setting process described by Locke and Latham (1990). The patients who participated in the meetings were assertive and motivated, and often knew what they wanted. They used the expertise of the team to clarify and assist them in attaining their goals. The meetings were rewarding and productive as the knowledge and experience of both patients and multidisciplinary team members were used to co-operatively arrive at mutually acceptable and realistic goals. In participatory goal-setting the decision making is shared and multidisciplinary members are learning and trying to relinquish control. The rehabilitation of these patients is a joint venture in which patients are beginning to take control. The following interaction is a typical example of joint problem solving and decision making in one of the meetings.

---

[51] This meeting evolved as a result of the benefits noted from the assigned and participative goal setting meetings.

Nurse [addressing the patient]**:** Could you summarise your goals from last week?
Patient: Yes, here you go. I want to continue driving my car, increase my strength by walking longer distances, lessen the number of medications, manage my bowels, increase my hours with home help, [and] get rid of chest irritation.
Physiotherapist: How do you feel about your strength, do you feel stronger?
Patient: Not really.
Physiotherapist: But you are walking a lot better?
Patient: Yes I am walking a lot better. Walking is not the real problem. The real problem, which is my chest, the breathing. It is not like it was at home. It is more difficult - far more difficult. I do not know why. I like to listen to the body. I have an idea that there is some connection with the bowel as well as breathing. I do not know why or for what reason, but I do have difficulties there. It seems to me that there is something there and it makes it very hard for me. I am trying hard to choose food that helps, as well as medication. I am still working on it.
Physiotherapist: You do have some great techniques when you do get breathless. Like you lean up against the wall to relax your diaphragm. You do know how to work in with your breathlessness.
Patient: I found that a good thing to do and [it] gave me a little bit of extra strength. That strength too has deteriorated quite a lot from the time I came into hospital and perhaps after the operation. Having had an infection and the coughing that went on with it. I do not know how the other patients put up with me. It was shocking. It shook the daylights out of me.
Geriatrician: There is a problem with your heart rate. It tends to go irregular at times but you are on the right medication for that. I have been talking to X (consultant) and we may have to talk to the cardiologist and see if they produce an alternative medication instead of what you are having now. It seems to flick back into irregular rhythm.
Patient: You know more about that being the doctor.
Geriatrician: But to see you walking like that, it is quite a difference!
Patient: Yes it is - even if it makes me breathless, I know I've got to do it.
Physiotherapist: Well we have done a 6-minute walk test, and after the new drug we will do another test and see if it improves your puffiness.
Geriatrician: Have we got oxygen saturation on exertion?
Physiotherapist: Yes.
Patient: You will be pleased that I walked around the whole lot (ward). I was only doing three corridors this morning!
Physiotherapist: Wonderful!
Patient: I am terrible - she calls me trouble (indicating PT).
Nurse: You have negotiated the exercise progress?
Patient: Yes - doing the strengthening ones in bed. I have always done that even before you told me about that. I heard it from surgeons.
Nurse: What about the kitchen skills?
Occupational therapist: We just found out that what we have been doing earlier in the week is not really what you want. I am not concerned about you not being able to do [that] at home. So it was just to help you to get more strength. So if you want to do it (bake a cake) by the end of the week.
Patient: Standing is a problem for me because then I start to lean on the [elbow] to ease the pain on the bottom of the back. [But] that will always be there I suppose.
Occupational therapist: Last time we did a home visit, I suggested purchasing a stool for you in the kitchen.
Patient: Yes.
Occupational therapist: Do you think that may help you? Although there is not much space (in the kitchen) at all.
Patient: No there is not, there is no space to push your legs underneath. But if I wanted to peel anything I take it through to the dining room.
Occupational therapist: So you can put things on that walker? It is just the standing for long periods - that is the problem?
Patient: Oh yes - and another thing I suppose as well. I can get things with the walker. I find different things [to cook] and I can get different things from Foodtown reasonably easily. Everything that I get is easy. I make up my mind early in the morning and say, 'All right' and I space myself out - I do that much now and by the time I need to have it done it is done.
Occupational therapist: Yes, good.
Nurse: Well, whereto from here? You have achieved some goals. You have cut back in medication. What about the inhalation? I have not given you any in the last couple of days.
Patient: No I have not. Yesterday I had one, it was morning, or was it just after lunch?
Nurse: Do you think you need to continue?
Patient: I think I need to continue to have them a couple of days?
Geriatrician: Yes, fine and the bowels? I know you are taking the prune mixture.
Nurse: You stopped taking that.

Textbox 3: Dialogue between multidisciplinary team and patient in participatory goal-setting meeting.

In this exchange it appears that this patient was very much a member of the team. She was listened to, and was given the authority to make decisions. The team members accommodated her needs, even though one of them appeared to have difficulties with the patient's prioritisation of some of the goals. The patient preferred to prepare her food while sitting in her chair in the living room, whereas the allied health professionals thought it would be beneficial for Mrs K to improve her mobility. In the event, Mrs K - with a little determination, her knowledge and experience, in combination with the multidisciplinary team's knowledge - was able to set (and later achieve) her own goals.

Participative goal-setting may have an influence on cognitive processes such as the development of self-efficacy, and the search for different solutions (Locke & Latham, 1990), which may provide a partial explanation for the positive effects of patient participation described in the literature and shown above. According to Payton et al. (1990) participation increases patient satisfaction and adherence to therapy. Moreover, participation in treatment design has also been associated with increased control and empowerment (Frey-Hoogwerf, 1996), a finding supported by Kreuger-Brophy (1983). According to Kreuger-Brophy, patient participation also enhances their ability to meet their own needs and solve their own problems, creating the best possible reality for themselves.

9.6.2: Assigned goal-setting

Some multidisciplinary and action research group members suggested that co-operatively defining goals may only be possible when the patient is motivated. Lack of motivation, for whatever reason, altered the process during the goal-setting meetings. They took on an entirely different form. Rather than co-operatively arriving at goals, the goals tended to be *assigned* by one or more of the multidisciplinary team members. The low level of patient participation during such meetings, and the fact that patients tended to follow the suggestions and decisions made by the multidisciplinary team, is nicely illustrated in the following extract.

Nurse: The goals that we set as a group were: to improve your mobility, improve your transferring, [and] get you from lying to sitting and standing?
Patient: Yes.
Nurse: We will go through all the goals.
Patient: Yes.
Nurse: Another one was to encourage you with dressing practice - that was for the top half of the body?
Patient: Yes.
Nurse: Another one was to socialise more with your family and friends?
Patient: Yes.
Nurse: And the other goal we set was to give you regular rest periods throughout the day?
Patient: Yes.
Nurse: And the last goal we set was for you to be comfortable from the neck strain?
Patient: Yes.
Nurse: So they will remain the goals that we have set?
Occupational therapist: Which goal do you want to start with?
Patient: Oh I don't know, something...
Occupational therapist: OK, all right.
Physiotherapist: We are now walking at the parallel bars and I am having to support her knee, but she's standing much better, she is keeping her bottom tucked in and she's keeping her trunk straight up and she's actually helping swinging her leg through, directly through.
Patient: Yes, I enjoy doing that. I can't get it to lift off the ground. Mmm, well, your effort has not been in vain.
Nurse: Well, you have been great, I mean you have tried really, really hard, it has worked both ways, and it's been a team effort.
Patient: Team effort.
Occupational therapist: This is the bed that we talked about last time, is this a normal bed?
Nurse: Yes, those hospital beds are too narrow. If we would take that top layer off, it might be better and it might be firmer.
Patient: Is it?
Nurse: Because you have got a Spenco mattress, which is very soft, you'd have to take the Spenco off.
Patient: Well I would like to try it; it is a long wait for another bed.
Nurse: OK, well we will leave it like that.
Nurse: Our other goal was to socialise more with family and friends and we will be talking about writing some fancy cards and Christmas cards.
Patient: Yes, Z bought some Christmas cards I am going this weekend to get the list and then I can start to get them done
Nurse: So, that's ongoing, that goal?
Patient: Yes.
Nurse: So I am delighted with that progress because I was concerned with that next stage over the last few weeks because you were so uncomfortable and now you are not using the wheat bags and it is so... {Discussion, laughing}
Patient: I have got tickets for Lord of the Dance.
Physiotherapist: Wonderful.
Patient: Yes, on the ... it's a Saturday in December, I think it's the thirteenth, it's the one in Albany (venue), could you ring them up and find out what sort of wheelchair access they have? [directed at the nurse].
Occupational therapist: It's on outside and I am just wondering if you are up to it, because it's not till 8 o'clock at night.
Physiotherapist: Oh, they definitely would, they do have wheelchair access ramps.
Nurse: And I think that if you had a rest period in the afternoon and got out, you would enjoy your evening, your night out.
Patient: I think that will be good. Well, I'll see what happens. You will get in touch with the ticket people, but if that falls through, well perhaps we can do something else, like go to a film.

Textbox 4: Dialogue between multidisciplinary team and patient during assigned goal-setting meeting.

During the first ten minutes of the meeting the patient nodded and answered using either ‘yes’ or ‘no’, making it a one-way interaction. The discussion around the other goals was very similar. It was clear that none of these goals were Mrs M’s goals. However, once she felt safe to share her concern the atmosphere of the meeting changed. There was laughter and the meeting was more relaxed, especially when the social goals were discussed. In this meeting the multidisciplinary team - with the guidance of the nurse - had created the space and time for Mrs M to begin to participate.

It became important to ensure acceptance of the goals that were suggested and prioritised for the patient. This type of goal-setting was termed assigned goal-setting. The goals determined in this manner tended to be related to predominantly physical activities. Nevertheless, it seems that even this process may have a created a sense of purpose, as the team frequently found that after an assigned goal-setting meeting patients asked questions and started to bring their concerns to the evaluation meeting. It is suggested that self-efficacy (the belief that one is capable of achieving a goal, or completing a task) (Bandura, 1982) plays a role in patients’ decision to participate. According to Locke and Latham (1990) self-efficacy may be positively affected by an expert, in this case the health professional, who credibly communicates the belief that the patient is capable of participation. This in turn influences the person’s perseverance, performance, and selection of appropriate strategies independent of actual ability (Bandura, 1990). During the rehabilitation period and subsequent evaluation meetings, the patients in this category may develop more insight and slowly become ready to participate more actively. This is demonstrated by the following excerpt.

> On Sunday one of my patients came back - I like to break the ice and ask them to think about goals and concerns. Before I had even finished my sentence she said, ‘I know my goals.’ When she told me, my eyes lit up and she said, ‘I knew you would like that’ and we had obviously been thinking about the same things. On Monday we talked about having the goal-setting meeting (ARGM30, tu 32).

The assigned goal-setting meetings also assisted the multidisciplinary team in developing a common direction for patients’ rehabilitation. The major distinction between participatory and assigned goal-setting meetings is that in the former the process is fully participatory. There is two-way interaction between the multidisciplinary team and the patient from the beginning. The patient comes to the meeting with concerns and is able to formulate goals with the assistance of the multidisciplinary team member. In other words, the patient is the initiator. In contrast, in the latter the communication tends to be almost exclusively one way - at least in the beginning phase. Patients do not voice their concerns and need a comparatively high level of ‘speaking for them’ from the team. In these meetings, multidisciplinary team members are the initiators of the goals. On the other hand some patients preferred not to participate at all, and the team set their goals.

9.6.3: Non-participative goal-setting

In June 1998 the action research group and allied health professionals had identified that the goal-setting meetings were giving the team a sense of direction, with effective communication being established. Consequently, goal-setting meetings were also arranged for some patients who were outside the inclusion criteria. These meetings were conducted without the direct participation of patients, and were consequently termed non-participative. These meetings were aimed at improving the functioning of the multidisciplinary team. The meetings achieved this aim, and it became evident that they were beneficial to family members too.

Geriatrician: In summary, our goal is to improve her ADLs. Basically we are looking at her ability to increase her function with activities of daily life. We know that she is improving but we do not know how much more. So we’ll keep working with her as long as she improves. As we see it now, she is not able to return home.

Occupational therapist: I have seen her a couple of times - mainly for her shower and dressing practice. She has only just started. She is having a few problems there. She gets her clothes on the wrong way and leaves them on. She cannot dress the top half and her bottom. We may be able to resolve it, but it depends on what she can comprehend. We’re mainly looking at dressing and eating at the moment.

Nurse: She does not want to eat herself - she says, “You do it, it is faster.’ And the right side is the weak side. She might hold the spoon, but she does not get any food. So you actually have to stay and do the movement with her. She will gradually improve.

Son 1: I noticed that it looked as if her tongue was getting in the way. And when she tried to get it [the food] off the spoon her tongue seemed to go under her spoon or to the side of the mouth. It seems that she did not know what to do with it once it was there. It [the food] was on her tongue and it was there for some time.

Physiotherapist: She’s actually made quite a good recovery, which is quite good. She can walk with assistance – so that is good, but the right side is weaker.

Nurse: Actually, she was talking about that this morning again. She is talking about that and her husband. We might hear that as ‘death’ but it came a little clearer than the other day. But she was talking about her sons and her husband.

Son 2: Dad died a few years ago.

Physiotherapist: What is her house like?

Son 2: It is a modern town house with one room down stairs with a reasonable space. Everything is flat - we put an upstairs on because mother wanted an upstairs.

Geriatrician: At the moment she has little insight as to how sick she is. She will tell you that she can do something but if you check with the therapist she may not be able to do things. She may cause accidents.

Son 2: We do not know what her long-term future is. So if you decide amongst yourselves what is best. It is something then that we have to provide - what ever that something is going to be. I mean I do not want her lying on the floor or you know something like that.

Geriatrician: As long as you’re clear with what we’re doing, and as long as you are happy with it.

Son 2: Yes and I appreciate that.

Physiotherapist: Going home might not be a possibility.

Son 1: We just have to make sure when she is going back home again [that] she is going to be all right. It is hard making that decision.

Son 2: How long are you going to be prepared to keep her?

Geriatrician: That is a good question because as long as people show improvements it is worth it to continue working. But no longer than six weeks. She would have to be transferred to a nursing home after that.

Son 2: So there is a time-line?

Son 1: We cannot sit in every week [the meeting], but if you feel it is appropriate [to meet again] in two weeks time please let me know.

Geriatrician: Are we all clear about where we’re going? [Nods all around]

Textbox 5: Non-participative goal-setting.

In this meeting the condition of the mother is explained in clear language to the two sons. The multidisciplinary members are willing to explain and contribute to the family’s understanding of the impact the CVA had on their mother’s life. They have to make a decision regarding their mother’s future. They need the technical knowledge of the multidisciplinary team to assist them in reaching that decision. It helped them to develop an insight into their parent’s illness and safety issues. They were then able to decide what support services they needed. It also assisted them with the difficult decision regarding residential care.

In all of the goal-setting meetings, regardless of the level of participation from the patient, the multidisciplinary team members aimed to respect the patient's/family's wishes and communicate in a way which was open and clear. They provided information and education. This assisted the patient in the development of insights and development of an empowering relationship with the team. Allowing individuals to name their own health concerns or issues is one of the most important aspects of an empowering practice (Labonte, 1996). In my view, to *name,* and be supported to *act* accordingly is empowering practice.

9.7: Reflections

9.7.1: Reflections in relation to practice advancement

The introduction of goal-setting resulted in several practice changes, which are reflected upon in this section. The goal-setting meetings had replaced the multidisciplinary ward meetings. Goal-setting had become ward routine, with an average of two initial goal-setting meetings being held each week. The evaluation meetings were held on a two weekly basis, and frequently involved only two multidisciplinary team members, depending on the goals under evaluation.

The nurses' confidence, certainly of those that participated in the action research group and in the goal-setting, had increased. There was an understanding of each other's roles, and respect for the discipline specific knowledge and the contribution made by each discipline. The nurses no longer felt under-valued or marginalised. Their leading role within goal-setting had made them visible and accountable within the team. Their role as facilitators of the goal-setting meetings stood in sharp contrast to the situation eighteen months previously, when they only attended a multidisciplinary meeting when one of their primary patients was discussed, and then sat on a chair close to the door, outside of the circle.

The patients and family members indicated that they appreciated the opportunity to participate. This became evident by their actions on the ward. Once they left the goal-setting meeting they discussed the outcome with their fellow patients. The patients who had progressed in their rehabilitation often functioned as role-models to other patients in their rooms, which, according to Locke and Latham (1990) has an influence on self-efficacy and thus goal attainment. They utilised their care/therapy plans after the goal-setting meeting, for example, when explaining their needs to agency nurses who were covering shifts not filled by regular staff. Patients used the Functional Independence Measure to evaluate their own progress, which they discussed with family and health professionals, and they attended educational sessions after the goal-setting meetings, asking questions for clarification when required. They also used the goal-setting as a learning experience. Moreover, it appeared that the goal-setting itself gave motivation for achieving. It did appear that they had become active members of the multidisciplinary team.

The care/therapy plans were a major change to nursing on Kauri Ward, and first audits indicated that the quality of nursing documentation generally improved during this time. The documentation reflected individualised care based on patients' needs. In addition, use of the Functional Independence Measure had contributed to a decrease in written documentation. The nurses no longer had to write a detailed report regarding patients' activities of daily living as this was replaced by the Functional Independence Measure score.

The health professionals were now generally practicing in collaboration with the patients, guiding and advising them. They listened to the patients and worked out creative solutions that fitted the needs of the patients. For instance, the Functional Independence Measure was regarded as an important outcome measure, but did not measure the patient's perceived quality of life. It was now accepted that patients might request assistance with dressing, so that they would have the energy to play a game of bowls later in the day. Previously the emphasis would have been on the dressing practice, leaving the patient fatigued and unable to participate in a game that provided her with the social contacts she needed to sustain her quality of life.

9.7.2: Reflections in relation to professional interaction

The relationship and interactions between the action research group members and ward staff, in particular between the allied health professionals, nursing and medical staff, showed respect and camaraderie.

On the other hand the interaction between the action research group and the nurses on evening duty was problematic. The responses that this group gave during the study were conflicting. Their espoused theories were incongruent with their theories-in-action, and this tended not to change over the course of the project. Most seemed to be unaware of the gap between their espoused theories and their actions. They worked with the assumption that their professional expertise placed them in a position to make the best possible decision for patients, a perspective that placed the patients' health above the patients' autonomy. Haggerty (1985) describes this as paternalism. Paternalism is guided by the principles of beneficence and nonmaleficence, with good and harm being defined from the perspective of the health professional (Taylor, 1995). In such a system, the experience and knowledge of the patient is not taken into consideration and their right to self-determination is frequently compromised. When this group of nurses was asked why they acted as they did, and presented with examples, they replied that they acted according to what they had learned and were used to. According to Argyris (1991), these theories may obstruct their own and other's learning. Through reflection it would be possible for them to become aware of the impact their actions had on the other staff members. The group agreed to a meeting with me to discuss the situation. They talked about their feelings about participative care for older people. They explained that this was a concept foreign to their culture[52]. They had great difficulty with the concept and felt marginalised and disempowered. This raised many questions. Did speaking English as a second language influence their decision not to take part in nurse-facilitated goal-setting meetings? Were they working according to espoused theories founded within their culture? If so, were they able to share them and practice accordingly? In their case, did they hold on to the past for cultural reasons or was it because they did not want to leave their safe and stable nursing practice environment? Perhaps they were experiencing the type of anxiety influenced by worries about changing, and

---

[52] This group belonged to neither the indigenous (Maori) nor the dominant (European) culture in New Zealand.

worries about not changing when indications are there that one should (Schein, 1993). Some in this group began to question their own, and other's, competence. Individuals' confidence in themselves, colleagues, managers, and at times the entire organisation, may be affected by change, (Gilmore *et al.*, 1997) and this needs resolution before a person can move into the final phase. At this stage these issues needed to be addressed with this group of nurses. It was apparent that a 'them' and 'us' situation had developed, which was compounded by the clinical charge nurse manager identifying with and supporting this group of nurses. Conflicting values have been identified as having the potential to lead to sabotage and conflict (Bridges, 1991; Dove, 1998; Pondy, 1967). Therefore it was important that the evening nurses worked through the issues with a respected nurse leader from their own culture. To help address the issues the clinical charge nurse manager was asked to plan a study day for this group alone, and a nurse leader from their own culture was invited, who was able to reflect and address their concerns from their own cultural background. The action research group conducted additional role plays and I engaged in further reflection sessions with those who wanted them.

The majority of the remaining observer participants were in the *integrating phase* (Bridges, 1991) described in section 3.3.3.4 (p. 36). They were searching for a new identity as nurses within a participative care framework, and for new meaning in their practice. Some were clearly excited about their new practice role. They worked towards facilitating and guiding, rather than directing, care for the patient. Some did experience anxiety related to the fact that they reverted back to the directive role when they experienced stress. Some were also a bit fearful. As mentioned above, additional role play and reflection sessions were offered for those who wanted them.

The members of the action research group and most of the primary nurses were now committed to goal-setting, and for them it was a new way of practice. They were positive and talked about implementation across the unit as it was now, and about future opportunities. For them participative care was now common practice. They moved towards consumer centric advocacy, where health professionals provide patients with information and then guide and support patients in their decision making (Bramlet, Gueldner & Sowell, 1990). Care was taken to avoid consumer advocacy, in which the health professional provides information and then withdraws, leaving the patient to decide the course of action they will take (Bramlet *et al.,* 1990). It was felt that the approach taken in this study combined the best of paternalism and consumer advocacy. Practice could also be seen to have progressed on the rungs of Arnstein's (1972) ladder (section 5.2, p. 53). In chapter 8 it was shown that the patients were asked to voice their opinions and concerns. These were acted upon by the action research group, which resulted in the development of goal-setting – an approach in which patients were invited to partake in the decision making process. With the implementation of goal-setting on Kauri Ward, the ward was moving towards 'citizen power', at the level of placation. At this 'rung' health professionals provide the necessary information and guidance to enable the patients to express their needs, and then search with patients for suitable solutions.

The clinical charge nurse manager experienced some difficulties regarding her own role. The transition towards participative care had empowered a large group of nurses. They had become reflective practitioners who critically investigated their own practice. They were no longer dependent on the clinical charge nurse manager to solve their problems. The patients directly addressed the primary nurse regarding their care/therapy planning. Consequently, the clinical charge nurse manager had lost her matriarchal position and she needed to make the transition from a rather authoritarian style towards a participative style of management. It became apparent at this stage that she experienced difficulties doing so.

At the beginning of the study the clinical charge nurse manager had been invited to join the action research group, which she declined. I had invited her again at the beginning of phase II, with the rationale being that it was important for the clinical charge nurse manager to develop an understanding of the goal-setting process. Again she declined, and insisted in various discussions that she viewed her role to be concerned with facilitation of staff development, management of resources, encouraging research-based practice, ensuring quality of care and providing guidance – this has been described as the new managerial role (Willmont, 1998). Moreover, the clinical charge nurse manager felt that research was the responsibility of the clinical nurse consultant. I had suggested that by not becoming involved in the action research group or the education sessions she risked becoming what Grundy and Kemmis (1981) call a “doer” instead of a “knower” (section 6.4, p 77). As phase II progressed the majority of the health professionals had become reflective practitioners who critically investigated their own practice. The study had challenged the existing culture and changed it. Although the research findings had been communicated to the ward throughout the duration of the study, by not actively being involved in the research process and the teaching sessions the clinical charge nurse manager did not have the same knowledge base and skills, as the staff nurses and multidisciplinary team members, with respect to goal-setting and participative care. Neither had she had the chance to develop more effective professional relationships with other members of the multidisciplinary team. This situation may have caused feelings of anxiety, uncertainty and loss of control (Carney, 2000) for the clinical charge nurse manager, which may have led her to engage in ‘occupational closure’. Occupational closure is described by Salvage (1992) as engaging in “non-discursive strategies that apparently work to control entry not merely into a particular type of training, but into a certain kind of space, a symbolic and political space, constructed by nurses” (p.20). Her way of dealing with conflict, namely avoidance (decisions on crucial issues are not confronted), appears to be a common strategy among nurse managers (Valentine, 2001). Furthermore, it may also have contributed to her feeling of disempowerment, as conflict avoidance in combination with a lack of openness are felt to hinder empowerment (Kuokkanen and Leino-Kilpi, 2001).

The combination of factors discussed above may have affected the clinical charge nurse manager’s decision to put a stop to the research project, 18 months after it had begun, without consulting with the action research group members. This decision was made after the action research group had presented the study at an International Qualitative Research Conference, held in New Zealand. Reflection on her decision was difficult as she declined to participate in an evaluation interview. It appeared that while the study empowered the majority of the staff nurses on Kauri Ward, it disempowered the clinical charge nurse manager.

Despite the decision to close the research project, the members of the action research group and of the wider multidisciplinary team decided to continue the goal-setting meetings, as they had proved to be beneficial. Guidelines for the goal-setting process were finalised in the multidisciplinary quality group.

9.7.3: Reflections in relation to the action research group

The first members of the action research group had certainly grown as a team. Yolanda and Stef had left the group because they transferred to other areas. When the new action researchers - Betty and the allied health professionals - joined, the group found that they reverted back to a previous stage. They had to work through the stage of defensiveness again (Heron, 1996), and resolve anxiety related to working interdisciplinarily. The group responded by re-adopting the ‘check in’ and ‘check out’ procedure described in section 7.2 (p. 86). They also shared practice stories, looking at practice through the view of each discipline. These approaches assisted the group members to understand each other’s language, leading to the development of trust, collegiality and camaraderie, and guided the group through the stage of defensiveness into authentic behaviour. This coincided with the shift in my role from co-operative to autonomous mode (see below). The action research group engaged in joint learning, reflection, and sharing. They felt safe to challenge each other and facilitate the action research meetings.

During the development of the goal-setting, my role within the group was in, what Heron (1996) describes as, co-operative mode. I guided the group in their learning and reflections, and encouraged them to become self-directing. That is, I encouraged them to develop their own discussion regarding the content of the material they were reading and discussing. As I was also a member of the action research group, I shared my opinions within the group. During the final action steps, the action research group's learning had signs of the autonomous mode. They directed the actions and only sporadically asked me for assistance. I continued to participate as an action research group member, sharing my reflections with the rest of the group, as they shared theirs. The action research group members’ behaviour and actions indicated that they had made the transition towards practical action research (see section 3.3.3.2, pp. 30-32 for a description).

9.7.4: Reflections in relation to the organisation

The organisation introduced a new rostering system (flexi-rostering) part way through the study. The clinical charge nurse manager had used this creatively to develop a system - in consultation with the action research group and observer participants - that anticipated staffing needs according to busy periods on the wards. Goal-setting was conducted between 12:00hrs and 14:00hrs. Consequently, two staff members started their evening shift at 12:00hrs and 13:00hrs. This meant increased staffing levels over lunch time, although it left a decrease in staffing levels during the evening. Senior management did not receive this arrangement favourably and the clinical charge nurse manager was asked to explain it. Even after her detailed explanation, management did not look upon goal-setting favourably. They were evaluating the rehabilitation setting according to outcome measures appropriate for the acute environment (length of stay, associated inputs, throughputs, and outcomes, unplanned re-admissions, and so on). Moreover, the policies and regulations within the organisation made it very difficult to deviate from the norm. Accordingly, Aged Care Services was asked to conform and asked to introduce objective outcome measures, despite the evidence available to show that rehabilitation and aged care services are poorly served by outcome measures used in the acute care services (Eager *et al.*, 1997).

The competitive environment created by the government[53] influenced the feeling of competition between health providers. One of the senior managers within Aged Care Services viewed the 'business of health care' as a production model, using the input, output and throughput model.

9.8: Summary

This chapter described the steps involved in the development of participative care and the resulting practice advancement. Goal-setting was explored and found to be a successful method of involving older patients in planning and decision-making regarding their rehabilitation. For the health professional participants in this study, goal-setting meetings were perceived to be beneficial for several reasons. It enabled the team to work together in a structured way and to develop patient directed goals. The goals, in turn, facilitated the development of a common direction, continuity, consistency of care/therapy, and open communication. Furthermore, an understanding of each other's discipline specific knowledge and the contribution it made to the multidisciplinary team developed. As a result the multidisciplinary team members began to trust and respect each other; these are important aspects of successful multidisciplinary team functioning. Working and learning in a multidisciplinary team context created a very positive atmosphere amongst the people involved, and this is beneficial for the development of shared understandings and patient involvement in care.

The feedback from patients who participated, and their family members, indicated that goal-setting provided them with an opportunity to participate in decisions regarding their rehabilitation. In particular, the patients participating in the goal-setting felt a real sense of control from the day that they entered the rehabilitation programme. They commented on the fact that they were listened to, and that their opinions were noted and acted on by the multidisciplinary team members. It provided them with a sense of control, which in turn positively influenced their well being. Moreover, feedback from patients and health professionals suggested that participation in goal-setting had a positive influence on patient motivation.

A local theory of goal-setting emerged that consisted of assigned, participative, and non-participatory goal-setting. In the assigned goal-setting meetings the goals were initially set by the health professionals. In contrast, patients in the participative goal-setting meetings were actively involved in the actual goal-setting process, and goals were set jointly with the health professionals. Because of the positive experience with these types of goal-setting, non-participatory goal-setting was introduced, at a

---

[53] Funding used to be controlled by the same organisation that provided the services, but the government had recently created a funder-provider split, meaning that hospitals, and other providers of health care services, had to 'compete' for the funding they required to provide their services.

later stage, for cognitively impaired patients. This too was found to assist the multidisciplinary team members in developing a care/therapy plan that ensured continuity. In order to operationalise the local theory, a local goal-setting guideline, audit procedure and care/therapy documentation systems were developed. During the study the multidisciplinary team encountered two cases in which they disagreed with the goals of the patient. In both cases, the patients were able to make the decision and discuss the consequences of their decision with the team, which was a learning experience for all.

The organisational environment, with its fixed routines, posed a real challenge. Goal-setting certainly disrupted and challenged the ward routine. Management expressed concerns about the duration of, and number of health professionals involved in, goal-setting meetings. It was pointed out that these meetings had shortened the duration of the ward meetings and family meetings.

Qualitative results indicated that goal-setting was regarded to be beneficial for both patients and multidisciplinary members. However, it is clear that the effectiveness of goal-setting in terms of patient outcomes (satisfaction, quality of life, functional independence, and follow-through with therapy) needs to be evaluated in more depth. Goal-setting is outcome directed and the measurement of clinical outcomes can be integral to the process. Similarly, from the organisation’s point of view, the cost effectiveness of goal-setting in a clinical context also needs to be evaluated.

In conclusion, this chapter demonstrated that through action research the knowledge gained through the action cycles was immediately applicable to clinical practice, which allowed for praxis that is based on an informed understanding. Participative goal-setting was advantageous for patients, health professionals, and multidisciplinary functioning. Having patients participate in planning and goal-setting sessions can be an empowering experience and often leads to motivated participation in the rehabilitation program. The planned evaluation of the effectiveness of goal-setting did not eventuate due to the amalgamation of Aged Care Services with community services.

10: Discussion

10.1: Introduction

The research questions posed in this study were:

- Is emancipatory action research suitable to advance nursing practice by developing the clinical nurse consultant role within the service?
- Can we develop participative care in collaboration with older rehabilitation patients based upon their feedback?

The previous chapters described the research process involved in answering the two main research questions. This chapter evaluates the validity of those answers and attempts to answer the following questions:

- Was emancipatory action research, as used in this study, suitable to advance nursing practice?
- How adequate was this research in developing the clinical nurse consultant role as a facilitator of advanced practice?
- Did participative care in collaboration with older rehabilitation patients indeed occur in this study?

The evaluation starts with a reflection on the methodology of the study. The theme of this reflection is the way the methodology made it possible for the nurses to become action researchers and start a self-reflective enquiry of their practice. The second and third questions are partly addressed by evaluating how this enquiry influenced, and was influenced by, the practice environment (the organisation, the consumer, and health professionals). In answering the latter questions in more depth the way in which the clinical nurse consultant role was developed and facilitated the advancement of practice is illustrated. The final sections address the development of practice advancement in relation to participative care and its advantages. To conclude considerations are given for utilising action research in a clinical setting.

10.2: A methodological reflection

In the position of researcher, I was able to stimulate an interest in the development of participative care amongst the staff nurses of Kauri Ward. During the health professional reconnaissance, the nurses were informants in the sense that they participated in group discussion and one-to-one guided interviews. This enabled me to develop an insight into ward practice, the nurses’ expectations of the research, and their understandings of their role, geriatric rehabilitation, the nurse patient relationship, the role of the nurse within the multidisciplinary team, the care delivery system, and preceptorship. Once the data had been interpreted, feedback was sought from the informants, as it was necessary to check if my interpretation was a thorough representation of the nurses’ reality in order to theorise about it. Establishing face validity was important in the development of a common understanding within the action research group. As researcher, I provided the nurses with information regarding action research, reflective practice, and participative care. This information enabled the nurses to make an informed decision regarding participation in the study. This strategy of establishing reciprocity is important in the research process (Lather, 1986).

Because I initiated and guided the process at the beginning of the study, one could suggest that the action research group was, at that point, engaged in technical action research. I, as the clinical nurse consultant, could be viewed as the principal researcher guiding the research process and enabling the action research group members to develop the necessary skills to become co-researchers. Through reflection (both individual and group) the action research group members became aware of their practice realities. A very early example was the recognition of the nurses' position within the multidisciplinary team. Once they recognised this they were able to take informed action, which involved consultation of the literature (on group dynamics, multidisciplinary team functioning and team building) and the development of an action plan. The action research group members began to theorise about their situation, sharing thoughts with each other, the organisational psychologist, and health professionals in other health care settings. Consequently, development of an understanding of this particular aspect of their practice occurred relatively early in the study. It can be seen that the research process had influenced the participants' understanding, thus establishing catalytic validity (which entails that the researcher show how the research process has provided the participants with insights into their situation and then stimulated them to change it). Moreover, through the research process, in particular the reflection phases, the researchers were able to identify other procedural practice issues that resulted in procedural action plans, such as 'a foot in the door', reintroducing the Functional Independence Measure, information/activity boards, and the orientation programme.

At the end of stage I participants were moving from what they knew to thinking about and acting to change their situation. This meant that they were moving towards practical action research which became more explicit in the second stage of phase I, the patient reconnaissance. The action research group moved from being informants to being co-researchers. They explored patients' opinions of practice and their interest in participative care. In this stage, the patients were the informants and the information they shared provided an insight into their perceptions of the nurse-patient relationship, privacy, lack of knowledge regarding the ward, lack of education/information, and lack of stimulation. Again the interpretations of the researchers were reflected upon, to check if they fitted the reality of the informants. The interviews were interactive, which means that the interviewer (a member of the action research group) responded directly to the concerns voiced by the informant (patient). Lather (1986) describes this as reciprocity between the researcher and the informant.

Information from patients, in combination with the literature study, developed the action research group's understanding of participative care. Reflection became more pronounced as the second stage of phase I progressed. The action research group members began to theorise about their assumptions and the way they practiced. They were in the process of formulating critical theorems, which involved historicizing about the origins and distortions related to the views about participative care. These new understandings were shared with the allied health professionals, patients and other health professionals. According to Lather (1986), "shared critical scrutiny (revealing false consciousness) advances emancipatory theory and empowers the researched" (p. 269), which is described as the process of enlightenment. Some structures and practices that constrained the move towards participative care were identified and consensus was reached about the implementation of new practice. We had been able to establish construct validity, that is, the action research group and observer participants' local theory of goal-setting was affected by Goal Setting Theory and the data evolving from the research process.

Because reflection and learning had occurred, the group members were able to participate in designing Phase II of the study (multidisciplinary goal-setting). The reciprocal relationship between myself (as principal researcher) and the action research members was in place. Reciprocity between the principal researcher and the action research group members is one of the essential requirements in critical action research. Because the group was engaged in collaborative and self-reflection they moved from practical to emancipatory action research. The strategies used within the study to transform practice were strategic action, creation of support systems for implementation, and ongoing critical review. Strategic action involved seeking the backing of like-minded health professionals. Therefore the action research group members invited allied health professionals and physicians to join in the development of participative care. The heads of the departments were kept informed and invited to participate in the critical reviews. Change was facilitated through ongoing in-service education (regarding skills that needed to be developed in order to engage in participative care), continuation of provision of time for the action research group, and funding to invite the critical reviewers. Ongoing critical review enabled the action research group to uncover unanticipated practical consequences, and these became the next issues to be subjected to critical conversations (improving pre-meeting preparation, facilitation and scheduling of the goal-setting meetings, documentation of the goal-setting meetings, medical involvement in the goal-setting process, unrealistic goal-setting, and the importance of orientation for new staff members). Critical conversations occurred between the action research group members and myself, colleagues, and peers during PhD schools[54] and conferences[55]. In these sessions assumptions were challenged. Those practices that reached consensus and were perceived to be just were further developed. This process of reflexive critique, that is, seeking other views, helped to prevent the development of a false [group] consciousness (Carr & Kemmis, 1986), assisted in developing a holistic understanding of the situation under study, and aided the development of a new local theory (Schön, 1987). Consequently, the research group developed a good understanding of goal-setting and were able to develop their own local theory of goal-setting. Figure 7 presents a graphic representation of the spiralling nature of the emancipatory research process.

Praxis occurs when theory is integrated into practice, combining reflection and action, and working with people to cause change through democratic processes (Senge, 1990).

---

[54] PhD students were required to attend the research school twice a year for six consecutive days. Fellow students, scholars and clinical experts would critique and offer suggestions for improvement.

[55] The study was presented at four national and two international conferences.

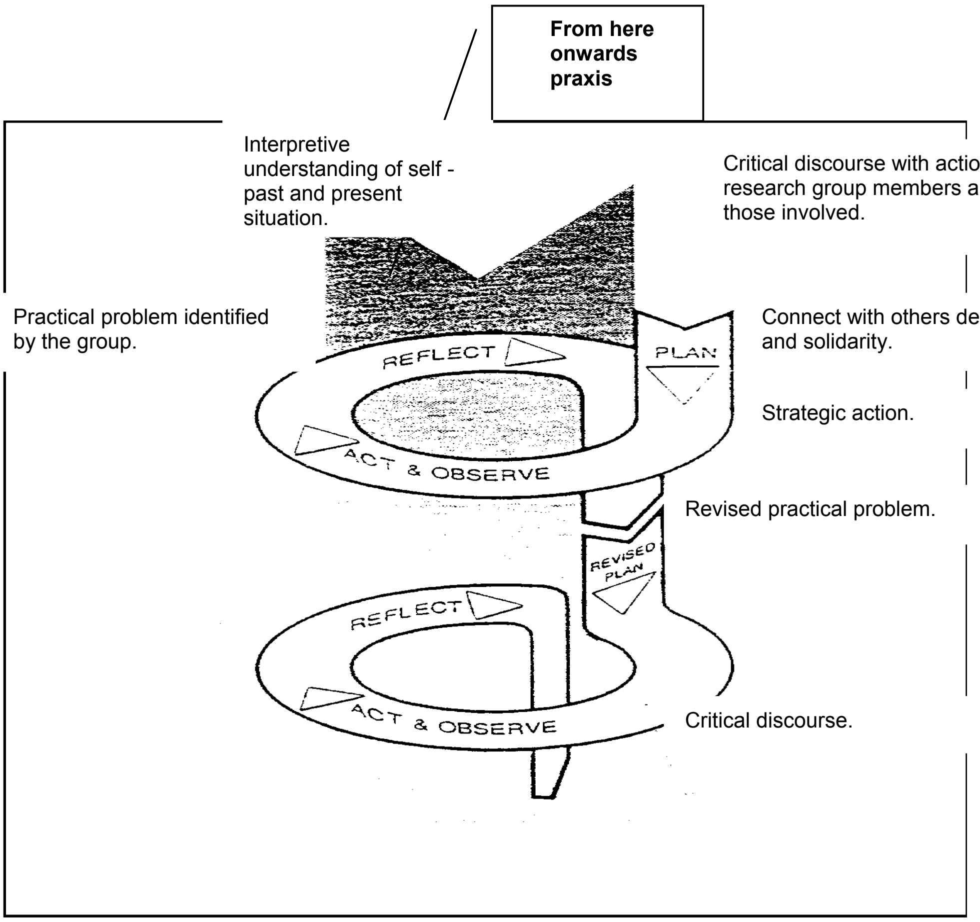


Figure 7: The praxis-research spiral.

In the multidisciplinary phase the informants (patients) became actively involved in the research process. In this phase care was transformed from non-participatory to what Arnstein (1972) describes as placation and, for some, citizen (patient) control. The notion of reappropriation of knowledge (Fals-Borda & Rahman, 1991) guided the process. This was achieved by acknowledging each patient's life experience, expertise and disease related knowledge, or "common-sense knowledge" (Fals-Borda & Rahman, 1991, p. 223). It was this type of knowledge from which the goals were derived in the participatory goal-setting meetings. Consequently, the goals represented each patient's reality and their needs, and functioned as personal outcome measures for the patients. In the multidisciplinary phase both catalytic and content validity were clearly present.

Using Quirke's (1996) framework as a background communication tool helped provide the steps needed to establish an audit trail, which is also regarded as a criterion for establishing credibility of praxis research. It helped us in taking the steps within the research spiral, where the provision of constant feedback, reflection, and discussions with the informants (patients, family members, and ward staff) are crucial for a positive outcome. Dependability, that is, reiteration of the study in similar situations, is possible even though the outcome of the study reflects the reality of the present practice situation. Both participative care and goal-setting have been beneficial in previous practice situations and proved to be so in the present local situation. The adjustment of practice by means of praxis research could be a way forward for other practice environments in the transformation of theory to practice and vice versa.

It should be noted that within the literature there is little attention given to nurse action researchers conducting a study within their own clinical setting (Coghlan & Brannick, 2001). Coghlan and Casey (2001) suggest that doing so may even pose an extra challenge to the ‘inside’ action researcher. Having a pre-understanding may have advantages and disadvantages. One of the advantages described is the understanding of the organisation’s culture. In the case of the present study it was certainly useful to know the informal lines of communication, and to be able to move freely within the organisation observing what was happening without being explicitly present. It may have given me, and the action research group, the opportunity to obtain richer data, as pointed out by Coghlan and Casey (2001). However, familiarity with the organisation is also seen as a disadvantage (Agyris, Putnam & Smith, 1985). These authors point out that the researcher could be less critical, with action research group meetings and interview questions being subsequently less probing. This could result in an interpretation based upon distorted realities. The possibility of ‘group think’ occurring and the development of a distorted reality are not explicitly mentioned within Kemmis and McTaggart’s (1988) framework. The fact that we engaged in critical discourse was due to our awareness of other participative methods.

10.3: The interaction between practice and the healthcare environment

The research process was influenced by the environment, that is, the organisation, funding agencies (Regional Healthcare Authorities), health professionals and consumers. Consequently, these stakeholders also shaped the development of advanced practice and the role of the advanced practitioner in the present context. Their role is described in this section.

10.3.1: The organisation

The organisation in the context of this study consisted of clinical areas, clinical leaders, and senior management. Prior to commencement of the study, within the clinical area practice tended to be non-reflective and based on routines. On Kauri Ward, for example, nurses acknowledged the importance of research but indicated that they had neither the time to read research reports, nor the knowledge required to implement research. Consequently, a gap between theory and practice existed. In contrast, clinical leaders were committed to the introduction of evidence-based practice and participative care, and senior management was outspoken in their support for the study. Their commitment extended to the provision of time and financial support to participants at all levels of the organisation. While support and commitment from these groups is regarded as important in new practice development (Weilder & Buckwalter, 1990), it was necessary for the senior managers’ and clinical leaders’ enthusiasm to filter down to the clinical area. One could argue that both a language and theory-practice gap existed at the beginning of the study. Through the reconnaissance (described in chapters 6, 7 & 8) insights were developed which led to a shared understanding of the practice concerns of all involved. This was possible through the conscious development of open communication, leading to a common language and reducing the existing language gap between the different groups. In other words, the different groups developed a common practice language and an understanding of each other’s roles within the organisation. During the research process theory and practice became dialectically related. That goal-setting theory informed practice, and knowledge obtained in practice, influenced the implementation of goal-setting on Kauri Ward. However, it is clear that the effectiveness of goal-setting in terms of patient outcomes (satisfaction, quality of life, functional independence, and follow-through with therapy) needs to be evaluated in more depth. Goal-setting is outcome directed and the measurement of clinical outcomes should be integral to the process. Similarly, from the organisation's point of view, the cost effectiveness of goal-setting in a clinical context also needs to be evaluated.

10.3.2: Funding agencies (The Regional Healthcare Authorities)

Both the level and type of funding influences healthcare. Therefore the most significant members within this group of stakeholders are the funding authorities, who are obviously interested in whether health care providers are making effective use of the funds given them. Outcomes based discourse represents the growing movement toward health professionals demonstrating the effectiveness of care delivery (Hovinga, 1995). The majority of programmes, however, evaluate goals set by management or the funding authority[56], and not goals based on the preferred outcomes of the people receiving the service (The Council on Quality and Leadership, 1997). The introduction of the Functional Independence Measure in Aged Care Services was an example of an objective outcome measure introduced by the Health Funding Authority. However, if a service is to be evaluated in terms of how effectively it meets the needs of its users, then goals need to be set that "focus on the items and issues that matter most to people in their lives" (The Council on Quality and Leadership, 1997, p 5). Goal-setting provided the framework in this study to set personalised goals with the patients. The goals that were set represented personal outcome measures for the patients involved. The evaluations centred on what the patients thought about their goal attainment. In addition, the patients themselves came to find the Functional Independence Measure useful to measure their progress using the Functional Independence Measure scores. Through working together and involving the patients in the setting and evaluation of goals on a personal level, the organisation was able to use creatively an outcome measure instrument imposed by the funding authority, and make it meaningful to those affected by it.

10.3.3: Health professionals

All the health professionals on Kauri Ward played a role in the development of participative care. They had to be willing and motivated to evaluate their own practice and explore new ways of practising, both individually and as a team[57]. Those involved in the action research group gained confidence in their own practice and ability to bring about change, and they moved from health professional directed care towards guidance. The development of participative care improved their communication with patients, family members, and other health care professionals. Nurses who participated in the goal setting meetings improved their ability to find out what patients really wanted. Through various action cycles, the nurses in the action

---

[56] Examples of these kinds of measures within Aged Care Services are length of stay and cost of pharmaceuticals per admission.

[57] The emphasis throughout this report, however, is on the skills gained by the nurse-participants during the study.

research group transformed their practice in several ways: from routine to research based, from health professional directed towards health professional facilitated care, and from not being valued within the multidisciplinary team toward valued team members. All the members of the action research group were able to provide each other with feedback through the reflective process, which enabled them to grow both personally and professionally. The implementation of participative care utilising goal-setting created an environment where joint learning occurred. The multidisciplinary team members learned side by side, which enabled them to engage in collaborative practice. Some official bodies (Institute of Health and Community Studies, 1997, as cited in Masterson, 2002) argue that collaboration enhances professional roles. The knowledge that was obtained during the research cycles resulted in direct changes in practice for all multidisciplinary team members. The goal-setting meetings not only assisted patients, but health professionals as well, in developing an insight into their own situations.

Those new graduates who participated in the action research process had a positive experience in terms of their own practice development and socialisation into the work environment. Involvement in the action research group reinforced the values of enquiry and reflective practice that were introduced at undergraduate level, and exposed them to the expert knowledge of their senior colleagues at the same time. Through participation in the study they were given the opportunity to combine the two elements rather than having to exchange one value system for the other. For the more experienced nurses, involvement in the group meant having to learn new skills, but it also served to validate their experiences as practitioners and, in some cases, experts in their field. It assisted them in moving through the clinical career pathway, as such movement is based on the level of skill acquisition, which not only occurs at varying rates, but which needs to be articulated by the individual concerned.

The process of involving patients and moving away from health professional directed care was difficult for some. Although the majority of the staff nurses became empowered, some of the evening shift staff nurses, and the clinical charge nurse manager, became disempowered. The issue with the evening shift nurses was also related to cultural differences. Their culture conflicted with both the indigenous New Zealand culture (Maori) and the predominant European New Zealand culture[58]. In order to ensure that this group of nurses felt culturally safe, they were working through issues related to the research and changes on the ward with a respected nurse leader from their community. Throughout this process they continued to practice in their own manner. The nurses concerned did request extra education and time spent in role-plays, as well as the chance to observe actual goal-setting meetings. In the end, after working with this group to try and resolve issues of concern, and inviting a culturally appropriate nurse leader, the action research group and other health professionals had to accept that these nurses were not engaging in goal-setting, and did not intend to do so. The action researchers had to accept that this was the case as coercion is against all principles of emancipatory research.

---

[58] Although the nurses concerned were from a particular cultural group, their apparent nursing philosophy was similar to the traditional patriarchal New Zealand European philosophy of nursing. Without the chance to reflect with these nurses it was difficult to establish whether their philosophy contained any special elements from their own culture.

Other nurses on the ward who identified with the same culture as the group of evening nurses, but who didn't belong socially or professionally to the 'group' they had established, were engaging in goal setting - or at least learning about it. Perhaps personality was a more important influence than their cultural group.

The clinical charge nurse manager had volunteered to facilitate the policy development and some of the newly developed programmes (for example orientation of new staff members). Moreover, she had made adjustments to the roster to accommodate the research. She was also positively commenting on the acceptance of two papers at the International Qualitative Research Conference. Therefore her action to stop the research was not understood by the action research group members. As mentioned in section 9.7.2 (p. 141), her way of practising tended to create a dependent nursing staff-charge nurse relationship, where nurses could neither make their own decisions nor challenge each other. She was the 'matriarch' of the ward. This position was challenged when the nurses who participated in the action research group and goal-setting meetings slowly transformed into autonomous health professionals, who were capable of taking informed actions. It was discussed with the clinical charge nurse manager, prior to the commencement of the study, that emancipatory action research critically examines the whole culture. Those working within it are asked to reflect on their practice and practice in general. The reflective process can be experienced as stressful as it poses questions and endorses participation. The way this study challenged the status quo in Kauri Ward may have exceeded her expectations. She had perhaps not imagined or foreseen the impact of such a project. Because the role of the advanced practitioner became prominent in the change process, as well as in setting the agenda she may have lost her sense of control. Her action of putting a halt to the study may not have been because she did not see the benefits of goal-setting, but directed more at eliminating the strong presence of the advanced practitioner on Kauri Ward. Resistance to change of the sort experienced in this study is not uncommon, and has been reported by Titchen and Binnie (1993a, 1993b) and Hart and Bond (1995).

In hindsight it may have been better to persuade the clinical charge nurse manager to become an active member of the action research group. It would have helped her retain clarity about her role and a sense of control over the change process. However, Agyris and Schön (1974) point out that an action research group consisting of members from different organisational layers may have difficulties achieving open democratic communication, and consequently interventions may be based on a distorted reality. Clearly there are advantages and disadvantages to involvement of the manager in an action research group, and the decision to involve may well depend on the personality of the person. The fact that personality has an effect on making such a role successful is discussed by Scholes, Furlong and Vaughan (1999). Although the action research project was brought to an unexpected close, goal-setting was embedded in practice at this stage and was maintained after the end of the study. As a matter of fact, patients actually requested goal-setting meetings without prompting by staff members.

10.3.4: The consumers

Patients were invited to become actively involved in planning and evaluating their care. The patients' desire to participate in their care was influenced, in this study, by their stage in the illness trajectory and their cognitive ability. The need to ensure that any attempt to involve patients in their care is based upon an individualised assessment[59] is self-evident.

The data obtained during patients' interviews indicated that patients wished to become involved in their care and therapy (discussed in chapter seven). Consequently, the action research group aimed to involve patients directly. Patients' knowledge was no longer suppressed by the dominant culture (that of the health professionals). Recognition of, and working with, the patient's knowledge led to the patient developing an improved insight into their own situation. The goals set by the patients appeared more important to them than those set by the health professionals. This is understandable as patients and health professionals bring different values and assumptions to the rehabilitation process. Although perceptions of the 'ideal outcome' differed between health professional and patient, personalised goals were set in almost all the goal setting meetings. The consumer advocacy (Bramlet *et al.*, 1990) approach enabled movement on Arnstein's ladder, from the rung of tokenism up towards citizen power.

It should be noted that the patient participants also developed an understanding of the new role of the health professionals. According to Schön (1983) many patients engage in a relationship with a health professional on the presumption that the professional has a body of expertise that gives them a certain legitimate power. The patients involved in this study proved able to understand and make good use of relationships with health professionals in which power was shared. In other words, they made use of the egalitarian clinical collaboration between health professional and patient, in which both bring their own specific knowledge to the goal setting meetings.

10.4: Developing the clinical nurse consultant role as facilitator of advanced practice

One of the objectives of the study was to determine if emancipatory action research could be used to facilitate the development of the role of the clinical nurse consultant. To reiterate, the key indicators of the role consisted of provision of a consultation service for staff, provision of professional leadership to nursing, contribution to continuous improvement of care through quality initiatives, undertaking and utilising research to enhance the quality and development of care delivery, and participation with the senior nursing team in planning and development of education and professional development opportunities.

Four main components of the role (clinical expertise, education, research and consultancy), with various interrelated sub-roles (collaborator, motivator and change agent), emerged during the study. These results mirror the National Nurse Executive's (Ministerial Taskforce on Nursing, 1998) and international literature on advanced practice roles (Castledine, 1998; Hamric & Spross, 1989; Hickey *et al.*, 1996), except that in this situation there appears to have been a greater emphasis on

---

[59] This included the Mini Mental State Examination and, in some instances, the Geriatric Depression Scale.

the skills necessary for creating a learning culture in which health professionals can engage in praxis.

At the beginning of the study I, as the clinical nurse consultant, concentrated on the development of the clinical component. I worked with the nurses during the busy times on the ward, delivering direct and indirect nursing care, which created a feeling of collegiality. Direct nursing care consisted of case-managing those patients and families who had complex nursing needs, and, later in the study, participation in the goal-setting meetings. Indirect nursing care consisted of nursing rounds (in which elements of the consultancy and educational components also came into play), facilitation of reflection, and identification of practice issues. Through sharing my expertise during this time I gained credibility as a practising nurse and as a nurse consultant. The learning was two-way, as I became involved in some of the realities of everyday practice as this particular group of nurses experienced it. At a later stage I was able to role-model the application of research to practice, teach nursing at the bedside, and enable nurses to become actively involved in practice change. Over time, in the position of clinical nurse consultant, I was able to raise awareness amongst nursing staff regarding a transition towards an alternative way of delivering care.

The educator role involved staff development, providing opportunities to learn, and establishing and maintaining a research culture within the ward. It emerged almost as soon as the action research cycles commenced, and the action research process helped create a good environment for learning. Opportunities for the nurses to acquire new knowledge and skills were created with respect to both the research process itself, and to nursing in general. Through the action cycles practice issues were raised. Guided reflection in the reflection step of the action cycle contributed towards professional, personal, and practice development. Nurses learned to identify their learning needs and this consequently helped them in developing the necessary competencies to advance in the clinical career pathway. In addition, various nurses were enrolled in advanced gerontology nursing modules. They frequently asked me for advice about integrating education and research into practice. These nurses began to make connections between classroom knowledge and local clinical knowledge. According to The Ministerial Taskforce on Nursing (1998), the ability to form connections between practical and technical knowledge is necessary for the development of professional knowledge. In this study health professionals' development and practice development were inter-linked, a finding supported by Manley (1997).

Several areas of consultancy evolved during the study. These were interlinked with the sub-roles and varied over time throughout the study. My research diary revealed that consultancies involving direct patient care were in relation to giving advice, guidance, and problem solving. In the study they usually involved issues around participative care, in particular goal-setting. Other consultancies were in relation to management of change and educational issues resulting from change. Besides the knowledge and skills necessary to develop a learning environment, knowledge and skills about organisations are necessary if a consultancy service is to be provided to the organisation while in an advanced practitioner role (Hickey *et al.*, 1996). In practice several types of consultancy may be used simultaneously.

I functioned, during this study, as a research mentor for the action research group. They were engaged, under my guidance, in the continuous processes of data gathering, data analysis, comparison of findings to existing research, and the development of action plans. Consequently, the nurses concerned critically examined their practice and made changes to it. Other nurses were able to see that the study benefited practice and was not merely an academic exercise, and the majority of them, once convinced, participated in the study. From a routine and non-reflective way of practising, many moved towards praxis, where they were able to combine theory and practice into a dialectical relationship. The collaborative nature of the study enabled health professionals without previous research experience to participate in and experience a research project.

Some of the skills and processes that I used as an advanced practitioner have been implied by the components described above. Throughout the study I focused on creating an environment where health professionals were able to challenge and transform practice. In other words enabling them to feel safe within a learning culture. The processes described below, in the scientific process evaluation, have some resemblance to transformational leadership as described by Sashkin and Rosenbach (1993). According to the authors, transformational leadership consists of developing a shared vision, being able to communicate a vision, valuing others, developing trust, and enabling others to take on new challenges while minimising the risks. As a consequence a cultural shift occurred that changed practice on Kauri Ward. It has been argued that an important indicator in practice development, in terms of successful outcome achievement, is a cultural shift (McCormack *et al.*, 2002).

Noteworthy sub-roles that emerged during the study were that of motivator, change agent, negotiator, and collaborator. Acting as a motivator encapsulates those activities engaged in to initiate action and stimulate change. Through raising awareness, initiation and facilitation of practice developments, guiding, and participation in action cycles, it was possible for all staff members to become, in one way or another, actively involved in the study. Experienced staff members were encouraged to participate in the advanced gerontology nursing modules and share their practice experience with new staff members. Discovering that their knowledge was regarded as valuable provided some with the impetus to become actively involved in the study. The new graduates were motivated by the opportunity to practice within an environment that valued research and education. For those novices (new graduates) who joined the action research group, I, and other members of the group, played an important role in their socialisation process. Through participation in the study the new graduates did not, as they normally would, become socialised into the dominant ethos of the ward. In fact, they were assisted to critically examine practice and challenge it where necessary. They were helped to use research to inform their nursing, thus becoming more likely to avoid routine-based practice. Involvement in the research group and the research process prevented them from relinquishing their theoretical preparation to comply with the culture of the ward (Perry, 1985). Such an opportunity was a positive motivating factor for the new graduates.

Through the process of the research, work excitement for the majority of existing staff also increased. Simms, Erbin-Roesemann, Darga and Coeling (1990) describe work excitement as a “personal commitment and enthusiasm for work evidenced by creativity, receptivity to learning and ability to see opportunity in everyday situations” (p.179). These attributes were fostered by involvement in the action research group, and were, in turn, valuable during each research cycle.

The ability to collaborate was pivotal in the development of participative care. The process required good communication between the nurses themselves and later between nursing and the other disciplines. Negotiation was an important sub-role for me as the principal researcher and the clinical nurse consultant, as I helped the various groups come together and build shared understanding. It was also important during the development of action plans.

Change management and assisting with the change process was evident in nearly every activity within the study. Even the nature of the relationship between myself and the ward nurses underwent a change, from a hierarchical relationship to one between equals. Generally speaking, each change involved a challenge to the existing culture. Change was facilitated through Kemmis and McTaggart’s (1988) framework; therefore the values underpinning collaborative research were guiding the changes in Kauri Ward.

In order to sustain the new ways of practising it was important to assist staff in more than just the transformation process. They needed support in the development of protocols and guidelines concerning participative care, education, study leave, and interdisciplinary assessment and goal setting. Creating and maintaining a learning culture, in which the health professionals felt safe and supported, was very important throughout the study. The positive outcomes in this study were partly due to the fact that I, as the clinical nurse consultant, gained credibility with the senior management team as well as with the staff nurses at ward level. The former group approved of the scientific approach used to develop participative care and advance nursing practice, as well as the development of the clinical nurse consultant role within the unit. Through expertise in nursing and collaboration with health professionals in the clinical area, credibility was gained with staff nurses. It should also be noted that as the principal action researcher I was an insider, with an insight into the informal organisation and awareness of many of the potential pitfalls that the study might encounter. However, the role each person plays within an action research project and the interpersonal skills (collaboration, assertiveness, negotiation and facilitation) needed to effectively participate in action research appears to have received little attention in the literature. The fact remains that organisational politics and practical problems will always arise and need to be addressed within the literature to allow novice action researchers to learn from these experiences McNiff (1991). Figure 8 depicts the process, key players, and outcomes in this study.

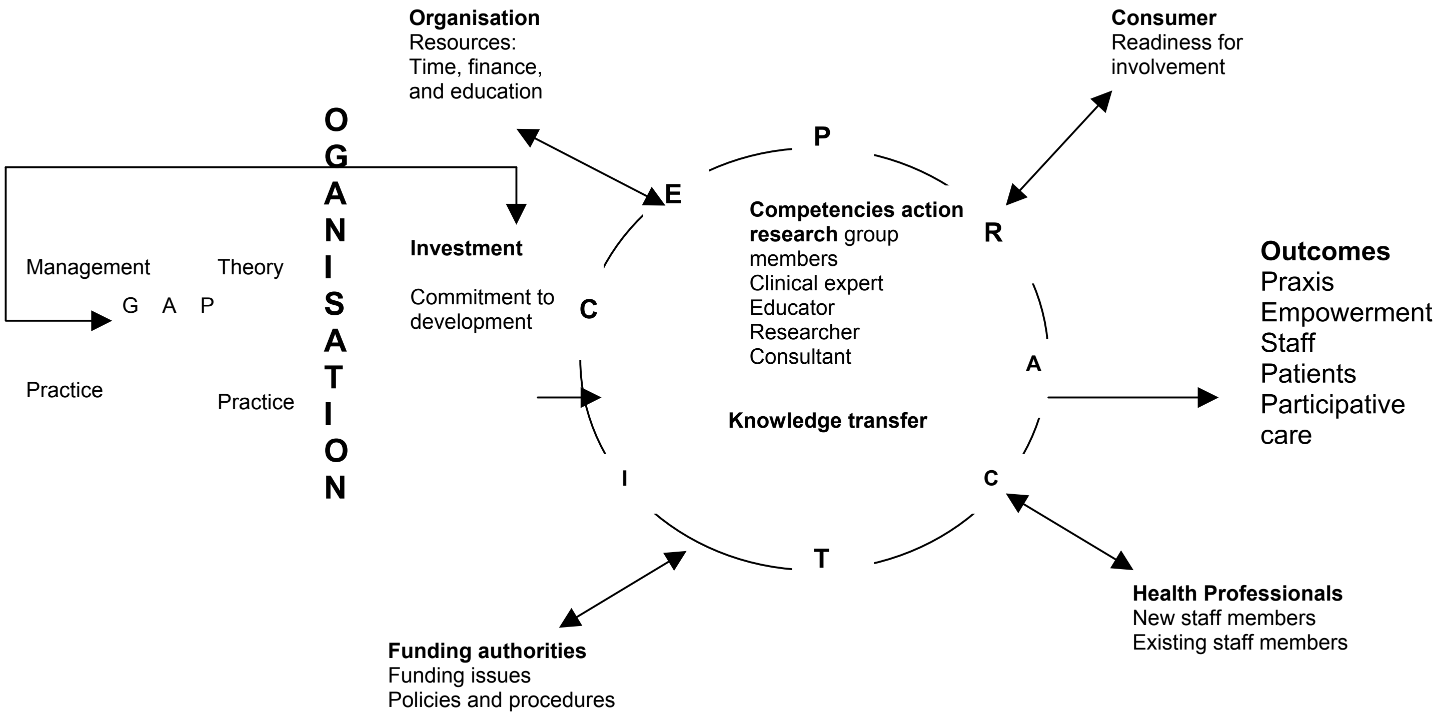


Figure 8: The process, key players, and outcomes in this study

10.5: Advanced practice and participative care was developed and valued

Advancing nursing practice: The chosen methodology, in which participation, collaboration and open democratic communication stood central, enabled nurses to join in a research approach where theory and practice are dialectically related. For the majority of health professionals on the ward it was their first exposure to research. The action research cycle linked thinking and doing, enabling those involved to develop, and transfer knowledge about research as well as knowledge about participative care. The health professionals were able to theorise and develop a local theory of participative care, which was built through patient involvement and the practical application of Goal-Setting Theory. Carr and Kemmis (1986) suggest that when a developed theory and solution to a problem is authentically based on the understanding and language of the participants, it is uniquely suited to provide immediate practical and theoretical guidance. This was only possible because the health professionals involved were able to learn the skills necessary to take a role in developing practice theory and began to view themselves as beginning practice-theorists. The fact that nurses, in particular, began to view themselves in this way was positive for the advancement of nursing practice in the unit. They no longer had self-doubts about their contribution within the multidisciplinary team and could now articulate the contribution nurses made to the multidisciplinary team, as well as in the wider context of health and health care. This was important for the nurses in this study, as they had previously felt under-valued within the multidisciplinary team. According to Falk-Rafael (1996), nurses often have self-doubts about their contributions to health and health care, and I agree with the author that nurses need to be the first to acknowledge their contributions, before they can expect others to do so.

An added benefit was that collaborative goal-setting provided a way of documenting nursing interventions that made nurses and nursing visible. Nurses became comfortable with documenting nursing actions and writing nursing recommendations in the clinical notes. Documentation was clearer, more concise, and furthermore, it was understandable for patients. Patient education improved, with nurses recognising its importance before the goal-setting meetings (ice-breaking), and throughout the period of hospitalisation (patient and family group education sessions). With growing confidence and credibility within the multidisciplinary team, many of the nurse participants recognised their ability to facilitate multidisciplinary team meetings, and went on to develop skills in this area. Their physical assessment skills, with the introduction of the Functional Independence Measure, were also further developed. Moreover, the nurses in the research group all became able, with varying degrees of guidance, to identify a practice concern, search for and assess relevant literature, and develop, implement, and reflect on/evaluate action plans. Development of these skills enabled them to transfer theoretical knowledge into practice, which transformed their practice. In other words, they moved away from working routinely and unreflectively, towards practice informed by research. By the end of the study these changes involved most of the nurses on Kauri ward to some extent. The new way of practising was ward culture. The differences between the way care was delivered prior to the study and at the end of the study are summarised in Table 7 below.

Pre-study	Post-study
Emphasis on routine	Reflection-research based
Health professional directed care	Patient centred
Little to no choice for patient	Choice for the patient
Little to no information provided to patients or families	Information-consultation-feedback with patients (and families when needed)
No activities	Provision of activities
Planning of care with multidisciplinary team only	Planning with patient present
Little co-ordination of care	Primary nurse co-ordinated care
Language used in patient care plans was health professional centred	Language in care plans patient centred
No post-discharge follow up	Post-discharge follow up.
Little possibility for patient to influence the process of care	Patient can influence the process of care
No role modelling between patients	Patients were role models for each other
Outcome measures directed by funding authority	Personal outcome measures in combination with those set by the funding authority

Table 7: The differences in care delivery before and after the study.

Development of participative care: prior to the study, patients' level of involvement within Aged Care Services was at the level of manipulation in terms of Arnstein's (1972) ladder (section 5.2, p. 53). Patients were not given the opportunity to participate in care planning or evaluation. During ward rounds patients' issues and questions were discussed at the bedside (in six-bed bays). The flow of information was clearly top down. The health professionals made the decisions, frequently without consultation with patients. The health professionals used a paternalistic approach to care giving, where the experience and knowledge of the patient is not taken into consideration and their right to self-determination is frequently compromised. The value of involving patients in their care was seen in the way those patients made use of the information, and the opportunity for consultation, to plan and evaluate their care and progress in collaboration with the health professionals. Patients had a greater chance to develop an insight into their own situation, and this often helped them in coming to terms with their change in health status or physical functioning. Although there were two instances of patients expressing dissatisfaction with the way in which the goal-setting process had been conducted, overall it became evident that goal-setting with patients was received positively by both health professionals and patients. The value of peer support became evident during the study. Patients would frequently discuss their goals with each other and seek advice from each other. Role modelling of discharged patients in the peer education session was perceived as valuable. In fact, such education sessions were frequently evaluated by patients as most useful.

10.6: Considerations for utilising action research in the clinical setting

Introducing research into practice has always been problematic. There are a number of conceptual models that can be used for implementation. The approach described in this study could best be described as a practice advancement approach. In order to engage in such an activity, several features are important. Prior to beginning an action research project, it is necessary to obtain support from the organisation at senior and middle management level, and from the clinical leaders in the area concerned. The organisation needs to invest in time and education in order to teach the required skills to the practitioners in the research group. To engage in critical reflection, time and a safe environment are needed. Management would need to be convinced of the benefits to the organisation. These benefits tend to be in the areas of practice advancement, professional development, and in the development of a research based culture in the area in which the study takes place. These factors combined can positively influence the quality of service delivered to the patient.

All health professionals in the proposed setting need to support the initial idea, as practice changes often have an effect on the practice of all health professionals. The health professional participants need to be willing to engage in journal writing and sharing their reflections. These activities take time and diligence and can be painful (Boud, Keogh & Walker, 1985). Ideally, participants would complete a journal entry after each duty and would attend a regular meeting, within work time, to share reflections. Health professionals entering into such a project need to be aware that they are likely to have to challenge their own beliefs and ways of practising, but that they are also likely to end up challenging prevailing practice in their work place. They may well become initiators of change, which could place them in conflict with colleagues, even if only temporarily. The primary group, that is the group that initiates the research, need to have understood their current practice and see the need to change it. The importance of careful descriptions of practice, and the ability of staff to reflect on and learn from these descriptions, and to transfer knowledge into practice, have been demonstrated.

The guidance of an advanced practitioner to initiate guided reflection and research is crucial in the process. They are the linking pin between the participants and safeguarding the scientific process of the study. They are responsible for writing up the study. An understanding of group dynamics is important, as the development of open democratic dialogue and a safe environment are vital if the action research group is to succeed. Without these elements, adequate critical reflection will not occur, and it is through reflection that concerns are identified and local theory is developed. Therefore the researcher should, as a minimum, be prepared at master's level. Hasten *et al.* (1998), in fact, suggest that the practitioner should be prepared at doctorate level, or at least have adequate supervision when pursuing this academic qualification. Academics who want to facilitate practice advancement using any form of action research need to get the support of both the clinical area and the faculty, as time in and commitment to the clinical area is necessary. One way of facilitating this would be the establishment of a joint appointment, which helps bring theory and practice together. When both the clinical area and the faculty work together the joint appointment can form a bridge between what Schön (1987) describes as the 'high hard ground' (the academic setting) and the 'swampy low lands' of the clinical environment. In other words, competencies and skills that are important for functioning within the health care environment could inform nursing education and vice versa. As pointed out by Reed and Procter (1993), it is not only academic theories which contribute to the theory practice gap, but also the local theories held by nurses in the practice area. The role of the advanced practitioner, in the form of a joint appointment, is important in helping to close the gap between research-based, or academic, theory and practice. Without such a supporting system it is unrealistic to expect diploma or bachelor prepared nurses to critically examine their practice by engaging in self and group reflection in order to change their practice.

The introduction of clinical career pathways in health care settings would create an opportunity for nurses to develop both personally and professionally. When implemented with the appropriate support of advanced practitioners new graduates might be attracted to health care settings that provide such challenging environments. In such a context advanced nurse practitioners have the potential to be linking pins between administrators, management, senior health professionals, the academic setting, practitioners, and consumers.

In today's environment, with an increasing focus on evidence based practice, participative research has a significant role to play. It can assist nurses and other health professionals to learn the skills and competencies necessary to engage in research based practice. In participative research health professionals learn, under the guidance of an advanced practitioner, to identify practice issues, and actively seek to change practice by transferring theory into the practice setting. As long as nurses and other health professionals are not able to do so, evidence, that is knowledge gained from research, will remain seated in desk drawers and the theory practice gap will remain. If nurses lack the ability to transfer knowledge to the practical setting and become owners of that knowledge, implementation of research into practice will not occur. Participative research, with its focus on researching with people and reflection (individual and group), provides a medium for people to actively become involved, incorporate knowledge, transfer it, and implement new ways of practising. The benefits of a participative method in combination with an advanced practice role within an organisation were demonstrated in this study. One could argue that all the components promoted in evidence based practice (clinical expertise, research, resources and the patient) interacted during the study. The distinguishing feature of this study was that the researcher worked in collaboration with those affected by the study.

The effective involvement of patients in the research and rehabilitation processes is possible, particularly when a safe environment is created. From experience in this study, to involve patients in rehabilitation required that the health professionals be educated regarding the processes of establishing participative care. For example, assessment skills with respect to patient's level of coping, social systems and the rehabilitation process.

10.7: Summary

The study demonstrated that collaboration between health professionals and older rehabilitation patients resulted in the implementation of participative care. A participative research approach, in this case emancipatory action research according to Kemmis and McTaggart's (1998) framework facilitated the process.

The role of the clinical nurse consultant became explicit in this process. The role was developed from the needs identified within the organisation and was congruent with the aspirations of Aged Care Services. Kemmis and McTaggart's framework enabled me, as the clinical nurse consultant, to develop my role in the context of the organisational expectations.

The action research group utilised technical, practical and emancipatory interests to generate knowledge about goal-setting - the vehicle used in the study to facilitate participative care. Both patients and health professionals were able to take strategic action to change their situations, leading to praxis. Participative care was developed in collaboration with patients, and their feedback and experiential knowledge proved to be valuable in this practice development. The organisational infrastructure, with its emphasis on research, education, and quality, provided the context for staff development, and the benefits of an advanced practice role within an organisation were also demonstrated in the study. The educational preparation, guidance of an advanced nurse practitioner, and multidisciplinary and organisational support all contributed to the success of the study.

In this study Kemmis and McTaggart's (1988) framework showed that action research has the potential to establish a culture change. The participant researchers were able to develop a holistic understanding of the practical situation under study. Additionally, the participants could immediately apply the results obtained. Thus, as soon as strategies were developed, the participants could use them to alter their situation. This study demonstrated the possibilities of emancipatory action research in guiding nursing praxis, when health professionals are committed to working towards partnership with patients. Research that aims for partnership and collaboration can be an empowering experience for all involved. Action research is a way to bring theory and practice closer together, to develop practice theory. Practitioners do have a wealth of knowledge that, in combination with existing theories, can be developed into local theories through the process of reflection.

It is hoped that this description and discussion of the study has provided the reader with an insight into the multidimensional nature of advanced practice, and the potential that action research and advanced practice roles have in practice development and patient care.

11: Summary

This praxis research study took place from 1996 to 1998 in an assessment, treatment and rehabilitation unit for the elderly, within a large metropolitan hospital in New Zealand. It was described in phases, namely the pre-reconnaissance, the health professional and patient reconnaissance, and the development of participative care. Each phase attempted to answer aspects of the following research questions:

- Is emancipatory research suitable to advance nursing practice by developing the clinical nurse consultant role within the service?
- Can we develop participative care in collaboration with older rehabilitation patients, based upon their feedback?

In ***Chapter 1, Rationale for and an overview of the thesis***, an introduction to the study setting is provided and the issues which played a role in the development of the research questions are described. An overview of the chapters was then given. The actions taken to set the scene for this study are described in ***Chapter 2, Introducing Aged Care Services: the research setting***. These actions included the interventions needed to create a supportive research environment, such as the creation of the reflective practice group and journal group, the development of the nursing focus and documentation groups, and the exploration of the clinical nurse consultant role. In addition, Kemmis and McTaggart's (1988) framework, in relation to the clinical nurse consultant role, is introduced. The positive outcome of this pre-research period provided the impetus to start the research project proper.

In ***Chapter 3, Approaches to collaborative research***, the reader is provided with a literature review of collaborative research methods. This begins with an overview of the historical development of action research, from the ideas of Kurt Lewin - thought of by some as the 'father' of action research - right through to contemporary collaborative methods, such as the developmental research associated with the Leadership, Organisation and Co-determination group in Norway, and Action Science as developed by Argyris and Schön (1974). The review then introduces praxis research, where the dialectical relationship between theory and practice, and empowerment, are central themes. These approaches are represented by participatory action research, as developed by Fals-Borda and Rahman (1991), which found its origin in community settings and in third world countries. Finally, the Australian community of action researchers is introduced, and their influence on the development and application of critical action research in nursing outlined. The work of these scholars, in particular, Grundy (1982) and Kemmis and McTaggart (1988), formed the basis for the methodology of this study. The chapter is concluded with a discussion of scientific rigour, ethical considerations, and general criticisms in relation to collaborative research.

The communication framework presented in ***Chapter 4, Planning phase one of the study: taking steps to promote practice advancement***, proved to be a valuable communication guide for the study. It comprises four steps: raising awareness, development of understanding, development of support, and obtaining involvement, which are the same principles that underpin Kemmis and McTaggart's (1998) framework. The study plan, which followed the steps within the action research spiral as described by Kemmis and McTaggart (1988), is explained, and the study described in terms of phases, stages and action cycles. Each of the action cycles included planning, implementation, observation and evaluation. Phase I consisted of four stages, including the health professional reconnaissance and the patient reconnaissance. Within each of these a number of action cycles were planned, each determined once the study was underway. The methods of data gathering (group discussion, open-ended one-to-one interviews, research journals, minutes from meetings, tape recordings from goal setting meetings, and evaluation interviews - both group and one-to-one), and data analysis are described.

The interventions of the action research group were based on a review of the literature, presented in ***Chapter 5, The literature that informed the study days and the first action research meeting (1996 - 1997)***. Arnstein's (1972) model was introduced as it provided a guide for describing where the Aged Care Services stood in the beginning of the study in terms of participative care. The model is represented in the form of a ladder, in which three levels of participation are identified: non-participation, degrees of tokenism, and degrees of citizen power. There are several factors that are thought to hinder the implementation of participative care, and these can be health professional, patient or organization related. Some health professionals are not willing to engage in participative care. In some instances they view the patient as a passive recipient of care who is not capable of participating. Nurses, therefore, can be reluctant to involve patients and resign control or power to them, because they do not trust the judgment of the patient. According to some authors, education in relation to participative care and the consequent understanding of its use in practice are yet to develop. Additionally, the bio-medical model still retains an influence in the way patients are viewed and treated by nurses. Patients, moreover, may not always be eager to participate, and others may not be able to due to the stage of their illness, rehabilitation or motivation. However, true patient participation would ensure that individual preferences and abilities are respected and cultural differences taken into account. Bureaucratic organisational structures and a lack of available resources form the final obstacle towards participative care within organisations. Problems are often related to organisational structure, resources and commitment towards implementation of a new care philosophy. Some examples of participative care that are advantageous are described in terms of patient satisfaction, empowerment, discharge planning, re-admission rates, and compliance with therapy and treatment. Participative care has also been seen to have a positive effect on health professionals as it has been shown to increase job satisfaction.

Goal-Setting Theory, developed by Locke (1968, as cited in Locke & Latham, 1990), was reviewed in this chapter, as it was thought to be an appropriate vehicle for implementation of participative care. Although Goal-Setting Theory originated in organisational development there are studies that indicate that goal-setting can be beneficial in the health care setting. Goals can be assigned, participatory, or self set, and there is no evidence to suggest that any one method is superior with respect to motivation and performance. However, participative goal setting appears to have an influence on cognitive processes and is thus thought to result in better strategies for goal attainment. Other influences on goal attainment, such as commitment, self-efficacy, feedback and social influences were identified within the literature.

The actual study, described in chapters six through nine, provides an answer to the two research questions. In ***Chapter 6, Phase I: Stage I: Understanding current practice: health professional reconnaissance****,* the health professional reconnaissance was described. The information obtained during the study days, group discussions and one-to-one guided interviews is presented, illustrating the nurses' views about the current nursing systems on Kauri Ward, and their disappointment that primary nursing was no longer being practiced effectively. The nurses' thoughts and beliefs about preceptorship, gerontological rehabilitation, the role of the nurse, their position within the multidisciplinary team, and the nurse-patient relationship are outlined. Their views on rehabilitation appeared to be described in terms of function and restoration. The components thought to comprise the nursing role were described as maintenance, teaching, bringing reality to the situation, advocacy, complexity, coordinator, and specialist. They felt that their role within the multidisciplinary team was not valued by the other team members, and were distressed about this. Trust, empathy and openness were seen as important factors in developing a relationship with the patient. The nurses also mentioned the communication processes within the unit, which were perceived to be one-way, the environment in relation to the physical outlay of the ward, and their workload, which was perceived to increase during the winter. A concern during the health professional reconnaissance was a group of nurses that declined to participate in the interviews. They had created their own practice culture and were indifferent to practice innovation. They worked evening and night shifts to avoid any practice change. There was, therefore, the potential for a 'them' and 'us' situation to develop.

Several other issues were of concern at this stage of the reconnaissance, for example, the fact that interpersonal relationships between staff members tended to be slightly stressed. This left the researcher with some concerns for the progress of the study. Nevertheless, many of the staff on Kauri Ward were enthusiastic about the study, which led to the development of the action plans for stage II of phase I. These are reported in ***Chapter 7*****.**

Chapter 7, Phase I: Stage II: The beginning of practice advancement: action plans based on the perspective of the health professionals, introduces the six nurses who volunteered to join the action research group and their role within the study. During the first action research group meetings it became evident that the discussions on the ward had had some influence on ward practice. This had a positive effect on the group as they prepared for the patient interviews. In subsequent meetings they shared their experiences with each other. The interviews were perceived as therapeutic since they provided the patients with the opportunity to describe their experiences, and discuss and clarify concerns. All group members experienced how the flow of the interview switched from sharing of information, to patient education, to expression of thoughts and feelings, and back to the nurse-patient relationship. Consequently, the time spent with the patient during the interview was perceived as beneficial to both nurse and patient. The action plans - 'a foot in the door', the Functional Independence Measure, information/activities board and orientation information - were partly in response to stage I, and partly in response to issues identified during the patient interviews. The action research group members worked well together. They shared practice stories, and reflected on them, which created trusting relationships. Maintaining open, effective communication with the ward became extremely important, as is also reported in ***Chapter 7***. The action research group worked continuously to provide feedback and teaching sessions in various forms and at various times to address the feelings of anxiety being experienced by some staff members. The role of the researcher centered on guidance and facilitation for the action research group at this stage in the study.

Chapter 8, Phase I: Stage III: Seeking patients' feedback: patient reconnaissance, was concerned with the outcome of the one-to-one guided patient interviews that had been conducted by the action research group. The analysis revealed that patients perceived the information they received about the ward and their condition to be insufficient. Receiving information and involvement in care were considered to be advantageous by this patient group, who also indicated that privacy and stimulating activities were minimal on the ward, and that they appreciated continuity of care. Noteworthy comments were made in relation to the ward's lack of sanitation, and the lack of staff during lunch and dinner time, which often contributed to functional incontinence. Patients felt that trust, honesty and openness played important roles in establishing the relationship between nurse and patient, and this mirrored the nurses' views on the nurse-patient relationship. The action plans resulting from the interviews addressed the concerns voiced by the patients and consisted of information giving prior to admission, a change in the admission procedure, the evaluation of nursing care with the patients, education sessions and an increase of activities chosen by the patients. The action plans influenced ward practice, which was threatening for some participant observer nurses but challenging for others. Important at this stage was the support of one the evening nurses. Her support and commitment in the form of her leadership enabled the action research group members to communicate more effectively with this group. Staff members were generally enthusiastic about opportunities, and ready to engage in the discussions regarding goal-setting.

Multidisciplinary goal setting stood central in ***Chapter 9, Phase II: Can we develop participative care in collaboration with older patients based upon their feedback?*** It became evident that it was beneficial to both patients and health professionals. The feedback from patients and their family members suggested that goal-setting provided them with the opportunity to participate in decisions regarding their rehabilitation. They indicated that participation in goal-setting had a positive influence on their motivation and acceptance of their situation. The health professionals indicated that it enabled them to work together in a structured way and to develop patient directed goals. The goal-setting process facilitated the development of a common direction, continuity, consistency of care/therapy and mutual learning. This in turn aided the development of trust and respect for each other. The contribution nursing makes to the continuity of rehabilitation, such as continence, skin care and continuity of care, was also acknowledged. During this phase a local theory of goal-setting emerged. Three types of goal-setting meetings had developed: participative goal-setting, assigned goal-setting, and non-participative goal-setting, which can be described as the local theory. It was demonstrated that through action research the knowledge gained through the action cycles was immediately applicable to clinical practice, which allowed for praxis that is based on an informed understanding. Participative goal-setting was advantageous for patients, health professionals, and multidisciplinary functioning.

The final chapter, ***Chapter 10, Discussion**,* deals with the evaluation of the study. The methodological reflection suggests that face, construct and catalytic validity, reciprocity, reflexivity, and an audit trail were established. The influence of the four key stake holders, namely organisation (resources and finance), health funding authority (funding in relation to outcomes), consumers (stage in the illness trajectory, and rehabilitation phase) and health professionals (time and investment) are described in relation to the study. The clinical nurse consultant role was put in place utilising praxis research. The study showed that the role, as described in this study, contributed to practice advancement, quality improvement, provision of clinical leadership and implementation of research on the ward. ***Chapter 10*** concludes with some suggestions for engaging in participative care and practice development using praxis research.

The major outcome of the study was that the ward moved from health professional directed care toward participative care, by using a praxis research methodology.

References

Alder, S. L., Bryk, E., Cesta, T. G., & McEachen, I. (1995). Collaboration: the solution to multidisciplinary planning. *Orthopedic Nursing, 14*(2), 21-29.

Andrews, K. (1987). *Rehabilitation of older adults*. London: Edward Arnold.

Argyris, C. (1982). *Reasoning, learning and action.* San Francisco: Jossey-Bass.

Argyris, C. (1985). *Strategy and change as defensive routines.* Boston: Pitman.

Argyris, C. (1991). Teaching smart people how to learn. *Harvard Business Review, May-June,* 99-109.

Argyris, C., Putnam, R., & Smith, D. (1985). *Action science*. San Francisco: Jossey-Bass.

Argyris, C., & Schön, D. A. (1974). *Theory in practice: increasing professional effectiveness*. San Francisco: Jossey-Bass.

Argyris, C. & Schön, D. A. (1987). Participatory action research and action science compared. *American Behavioral Scientist, 32*, 612-623.

Arnstein, S. R. (1972). A ladder of citizen participation in the USA. *Journal of the Town Planning Institute, 57*(4), 176-182.

Bäck, E., & Wickbald, K. W. (1998). Privacy in hospital. *Journal of Advanced Nursing, 27*, 940-945.

Baggerly, J., Belmosto, L., Drinkwater, J., & Master, M. (1995). Patients' readiness for scheduled therapy: nursing's positive contribution. *Rehabilitation Nursing, 20*(3), 161-163.

Bandura, A. (1977). Self-efficacy: towards a modified theory of behavioural change. *Psychological Reviews, 4*, 191-215.

Bandura, A. (1982). Self-efficacy mechanisms in human agency: a social cognitive theory. *American Psychologist, 37*, 122-147.

Bandura, A. (1986). *Social foundations of thought and action.* Englewood Cliffs, NJ: Prentice Hall.

Bandura, A. (1990). Perceived self-efficacy. *Journal of Sport Psychology, 2*, 128-163.

Barr, O. (1997). Interdisciplinary team work: consideration of the challenges. *British Journal of Nursing, 6*, 1005-1010.

Baskett, J. (1996). *Life after stroke: New Zealand guidelines for best practice in rehabilitation after stroke.* Wellington, NZ: Stroke Foundation New Zealand Inc.

Baynton-Lees, D. (1992). Reviewing the nurse-patient partnership. *Nursing Standard, 6*(42), 36-39.

Beardshaw, V. (1988). *Last in list: community services for people with physical disabilities.* London: King's Fund.

Bell, E., Bendall, J., Bowie, I., Davies, S., Elliot, A., Phoenix, J., & Stanley, A. (1994). *Rehabilitation Nurses Forum Committee Working Group*. Harrow, Middlesex: Royal College of Nursing.

Benner, P. (1984). *From novice to expert.* Sydney: Addison-Wesley.

Biley, F. C. (1992). Some determinants that effect patient participation in decision making about nursing care. *Journal of Advanced Nursing, 17*, 414-421.

Bion, W. R. (1968). *Experiences in groups and other papers*. London: Tavistock Publications.

Blair, C. (1995). Combining behaviour management and mutual goal setting to reduce physical dependency in nursing home residents. *Nursing Research, 44*(3), 160-164.

Boud, D., Keogh, R., & Walker, D. (1985). *Reflection: turning experience into learning.* London: Keagan Page.

Bramlett, M. H., Gueldner, S. H., & Sowell, R. L. (1990). Consumer-centric advocacy: it's connection to nursing frameworks. *Nursing Science Quarterly, 3*, 156-161.

Brearly, S. (1990). *Patient participation: the literature*. London: Scutari Press.

Bridges, W. (1991). *Managing transitions: making the most of change*. Massachusetts: Addison Wesley.

Brillhart, B., & Sills, F. B. (1989). Analysis of the roles and responsibilities of rehabilitation nursing staff. *Rehabilitation Nursing, 19*(3), 145-150.

Brown, A. (1988). Effects of educational interventions in diabetes care: a meta analysis of findings. *Nursing Research, 37*, 223-230.

Brownlea, A. (1987). Participation: myths, realities and prognosis. *Social Science and Medicine, 25,* 605-614.

Bunning, C. (1992). *Professional development using action research: position paper.* Brisbane: International Management Centre.

Burnes, B. (1996). *Managing change: a strategic approach to organisational dynamics* (2nd ed.). London: Pitman Publishing.

Campbell, S. (1995). *Family centred care*. London: Mosby.

Carney, M. (2000). The development of a model to manage change: reflection on a critical incident in a focus group setting. An innovative approach. *Journal of Nursing Management, 8*, 265-272.

Carr, W., & Kemmis, S. (1986). *Becoming critical: knowing through action research.* Victoria, Australia: Deakin University.

Castledine, G. (1998). *Advanced nursing practice*. Oxford: Butterworth Heinemann.

Cherniss, G. (1980). Human service programs as work organizations: using organizational design to improve staff motivation and effectiveness. In R. Proce & P. Polister (Eds.), *Evaluation and action in the social environment.* New York: Academic Press.

Chien, I., Cook, S., & Harding, J. (1948). The field of action research. *American Psychologist, 3*, 43-50.

Clark, H., & Mass, H. (1998). Comox Valley Nursing Center: from collaboration to empowerment. *Public Health Nursing, 15*(3), 216-224.

Clark, J. M., & Latter, S. (1990). Working together. *Nursing Times, 86*(48), 28-31.

Clark, M. S., & Caudrey, D. J. (1983). Evaluation of rehabilitation services: the use of goal attaining scaling. *International Rehabilitation Medicine, 5*, 41-45.

Clayton, S. (1988). Patient participation: an underdeveloped concept. *Journal of the Royal Society of Health, 108*(2), 55-56.

Coghlan, D., & Brannick, T. (2001). *Doing action research in your own organisation.* London: Sage.

Coghlan, D., & Casey, M. (2001). Action research from the inside: issues and challenges in doing action research in your own hospital. *Journal of Advanced Nursing, 35*, 674-682.

Collier, J. (1945). United States Indian Administration as laboratory of ethnic relations. *Social Research, 12*(May), 275-276.

Comstock, D. E. (1982). A method for critical research. In E. Bedo & W. Feinberg (Eds.), *Knowledge and values in social and educational research*. Philadelphia: Temple University Press.

The Concise Oxford Dictionary, (8th ed.). (1991). Oxford: Clarendon Press.

Corbin, J. M., & Strauss, A. (1996). A nursing model for chronic illness management based upon the trajectory framework. In P. Woog (Ed.),*The Chronic illness trajectory framework: the Corbin and Strauss Nursing Model* (pp. 9-28). New York: Springer Publishing Company.

Corey, S. M. (1953). *Action research to improve school practices.* New York: Bureau of Publications, Teachers College, Columbia University Press.

Cott, C. (1998). Structure and meaning in multidisciplinary team work. *Sociology of Health and Illness, 20*, 848-873.

The Council on Quality and Leadership in Supports for People with Disabilities (1997). *Personal outcome measures*. Townson.

Denzin, N. K. (1994). The art and politics of interpretation. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 500-515). London: Sage Publications.

Dewey, J. (1933). *How we think*. New York: New York Health.

Dove, M. A. (1998). Conflict: process and resolution. *Nursing Management, 29*(4), 30-32.

Eager, K., Gordon, R., Hodkinson, A., Green, J., Eager, L., Erven, J., Eckstein, G., Spooner, G., Kennedy, C., Owen, A., Cromwell, D., Leotta, T., & Rigley, A. (1997). *The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): report of the National Sub-Acute and Non-Acute Casemix Classification Study.* Wollongong, Australia: Centre for Health Service Development, University of Wollongong.

Earley, P. C., & Kanfer, R. (1985). The influence of component participation and role-models on goal acceptance, goal satisfaction and performance. *Organizational Behavior and Human Decision Processes, 36*, 378-90.

Egan, G. (1994). *The Skilled helper: a problem-management approach to helping.* Pacific Grove, CA: Brooks/Cole Publishing Company.

Ehrenreich, J. (1978). *The Cultural crisis of modern medicine*. New York: Monthly Review Press.

Eisenthal, S., Koopman, C., & Lazare, A. (1993). Evaluation of the initial interview in a walk incline: the clinician perspective of a negotiated approach. *Journal of Nervous and Mental Disease, 164*, 30-35.

Falk-Rafael, A. R. (1996). Power and caring: a dialectic in nursing. *Advances in Nursing Science, 19(*1) 3-17.

Fals-Borda, O., & Rahman, M. A. (Eds.). (1991). *Action and knowledge: breaking the monopoly with participatory action-research.* New York: The Apex Press.

Folden, S. L. (1993). Effect of a supportive-educative nursing intervention on older adults' perceptions of self-care after a stroke. *Rehabilitation Nursing, 18*(3), 162-167.

Folstein, M., Folstein, S., & McHugh, P. (1975). Mini-Mental State: a practical method for grading cognitive state of patients for the clinician. *Journal of Psychiatric Research, 12*, 189-198.

Fontana, A., & Frey, J. H. (1994). Interviewing: the art of science. In N. K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 361-376). London: Sage Publications.

Freire, P. (1970). *Cultural action for freedom*. Cambridge, MA: Center for Study of Development and Social Change.

French, W. L., & Bell, C. H. (1995). Organizational development: behavioural science interventions for organization improvement (5th ed.). Englewood Cliffs, NJ: Prentice Hall.

Frey-Hoogwerf, L. J. R. (1996). A journey towards continence through emancipatory action research. *International Journal of Nursing Practice, 2*, 77-81.

Fricke, W., & Hofmaier, B. (1996). Action research and regional development. In S. Toulmin & B. Gustavsen (Eds.), *Beyond theory: changing organizations through participation* (pp. 83-88). Amsterdam: John Benjamin's Publication Company.

Gale, A., & Gaylard, J. (1996). The role of the nurse in rehabilitation of older people. In A. J. Squires (Ed.), *Rehabilitation of Older People: A Handbook for the Multidisciplinary Team*. London: Chapman and Hall.

Garratt, B. (1991). The power of action learning. In M. Pedler (Ed.), *Action learning in practice* (2nd ed.). Hants: Gower Publishing Company.

Gerdner, L. A., Richards-Hall, G., & Buckwalter, K. C. (1996). Caregiver training for people with Alzheimer's based on a stress threshold model. *Image: Journal of Nursing Scholarship, 28*(3), 241-246.

Gibb, H. (1990). *Representations of old age: notes towards a critique and revision of ageism in nursing practice* (Vol. 2). Victoria, Australia: Deakin University.

Gilmore, T., Shea, G., & Useem, M. (1997). Side effects of corporate culture transformation. *Journal of Applied Behavioral Science, 33*, 174-189.

Godfrey, H. P. D., & Smith, L. M. (1996). *Facilitating psychosocial adjustment following traumatic brain injury: a family based approach.* (Workshop manual), Dunedin, NZ: Otago University.

Govier, T. (1993). Self-trust, autonomy and self-esteem. *Hypatia, 8*(1), 99-120.

Greenwood, J. (1984). Nursing research: a position paper. *Journal of Advanced Nursing, 9*, 77-82.

Greenwood, D. J., Whyte, W. F., & Harkavy, I. (1993). Participatory action research as a process and as a goal. *Human Relations, 46*, 175-192.

Grundy, S. (1982). Three modes of action research. *Curriculum Perspectives 2*, 24-33.

Grundy, S., & Kemmis, S. (1981). *Social theory, group dynamics and action research.* Paper presented at the Action Research Symposium at the 11th Annual Meeting of the South Pacific Association for Teacher Education, Adelaide.

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Newbury Park, CA: Sage.

Gustavsen, B. (1996). Development and the social sciences: an uneasy relationship. In S. Toulmin & B. Gustavsen (Eds.), *Beyond theory: changing organizations through participation* (pp. 5-30). Amsterdam: John Benjamin's Publication Company.

Haas, J. (1993). Ethical considerations of goal setting for patient care in rehabilitation medicine. *American Journal of Physical Medicine and Rehabilitation, 72*, 228-232.

Habermas, J. (1971). *Theory and practice.* Boston: Beacon Press.

Habermas, J. (1974). *Knowledge and human interests*. London: Heinemann.

Hackman, R. J. (Ed.). (1990). *Groups that work (and those that don't): creating conditions for effective teamwork*. San Francisco: Jossey-Bass Publishers.

Haddock, K. S. (1994). Collaborative discharge planning: nursing and social services. *Clinical Nurse Specialist, 8*, 248-252.

Haggerty, M. C. (1985). Ethics: nurse patron or nurse advocate. *Nurse Manager, 16,* 340-348.

Hamric, A. B., & Spross, J. A. (1989). *The Clinical nurse specialist in theory and practice* (2nd ed.). Philadelphia, PA: WB Saunders.

Harrison, R. (1987). Organization culture and quality of service: a strategy for releasing love in the work place. In Cunnigham (Ed.), *What is making a difference in organizations*? London: West Publishing Company.

Hart, E., & Bond, M. (1995). *Action research for health and social care: a guide to practice* (pp. 25, 81-102). Buckingham: Open University Press.

Harvath, T. A., Archbold, P. G., Stewart, B. J., Gadow, S., Kirschling, J. M., Miller, L., Hagan, J., Brody, K., & Schook, J. (1994). Establishing partnerships with family caregivers: local and cosmopolitan knowledge. *Journal of Gerontological Nursing, 20*(2), 29-35, 42-3.

Hastings, M. (1996). Team working in rehabilitation. In A. J. Squires (Ed.), *Rehabilitation of older people: a handbook for the multidisciplinary team*, (2nd ed., pp. 72-88). London: Chapman and Hall.

Hendry, C. (1998). Understanding and creating whole organizational change through learning theory. *Human Relations, 49*, 621-641.

Herbert, C., & Powel, G. (1989). Insight and progress in rehabilitation. *Clinical Rehabilitation, 3*, 125-130.

Heron, J. (1996). *Co-operative inquiry: research into the human condition.* London: Sage Publications.

Hewison, A. (1995). Nurses' power in interactions with patients. *Journal of Advanced Nursing, 21*, 74-82.

Hickey, J., Ouimette, R. M., & Venegoni, S. (1996). *Advanced practice nursing: changing roles and clinical applications.* Philadelphia: Lippencott.

Hickson, P. (1990). The promise of critical theory. *Conference proceedings: Embodiment, Empowerment, Emancipation Conference,* Melbourne.

Hoeman, S. P. (1996). Conceptual basis for rehabilitation nursing. In S. P. Hoeman (Ed.), *Rehabilitation nursing process and application* (pp. 3-20). St Louis: Mosby.

Hohman, G. W. (1975). The insider/outsider position and the maintenance of hope. *Rehabilitation, 22*, 136-41.

Holly, M. L. (1987). *Keeping a personal-professional journal* (2nd ed.). Victoria, Australia: Deakin University.

Houts, P., and Scott, R. (1976). Goal planning in mental health rehabilitation: an evaluation of the effectiveness of achievement motivation training for mental patients being rehabilitated to the community. *Goal Attainment Review*, 33-34.

Hovinga, E. (1995). Information and infra-structure requirements to measure outcomes. *Informatics in Healthcare-Australia, 3*(5), 4-5.

Husband, A. (1988). Application of King's theory of nursing to the care of the adult with diabetes. *Journal of Advanced Nursing, 78*, 484-488.

Hutchinson, S. A., Wilson, M. E., & Skodol-Wilson, H. (1994). Benefits of participating in research interviews. *Image: Journal of Nursing Scholarship, 26*(2), 161-164.

Jansen, R., Harrison, D., Richmond, D., Suckling, S., & Nixon, A. (1997). *Prime Ministerial task force on positive ageing: facing the future. A strategic plan*. Wellington, NZ: Department of the Prime Minister and Cabinet.

Jewel, S. E. (1994). Participation: what does it mean to nurses? *Journal of Advanced Nursing, 19*, 433-438.

Kemmis, S., & McTaggart, R. (1988). *The Action research planner* (3rd ed.). Victoria, Australia: Deakin University.

Kemp, B. J. (1993). Psychological care of the older rehabilitation patient. *Geriatric Rehabilitation, 9*, 841-857.

Kim, H. S., Holter, I. M., Lorensen, M. L., Inayoshi, M., Shimaguchi, S., Shimazaki-Ryder, R., Kawaguchi, Y., Hori, R., Takezaki, K., Leino-Kilpi, H., & Munkki-Utunen, M. (1993). Patient nurse collaboration: a comparison of patients' and nurses' attitudes in Finland, Japan, Norway and the U.S.A. *International Journal of Nursing Studies, 30*, 387-401.

King, I. M. (1981). *A theory for nursing: systems, concepts, processes.* New York: John Wiley & Sons.

King, I. M. (1983). The family coping with a medical illness: analysis and application of King's theory of goal attainment. In I. W. Clements & F. B. Roberts (Eds.), *Family health: a theoretical approach to nursing*. New York: John Wiley & Sons.

King, I. M. (1984). Effectiveness of nursing care: use of a goal oriented record in end stage renal disease. *American Association of Nephrology Nurses and Technicians Journal, 11*(2), 11-17-60.

Kiresuk, T., & Sherman, R. E. (1968). Goal attainment scaling: a general method for evaluating comprehensive mental health programs. *Community Mental Health Journal, 4*, 443-53.

Koperski, M., Rogers, S., & Drennan, V. (1997). Nurse practitioners in general practice - an inevitable progression? *The British Journal of General Practice, 47*(424), 696-8.

Kreuger-Brophy, C. B. (1983). Shared goal setting – a motivational tool for stroke patients and their families. *Clinical Management, 3*(3), 29.

Kuokkanen, L., & Leino-Kilpi, H. (2001). The qualities of an empowered nurse and the factors involved. *Journal of Nursing Management, 9*(5), 273-280.

Labonte, R. (1996). *Health promotion and empowerment: practice frameworks.* (#3 in Issues in Health Promotion Series). Toronto, Ontario: Centre for Health Promotion, University of Toronto.

Lather, P. (1986). Research as praxis. *Harvard Educational Review, 36*, 257-277.

Law, M., Baptiste, S., McColl, M., Polatajko, H., & Polock, N. (1991). *Canadian Occupational Performance Measure*. Toronto: Canadian Association of Occupational Therapists.

Leutz, W., Sciegaj, M., & Capitman, J. (1997). Client-centered case management. *Journal of Case Management, 6*(1), 18-24.

Lewin, K. (1946). Action research and minority problems. *Journal of Social Issues, 2*(4), 34-46.

Lewin, K. (1948). *Resolving social conflicts*. New York: Harper & Bross.

Lewin, K. (1958). Group decision as social change. In G. E. Swanson, T. M. Newcomb & E. L. Hartley (Eds.), *Readings in social psychology* (pp. 459-473). New York: Henry Holt.

Lincoln, Y. S. (1985). *Organizational theory and inquiry: the paradigm revolution.* Beverley Hills: Sage.

Locke, E. A., & Latham, G. P. (1990). *A theory of goal-setting and task performance*. Englewood Cliffs, NJ: Prentice Hall.

Locke, E. A., & Schweiger, D. M. (1979). *Participation in decision making: one more look* (Vol. 1). Greenwich, CT: JAI Press.

Lumby, J. (1991). Threads of an emerging discipline: praxis, reflection, rhetoric and research. In G. Gray & R. Pratt (Eds.), *Towards a discipline of nursing* (pp. 461-483). Melbourne, Australia: Churchill Livingstone.

Macias, C., Kinney, R., Farley, O. W., Jackson, R., & Vos, B. (1994). The role of case management within a community support system: partnership with psychosocial rehabilitation. *Community Mental Health Journal, 30*, 323-339.

Manley, K. (1996). Advanced nursing practice is not about medicalising nursing roles. Editorial. *Nursing Critical Care, 1*(2), 56-57.

Manley, K. (1997). A conceptual framework for advanced practice: an action research project operationalizing an advanced practitioner/consultant nurse role. *Journal of Clinical Nursing, 6*, 179-190.

Masterson, A. (2002). Cross-boundary working: a macro-political analysis of the impact on professional roles. *Journal of Clinical Nursing, 11*, 331-339.

Matsui, T., Kakuyama, T., & Onglatco, M. L. (1987). Effects of goals and feedback on performance in groups. *Journal of Applied Psychology, 72*, 407-15.

McCormack, B., Kitson, A., Harvey, G., Rycroft-Malone, J., Titchen, A., & Seers, K. (2002). Getting evidence into practice: the meaning of 'context'. *Journal of Advanced Nursing, 38*, 94-104.

McTaggart, R. (1991). Principles for participatory action research. *Adult Education Quarterly, 41*(3):168-87.

McTaggart, R. (1997) Is validity really an issue for participatory action research? *Culture, Organisations and Societies*, *5*(1).

Melrose, M. J. (1996). Got a philosophical match? Does it Matter? In O. Zuber-Skerritt (Ed.), *New directions in action research* (pp. 49-65). London, Washington: Falmer Press.

Mento, A. J., Cartledge, N. D., & Locke, E. A. (1980). Maryland vs. Michigan vs. Minnisota: another look at the relationship of expectancy and goals to task performance difficulty. *Organizational Behavior and Human Performance 25,* 419-440.

Mento, A. J., & Locke, E. A. (1989). *Studies of the relationship between goals and valences.* Baltimore: Loyala College.

Meyer, J. E. (1993). New paradigm research in practice: the trials and tribulations of action research. *Journal of Advanced Nursing, 18*, 1066-1072

Ministerial Taskforce on Nursing. (1998). *Report of the Ministerial Taskforce on Nursing: releasing the potential of nursing.* Wellington NZ: Ministry of Health.

Morse, J. M. (1991). Negotiating commitment and involvement in the nurse-patient relationship. *Journal of Advanced Nursing, 10,* 455-468.

Muir-Gray, J. A. (1997). *Evidence-based health care: how to make health policy and management decisions.* New York: Churchill Livingstone.

Munhall, P. (1988). Ethical considerations in qualitative research. *Western Journal of Nursing Research, 10*, 150-162.

Naylor, M., Brooten, D., Jones, R., Lavizzo-Mourey, R. M., & Pauly, M. (1994). Comprehensive discharge planning for the hospitalized elderly: a randomized clinical trial. *Annals of Internal Medicine, 120*, 999-1006.

Noack, H. (1995). A partnership in Broadmoor. *Nursing Standard, 18*(9), 22-23.

Nolan, M., Nolan, J., & Booth, A. (1997). *Preparation for multi-professional/multi-agency health care practice: the nursing contribution to rehabilitation within the multidisciplinary team. Literature review and curriculum analysis.* Sheffield: The University of Sheffield.

NUD.IST (Version 4), (1994), *User manual.* Victoria, Australia: Qualitative Solutions and Research, Latrobe University.

O'Connor, S. (1993). Nursing and rehabilitation: the perceived role of the nurse in the medical and nursing literature. *Journal of Clinical Nursing, 2*, 29-34.

O'Leary-Kelly, A. M., Martocchio, J. J., & Frink, D. D. (1994). A review of the influence of group goals on group performance. *Academy of Management Journal, 5*, 1258-1301.

O'Neill, M. (1992). Community participation in Quebec's health system: a strategy to curtail community empowerment? *International Journal of Health Services, 22*, 287-301.

Øvretveit, J. (1990). Making the team work. *Professional Nurse, 5*(6), 284-288.

Parker, J., & Gardner, G. (1991). The silence and the silencing of the nurse's voice: a reading of patient progress notes. *The Australian Journal of Advanced Nursing, 9*(2), 3-9.

Parrott, R., Burgoon, J. K., Burgoon, M., & LePoire, B. A. (1989). Privacy between physicians and patients: more than a matter of confidentiality. *Social Science and Medicine, 29*, 1381-1385.

Patton, M. Q., (1990). *Qualitative evaluation and research methods* (2nd ed.). London: Sage Publications.

Pawlson, L. G. (1994). Healthcare reform: chronic illness - implications of a new paradigm for healthcare. *Joint Commission Journal on Quality Improvement, 20*(1), 33-39.

Payne, J. A. (1993). The contribution of group learning to the rehabilitation of spinal cord injured adults. *Rehabilitation Nursing, 18*, 375-379, 427-428.

Payton, O. D., Ozer, M. N., & Nelson, C. E. (1990). *Patient participation in program planning: a manual for therapists*. Philadelphia: F.A. Davis Company.

Pearson, A. (1983). *The clinical nursing unit*. London: William Heinemann Medical Books.

Perry, J. (1985). *A study of the initial professional induction of graduate nursing students: a thesis submitted in partial fulfillment of requirements of the degree Master of Arts*, Palmerston North, New Zealand: Massey University.

Philips, M. E., & Rehnström, K. (1996). Workplace development, gender, and communicative competence. In S. Toulmin & B. Gustavsen (Eds.), *Beyond theory: changing organizations through participation* (pp. 53-66). Amsterdam: John Benjamin's Publication Company.

Pondy, L. R. (1967). Organisational conflict: concepts and models. *Administration Science Quarterly, 12*, 296-320.

Porter-O'Grady, T. (1996). The seven basic rules for successful redesign. *Journal of Advanced Nursing, 26*, 46-53.

Prigatano, G. (1986). *Neuropsychological rehabilitation after brain injury*. Baltimore: John Hopkins.

Qualls, S. H., & Czirr, R. (1988). Geriatric health teams: clarifying models of professional and team functioning. *The Gerontologist, 28*, 372-376.

Quirke, B. (1996). *Communicating corporate change: a practical guide to communication and corporate strategy*. London: McGraw-Hill.

Rakestraw, T. L., & Weiss, H. M. (1981). The interaction of social influences and task experience on goals, performance, and performance satisfaction. *Organizational Behavior Management, 8*, 5-18.

Ramsdell, J. W. (1990). A rehabilitation orientation in the work-up of general medical problems. In B. Kemp, K. Brummel-Smith, & J. W. Ramsdell (Eds.), *Geriatric rehabilitation* (pp. 23-40). Boston: Little Brown & Company.

Rapoport, R. N. (1970). Three dilemmas in action research. *Human Relations, 23*, 499-513.

Reason, P. (1994). Three approaches to participative inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 324-339). London: Sage Publications.

Reed, J., & Procter, S. (1993). *Nurse education: a reflective approach.* London: Edward Arnold.

Renwick, R., Brown, I., & Nagler, M. (Eds.). (1996). *Quality of life in health promotion and rehabilitation: conceptual approaches, issues, and applications.* London: Sage Publications.

Richards, T. J., & Richards, L. (1994). Using computers in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 445-462). London: Sage Publications.

Richmond, D., Baskett, J., Bonita, R., & Melding, P. (1995). *Care for older people in New Zealand: a report to the National Advisory Committee on Core Health and Disability Support Services.* Wellington, New Zealand: Core Services Committee, Ministry of Health.

Robinson, I. (1988). The rehabilitation of patients with long term physical impairments: the social context of professional roles. *Clinical Rehabilitation, 2*, 339-347.

Rodriquez, N. M. (1988). A successful feminist shelter: a case study of the Family Crisis Shelter in Hawaii. *Journal of Applied Behavioral Science, 24*, 235-250.

The Royal College of Nursing. (1994). *Standards of care for rehabilitation nursing*. Suffolk: St Edmundbury Press.

Salinck, G. R. (1977). Commitment and the control of organizational behavior and belief. In B. M. Straw & G. R. Salinck (Eds.), *New directions in organizational behavior*. Chicago: St. Clairs Press.

Salvage, J. (1992). The new nursing: empowering patients or empowering nurses? In J. Robinson, A. Gray, & R. Elkan (Eds.), *Policy issues in nursing* (pp.9-23). Milton Keynes: Open University Press.

Sandelowski, M. (1993). Rigor or rigor mortis: the problem of rigor in qualitative research revisited. *Advances in Nursing Science, 16*(2), 1-8.

Sashkin, M. E., & Rosenbach, W. E. (1993). A new leadership paradigm. In W. E. Rosenbach & R. Taylor (Eds.), *Contemporary issues in leadership* (3rd ed.). Collarado: Westview Press.

Saunders, P. (1995). Encouraging patients to engage in their own care. *Nursing Times, 91*(9), 42-43.

Schein, E. H. (1993). How can organizations learn faster? *Sloan Management Review, 32*(2), 85-92.

Schmidt, N. (1995). Preparing rehabilitation teams for outcome-based rehabilitation. In P. Landrum, N. D. Schmidt, & A. McLean (Eds.), *Outcome-oriented rehabilitation*. Gaithersburg Maryland: Aspen Publishers.

Scholes, J., Furlong, S., & Vaughan, B. (1999). New roles in practice: charting three typologies of role innovation. *Nursing in Critical Care, 4*(6), 268-275.

Schön, D. (1983). *The reflective practitioner: how professionals think in action*. New York: Basic Books.

Schön, D. (1987). *Educating the reflective practitioner*. San Francisco: Jossey-Bass.

Schulz, R. (1975). Effects of control and predictability on the physical and psychological well being of the institutionalized aged. *Journal of Personality and Social Psychology, 33*, 563-73.

Seltzer, M. M., Ivry, J., & Litchfield, L. C. (1987). Family members as case managers: partnership between the formal and the informal support networks. *The Gerontologist, 27*, 722-728.

Seltzer, M. M., Litchfield, L. C., Kaphurst, L. R., & Mayer, J. B. (1992). Professional and family collaboration in case management: a hospital based replication of a community study. *Social Work in Health Care, 17*(1), 1-21.

Senge, P. (1990). *The fifth discipline: the art and practice of the learning organisation*. New York: Doubleday Currency.

Shamian, J. (1997). How nursing contributes towards quality and cost-effective health care. *International Nursing Review,* 44(3), 79-84.

Simms, L. M., Erbin-Roesemann, M., Darga, A., & Coeling, H. (1990). Breaking the burnout barrier: resurrecting work excitement in nursing. *Nursing Economics, 8*(3), 177-187.

Smith, A. (1981). Goal attainment scales: a method for evaluating the outcome of mental health treatment. In P. McReynolds (Ed.), *Advances in psychological assessment* (Vol. 5). San Francisco: Jossey-Bass.

Stanley, B. (1984). Evaluation of treatment goals: the use of goal attainment scaling. *Journal of Advanced Nursing, 9*, 351-6.

Street, A. (1990). *Nursing practice: high, hard ground, messy swamps and the pathways in between.* Victoria, Australia: Deakin University.

Swift, C. (1996). Disease and disability in older people: prospects for intervention. In A. J. Squires (Ed.), *Rehabilitation of older people: a handbook for the multidisciplinary team* (2nd ed.). London: Chapman & Hall.

Tahan, H. (1998). Case management: a heritage more than a century old. *Nursing Case Management, 3*(2), 63-66.

Taylor, S. L. (1995). Quandary at the crossroads: paternalism versus advocacy surrounding end-of-treatment decisions. *American Journal of Hospice and Palliative Care, 12*(4), 43-46.

Tettersell, M. J. (1993). Asthma patients' knowledge in relation to compliance with drug therapy. *Journal of Advanced Nursing, 18*, 103-113.

Thompson, S. (1981). Will it hurt less if I can control it? A complex answer to a simple question. *Psychological Bulletin, 1981*(90), 89.

Thorne, S. E. (1993). *Negotiating healthcare*. London: Sage Publications.

Thurgood, A. (1990). Seven steps to rehabilitation, *Nursing Times, 86*(25) 38-41.

Titchen, A., & Binnie, A. (1993a). Research partnerships: collaborative action research in nursing. *Journal of Advanced Nursing, 18*, 858-865.

Titchen, A., & Binnie, A. (1993b). What am I meant to be doing? Putting practice into theory and back again in new nursing roles. *Journal of Advanced Nursing, 18*, 1054-1065.

Tjosvold, D. (1989). Participation: a close looks at its dynamics. *Journal of Management, 13*, 731-50.

Toulmin, S. (1996). Is action research really 'research'? *Concepts and Transformation, 1*(1), 51-56.

Toulmin, S., & Gustavsen, B. (1996). *Beyond theory: changing organizations through participation*. Amsterdam: John Benjamin's Publication Company.

Valentine, P. E. B. (2001). A gender perspective on conflict management strategies of nurses. *Journal of Nursing Scholarship, 33*(1), 69-74.

Veatch, R. M. (1981). Nursing ethics, physician ethics, and medical ethics. *Law, Medicine, & Health, 9*, 17-19.

Wade, D. (1992). *Measurement in neurological rehabilitation*. Oxford: Oxford University Press.

Wagner, J. A., & Gooding, R. Z. (1987). Shared influence and organizational behavior: a meta-analysis of situational variables expected to moderate participation-outcome relationships. *Academy of Management Journal, 30*, 524-541.

Walker, R. (1998). *People in the Northern Region: a demographic profile from the 1996 census.* Auckland: Health Funding Authority.

Waters, K., & Luker, K. A. (1996). Staff perspectives on the role of the nurse in rehabilitation wards for elderly people. *Journal of Clinical Nursing, 5*, 103-114.

Waters, K. R. (1987). The role of nursing in rehabilitation care. *Science and Practice, 5*(3), 17-21.

Waters, K. R. (1996). Rehabilitation: core themes in gerontological nursing. In L. Wade & K. R. Waters (Eds.), *A textbook of gerontological nursing: perspectives on practice* (pp. 238-257). London: Bailliére Tindall.

Waterworth, S., & Lucker, K. (1990). Reluctant collaborators: Do patients want to be involved in decisions concerning care? *Journal of Advanced Nursing, 15*, 971-976.

Wess, S., & Page, J. (1995). Creating more effective human service organizations through strategies of empowerment. *Administration in Social Work, 19*(4), 1-13.

Wheeler, C. E., & Chinn, P. L. (1989). *Peace and power: a handbook of feminist process.* New York: National League for Nursing.

Wielder, K., & Buckwalter, K. C. (1990). Is nursing research used in practice? In J. C. McCloskey, & H. K. Grace (Eds.), *Current issues in nursing* (3rd ed.). St Louis: Mosby.

Willer, B., & Miller, G. H. (1976). Client involvement in goal-setting and its relationship to therapeutic outcomes. *Journal of Clinical Psychology, 32*, 687-690.

Willmont, M. (1998). The new ward manager: an evaluation of the changing role of the charge nurse. *Journal of Advanced Nursing,* 28, 419-427.

Wilson, J. (1987). Self-help and consumerism. In C. D (Ed.), *Towards the sensitive bureaucracy: consumers, welfare and the new pluralism*. Aldershot: Grower.

Winter, R. (1996). Some principles and procedures for the conduct of action research. In O. Zuber-Skerritt (Ed.), *New directions in action research* (pp. 13-27). London, Washington: Falmer Press.

Wood, R. E., Mento, A. J., & Locke, E. A. (1987). Task complexity as a moderator of goal effects: a meta analysis. *Journal of Applied Psychology, 72*, 416-425.

Woods, E. C. (1994). King's theory in practice with elders. *Nursing Science Quarterly, 7*(2), 65-69.

Woodward, C. A., Santa-Barbara, J., Levin, S., & Levin M. B. E. (1978). The role of goal attainment scaling in evaluating family therapy outcomes. *American Journal of Orthopshychiatry, 48*, 467-67.

World Health Organisation. (1986). *The Ottawa Charter for Health Promotion.* Copenhagen: World Health Organisation.

Wright, S. (1995). Can patients become empowered? *Professional Nurse, 10*(9), 599.

Young, A., & Chesson, R. (1997). Goal attainment scaling as a method of measuring clinical outcome for children with learning disabilities. *British Journal of 0ccupational Therapy, 60*(3), 111-114.

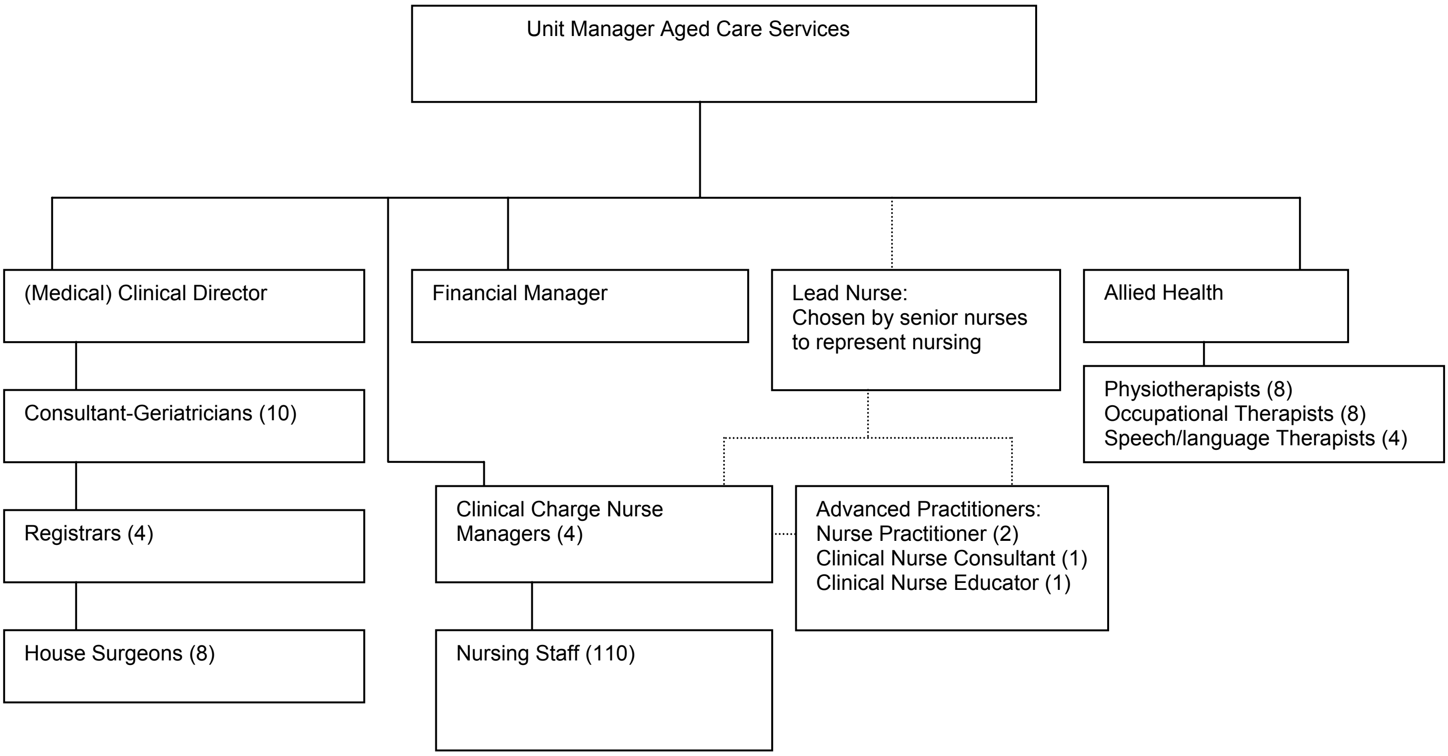
Zeichner, K. M., & Noffle, S. E. (1998). Practitioner research. In V. Richardson (Ed.), *Handbook of research on teaching* (4th ed.). Washington D.C.: American Educational Research Association.

Zuber-Skerritt, O. (Ed.). (1996). *New directions in action research*. London, Washington: Falmer Press.

APPENDICES

Chapter 2

Appendix 2A: Organisational chart of Aged Care Services.



Chapter 4

Appendix 4A: Timeline and summary of data gathering procedures

	October - November 1996	December 1997January	February	March	April	May
Groups within the unit:	Journaling, journal, nursing focus groups.					
Plan meetings with:	Clinical charge nurse managers, Maori Health, clinical director, business manager, nurse advisor, research unit, clinical nurse consultants.					
Finalise literature study:	Action research, participative care, goal-setting.					
Start study:	Submit ethics proposal, study days (action research, patient participation, reflective practice, goal-setting).	Approval expected mid-December.				
Conduct documentation audit:		Start documentation audit.				
Conduct interviews:		Health professional reconnaissance: developing understanding interviews with nurses (26).	Interviews continue, analysis of interviews			
Establish action research group:			Development of action plans resulting from health professional reconnaissance Start action cycles. Teach interview skills.	Interviews of patients by action research group members (20). I invite patients to participate in action research study.	Develop action plans based on patient feedback. Start multidisciplinary action group goal setting.	Develop action plan for goal setting.
Plan for submission of paper at the qualitative research conference in Palmerston North:				Start thinking about the paper.	Write paper.	Submit paper.

Table 1: Time-line for the first six months of study.

Timeline and summary of data gathering procedures; continued

Phase	Aim(s)	Actions	Data gathering	ANALYSIS
Health professional reconnaissance:	Developing a shared understanding regarding participative care.			
Stage I: step I: pre-ethics clearance:	Raise awareness and Develop understanding of action research on the ward. Explore the concept of participate care, obtain a baseline of practice and attitudes.	Ward meetings.	Documentation audit (in line with accreditation).	Excel descriptive analysis.
Stage I: step I: post-ethics clearance:	Develop an understanding of the current situation (develop an insight into the nurses perception of ward practice and research expectation, practice concerns, understanding of gerontological rehabilitation, the role of the nurse, the nurse-patient relationship. Discuss the literature review on participative care.	Study days (9).	26 open-ended-interviews audio-taped. Research journals Ward meetings Feedback sessions	Transcribed thematic analysis. Thematic analysis. Thematic analysis. Face validity.
Stage I: step II:	Establish the action research group.	Action plans in response to step I. Preparing for stage II.		
Patient reconnaissance:	Examine patients' and their families/significant others' opinion of current practice and their need for participative care. Compare patients' understanding of ward practice to that of the ward staff. Compare the literature to the research findings.	Ward meetings, evaluation of action plans initiated in health professional reconnaissance.	20 open-ended-interviews audio-taped. Entries in research journals. Discussions in action research group & ward meetings.	Transcribed thematic analysis. Thematic analysis. Thematic analysis.
Stage II: Step II: Response to step I:	Development and implementation of action plans.	Ward meetings. Evaluation of action plans.	Entries in research journals. Discussions in action research group and ward meetings.	Thematic analysis. Thematic analysis.
Phase II: step I:	Establishing a multidisciplinary action research group. Creating a safe environment for participative care, develop an acceptable method for participative care.	Ward meetings. Development of action plans based on literature and patient feedback.	Observations of participative meetings (audio taped). Evaluation forms Evaluation of multidisciplinary team members.	Thematic analysis. Thematic analysis. Thematic analysis.
Phase IV:	Primary nurse conducting home visits after discharge, family members as case managers, and strengthening links with the community.			

Table 2: Summary of data gathering methods.

Appendix 4B: Content of the study days

DAY ONE

8.00-8.15	Welcome
8.15- 12.00 coffee-beak at group's indication	Action research: What is it?
12.00-13.00	Lunch
1300-1400	Your role
14.00-14.30	Tea break
14.30-16.30	Current care delivery model
16.30-17.00	Closure

DAY TWO

8.00-8.15	Welcome
8.15- 1200 coffee-beak at group's indication	Reflective practice
12.00-13.00	Lunch
13.00-15.00	Journaling
15.00-15.30	Tea break
15.30-16.30	Introduction to the literature regarding goal setting, explanation of the take-home exercise (goal setting and interviewing)
16.30-17.00	Closure

DAY THREE

7.30-8.30	Welcome: breakfast
8.30-9.30	Feedback: take home exercise
9.30-12.30 coffee-beak at group's indication	Introduction to participative care
12.30-13.30	Lunch
13.30-16.30	Interview practice
16.30-17.00	Feedback
17.00-17.30	Closure and drinks

Appendix 4C: Plain language statement and consent form for health professionals

DEAR COLLEAGUE

My name is Lucienne Frey-Hoogwerf, a researcher and nurse interested in developing a rehabilitation model based on the client's experience. I am doing this research for a course of study, which will give me a Ph.D. in Nursing Studies at Victoria University, Wellington, and New Zealand. I am very interested in the care we deliver to our stroke clients. Previous studies have indicated that it was both enjoyable and beneficial for the older individual to be involved in their own care The anticipated move from rehabilitation model driven by health professionals to one driven by the client will require education, exploration of advantages and disadvantages, and planning. It will require a change in thinking and practice for all involved. It is anticipated that the research process will facilitate this.

I believe that a client-driven ward practice/rehabilitation model will contribute to client satisfaction and improve outcomes. Without the clients' involvement and suggestions, we cannot guarantee that we are addressing their needs. As a consequence, we may have a large number of unsatisfied clients - not because they did not receive good care, but ***because they did not receive the care they needed***.

I would like to invite you into this action research project. To enable you to decide if you want to participate in this study I would like to explain the procedure to you.

What is action research?

Emancipator action research is described as a process in which each participant is given the opportunity to participate and contribute on an equal basis to the research problem. The research process is no longer controlled and planned (dominated) by the researcher. It is a collaborative process in which researchers and participants work together towards the development of insightful knowledge. Emancipator action research is cyclic in nature. Each cycle consists of four steps: (a) identification of a thematic concern/problem, (b) strategic planning, (c) action and observation, and (d) reflection. During the first step information is obtained to formulate a plan. The translation of the plan into action, observation of its effects, and the subsequent evaluation of that action form the remaining stages in the action research spiral. The information obtained from previous stages in turn influence the following planning stage. Action research takes place in the practical setting and is conducted by clinicians and clients.

Work plan

This study will take place over a period of two years. The following sections are intended to give you some idea of the process.

Phase 1: Nursing staff is asked to complete two questionnaires and to participate in-group discussion. This is necessary in order to establish a baseline. Once the questionnaires are completed the education programme will be implemented (case management, participative goal setting, the caregiver as case manager, and partnership). The questionnaires are kept in a safe place and nobody other then me and _____ _____ (my supervisor) will see them.

Phase 2: Involvement of clients, i.e., interviews, questionnaires, and group discussion.

Phase 3: Involvement of both health professionals and clients/caregivers on the ward. In this stage you will be asked to participate in group discussions. If you all agree I would like to tape-record our group discussions so that I will not have to rely on my memory all the time. The discussions will be transcribed so that you will be able to read them and to reflect on previous meetings. In addition to the transcript I will provide you with my interpretation of the previous meeting. Again you will be asked to reflect and comment. If you do not agree with parts of the text in either the transcript or the interpretation, or if you changed your mind about information you have already disclosed, I will remove these from the text. To ensure confidentiality, your real names will not be used in the report. You will be given other names when I write my report. The tapes will be destroyed as soon as I have typed their contents. Until then they are kept in a safe place and nobody other then me and _____ _____ (my supervisor) will listen to them.

Phase 4: In this phase health professionals from the community are asked to join us and together we will develop a rehabilitation model based on clients' experiences.

I do not believe that this study will be in any way harmful to you. However, due to the location of the study people might be able to recognise the participants. As mentioned above I will to try minimise this by providing the participants with (fictitional) research names. According to previous research the benefits are improved communication, collaborative practice and possible increased job satisfaction.

Your participation is voluntary: you can withdraw from the research at any time and, if you wish, any information you have given to me will not be used in my report. The findings from this study will be used in my thesis, for educational purposes, and some of the findings may be published in academic journals.

If you have any queries or concerns regarding your rights and participation in this research you may contact the Health Advocates Trust, phone *** ****.

Lucienne Frey-Hoogwerf, phone *** ****

I am looking forward to our meetings.

I,...Of..
....
....

Hereby consent to be a participant of a human research study to be undertaken by Lucienne Frey-Hoogwerf.

I understand that the purpose of the research is

I agree that _____ ____ (academic supervisor) is allowed to review the information given to Lucienne Frey-Hoogwerf for the sole purpose of checking the accuracy of the information recorded in the study

I acknowledge

1. That the aims, methods, and anticipated benefits, and possible hazards of the research study, have been explained to me.
2. That I voluntarily and freely give my consent to my participation in such research study.
3. I understand that results will be used for research purposes and may be reported in scientific academic journals.
4. That I am free to withdraw my consent at any time during the study, in which event my participation in the research study will immediately cease and any information obtained from me will not be used.

Participant
Signature:_____________________________ Date:____________________

Researcher
Signature:_____________________________ Date:____________________

Appendix 4D: Plain language statement and consent form for patients

---

My name is Lucienne Frey-Hoogwerf. I am a nurse and researcher interested in the development of ward practice and ultimately a rehabilitation model based on your experience. I am doing this research for a course of study, which will give me a Ph.D. in Nursing Studies at Victoria University, Wellington, and New Zealand. I am interested in the care we deliver to our stroke patients. I would like to investigate if the care we deliver suits your needs and helps you for your life at home once you are discharged from hospital. I am interested in your feelings, the ways you deal with your disability, and how it affects your life during hospital admission and at home. I would like your opinion about what you think we as health professionals could do to assist you.

This study will take place over a period of two years and consists of several stages. The first stage involves the staff on Kauai Ward. The second phase involves you and your care givers/spouses. In this stage you are asked to fill out a questionnaire (which investigates your satisfaction with present care), participate in interviews (face-to-face with the researcher), and to participate in group discussion. If you only have a limited amount of time available I will ask you to participate in two group interviews (the first one at one week, the second at six months after discharge from the hospital). With your permission, the meetings will be tape-recorded, and you will be given the opportunity to look at the written records. I will post them out to you and if I do not receive any feedback within fourteen days I will assume that the content is acceptable to you.

If you have more time available and are willing to commit yourself to several group sessions you are invited to participate in the actual study. The third stage will bring you, your health professionals, and your caregivers together and the group will discuss and try to develop ward practice that is based on your needs and experience. In the final stage of the research health professionals from the community will join us in order to develop a rehabilitation model based on the your experience and needs. There are monthly meetings planned of at least one hour.

To improve the way we deliver our care I would like to invite you to participate in this action research study. To enable you to decide if you want to participate in this study I will explain the procedure to you: In the first three meetings you will be able to discuss the study with me and you also receive a written explanation of the study. In the second meeting I will again give you the opportunity to ask questions and sign the consent form. In the third meeting you will be asked to talk about how you feel about having experienced stroke, what your beliefs are about stroke and the factors that shaped these beliefs. We will then discuss your beliefs and expectations of rehabilitation, your feelings about discharge and how you see your future. During these meetings I will ask you to complete a questionnaire and start a research diary. I will ask you to describe in your diary how you feel about your stroke, the planned management, and how you feel about the interview and participating in this study. ***It is important for me to develop an understanding of your experience.*** That is why you are asked to keep the diary throughout the entire time that you are participating in this study. At the end of the meeting I will provide you with information about stroke and you are encouraged to ask questions during the entire interview. At the end of each meeting we will then set a date for the next meeting. I will be available for you to contact me at any time if you have any questions or concerns between meetings. After the fourth individual meeting I will ask you to join the research group on the ward. This group consists of other stroke patients and their spouses/caregivers.

With your permission, I would like to tape-record our discussions so that I will not have to rely on my memory all the time. In the second meeting I will provide you with a copy of the written record of the first meeting for verification. You will be encouraged to comment on this. If you wish, I will remove anything from the text with which you are not happy. In this meeting we will also discuss what you have discovered about your disability and explore whether your understanding and feelings towards it have changed in any way. Again you are encouraged to ask questions throughout all the meetings and together we will look for the answers. We also discuss the entries in the research diaries and I will again provide you with more information during this meeting. We will discuss and reflect on the entries in the diaries each time we meet. Again, I will give you copies of the written records of the previous meeting for verification.

The group meetings

If everyone agrees, the participants will meet after the third meeting (from then on the agenda for the meetings will be set together) and we will share our experiences. I believe that this is very important since all of you have valuable personal knowledge and experience from which we can learn. The meetings can also be used for educational purposes. I will provide you with information and will invite other health professionals to the meetings if you wish. But remember: I would like to find out from ***you*** what it is you need to know or the support you need in order to function well at home. If you have topics you would like to discuss or want more information about, you will be encouraged to bring this up in the group. If you all agree, I would like to tape-record our group discussions so that I will not have to rely on my memory all the time. The discussions will be written down so that you will be able to read them and to reflect on previous meetings. In addition to the written record I will provide you with my interpretation of the previous meeting. Again you will be asked to reflect and comment on it. If you do not agree with parts of the text in either the record or the interpretation, or if you changed your mind about information you have already disclosed, I will remove these from the text. To ensure privacy your real names will not be used in the report. You will be given other (fictional) names when I write my report. The tapes will be will be destroyed as soon as I have typed their contents. Until then they are kept in a safe place and nobody other than me and _____ _____ (my supervisor) will listen to them.

Will the study help you, or can it be harmful to you?

I do not believe that this study is in any way harmful to you. I would like to point out to you that although you are given a 'research name' there is a slight possibility that other people could identify you. It is also possible that you may feel uncomfortable with the interview. I would like to ask you to tell me whenever this occurs, and we will then stop the interview.

On the other hand, you may find that the contact with other stroke patients and their support is helpful to you. Other benefits of the study may not be seen immediately but you are offered the opportunity to assist in the development of a care delivery system that values and incorporates your opinion. This may be beneficial to people in a similar situation in the future.

Participation is voluntary

I would like to point out to you that your participation is voluntary. You can withdraw from the research ***at any time*** and, if you wish, any information you have given to me will not be used in my report. I realise that this study takes a considerable amount of your time, so I really appreciate your participation. The results of this study are published in my thesis and may be used for educational purposes and publication in an academic journal.

If you wish, you will be provided with a copy of my final report. If there is anything in the text which you are not happy about, you are encouraged to tell me and I will change it. If you have any questions or concerns regarding your rights and participation in this research you may contact the Health Advocates Trust, phone *** ****.

Your experience will help me to build a rehabilitation model around your experience. I believe that, in doing so, we will gain valuable knowledge and will get to understand the needs of our patients better.

Lucienne Frey-Hoogwerf: phone *** ****

I am looking forward to our to our meetings.

Developing ward practice from older clients' experience: A ParticipatoryAction Research Approach

Invitation

You are invited to participate in a research project aimed at improving the care provided to older patients in Kauri Ward.

Purpose

The purpose of this study is
1) to investigate whether the care delivered to you in Kauri Ward meets your needs and helps you after you are discharged from hospital
2) to develop a model of care that involves you and your caregivers in decision making regarding your own care

Procedure

Your involvement

If you choose to become involved during your stay on the ward you will be invited to work together with your nurse, other patients, staff members, and myself.

To help you to make your decision I would like to explain to you what you have to do in this study.

- You will be given information about the study and a few days later I will contact you again to invite you to participate. You will also be given the opportunity to ask questions about the study. You will then be asked to sign a form indicating your voluntary agreement to participate in the study.
- You will then be asked to complete a questionnaire asking for demographic information (e.g., were you live, your date of birth, place of birth, etc.).
- You will also take part in a personal interview with the researcher.
- One week later you will meet with the research group. In this group are other patients and nurses. In this meeting we well talk about your stay on the ward, your experience of being in a hospital, your experience of the care you received, and ways of improving your care.
- After this meeting you and your nurse will try to work with the ideas from the meeting. After a further week the research group will meet again and you will be invited to complete a questionnaire assessing your satisfaction with the care received to date.
- With your permission the nurse and I will visit you at home after your hospital stay (at two weeks and again at three months after you have left the hospital) and we will talk about your experience at home.
- With your permission, I would like to tape-record our discussions so that I will not have to rely on my memory all the time and you will be given the opportunity to look at the written records.

If you find the idea of group participation a bit threatening you may choose to work together with only your nurse and myself.

If you do not want to become involved to this extent I would like to invite you to participate in an interview and complete a questionnaire at two weeks and at three months after you have left the hospital.

If you choose not to participate, the care you receive in our ward will not be compromised.

Discomforts and Risks

Should you experience distress or feel uncomfortable during the interviews or discussions, we will stop (terminate) the interview or discussion.

Compensation for Injury or Negligence

Everything we can think of has been done, and will continue to be done, to prevent problems occurring during this research. However, should you suffer personal injury resulting from medical error or medical mishap in the trial you are entitled to ACC cover (Accident Rehabilitation and Compensation Insurance), and may be entitled to compensation. ACC has the final decision on the level of compensation, which may be provided.

The ACC booklet "Clinical trials - Your Guide to ACC Cover" is available on request.

Benefits

This study may be of immediate benefit to you in that we will be able to deliver care to tailored to your individual needs. In addition, your contribution will assist in the development of a care delivery system that values and incorporates patients' opinions. The implementation of the resulting care-delivery system is anticipated to be of considerable benefit to patients (client centered care) as well as staff (increased levels of competence) of Aged Care Services

Confidentiality and Privacy

Tape recordings of discussions and interviews will be kept in a locked cabinet and will only be available to myself and my immediate academic supervisor. After the contents are typed the tapes will be destroyed. You will be given fictitious names and every effort will be made to remove other identifiable information in any reports. If you wish, you will receive a copy of the final report. The findings from this study will be used in my thesis, for educational purposes, and some of the findings may be published in academic journals.

PLEASE REMEMBER THAT YOU CAN WITHDRAW FROM THE STUDY AT ANY TIME.

Queries

If you have any questions or concerns please contact:

Lucienne Frey-Hoogwerf
Clinical Nurse Consultant/Researcher
Aged Care Services (Kauri Ward)

Tui Hospital
telephone **-***-****, ask for locator number **-****

Dr. ______ _____
Research Supervisor
Department of Nursing Studies
_________ University
_________ City
telephone **-***-****

If you have any queries or concerns regarding your rights as a participant in this research you may contact the Health Advocates Trust, telephone **-***-****.

English	I wish to have an interpreter	Yes/No
Maori	E hiahia ana ahau ki tetahi tangata hei korero	Ae/Kao
Samoan	Oute mana’o e iai se fa’ amatala upu	Ioe/Leai
Tongan	‘Oku fiema’ u ha fakatonulea	Io/Ikai
Cook Island	Ka inangaro au i tetai tangata uri reo	Ae/Kare
Niuean	Fia manako au ke fakaaoga e tagata fakahokohoko /Nakai	vagahau E

CONSENT FORM

This study has been approved by the following ethics Committees: _____ Health Authority, _____ City and ________ University, ______ City.
Reason for the project: *Development of a rehabilitation model based on the client's experience*
Your task in this project:

1) *To work together with Lucienne Frey-Hoogwerf towards a better understanding of the needs of stroke patients*
2) *To participate in the development of client focused ward practice and a rehabilitation model based on stroke patients experience*

Risks associated with participation: *minimal*

Benefits: *Collaborative practice development of practice theory*

Confidentiality: *Data will be recorded and treated according to identification numbers, which are not linked, to names of the participants. Care will be taken not to publish any text that may expose the real identity of participants.*

Voluntary participation: *Your participation in this project is voluntary.*

Time required: *Monthly group meetings of approximately 1 hour over a period of two years*

Name of researcher/supervisor: *Lucienne Frey-Hoogwerf /*______ _____

English	I wish to have an interpreter	Yes/No
Maori	E hiahia ana ahau ki tetahi tangata hei korero	Ae/Kao
Samoan	Oute mana'o e iai se fa' amatala upu	Ioe/Leai
Tongan	'Oku fiema' u ha fakatonulea	Io/Ikai
Cook Island	Ka inangaro au i tetai tangata uri reo	Ae/Kare
Niuean	Fia manako au ke fakaaoga e tagata fakahokohoko	vagahau
	E/Nakai	

I,..Of..
....
....
Hereby consent to be a participant of a human research study to be undertaken by Lucienne Frey-Hoogwerf.

I understand that the purpose of the research is

I agree that _____ _____ (academic supervisor) is allowed to review the information given to Lucienne Frey-Hoogwerf for the sole purpose of checking the accuracy of the information recorded in the study

I acknowledge

1. That the aims, methods, and anticipated benefits, and possible hazards of the research study have been explained to me.
2. That I voluntarily and freely give my consent to my participation in such research study.
3. I understand that results will be used for research purposes and may be reported in scientific academic journals.
4. That I am free to withdraw my consent at any time during the study, in which event my participation in the research study will immediately cease and any information obtained from me, will not be used.

Participant
Signature:______________________________ Date:____________________

Researcher
Signature:______________________________ Date:____________________

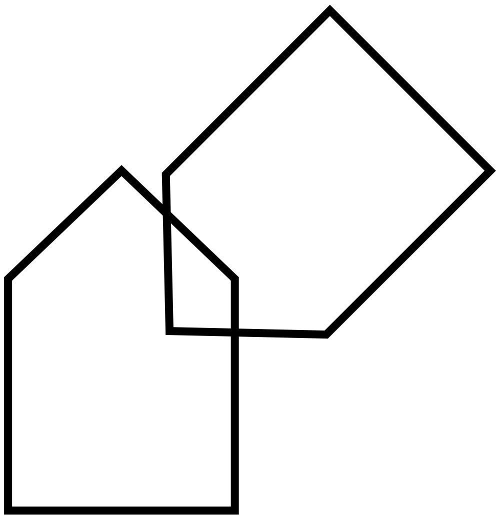
PATIENT/CLIENT LABEL

Folstein Mini-Mental State Examination Data Collection Sheet

ORIENTATION:	SCORE POINTS
What is the year?	1
What is the season?	1
What is the date?	1
What is the day of the week?	1
What is the month?	1
What city/town are we in?	1
What state are we in?	1
What country are we in?	1
Can you tell me where we are? (Residence/hospital or street name)	1
What floor of the building are we on?	1
REGISTRATION:	3
Name three objects, taking one second to say each. Then ask the person to repeat them. Give one point for each correct answer. 'Appie Tabie Penny.' Repeat the answers (up to six times) until the person learns them	5
ATTENTION AND CALCULATION: A Ask the person to subtract 7 from 1 00, then subtract 7 from the answer. Keep subtracting 7 until they reach 65. (93, 86, 79, 72, 65) B Ask the person to spell the word WORLD backwards. NB *Subjects are given both A and B. Record the highest score.	5
RECALL: Ask the person 'Now what were the three words 1 asked you to remember?	3
LANGUAGE: Naming: What is this called? (Show the Person a wrist watch) What is this called? (Show the person a pencil)	2
Repetition: Have the person repeat 'No ifs, ands or buts." Allow only one trial.	1
Reading: Have the person read and do the following command as printed on the back of this form ('CLOSE YOUR EYES')	1
3 stage Have the person follow a 3 stage command: ***command: 'Take a paper in your right hand, fold the paper in half using both hands, and put the paper down using your left hand.***	
Vriting: Have the person write a short sentence. Do not dictate a sentence,it is to be written spontaneously. It must contain a subject andverb and be sensible. Correct grammar and punctuation are not necessary.	3
Copying: Now copy the design that you see printed (design on back of this form). The results must have 5 sided figures withntersection forming a four sided figure. Ignore tremor and rotation.	1
command: in your right hand, fold the paper in half using both hands, and put the paper down using your left hand.	
Writing Have the person write a short sentence. Do not dictate a entence,it is to be written spontaneously. It must contain a subject and verb and be sensible. Correct grammar and punctuation are not necessary.	1
Copying: Now copy the design that you see printed (design on back)of this form). The results must have 5 sided figures with intersection forming a four sided figure. Ignore tremor and rotation.	1
Total	**[30]**

Backof the form

CLOSE YOUR EYES



Appendix 4F: Interview guide for health professionals interviews

PERCEPTIONS ABOUT THE RESEARCH

Feelings about participating in the research:
To what extent anxious, happy, intimidated concerned?
What is your opinion of the research?
What do you think about it?
What do you know about action research?
How do you feel about interviewing patients in a more in-depth way, asking them about their life before they came into hospital?

GERONTOLOGICAL REHABILITATION NURSING

What does it mean for you to be a gerontology nurse?
Is there a difference between gerontology nursing and general medical nursing?
If so could you describe it?
How would you describe rehabilitation?
What do you think is the role of nursing in rehabilitation?
How do you think other health professionals in the team see the role of nursing?
Could you describe what gerontology/rehab nursing contributes to patient outcomes?

PARTICIPATIVE CARE

Could you describe how you would "ideally" deliver nursing care? Also think about why it is that you are or are not able to deliver that care.
How do you feel about patient participation in care?
What do you see as the role of rehabilitation nursing?
(Goals for maximum independence and activities of living, promote self care prevent complications of further disabilities, ensure access with continuity of service and care, advocate for optimal quality of life)

WARD PRACTICE

Could you describe you daily routine to me?
If I asked you to draw a picture of the team what would it look like?
If you were to define partnership what are the major components in it for you?
How do you think patients view nursing?
In the ward what is most positive?
If there was anything you could change what would you change?

Appendix 5A: Tables 1 and 2 regarding participation

“Is the simple interaction of consumers and policy makers.”	Richardson, 1983, p.19
“Getting involved or being allowed to become involved in the decision making process of the delivery of a service or the evaluation of a service or even simply to become one of a number of people consulted on an issue or matter.”	Brownlea, 1987, p.605
Involvement of the patient in clinical practice and decision making. Through formal (nursing process) and informal (day to day) interactions (between nurses and patients) and channels.	Jewel, 1994

Table 1: Definitions and descriptions of participation.

To participate	To take a part or share in.
To involve	To participate, or share
To collaborate	Work jointly, cooperate

Table 2: Descriptions of participate, involve, and collaborate.

Chapter 6

Appendix 6A: NUD.IST 4 text search and corresponding nodes

The extract below shows an output from NUD.IST 4. In order to produce this output, the transcription of the tapes were entered in NUD.IST. A search command is then given. For example, “research expectations” begins a search for paragraphs containing the words research expectations. The output below shows some of these findings. These are then placed under a node, which is a collection of statements with a related theme. See below.

Text search

```
S.R. NUD.IST Power version, revision 3.0.4 GUI.
Licensee: jellyfish.

PROJECT: PHD, User lucienne, 2:07 pm, April 7, 1997.

********************************************************************************
(1 1)               /Research /expectations
*** Definition:
relation to participants expectations
++++++++++++++++++++++++++++++++++++++++
+++ ON-LINE DOCUMENT:
+++ Retrieval for this document: 1 unit out of 374, = 0.27%
++ Text units 26-26:
26    It's a marvellous opportunity to be involved and contribute.  I really
      didn't know what I was letting myself in for because you did it in a
      method that I'm not familiar with, but one that I wanted to find out more
      about, because it's in line with something that I heard and I was
      introduced to in 1993 when I was involved with organising the workshop
      for - on contraception for the Health Research Council.
++++++++++++++++++++++++++++++++++++++++
+++ ON-LINE DOCUMENT:
+++ Retrieval for this document: 3 units out of 323, = 0.93%
++ Text units 7-7:
7     How did I feel about it?  Um - research it's um - often I hear quite a
      bit about it, but I never know anything about it, so I was quite
      interested to find out more.
++ Text units 15-15:
15    Yeah, yeah.  So far, yeah, I am getting to see more about it and finding
      more about it - Oh yeah, it really is interesting.  Um, it - you know
      like - its where you - you'll have your trials and errors and find the
      right answer - where you find the facts and the truth really.
++ Text units 307-307:
307   Um, yeah, I'm sure that after the research we will be looking forward to
      have a better system and then we will be able to give better service and
      um, change the old traditional way of (ha, ha) nursing focussing on us,
      what we do, but to more focus on our client as the patients themself and
```

```
     hopefully we'll make a better place where the people come here and not
     only gain a lot more physically but ah, also as the whole person, sort of
     thing.  Benefit from the research, the nurses will be able to give more,
     the best of care.
++++++++++++++++++++++++++++++++++++++++
+++ ON-LINE DOCUMENT:
+++ Retrieval for this document: 2 units out of 641, = 0.31%
++ Text units 51-52:
51      Umm, I suppose working more in partnership with our patients.  Like
     instead of doing things on our own.  And I think more working together
     with the other health members as well, instead of just keeping nursing on
     its own.
52    Because if we're looking after patients then we - I think we've got to
     have everybody's input as well as the patients themselves.
++++++++++++++++++++++++++++++++++++++++

+++ ON-LINE DOCUMENT:
+++ Retrieval for this document: 1 unit out of 825, = 0.12%
++ Text units 210-210:
210   Um, having done research days and seeing what we have to look forward to
and getting the chance later, to talk to the patients and see how they see nurses, I'm
sure my focus will change, you know, come back into alignment.
++++++++++++++++++++++++++++++++++++++++
+++ ON-LINE DOCUMENT:
+++ Retrieval for this document: 1 unit out of 921, = 0.11%
++ Text units 50-50:
50      Yeah, it still scares me, just in respect of the actual extra work.
     But a lot of that is partly because I'm just coming down from being so
     wound up and so stressed out - I've got a few things going on in my life.
     So um, as that's starting to settle things are starting to become a
     little bit clearer and a little bit less murky, so yeah.  Time for a big
     - big issue really.
++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++
++++++++++++++++
+++ Total number of text units retrieved = 12
+++ Retrievals in 8 out of 43 documents, = 19%.
+++ The documents with retrievals have a total of 4273 text units,
   so text units retrieved in these documents = 0.28%.
+++ All documents have a total of 26464 text units,
   so text units found in these documents = 0.05%.
++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++
+++++++++++*********************************************************************
(1 2)              /Research /feelings about reseach
*** Definition:
all statements  about  feeling towards  research
```

Example of the nodes

```
Q.S.R. NUD.IST Power version, revision 3.0.4 GUI.
Licensee: jellyfish.

PROJECT: PHD, User lucienne, 8:42 pm, April 23, 1997.
(1)                /Research
        (1 1)              /Research /expectations
        (1 2)              /Research /feelings about research
        (1 3)              /Research /roles
        (1 4)              /Research /change
        (2)               /diary
(3)                /gerontology nursing
        (3 1)              /gerontology nursing/continuity
        (3 2)              /gerontology nursing/ageism
        (3 4)              /gerontology nursing/support

(4)                /knowledge
        (4 1)              /knowledge/technical
        (4 2)              /knowledge/practical

(5)                /p&nrelationship
        (5 1)              /p&nrelationship/partnership
        (5 1 1)             /p&nrelationship/partnership/trust
        (5 1 1 1)            /p&nrelationship/partnership/trust/intimate
        (5 1 2)             /p&nrelationship/partnership/communication
        (5 1 3)             /p&nrelationship/partnership/humour
        (5 1 4)             /p&nrelationship/partnership/honesty
        (5 1 5)             /p&nrelationship/partnership/comforting
        (5 1 6)             /p&nrelationship/partnership/friendship
        (5 1 7)             /p&nrelationship/partnership/empathy
        (5 1 8)             /p&nrelationship/partnership/time
        (5 1 9)             /p&nrelationship/partnership/equality
        (5 1 10)             /p&nrelationship/partnership/teaching
        (5 1 11)             /p&nrelationship/partnership/advocacy
        (5 1 12)             /p&nrelationship/partnership/interest in
        (5 1 13)             /p&nrelationship/partnership/encouragement
        (5 1 14)             /p&nrelationship/partnership/family
        (5 1 15)             /p&nrelationship/partnership/listening
        (5 1 16)             /p&nrelationship/partnership/personhood
        (5 1 17)             /p&nrelationship/partnership/respect
        (5 1 18)             /p&nrelationship/partnership/caring
        (5 1 19)             /p&nrelationship/partnership/responsibility
        (5 1 20)             /p&nrelationship/partnership/information
        (5 1 21)             /p&nrelationship/partnership/approachable
        (5 1 22)             /p&nrelationship/partnership/counselling
        (5 1 23)             /p&nrelationship/partnership/sharing
        (5 1 24)             /p&nrelationship/partnership/motivation
        (5 1 25)             /p&nrelationship/partnership/hope
        (5 1 26)             /p&nrelationship/partnership/choice
```

(5 2)	/p&nrelationship/professionalism
(5 2 1)	/p&nrelationship/professionalism/satisfaction
(5 2 2)	/p&nrelationship/professionalism/dissatisfaction

Chapter 7

Appendix 7A: Guidelines for journaling

The research diary

Smyth's (1987, cited in Holly, 1987) approach to reflective writing was utilised throughout the study.

Journaling can be seen as another form of exemplar writing. Generally speaking it can be regarded as a collection of exemplars written by a practitioner over a period of time, developing in three stages.

At the first stage the diary entries are descriptive. During the second stage the practitioner is slowly introduced to reflection. The writer is asked to reflect on the diary entry (this is termed 'initiating systematic inquiry'). This allows the practitioners to locate themes, investigate what it is they know and how they came to know about it. In other words, they develop an understanding of, and find meaning in, the things we do as nurses.

Looking at one's own practice and then sharing our ideas, feelings and knowledge will contribute to the development of our nursing knowledge. This process is important for nursing since nursing as a discipline is trying to identify and articulate its own unique body of knowledge.

The third stage encourages the practitioner to move from reflection to reconstruction of practice. At this stage practitioners no longer accept their practice uncritically. They actively search for ways to change it. In other words, the scene is being set for research based practice.

Writing Journal Entries - some basic guidelines

The first stage

- Writing is descriptive.
- Describe the events (who, what, where, when, how)
- Describe the feelings of all involved
- Analysis and comments
- In this stage you could try and identify/examine themes in your practice.

The second stage

- Try to incorporate the 'verbatim principle' (try to record what people say, avoid summarising).
- At this stage the analysis part becomes important because you are trying to develop a meaningful understanding of practice. This involves asking questions like
    - Where did the ideas I embody in my nursing came from historically?
    - How did I come to appropriate them?
    - Why do I continue now to endorse them in my work?

(Adapted from Smyth, 1987, cited in Holly, 1987)

The third stage:

- You are taking a critical view of nursing and moving toward reconstruction of practice.
- In this stage you will have developed your personal theories of nursing, and practice accordingly.
- To critically analyse your practice your focus on
    - Whose interest do my personal theories serve?
    - What power relations are involved (personal and organisational)?
    - How does my practice influence my relationship with my clients?
    - In the light of what I have discovered how might I act differently?

Write about practices and discourse regarding practice.

Formulate action plans for discussion in the group.

Describe the effects of the actions on practice.

Use the entries for reflection

It might be a good idea to use the headings: reflection, plan, action and observation.

Examples of journal entries

The first is an example of descriptive writing and the second an example of reflective writing.

DESCRIPTIVE
After looking through the readings that Lucienne gave to us, it helped to prompt me to take a look not only at my own practice, but also at others, to depict what therapeutic techniques we used on our ward.

One incident that stands out to me, is when a fellow staff member was with a patient who had multi-infarct dementia with a tendency to wander. This staff member took on board what sort of things that that the patient was now able to do, and do safely, and included it in what she had to do for the day. So, when this particular nurse was restocking up the linen, she had the patient come along with her, pushing the linen trolley, to think about what sort of items they might need in the room, (the patient believed that he was in a hotel, so he would choose things that would be required to make the beds, etc.), and to help put the linen back into the room. This might have still been a 'task' that was necessary to carry out the rest of the day more efficiently, however this nurse had turned it into a time whereby she was able to be present with a patient, talk to the patient on a one-to-one basis and developing more the nurse-client relationship rather than conversation to develop on medical information of the client.

I recall this quite vividly, since I saw all these other aspects of therapeutic nursing being used, rather than seeing getting the linen as being a task. And so I used the exact same technique yesterday. A patient in my room, who is also being queried as to whether he has multi-infarct dementia, was looking a bit restless while sitting in his bedside chair. I asked him if he would be able to help me with getting some more things for the ward. Agreeing, he pushed the linen trolley down to the cupboard alongside with me.

The linen cupboard on our ward is outside the ward, sometimes a hassle as it is that far away therefore time consuming, and you are not able to be with your patients when you are there, except in this situation. By being one-to-one with the patient without any other distractions, it allowed for the therapeutic interventions to step in. I can't actually recall what I had initially said, however what followed in reply by this patient was mind-boggling in that so much could result from such a small (and what seemed insignificant) question. This patient began to describe to me about how his wife was very ill around the age of thirty. He recapitulated how he woke up one morning, with a feeling that something was wrong with his wife - turning to her he discovered that she had passed away during the night. He went on to say that he was able to recognise a dead person's body as he had seen many soldiers in that state when he was in the war. The conversation then went on to talk about how he had to bring up his five children by himself, the youngest at that time being five years old.

The therapeutic intervention of being 'present' for this patient, seemed so much more than what we had been 'taught' to do at Tech. This is something that had developed with much feeling and emotion, from the both of us, that only developed on our nurse-client relationship. Something that I didn't expect to develop with this patient, as personally, I was unable to get to know him. Whether it was because of the fact that he did wander and therefore became 'time-consuming', I'm not too sure. The education of what was therapeutic, for sure, was in the background to being able to develop the relationship, however it had expanded past that. The 'task' of getting the linen had definitely turned into something much more, something special.

REFLECTIVE

People involved Joy and Mrs V.

Situation: *This incident occurred during my orientation to the wards. Mrs V's Primary Nurse had left the ward for morning tea.*

The incident:

J: Good morning, my name is Joy what can I do for you?

Mrs V: I coughed up some blood and the nurse told me that when it happened again to ring the bell so that she could have a look at it.

Observation: *I noticed that she was in some distress. Her breathing was somewhat laboured. There was some blood in her sputum. I took her vital signs (pulse, respiration and blood pressure) which were normal. I believed that since her vital signs were normal that her distress was related to something else. I decided to stay with her and talk to her (trying to comfort her)*

J: How are you feeling? *(sitting down on the chair next to her bed indicating that I was willing to listen)*

Mrs V: I wish I could get up and walk away from this place.

J: Would you like to tell me why that is?

Observation: *At this stage she burst into tears. I put my arm around her and just let her cry. After a few minutes she calmed down.*

J: Can you tell me why you are upset or would you like to talk someone else?

Mrs V: No it is just that I feel such a burden. You do not have the time to sit here and talk to with me.

J: I have plenty of time, I am spending some time on the wards today, I am extra.

Observation: *Mrs V. started crying again.*

Mrs V:. My mother was on the same ward and just a few days ago she went to the heart ward. I have not seen her since. I am really worried about her you know?

J: Have you not received any information about your mother's condition?

Mrs V: No, only that she was fine, and I am worried about her.

J: That is understandable.

Mrs V: We live together and we are really close

J: Would you like me to try and find how your mother, is or even better, would you like to visit her sometime during the day?

Reflection on action

Even before I finished my sentence I realised that I was not acting according to my espoused theory (partnership). Through my choice of words, I directed her into a certain direction (imposing my opinion upon her). By doing so I, the nurse, was in control of the situation. However, by giving her the opportunity to discuss several other options, she would be able to make a decision about and feel in control of her situation.

Mrs V: Can you arrange that? But how can you when I am on bedrest?

J: Can you tell me why you are on bedrest?

Mrs V: They told me that I may have a small fracture in my hip.
J: That is painful. Are you in pain at the moment?
Mrs V: No I am not. So can I go?
J: *(trying to give her control over the situation)* I would like to go over a few options. For example, I could phone the unit and find out a bit more about your mother's condition. On the other hand, you or one of your family members could do that. Or we could take you down to visit your mother.
Mrs V: I'd love to go. I am really worried about her. We live together and are really close. Not being able to see her makes me feel uncomfortable.
J: Yes I can understand that. What do you think is the best way to solve your problem?
Mrs V: I would love to go down, and see my mother. You know, to see for myself that she is fine. It is not that I do not trust you but you know how it is.
J: Yes I think I do. I'll discuss it with your nurse as soon as she is back and she will be able to arrange that visit for you. *We then talked for a while about her family and her stay in hospital. She mentioned that she had difficulties adjusting to the hospital environment.*
Observation: *She was talking freely now and her breathing had returned to normal. She was obviously relieved that she had been able to discuss her problem.*

Outcome

I had spent about 15 minutes talking to Mrs V. During this time we had been able to solve her problem. I had informed the primary nurse about Mrs V's needs and asked her to arrange a visit. This was arranged for the afternoon.

Analysis of the situation

Mrs V's distress was related to the fact that she had not been able to access information about her mother's condition. The only information Mrs V had received was that her mother was "fine". The factors that contributed to this situation were threefold. First, Mrs. V believed that because she was on bedrest she was not able to visit her mother. Second, she had no access to the phone. Third her primary nurse was unaware of Mrs V's distress.

It had never occurred to Mrs V that her primary nurse would have assisted her if she had expressed her needs. When I discussed this with her she mentioned that the nurses were too busy and she did not want to be a burden. Because Mrs V. did not express, and her nurse did not recognise, her needs, Mrs V experienced feelings of frustration and helplessness. This in turn caused her a great deal of distress which affected her well-being.

Through my practical knowledge I was able to identify the cause of her distress. By beginning to establish a therapeutic relationship (active listening, compassion, empathy, touch, caring, empowerment) between myself and Mrs V she was able to disclose her feelings. Together we could address her needs and resolve her distress.

I want to point out by sharing this incident, that the nursing skills generated through our personal/practical knowledge (interpretive paradigm) are equally as important as our skills derived from the technical nursing knowledge (emperico-analytical paradigm). The former is often taken for granted and perceived as less valuable. I would like to suggest here that through the skills we have acquired from our practical knowledge we really can make a difference to the patient.

Reflection

I believe that in this situation I acted according to two of my espoused personal theories (partnership and availability). I tried to give Mrs V control over the situation by asking her what she thought would be a suitable solution to accommodate her needs. In so doing I tried to avoid language that may have influenced her in one or the other way. However, by using the words "even better" I indicated that I believed visiting her mother was the best option, thereby slipping back into the traditional nursing role, where the nurse imposes her opinion/expert knowledge onto the client. This practice was not according to my espoused theory of partnership in which I view the client as an equal partner. I was able to recognise this through reflection on action and reconstruct my practice accordingly.

Types of knowledge demonstrated

In this description three types of knowledge are demonstrated. According to Habermas (1974, cited in Carr and Kemmis, 1986) knowledge is derived from three forms of human interest, namely technical, practical, and emancipatory interests. Technical nursing knowledge derives from the emperico-analytical paradigm and generates scientific and procedural knowledge. In other words, knowledge derived from the practical sciences. An example of technical nursing knowledge in this example would be my ability to assess and interpret Mrs. V's vital signs.

Practical nursing knowledge is generated from the interpretive paradigm. It enables us to form an interpretive understanding which can inform and guide practice (Habermas, 1974, cited in Carr and Kemmis, 1986). This often leads to creative and innovative nursing practice. It has rightly been argued that our practical knowledge forms the basis for holistic, empathetic care and constitutes the essence of nursing (Moss and Cox, 1988).

I believe that practical nursing knowledge is demonstrated in the above description by my understanding of the need of this patient. It helped me to respond and relate to the patient.

Emancipatory knowledge arises from the critical paradigm. Through critical reflection on our practice we try to improve/reconstruct our practice. This may result in creative and liberating care and is very much part of nursing actions. In addition, emancipatory nursing knowledge enables us to provide care that is equitable and responsive to the patients' changing needs/situations. An example of emancipatory knowledge in the present situation would be both reflection in action which enabled me to reconstruct my practice, and reflection on action. Through reflection on action I was able to recognise that I acted according to two of my espoused theories. Moreover, I realised that I did not complete a follow-up visit with Mrs V which in my view is necessary to complete the relationship.

Reflection at a later stage

I realise now while I reflect upon this incident that I do miss the contact with clients and my clinical world. Borrowing from Schon (1987), our clinical world can be part of the 'high hard ground' where the practitioner can effectively use the research-based techniques and methods since they provide us with rules and guidelines for practice. In contrast, in the 'swampy lowlands' situations are not as clear cut and not often amenable to purely technical solutions. It is here were we develop our practical knowledge.

The question that I propose here is as follows: How can I further develop my knowledge when I no longer dwell in the lowlands? Is it possible to develop a theory of practice when I no longer have the same level of involvement with my clients as I used to? Whenever I enter the clinical world I seem to be involved with my colleagues rather than clients. Can I develop my practical knowledge from these encounters?

Reflection

I seem to be thinking an awful lot about the development of my knowledge and practice. Is it not part of my role to assist others to discover their knowledge and understanding of the 'swampy lowlands'? Sharing our knowledge, understanding and documenting it, may enable nurses to begin to develop a common language in nursing (Meleis, 1991). A language based on the understanding of the practitioner may lead to the development of theories of practice.

Appendix 7B: Tables 3 to 6, responses from the action research group

I mean you don't have to write whole stories about it [practice]. This is how I sort of hope that nursing practice will be in the future. That we look at what we are doing then reflect on it and say you know *this* is really good, I'll keep *that* in my practice and do that next time with a patient. (Yolanda, GD G3, p 18)
Since our first meeting when we talked about primary nursing, and our initial assessment sheet, and writing our care plan with the patient, I have been doing it like that. I go away and write and then come back and say, 'Do you agree with this' [to patient] - but I need to work on it more. (Joc (ARGM1, p 5)

Table 3: Comments in relation to reflective practice

You have to have someone who is an experienced nurse to guide the discussion. So that people do not feel judged. You have to have a situation whereby colleagues feel comfortable to share their practice because nobody wants somebody else to say, 'What a twit'. You've got to trust the people in the group to open yourself up. To listen and to look at your practice and when it is wrong, recognise it so that you could change that practice. So that you could go back and do something constructive about it. (Stef, ARGM1, p 12)

Table 4: Comments in relation to trust within the group

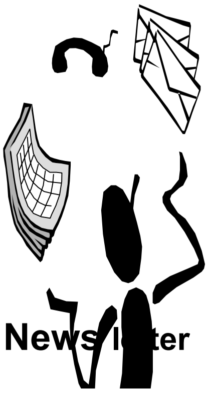
I just enjoyed the listening and the sharing that went on. I went away thinking that there were a lot of issues here that we need to resolve. The ones that jumped out and hit me in the eyeball, were the issues of primary nursing. We all have the commitment and the motivation, but it seems to me that at times we are sort of talking past each other. I think that for me it's an important thing within the unit that we sit down and everybody is told what primary nursing is for the ward. (Irmgard, ARG1, p 36)
I enjoyed the day and like to talk about how we can change things a round. I like the talking and sharing. We do not take enough time to do that. (Betty ARGM16, p 50)

Table 5: Comments in relation to sharing practice stories

Funny, when the tape was turned on, I suddenly went blank and couldn't think of what to say. (Yolanda, T, tu 13)
I found that I a little difficult but I seemed to get along well in passing and that made me comfortable. It [the interview] definitely had a flow and I was able to pick up on this during the conversation and be able to go off on a tangent and come back. Afterwards when I took him back he quite liked the flow as well he said. He said that he felt quite comfortable which was good to hear especially since it was my first one (Gemma, T, tu 17)
Well it is a bit easier now. I was a bit scared doing the interviews in the beginning. But the more I am doing the more at ease I am feeling. (Ann, T, tu 190)

Table 6: Comments in relation to the interview experience

Appendix 7C: Newsletters



Newsletter December 15

Welcome to the first update of the research project.
What has happened so far:

Lucienne has completed the interviews with the nurse clinicians and will provide some feedback next month.

The patient interviews are well on the way and are providing us with useful information.

From this information we have developed the following action plans

- Ward admission
- Visiting other wards
- Photoboards
- Admission check list
- Colour scheme

All of these are still in progress. In the ward meeting meeting (next week) we will discuss the advantages and disadvantages.

Please do remember that the research project is completely separate from the accreditation.

Please discuss any concerns you have.

Looking forward to our next ward meeting

News Letter February

Hope all of you had a good break over the summer.

FIM

In December we all agreed that the reintroduction of the FIM was a good idea. As a result Lucienne and B have developed an education booklet and have conducted several one to one teaching sessions. These will continue until the end of the month.

Colours for the doors

They have been finalised and painting has been completed

Feedback from visitors and patients is positive.

Patient interviews are providing very useful information

They are slowly progressing and we hope to share some of the findings next month.

Looking forward to the next ward meeting

News letter March

Goal setting meetings
These are still in the developmental stage, several patients are involved. Their participation is very valuable
Working out guidelines for the goal setting meetings

Patient interviews
We conducted 20 interviews. The emerging themes are

- Lack of privacy
- Lack of knowledge regarding the ward
- Lack of information regarding care
- Boredom

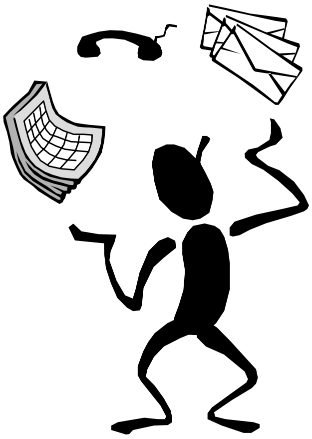
Communication between the action research and ward participants is improving. We had a ward meeting to clarify some miscommunication
Please continue to voice your concerns, as your input is valuable

There is a ward meeting Thursday to discuss the action plans.

Looking forward to seeing you all

The action research group

News letter April



Patient information
As you have noticed, the information folders given to the patients during the PN visits are appreciated by the patients and families

Admission Checklist
Some problems have occurred but we have discussed this in the ward meeting.

Goal Setting
We are still in an experimental stage but are making progress.

Admission Procedure
This is now finalised. A flow chart is developed and guidelines are placed in the nursing manual under the area specific section.
Patients and staff are enjoying the experience.

Photoboards
No support for this but the majority of people liked the idea of cartoons. P has agreed to draw them.

Looking forward to our next ward meeting

The AR group

Appendix 7D: Functional Independence Measure

The Functional Independence Measure was developed by Granger and Hamilton (1990). It has been validated as an appropriate functional assessment instrument for the older individual (Pollack *et al.*, 1996; Ottenbacher *et al.*, 1994) and has been extensively used throughout the world. Its reliability and validity has been verified by a number of studies (Granger, 1993; Grey 1993; Polack *et al.*, 1996). The Functional

Independence Measure measures change in patients’ status over time, allowing functional rehabilitation outcomes to be quantified. Moreover, the Functional Independence Measure can be administered by any trained health professional and is not discipline specific. The instrument assesses whether the patient is able to carry out an activity and provides a description of the level of assistance required by the patient (the seven-level scale designates gradations in behaviour ranging from dependence to independence). The instrument is used to assess what the patient actually does, not what he/she is capable of doing. The scale examines various components (such as self-care, sphincter control, transfer, locomotion, communication and social cognition). It is a measure of disability not one of impairment.

Chapter 8

Appendix 8A: Interview guide for the patient interviews

SUGGESTED TOPICS TO COVER
Perception of rehabilitation
Experience of hospital admission
Experience of discharge
Experience of being a patient
Relationship with health professionals
The environment of the ward (especially privacy)
Level of involvement in care, treatment and therapy
Involvement in goal setting and decision making
Exploring ways for improvement

EXAMPLES OF DIFFERENT STYLES OF QUESTIONS
Descriptive: Could you describe how you feel about your admission to hospital?

Structured: Could you tell me about your admission to this ward?

Comparison: Did you notice any difference between this admission on and the previous admission?

Opinion: What is your opinion of your nursing care?

Feeling: How do you feel about your nursing care?

Sensory: Could you tell me, what did you see when you walked into your hospital room?

Nudging probe: e.g. Tell me more, oh I see, go on, and then, oh really, is that so, what happened then, please continue, hmmm, yes?

FURTHER EXAMPLES OF QUESTIONS
In your view, what would be the ideal nurse? What qualities would she or he have?
How would you describe the ideal hospital stay?
What would be the ideal care after you have left the hospital?
How could we make the day more interesting?

Appendix 8B: Tables 7 to 18 in relation to patient reconnaissance

They did not explain, they just said it was a rehabilitation ward. I didn't realise it was a lot of elderly people with stroke problems and.the wide area that it covered. (PI 2, tu 667)

Table 7: Comments about not knowing what to expect on the rehabilitation ward

I suppose once you are over 60 you are an older person so it's a fact of life. I am 65 and that is why I am up here - an older person. (PI 1, tu 115)

Table 8: Comments in relation to ageing

And while I can tell them certain things about how I'm feeling, I don't always know what is happening, and why, and they can tell me. So I believe that information is very necessary to be able to make good decisions. (PI 5, tu 446)
It would be great if they gave you a programme and said to you this is what your mum is doing so that we know what is happening. So that if we take her to the park in a wheel chair, I know that am not going to interrupt her physiotherapy. But there is no liaison like that. (FM2, tu 8)
I found the information board helpful. Now I know when dad is away and what he is doing. I also know who is looking after him. I think that it is helpful for dad. He never knew the names. The other's [family members] also commented on it. (FM14, tu 75)

Table 9: Comments about wanting to receive information

I went down to the other rooms and played bowls and that was good, but otherwise you just had the corridors to wheel up and down and there wasn't much in the afternoons. As I say there was no stimulation in the ward itself and the nurses are off for a while in the afternoons. (PI 17, tu 174)
It is a bit boring here, isn't it? But that's up to us. We have radios. Unfortunately I can't read, but you know, most of the people in my room can read, so there is reading to be done (PI 13, tu 82)

Table 10: Comments about lack of activities on the ward

Those curtains are certainly not private and they are much too short of course. But I have been on both sides of the procedures. You know the bowel procedure [enema] I had done. Well, yes. I have heard it happening to other people. It is, and it must be the same for them, as it was for me. While you were giving me an enema, I could still hear everything...and I'm just being a bit...bit worried about that. (PI 2, tu 68)
Well there is not a lot of privacy let's put it that way and it depends on the type of patients that are in the ward. Particularly at night time, particularly then it is very un-private. (PI 16, tu 85)

Table 11: Comments about lack of privacy on the ward

It is lovely having the continuity, and you've got all five nurses that are involved and that's great. A bureau nurse...they just don't know my routine and I guess it's because I am not being able to take my own weight. I'm a bit nervous. (PI 3, tu 34)
It was because of the relationships that I'd built up with some of the nurses in there, and once I'd got to know the patients. I'd got myself sort of settled, bits and pieces. I have a vague idea where they were, and then I suddenly got transferred to another room and started from scratch again. I found that a bit stressful. (PI 14, tu 179)

Table 12: Comments about continuity of care (dependent patients)

I do not mind having different people looking after me. But what I do not like is that they all give me different information and instructions. (PI 16, tu 40)

Table 13: Comments about continuity of care (independent patients)

Trust I am very grateful because for some reason I feel there is something there between us, a trust between us. That is good. (PI 16, tu 577)
Feeling at ease I think it's nice to have that relationship with the person that you can feel you can relax and, and talk to them. I um...yeah have probably told X [the nurse] all sorts of stupid things. (PI 7, tu 419).
Honesty I think you should be able to trust them, and that they are telling you the truth, and not withholding anything in any way. They don't say to me, "Oh, you're doing fine", when I'm not doing so fine, you know? It would be like lifting you up in the air, and then dropping you down like a sack of spuds. (PI 13, tu 136)
Respect They were never dominant in any way. There was just togetherness. And that's what cures people. They treated me more like a friend than a patient. It just comes without many words. It just happens. There's no words said or spoken. Just that lovely relationship between nurse and patient (PI 7, tu 191).

Table 14: Comments about the nurse-patient relationship

They're conscious of me, and my needs. They recognise them somehow, I don't know. (PI 8, tu 341)
The ward was taken over by a (pause) a new person, not an altogether new person, but a person who I did not think had done that sort of thing before. I was a bit dismayed how long it took her to get through the sort of things that had to be done as compared to the others who had been in that position. (PI 1, tu 824)
There never seems to be any trouble for you ladies and gentlemen. Its never any problem. And sometimes, you almost seem to anticipate. (PI 12, tu 26)

Table 15: Comments about confidence in the nurses

He has communicated with me very much. In fact he even telephones me at home and I was greatly impressed that he should bother to do that. (FM 8, tu 128)
They [nurses] can encourage you so much. Whereas the physiotherapists, you have them for an hour or a couple of hours a day and they're wonderful really. They do get me going. Give me exercises I've got to do. You need the support of a nurse to help you. She [the nurse] got me walking, and she watched along the corridor. She comes up with these good ideas, she really does. When I've been down and had a wee weep, she is there (PI 3, tu 435).

Table 16: Comments about nurses providing support

I think everybody is probably working under a good deal of strain. The thing I have noticed, if I may so say, is after lunch when patients normally want to go and use the toilet, very often there is quite hurry. It is during this time that there are very few people available and that is the time that problems can occur. I wondered if there could be more of a roster system so that there are more nurses during lunchtime. I find that very difficult and I am reluctant to bother the nurses on duty because that person is so stretched at that moment. But I think it would be more efficient for them if they had more people because then patients would not get desperate. They either have a disaster going to the toilet or they mess the bed and it makes far more work for them in the end. (PI 8, tu 31)

Table 17: Comments about nurses' workload

With all due respect, many times I wanted the toilet it has been locked up. When you have one patient that requires the toilet for such a length of time - the cannot help it they need it but it is a bit of an embarrassment at times. (PI 17, tu 73)
I did have a bowel problem and when I wanted to go, someone was always in the toilet - well I couldn't get there at the right time, so I never went when I wanted to (PI 3, tu 264).

Table 18: Comments about difficulties maintaining a usual toilet routine

Appendix 8C: Tables 19 to 21, reactions to the action plans made in response to the patient reconnaissance

I was pleased you came to see me. I did not know what rehabilitation was. You explained that you were doing some kind of an experiment. It was good that you left that wee booklet. My husband and I read it that night (PI 19, tu 30)

Table 19: Patient feedback about providing information

Yesterday I was on in the morning and X came on. I had an admission in room four and I did all the paper work and took the patient into the Bellbird Room: it was a lot easier and you were able to concentrate more and not be interrupted (Gemma, ARGM4, tu 20)
The nurse took the time to really listen to me. Having that time made me feel she was interested in me. It was different (PI 20, tu 203)

Table 20: Comments about the admission procedure

I took a patient out of a room to discuss [the] care plan with her. She said it would have been more helpful if it had been done earlier in her admission. I agreed. (Journal, Yolanda).

Table 21: Comments about the evaluation meeting

Chapter 9

Appendix 9A: Goal-setting guidelines

Guidelines for a multidisciplinary goal-setting meeting

Criteria for participation in a goal-setting meeting

- Patients with complex needs
- Patients participating in rehabilitation
- Involvement of three or more disciplines

Organising a goal-setting meeting

- The best time to start a goal-setting meeting is between 1300 and 1315 hrs. Please note that this time is negotiable.
- The patient is to be informed about the purpose of the meeting and agreement to participate must be obtained.
- Ideally the meeting should be initiated within the first week of admission.
- The primary nurse arranges a time for the meeting and informs the MDT.
- A room is booked and written on the board.
- The patient is asked to think about his/her concerns and, if possible, to put them in writing before the meeting. Assistance should be offered by one of the MDT members.
- The patient is asked if s/he wants to involve family/whanau in the planning stage and/or in the goal-setting meeting. If affirmative, the purpose of the goal setting meeting is explained to family/whanau.
- The MDT meets five minutes before the meeting to
  - discuss goals from the MDT perspective so there is agreement,
  - determine who facilitates the meeting. Ideally, the facilitator should take this role for all subsequent meetings.
- The initial goal-setting meeting must not take longer than one hour. If additional time is needed, another meeting should be arranged.

The meeting

- Ensure care of other patients is covered by another staff member.
- Ensure the patient is comfortable.
- The facilitator asks the team members to explain their role in the rehabilitation process. The facilitator asks the patient to voice his/her concerns (basis for goal setting). If necessary, the facilitator might prompt the patient or make some suggestions to start the process.
- Limit the number of goals to no more than four. A long-term goal is chosen which is broken down into short obtainable goals. The patient should be able to obtain the goals within two weeks. Goals are written in specific terms. During the meeting the scribing rotates as the goals are discussed. Each team member documents the discipline specific agreed goals (including time frame) and actions.
- With consent of the patient, arrange for the care/therapy plan to be left at the bedside.
- Towards the end of the meting the goals are summarised, and a date is set for the evaluation meeting. Goals are checked to ensure that the patient understands the expectations and feels able to complete them.
- After the meeting the MDT takes five minutes to evaluate the session (without the patient) by discussing;
  - the process,
  - any difficulties,
  - the set goals,
  - Ways of working together to achieve goals.

Please note that progress towards goals is monitored in the clinical notes and goals are verbally reinforced at each interaction with the patient.

Guidelines for a multidisciplinary goal-setting evaluation meeting

Organising a evaluation meeting

- The best time to start an evaluation meeting is between 1300 and 1315hrs. Please note that this time is negotiable.
- The patient is to be informed about the purpose of the meeting and agreement to participate must be obtained.
- Ideally the meeting should be initiated within one or two weeks of the goal setting meeting.
- The primary nurse arranges a time for the meeting and informs the MDT.
- The patient is asked to think about his/her concerns, progress and further goals and, if possible, to put them in writing before the meeting. Assistance should be offered by one of the MDT members.
- The patient is asked if s/he wants to involve family/whanau in the evaluation meeting. If affirmative, the purpose of the evaluation is explained to family/whanau.
- The MDT meets five minutes before the meeting to
  - Discuss goals from the MDT perspective so there is agreement,
  - Determine who facilitates the meeting. Ideally, this should be the person who had this role in the first meeting.
- The evaluation meeting must not take longer than one hour. If additional time is needed, another meeting should be arranged.

The meeting

- Ensure another staff member covers care of other patients.
- Ensure the patient is comfortable.
- If necessary the facilitator asks the team members to explain their role in the rehabilitation process. The facilitator asks the patient to voice his/her opinion regarding progress. If necessary, the facilitator might prompt the patient or make some suggestions to start the process.
- Progress towards meeting the goals is discussed by the MDT. Goals may be abandoned, in progress, or achieved. New goals need to be set when previous goals have been revised or completed.
- During the meeting the scribing rotates as progress and goals are discussed. Each team member documents the discipline specific agreed goals (including time frame) and actions.
- With consent of the patient arrange for the care/therapy plan to be left at the bedside.
- Towards the end of the meting the goals are summarised, and a date is set for the next evaluation meeting.
- After the meeting the MDT takes five minutes to evaluate the session (without the patient), by discussing;
  - the process,
  - any difficulties,
  - the set goals,
  - Ways of working together to achieve goals.

Appendix 9B: A summary of the patient information booklet

Goal-Setting Meetings

Goal-setting is a process which enables you to formally discuss your needs, wants and concerns with the team involved in your care. It provides an opportunity for you to express what you would like to get out of your time on Kauri Ward, and where you would like to move on to, once you have been discharged.

Planning for the meeting

We suggest that you think about your needs and concerns before the meeting. You may want to involve family/whanau members. The team members are happy to help and guide you in the process.

The goal-setting meeting

This would take place in one of three private rooms on the ward, away from distractions, so that you and the team are able to discuss information regarding yourself in private, and in confidence. If you wish you can invite family/whanau members to the meeting.

The meeting usually takes approximately 45 minutes. In that time you would be able to express what you would like to achieve, what concerns you have, and to ask questions regarding your care and rehabilitation. As a team, we create a plan that can be followed to help you achieve the goals you have identified.

This patient care/therapy plan will be placed in your bedside folder, to enable you to look through it and take note of what progress you have made.

Evaluation meetings

Your progress will be discussed in evaluation meetings. To make sure that we are heading in the right direction the team will meet together with you to evaluate the goals and plan. During the meeting we may have to, in consultation with you, make alterations to the plan, or goals, or both. After an evaluation meeting any changes or additions will be recorded in the care/therapy plan.

Goals or milestones that have been met in your progress will be noted on the Achievements form of the Patient/ Therapy Care Plan.

The goal-setting and evaluation meetings are your time, and the goals that are discussed are ones that you own. Ultimately, here on Kauri ward, we believe that you should be the one that dictates how and what issues need to be addressed, and how you would like them achieved with the therapists' interventions and suggestions.

Remember that the meetings are not the only time that you are able to express any issues you may have. If there are concerns that you may have about your care, explanations you need about a certain procedure, or any suggestions you may have, please feel free to take these to anyone who is involved in your care at any time.

Appendix 9C: Table 22, nurses gaining confidence with goal-setting and facilitation

I just had a family meeting. That was good. It was half goal setting and [half] family meeting. It was a different family meeting than we had before and that was really good. The other good thing was that I was chairing it. (Journal, Irmgard).
The reflections we had after the goal setting meetings helped me tremendously. I had some difficulties with facilitation in the beginning but the role plays helped. The goal setting meeting audits were great to help me build my confidence. They did show that the other's appreciated my facilitation. (Journal, Irmgard).
We are team-focused and are still learning, it is a learning process for all of us. (ARGM, tu 279)
I feel like in the beginning goal-setting was a bit stilted. The patients gave me the feeling that I did not know what I was doing!! But now it comes more natural and what is even better the patients have achieved some of the goals (Journal, Yolanda)

Table 22: Confidence with goal-setting and role play improving

Appendix 9D: Audit form for goal-setting meetings

PRACTICE AUDIT

Goal Setting Meeting Audit			
	Yes	No	Comments
Room was booked			
Information booklet given to the patient			
Patient/Whanau informed			
Meeting starting time			
Meeting within the first week of admission			
All MDT members involved are present			
The MDT meets 5 minutes before the meeting			
The meeting is facilitated by?			
Patient is asked to voice concerns/state goals			
Long-term goal is set			
No more than 4 goals are set			
Scribing rotates			
Goals are summarised at the end of the meeting			
Date is set for evaluation meeting			
MDT evaluates meeting			
Time meeting finished			

(On the back of the form)

On a scale form 0-10, how useful was the meeting?

PT:	1	2	3	4	5	6	7	8	9	10
OT:	1	2	3	4	5	6	7	8	9	10
Nurse	1	2	3	4	5	6	7	8	9	10
SPL	1	2	3	4	5	6	7	8	9	10
Med	1	2	3	4	5	6	7	8	9	10
SW	1	2	3	4	5	6	7	8	9	10
Patient	1	2	3	4	5	6	7	8	9	10

Appendix 9E: Multidisciplinary care plan

date	PATIENT & FAMILY/WHANAU NEEDS & WANTS	signature

NAME: HOSP. No.:

DATE OF BIRTH: ____ / ____ / ____

WARD/UNIT:

Please attach patient label here

Date	PATIENT & TEAM GOAL	LI 1, 2, 3	Signature
	PLAN		

NAME: ____________________ HOSP. No.: ________

DATE OF BIRTH: ____ / ____ / ____

WARD/UNIT: ______________________________

Please attach patient label here

DATE	ACHIEVEMENTS	FIM score	Signature

PATIENT CARE/THERAPY PLAN

Appendix 9F: Table 23, patients' feeling safe during the goal-setting meetings

I had that goal setting meeting and the social worker was quite firm with C (physio). Everybody had their own say in turn, and everybody listened to you, and writing notes down. (PI 22, tu 148)
We have had three meetings - the first when she said, 'What do you want most of all?' I said "... and go to the toilet on my own." But I can't do that yet, but I can swing to the commode. I can't just walk yet. I enjoyed it, I enjoyed listening to it all. (PI 26, tu 83).
In a way, I don't know whether it was our family structuring or what, but we could discuss most of that before we actually came to the meeting. I think people [who] didn't know the system and what existed I think possibly it would be quite beneficial to them, yes. I think the one thing that we benefited [from] was the way that different ones were working - the different divisions were working together in what the outcome would be (FM 1, tu 355).
I found them all very helpful and never at any stage did they appear threatening to me. They appeared there as helpers to me and they were prepared to listen, so I found them good (PI 30, tu 75)
That really was the eye opener - was to actually sit down and take note what a patient really feels is right for them because I mean he used to even speak about certain ways that he wanted to be lifted to his chair or to the bed and they would always have their own ideas didn't they? Then he would say a certain way of how he wanted it done to make it a lot easier for him. But finally we worked around that, we compromised a lot, the nurses were prepared to give a little, and the physiotherapist. It just needs communication that's all. (FM 2, tu 83, 134)

Table 23: Comments about feeling safe and enjoying the goal-setting meetings

Curriculum Vitae

Lucienne J.R Hoogwerf was born on June 27, 1958 in Rotterdam, The Netherlands. She became a registered nurse in 1980. In the period 1980-1984 she worked in Austria as a surgical nurse and held a position as staff nurse. Lucienne specialised in gerontological nursing in 1987 in New Zealand. In the period 1986 through to 1996 she held positions as staff nurse and sister in charge. She obtained a bachelor degree in psychology from Otago University in New Zealand in 1991 and a master of nursing studies in 1996 from Deakin University, Geelong, Australia. In the period 1996 through to 2000 Lucienne worked at Auckland Healthcare, Massey University, and Auckland University of Technology were she taught gerontology nursing and worked as a clinical nurse consultant. End 1996 Lucienne started working towards a PhD in Nursing at Victoria University of Wellington. Lucienne returned to the Netherlands in 2000. She started to work for Fontys Hogeschool in Eindhoven were her responsibility was to help establish evidence based nursing. At this stage her work towards her PhD in New Zealand ended. She finalised her PhD work at the University of Utrecht. Lucienne now holds the postion of director of nursing at Fontys Hogeschool Eindhoven.

11: Samenvatting

Dit proefschrift doet verslag van een emancipatoir actieonderzoek dat plaats vond in Nieuw-Zeeland Het betrof de invoering van enkele interventies op een geriatrische afdeling genaamd Kauri die erop gericht zijn emancipatie van patiënt en verpleegkundige te bevorderen. Zo is er systematisch aandacht gekomen voor participerende zorg van patiënten en is een advanced nurse practitioner (clinical nurse consultant) op de afdeling geïntroduceerd. Centrale vragen waren dan ook: kan de actieonderzoekgroep "participatieve zorg" ontwikkelen in samenwerking met ouderen patiënten/revalidanten op basis van hun eigen feedback? Is emancipatoir actieonderzoek bruikbaar om de verpleegkundige praktijk op een hoger plan te brengen door de functie van de advanced nurse practitioner (clinical nurse consultant) te ontwikkelen in de praktische setting? Zoals actieonderzoek betaamd ligt er veel nadruk op processen. Uiteraard liggen daar wel theorieën en modellen aan ten grondslag. Dit proefschrift beschrijft in hoofdstuk 1t/m 5 de vraagstelling en theoretische noties. Vanaf hoofdstuk 6 komen de interventies aan bod. Hoofdstuk 10 geeft een reflectie op het totaal.

Hoofdstuk 1 bevat een inleiding tot de onderzoekssetting en een beschrijving van datgene een rol speelde in de ontwikkeling van de vraagstellingen van het onderzoek. De functieomschrijving van de advanced nurse practitioner (clinical nurse consultant) zoals deze in dit onderzoek wordt gebruikt is beschreven. Binnen de organisatie verwachte men dat deze rol bijdroeg tot praktijkvernieuwing, kwaliteitsverbetering en klinisch gericht leiderschap

Hoofdstuk 2 beschrijft een vooronderzoek; de activiteiten die ondernomen werden om de uitvoering van dit onderzoek voor te bereiden. Hiertoe behoren ook de interventies die nodig waren om een geschikte omgeving te creëren voor het onderzoek. Zo formeerden ik binnen Aged Care Services een groep verpleegkundigen die literatuur onderzoek deed en een andere groep die zich op toekomstige publicaties richtte, groepen die zich op de verpleging richtten en de bevindingen documenteerden, en één die de verkenning van de rol van de clinical nurse consultant op zich nam. Ook wordt het schema voor actieonderzoek, van Kemmis en McTaggart (1988), in relatie tot de rol van de klinisch specialistische verpleegkundige geïntroduceerd. De positieve resultaten van dit vooronderzoek waren de aanzet tot het opstarten van het eigenlijke onderzoeksproject.

In Hoofdstuk 3 vindt de lezer een literatuuroverzicht van participatieve onderzoeksmethoden Om te beginnen, een overzicht van de historische ontwikkeling van actieonderzoek voortkomend uit de ideeën van Kurt Lewin – door sommigen beschouwd als de 'vader' van het actieonderzoek – tot aan de tegenwoordige participatieve onderzoeksmethoden (Kemmis and McTaggart, 1988) zoals het ontwikkelingsonderzoek van de 'Leadership, Organisation and Co-determination' groep in Noorwegen, (Toulmin, 1996) en 'Action Science' (Argyris en Schön 1974). Vervolgens wordt in dit overzicht het praxisonderzoek geintroduceerd. Centrale thema's hierin zijn: de dialectische relatie tussen theorie en praktijk, en empowerment. Deze benaderingswijzen worden geïmplementeerd in 'participatory actionresearch', dat door Fals-Borda and Rahman (1991) is ontwikkeld in leefgemeenschappen in de derde wereld. Tenslotte wordt het Australische gezelschap van activiteitsonderzoekers geïntroduceerd, met een korte beschrijving van hun invloed op de ontwikkeling en toepassing van emancipatoir actieonderzoekonderzoek in de verpleegkunde. Het werk van deze wetenschappers, vooral van Grundy (1982) en Kemmis en McTaggart (1988), vormt de basis van de methodologie die in dit onderzoek wordt toegepast. Het hoofdstuk eindigt met een bespreking van wetenschappelijke starheid en ethische overwegingen,.

Het communicatieschema dat gepresenteerd wordt in **Hoofdstuk 4,** bleek een belangrijke leidraad te zijn voor communicatie in het onderzoek. Er zijn vier stappen: het bewustmakingsproces op gang brengen, ontwikkeling van begrip, ontwikkeling van ondersteuning en het creëren van betrokkenheid, dezelfde beginselen die de basis vormen van het schema van Kemmis en McTaggart (1988). Het onderzoekplan, waarin dezelfde stappen worden doorlopen die in de emancipatoire actieonderzoekspiraal van Kemmis and McTaggart (1988) worden genoemd, wordt uitgelegd, en het onderzoek wordt beschreven in termen van fasen, stadia en activiteitscycli. In elke activiteitscyclus speelden planning, implementatie, observatie en evaluatie een rol. Fase I bestond uit vier stadia, o.a. de verkenning van de rol van de gezondheidszorgdeskundige en de rol van de patiënt. Binnen elk van deze stadia waren een aantal activiteitscycli gepland. Elke cyclus werd vastgesteld zodra het onderzoek goed liep. De methoden om gegevens te verzamelen (groepsdiscussie, open-eind een-op-een interviews, researchtijdschriften, notulen van vergaderingen, bandopnames van bijeenkomsten, en evaluatie-interviews – zowel in een groep als een-op-een) worden beschreven.

De interventies van de actieonderzoeksgroep berustten op een literatuuronderzoek, dat in **Hoofdstuk 5** wordt gepresenteerd. Het model van Arnstein (1972) wordt geïntroduceerd omdat dit een goede leidraad was voor de beschrijving van "participatie in zorg" zowel aan het begin als gedurende het onderzoek. Dit model wordt uitgebeeld als een ladder waarop drie niveaus van participatie onderscheiden kunnen worden: 1. non-participatie, 2. 'tokenism' (het maken van een loos/symbolisch gebaar om de aandacht af te leiden) en 3. gradaties van 'citizen power' (medezeggenschap). Er zijn verschillende factoren waarvan onderzoekers vermoeden dat zij de implementatie van participerende zorg verhinderen. Deze kunnen gerelateerd zijn aan de verpleegkundigen, medici paramedici de patiënt of de organisatie. Soms zien zij de patiënt als een passieve ontvanger van zorg die niet in staat is om mee te denken. Verpleegkundigen kunnen bijvoorbeeld weigeren om patiënten in het zorgplan te betrekken en hen zeggenschap of macht ontzeggen over hun eigen situatie, omdat zij het oordeelvermogen van de patiënt niet betrouwbaar vinden. Ook heeft het biomedisch model nog steeds invloed op de manier waarop patiënten door verpleegkundigen worden ingeschat en behandeld. Bovendien komt het voor dat patiënten soms niet betrokken willen zijn, en anderen zijn misschien (tijdelijk) niet in staat tot betrokkenheid door hun ziekte, revalidatieproces of gebrek aan motivatie. Het is echter wel zo dat werkelijke participatie van de patiënt zou leiden tot een respecteren van individuele voorkeuren en mogelijkheden, en culturele verschillen. Bureaucratische organisatiestructuren en een gebrek aan beschikbare middelen zijn een laatste obstakel voor een geslaagde ingang van "participatie in zorg" in organisaties. Problemen worden vaak in verband gebracht met de organisatiestructuur, gebrekkige middelen en een gebrek aan een enthousiaste houding tegenover een nieuwe manier van zorgverlening. De voordelen van “participatie in zorg“ komen bijvoorbeeld tot uiting in meer tevredenheid van de patiënt meer empowerment, een betere ontslagplanning, een vermindering van de heropnamefrequentie, en een betere therapietrouw. Ook is gebleken dat “participatie in zorg“ een positief effect kan hebben op gezondheidszorgdeskundigen, in die zin dat zij meer voldoening vinden in hun taak.

De door Locke ontwikkelde ´Goal-setting Theory´werd in dit hoofdstuk besproken omdat de actie onderzoek groep dacht dat de theorie een geschikt middel was om “participatie in zorg“ te implementeren. Hoewel de theorie voortkwam uit organisatieontwikkeling wijzen sommige onderzoeken erop dat het bepalen van doelen nuttig kan zijn in de gezondheidszorg. Doelen kunnen toegewezen of door de persoon zelf gesteld zijn, of gedeeld worden met (een) ander(en) die het doel reeds hadden. Er zijn geen bewijzen dat de ene manier beter is dan de andere wat motivatie en prestatie betreft. Het is echter wel zo dat een samen met anderen gedeeld doel invloed schijnt te hebben op cognitieve processen en daarom wordt verondersteld dat een gezamenlijk doel resulteert in betere strategieën om het doel te bereiken

Hoofdstuk 6 geeft de lezer een inzicht in hoe de verpleegkundigen hun praktijk ervaren. De informatie, die tijdens de onderzoekdagen, groepsdiscussies en gedeeltelijk gestructureerde een-op-een interviews werd verkregen, wordt hierin gepresenteerd. Deze informatie laat op de eerste plaats zien hoe de verpleegkundigen denken over de huidige structuren voor het verpleegkundig handelen op de Kauri afdeling. Op de tweede plaats geeft het hun teleurstelling weer over het feit dat primairy nursing (eerste verantwoordelijke) niet meer effectief wordt gepraktiseerd. De gedachten en uitgangspunten van de verpleging over patiënten educatie, gerontologische rehabilitatie, de rol van de verpleegkundige, hun positie in het multidisciplinaire team, en de relatie verpleegkundige-patiënt worden in het kort beschreven. Het bleek dat zij hun ideeën over revalidatie voornamelijk verwoorden in termen van functie en herstel. De rol van de verpleegkundige is volgens hen opgebouwd uit de componenten behandeling, informatie overdragen, de realiteit naar voren halen in een situatie, het opnemen voor mensen, complexiteit, coördinator en specialisme. Zij vonden dat hun rol in het multidisciplinaire team niet werd gewaardeerd door de andere teamleden en dit zat hen dwars. Vertrouwen, empathie en openheid werden beschouwd als belangrijke bouwstenen van een goede relatie met de patiënt. De verpleegkundigen uitten zich ook aangaande de communicatieprocessen op de afdeling (volgens hen eenrichtingsverkeer), de sfeer in relatie tot de kosten die aan het uiterlijk van de afdeling werden gespendeerd, en de werkdruk die volgens hen in de winter toeneemt. Een extra aandachtspunt was dat een groep van vijf verpleegkundigen die weigerden om deel te nemen in de gedeeltelijk gestructureerde een-op-een interviews was. Zij hadden hun eigen praktijkcultuur ontwikkeld en innovatie van de praktijk liet hen koud. Zij werkten in avond- en nachtdiensten om elke verandering van de werkmethode te vermijden. Het was dus mogelijk dat er een ‘zij’ en ‘wij’ situatie zou ontstaan. Natuurlijk waren er ook andere moeilijkheden in dit stadium. Zo kwamen interpersoonlijke relaties tussen stafleden vaak onder een druk te staan. Hierdoor begon de onderzoeker te twijfelen of het onderzoek wel zou kunnen doorgaan. Veel stafleden op de Kauri afdeling waren echter enthousiast over het onderzoek, zodat actieplannen konden worden ontwikkeld.

In ***Hoofdstuk 7,*** worden de zes verpleegkundigen geïntroduceerd die zich vrijwillig aanmeldden om lid te worden van de actieonderzoekgroep en hun rol in het onderzoek wordt beschreven. Tijdens de eerste vergaderingen van de actieonderzoekgroep werd duidelijk dat de discussies op de afdeling al een bepaalde invloed hadden gehad op de werkmethode op de afdeling. Dit had een positief effect op de groep verpleegkundigen tijdens voorbereidingen voor de interviews met de patiënten. In daaropvolgende vergaderingen deelden zij hun ervaringen met elkaar. Zij merkten op dat de interviews een therapeutisch effect hadden omdat zij de patiënten in de gelegenheid brachten om hun ervaringen te delen, aandachtspunten te bespreken en er duidelijker zicht op te krijgen. Alle leden van de groep ervoeren hoe tijdens het verloop van het interview een omslag optrad. Zo begon men met het meedelen van informatie om door te gaan naar het adviseren van de patiënt dan naar uiten van gedachten en gevoelens, en vervolgens weer terug naar de relatie verpleegkundige-patiënt. Het gevolg was dat de tijd die met de patiënt werd doorgebracht als zinvol werd ervaren zowel voor de verpleegkundige als voor de patiënt. De actieplannen – ‘een voet tussen de deur’, de Meting van de Functionele Onafhankelijkheid, informatie/activiteiten-plank en oriëntatieinformatie– waren deels reacties op benoemen wat dat is, en deels reacties op zaken die tijdens de interviews naar voren waren gekomen. De leden van actieonderzoekgroep werkten goed samen. Zij wisselden verhalen uit over de praktijk en dachten daarover na, waardoor vertrouwensbanden ontstonden. Het werd buitengewoon belangrijk om een open en effectieve communicatie in stand te houden met de afdeling, zoals ook in wordt genoemd. De actieonderzoekgroep was voortdurend bezig feedback en onderwijssessies te geven op verschillende manieren en tijden, om de gevoelens van bezorgdheid die sommige stafleden ervoeren aan te pakken. In deze fase van het onderzoek waren de voornaamste taken van de onderzoeker het geven van raad en ondersteuning aan de groepsleden.

In hoofdstuk 8 worden de uitkomsten van de gedeeltelijk gestructureerde een-op-een interviews die door de actieonderzoekgroep waren gehouden besproken. Uit de analyse bleek dat patiënten de informatie die zij hadden ontvangen over de afdeling en hun aandoening ontoereikend vonden. De patiënten van deze groep vonden het nuttig om informatie te ontvangen en in het zorgplan betrokken te worden. Zij gaven ook aan dat er slechts minimale aandacht aan privacy en stimulerende activiteiten werd besteed, en dat zij continuïteit van de zorg op prijs stelden. Zij hadden belangrijke opmerkingen met betrekking tot de gebrekkige sanitaire voorzieningen op de afdeling en het feit dat er weinig toezicht aanwezig was bij de middag- en avondmaaltijden, waardoor sommige patiënten vaak alle remmen los gooiden. Patiënten waren van mening dat vertrouwen, eerlijkheid en openheid van belang waren voor het ontwikkelen van een relatie met de verpleging. Verpleegkundige hadden zelf ook aangegeven dat zij dit belangrijke aspecten vonden in de ontwikkeling van de relatie tussen patiënten en verpleegkundigen. De actieplannen die aan de hand van de resultaten van de interviews werden opgesteld waren gericht op de aandachtspunten die de patiënten naar voren hadden gebracht. Het ging ondermeer over de ontvangst van informatie vóór opname, wijziging van de opnameprocedure, evaluatie van de geboden verpleegkundige zorg met de patiënten bijeenkomsten waarin de patiënten geïnformeerd worden. Deze actieplannen hadden een invloed op de werkmethode op de afdeling, hetgeen als bedreigend werd ervaren door sommige verpleegkundigen die moeite hadden met hun eigen gevoelens maar door sommige andere verpleegkundigen als een interessante uitdaging werd gezien. In dit stadium bleek de steun van één van de verpleegkundigen die avonddiensten deed van belang. Haar steun en inzet als leidinggevende stelde de groepsleden in staat om effectiever met andere verpleegkundigen te communiceren. Over het algemeen waren de stafleden enthousiast over de nieuwe uitdaging en bereid om te participeren in de discussies over het zetten van doelen.

Het zetten van multidisciplinaire doelen was het centrale thema in ***Hoofdstuk 9.*** Het werd duidelijk dat dit zowel voor patiënten als voor de verschillende beroepsgroepen voordelen had. Uit de feedback van patiënten en hun familieleden werd geconstateerd dat zij door het zetten van doelen in staat werden gesteld om een rol te spelen in de besluitvorming over hun revalidatie. Zij gaven aan dat participatie in doelen zetten een positieve invloed had op hun motivatie en acceptatie van de situatie. Het multidisciplinaire team gaf aan dat door het zetten van doelen zij in staat werden gesteld om op een gestructureerde manier samen te werken en op de patiënt gerichte doelen te ontwikkelen. Het proces van doelen zetten versnelde de ontwikkeling van een gemeenschappelijke richting, continuïteit, consistentie van de zorg/therapie en wederzijdse communicatie. Dit had weer een stimulerend effect op het ontstaan van vertrouwen en respect voor elkaar. De contributie van verpleegkunde op de continuïteit van therapie en zorg, continentie management, en huidverzorging werd ook erkend. Tijdens deze fase werd een zogenoemde lokale theorie met betrekking tot het zetten van zichtbaar. Er waren drie soorten bijeenkomsten ontstaan waarin op verschillende manieren doelen werden gezet: participatieve toegewezen en non-participatieve .Hiermee werd aangetoond dat door het actieonderzoek de kennis die door de actiecycli werd verkregen direct toepasbaar was in de klinische praktijk. Het zetten van doelen bevorderde de samenwerking tussen patiënten en multidisciplinaire team leden en had voordelen voor patiënten verpleegkundigen, medici, paramedici en het multidisciplinair functioneren.