

**“I BET YOU WISH YOU’D PICKED A
DIFFERENT GROUP”**

**AN ETHNOGRAPHIC STUDY OF
PRACTICE DEVELOPMENT UNIT
ACCREDITATION**

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requirements of Bournemouth University for the degree
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ABSTRACT

“I BET YOU WISH YOU’D PICKED A DIFFERENT GROUP”: AN ETHNOGRAPHIC STUDY OF PRACTICE DEVELOPMENT UNIT ACCREDITATION

Corrina Lailla Dickson

Research Aims

Practice development accreditation is growing rapidly as it is praised for transforming cultures of health care, inciting empowerment, instigating multidisciplinary teamwork and creating more effective services. However, literature is vague on what occurs during accreditation, the role of culture within this process and the experiences of different professional groups in practice development. This research therefore sought to address the following research aims:

- To investigate practice development accreditation by studying a unit undertaking this process
- To examine the culture of a unit during accreditation
- To portray a multidisciplinary account of practice development

Method

These aims were investigated by conducting a twelve month observational study of a group undertaking the accreditation process. Despite the accreditation attempt being unsuccessful, important concepts around leadership and culture emerged.

Findings

This study found that the core group of practitioners instigating practice development lacked shared beliefs, aims or commitment which caused disputes (particularly over the distribution of work) and that a lack of management support dampened morale and made progression difficult. The core group’s leadership style also hindered the accreditation attempt as they both restricted and forced involvement from the staff, leaving them feeling unempowered and reluctant to participate. Finally, the participants were unable to overcome divides based on hierarchical and professional identity to work as part of a multidisciplinary team in order to implement practice development.

Recommendations

Four recommendations for the instigators of any empowering change initiative emerged. These are: i) to create a ‘vision’ in order to ensure the

entire organisation understands the purpose and goal of implementing changes; ii) to erode divides between employees that are based on professional and hierarchical identities; iii) to create succession plans in order to maintain effective leadership; iv) those initiating change should understand the notion of functional conflict.

Further Research

This study suggests further research is needed into the roles of excluded professionals in practice development, to explore the relationship between accredited and non-accredited units within organisations, to assess the impact of gender within practice development units, to discover how units successfully achieve accreditation and the strategies utilised by ethnographers to disengage from the field.

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CHAPTER I

PROLOGUE

INTRODUCTION

“I bet you wish you’d picked another group” were the words uttered to me by almost every person I encountered during this three year PhD research project; from the participants, to their managers, administrators within my department and most close colleagues. By selecting this as the thesis title, it will come as no surprise that what is revealed over the forthcoming chapters is a multitude of problems the participants in this study encountered during their attempt at becoming an accredited practice development unit. This study is the first to trace the journey of a multidisciplinary group of health care practitioners in their efforts to become accredited and reveals problems previously undocumented within existing literature. The high and low points of this process are illuminated by uniquely applying the method of ethnography to practice development in order to satisfy the three research aims of this study, which were:

- To investigate practice development accreditation by studying a unit undertaking this process
- To examine the culture of a unit during accreditation
- To portray a multidisciplinary account of practice development.

In addition to documenting the highs and lows of the accreditation journey, the following pages also detail the highs and lows of my own personal journey as a researcher. The highs came when I made achievements such as attaining insider status among the participants and the lows included experiencing ‘culture shock’ at spending time in a health care setting. Before these two journeys of practice

development accreditation and conducting PhD research are documented, the central concepts which this study revolves around – ‘practice development’ and ‘accreditation’ – need to be defined. This is presented in the following section, after which an outline of the remaining chapters in this thesis is documented.

PRACTICE DEVELOPMENT

Practice development evolved from the work undertaken by a handful of nursing development units, which were in existence during the 1980s in England (Williams et al 1993). Nursing development units were centres of pioneering and innovative practice, where work was uniquely undertaken by nurses (Gerrish 2001), which was funded as part of the National Health Service’s (NHS) commitment to develop nursing and nursing practice during this period (Wright 1989). Simultaneously, a transformation in British nursing philosophy was occurring (McSherry and Warr 2006); whereby increasing recognition of the need to eliminate the practice-theory gap in nursing (Hayes and Savage 2001) and to base practice on evidence was promoted (Ward et al 1998). Increased prominence was also given to developing a more educated nursing workforce (Bishop 2002) and care was moving from being based on medical models to models where care was driven by the needs and wants of the patients during this time (Restas 1999).

In addition to the developments in nursing philosophy and practice, during the 1980s and 1990s strategies and policies which aimed to modernise the NHS were implemented by the government (such as DoH 1997). These stated that practitioners should develop their services in order to meet the needs of patients and their families (Walsh 2000) and that patients should be given more choice in the care they receive (Cowman et al 2000). Practitioners were informed of the

benefits of delivering services as a multidisciplinary team – such as continuity of care (Williams et al 1993) – and were encouraged to become innovative in providing services (Page 2002). The policies introduced as part of the modernisation agenda emphasised the need for practitioners to conduct research into finding more effective ways to provide care, to evaluate and disseminate ideas for improvements in practice (Gerrish 2001) and encouraged the continuation of professional development in order to develop the skills necessary to achieve this (Elwyn 1998). Emphasis was placed through the modernisation agenda on the individual practitioner's accountability and responsibility to develop their care in an effort to erase the traditional managerial ideology of the NHS (Clarke and Procter 1999). It was hoped these changes and the incorporation of more elements from the field of business into health care practice development would 'drag the NHS kicking and screaming into the 21st century' (Page 2002:34).

The multidisciplinary focus in government guidelines and recommendations led to the work undertaken in nursing development units (which were already in keeping with the modernisation agenda) to be extended and include all members of a health care team; this was the birth of practice development. The following definition, which is the most frequently cited within the literature¹, demonstrates how practice development encompasses the aims of the modernisation agenda as outlined in this section:

¹ The main participants of this research were also shown this definition and agreed that all concepts within it satisfactorily defined practice development. They did not believe this definition lacked any other aspects in their view. Other definitions which have been presented in practice development literature but which are not as commonly cited can be found in Appendix One.

Practice development is a continuous process of improvement towards increased effectiveness in person-centred care, through the enabling of nurses and health care teams to transform the culture and context of care. It is enabled and supported by facilitators committed to systematic, rigorous and continuous process of emancipatory change

(McCormack et al 1999:256).

Ten years ago practice development was being predicted as 'a significant movement' (Manley 1997:5), as it started to gather increasing interest and had importance placed on it within health care (Kitson and Currie 1996). This prediction was realised faster than its advocates had anticipated and within three years practice development was acknowledged to be a 'common phrase in health care' (McCormack et al 1999:255) and with the numbers of practitioners utilising it having 'soared' (Glover 1998:58) during this period. Just three years after it was forecasted to become a 'significant movement' (Manley 1997:5) practice development had become a 'widely used' term in British health care (Unsworth 2000). More recently, it has achieved 'monumental recognition' for its value (McSherry 2002:26), has been cited as an 'essential part' of any health care strategy (Bassett 2002:1) and has become incorporated into governmental white papers (i.e. DoH 2001). Practice development today is utilised to such an extent that a journal² dedicated entirely to it has been established and an internet forum to support practitioners engaging in it, which so far has over four hundred members, has been launched (McSherry 2006). The support for practice development is now worldwide, which is reflected by the multi-national delegates at its annual conference and the number of published articles in peer-

² This is entitled 'Practice Development in Health Care' and has published over eighteen issues to date.

reviewed journals authored by advocates from around the globe (i.e. Walker 2005).

This section has demonstrated the growing interest in practice development within the UK and internationally and has highlighted that increasing numbers of practitioners are undertaking this change strategy in their own care environments. Accreditation in practice development is a key way to acknowledge the work being conducted by such practitioners and as a result the numbers registering to undertake accreditation is rising at a fast pace. The following section explores the view of accreditation presented within practice development literature.

PRACTICE DEVELOPMENT ACCREDITATION

Accreditation is used to formally recognise practice development work and as such, hundreds of practitioners are volunteering to undertake it. Accrediting practice in British health care has been in place for over ninety years (Rawlins 2001). This is due to increased privatisation, greater organisational autonomy and increased interest in improving efficiencies and quality improvements in public and private settings (Montagu 2003). Accreditation has received particular attention over the last twenty years because of governmental policy reforms which emphasise the importance of excellence in practice (i.e. DoH 1997, DoH 1998). The 'Kings Fund' accreditation scheme recognised excellence in practice among nurses in developing their care in the late 1980s (Pearson 1997) and around the same time a nursing development unit accreditation scheme was established at Leeds University (Page 1995). This scheme developed fifteen criteria nurses on the program had to meet, which would demonstrate that 'best

practice' had been met by them. A group registered on the scheme in 1990 however, were unsatisfied because of its failure to recognise the contributions of the wider multidisciplinary health care team who aided developments in practice for the accreditation. More units undertook the scheme and reported similar concerns – that it isolated non-nurses, who played a critical role in creating developments – and four years after it was established the nursing development scheme at Leeds was adjusted and renamed to reflect the multidisciplinary nature of health care teams, creating the first 'practice development unit' accreditation program (Page 1995).

Since this, four further academic institutions have established practice development unit accreditation programs. The first was Bournemouth University (1997-present), followed by Northumbria University (1998-2002³) and Edge Hill University (2000-present) and most recently Teesside University (2003-present). The establishment of more accreditation schemes is possibly attributable to the growing numbers of practitioners interested in undertaking this in response to government policies, which highlight the importance of demonstrating excellence in practice (i.e. DoH 1997, DoH 1998, DoH 2000). To date over 198 units⁴ have successfully become accredited in Britain and America, from a range of professional services such as mental health and palliative care.

³ This ceased in 2002 as the key figures running the scheme all moved on to other posts. The information gained about this scheme is a result from my correspondence with one of the original key leaders who had been involved in it.

⁴ Bournemouth University have had fifty one units gain accreditation, the University of Leeds have had over one hundred units (Totterdell 2004), Teesside University have had over thirty units (Kell et al 2004), Edge Hill University have had eleven units and Northumbria University had six units gain accreditation during its existence.

All of the accreditation schemes require units to fulfil a set of criteria which reflect significant improvements in practice (the criteria for each of these schemes can be found in Appendix Two). The basis for Edgehill, Northumbria, Bournemouth and Leeds Universities accreditation criteria are unpublished, but it has been suggested in one piece of literature that the criteria emerged as a result of a liaison between the Yorkshire Regional Health Authority and Leeds University during the 1990s where 'best practice' was defined (Totterdell 2004). Alternatively, the basis for the Teesside practice development accreditation scheme has been published, where it is documented that the criteria emerged from a critical review of general organisational and accreditation frameworks, whereby key themes were identified and then used to form its basis (McSherry et al 2003; Kell et al 2004).

The criteria vary between the institutions. I identified a total of thirty eight differing aspects, which can be found in Appendix Three. They do share some similarities however, with four out of five insisting changes are evidence based, are evaluated and audited, that changes are disseminated and that an academic partnership needs to be established⁵. As with the criteria, the accreditation process itself at the different institutes also share similarities and Figure 1 represents the accreditation process at one of these - Bournemouth University - to illustrate this process.

⁵ Creating an academic partnership allows the academic institute to keep 'up to date' with current practice, which can then be taught to new students, thus closing the gap between theory and practice (Totterdell 2004).



Fig 1. The Accreditation Process

This process begins by a representative group of practitioners who will lead practice development in their work setting expressing interest in doing so with the university. They then attend an induction course on how to undertake practice development and return to their place of work to implement projects aimed at improving practice with their colleagues. These improvements and the evidence behind them are then written up into a submission document⁶. At the start of the accreditation process, groups are allocated a consultant to guide them through the process and when the consultant and the group feel they are ready to complete accreditation, the submission document is given to an inter-professional panel from the university, who then visit the unit to assess the developments which have been made. If successful in becoming accredited, the group receives written confirmation of this and is awarded a plaque.

Units retain their status of accreditation for three years. Within this period they are required to submit an annual report which details how the accreditation criteria continue to be met in practice and their future plans for further practice development. Once the three year period of accreditation has expired, units begin the entire accreditation process again from scratch. It is at the very start of the accreditation process where the research documented in the following chapters of this thesis begins. The next section which outlines the forthcoming chapters will illustrate this.

⁶ The submission document details how and why projects were implemented and evaluated, how the accreditation criteria has been made, information regarding the support provided by the organization to meet practice development outcomes and a 'health plan' for the local area.

CONTENT OF THESIS

The journey of practice development accreditation begins in Chapter Two, where the literature is outlined. The search strategy used to obtain articles and the central focus of the published literature are documented, which highlights the importance of practice development in British health care and exposes the gap in knowledge which this research endeavoured to close. This gap in knowledge focuses around the 'informal' aspects of practice development, such as what happens to a team during the accreditation process, the role of culture within practice development and the experiences of non-nurses within a group undertaking it. The identification of this gap prompted three research aims which have driven this study; these are to investigate practice development accreditation by studying a unit undertaking this process, to examine the culture of a unit during accreditation and to portray a multidisciplinary account of practice development.

Chapter Three progresses from these aims by detailing why the symbolic-interpretive perspective was selected to investigate these aims and how it was the most appropriate framework to do so. The principles of the symbolic-interpretive perspective are outlined, which allows the rationale of why ethnography was selected as the research method in this study to become evident. This is then followed by the documentation of the theoretical aspects of ethnography; this enables Chapter Four – which documents how data was collected using ethnographic techniques – to be placed in context. Within Chapter Four, how I used participant observation, fieldnotes and interviews to gain a multitude of perspectives and opinions from the participants is detailed along with ethical considerations and the problems I encountered when engaging with ethnography as a method for the first time. It is here that my

journey and development as a researcher is most evident, as I describe my experiences of building relationships with the participants and incidents of 'culture shock' due to my status as an outsider to the health care system⁷. These experiences are placed in context in Chapter Five which describes the research setting, the central participants in this research (the 'core group') and my first encounters with both of these. It concludes with an overview of the events which unfolded during the twelve months of the accreditation process I observed, which enables Chapters Seven and Eight, where these are explored in more detail, to be better understood.

Prior to the in-depth exploration of the 'findings' from observing the accreditation journey detailed in Chapters Seven and Eight, strategies I used to analyse and interpret data is presented in Chapter Six. A detailed outline of how I coded fieldnotes and transcriptions and collapsed themes is provided together with an audit trail documenting how the two primary central themes of this research – leadership and culture – were generated. How these central themes were interpreted using the symbolic-interpretive perspective is also discussed in Chapter Six and these concepts are defined from this theoretical position.

Chapter Seven is dedicated solely to issues revolving around leadership uncovered in this research – including leadership problems within the core group itself, leadership over the rest of the staff and leadership of the core group in the form of management support. Chapter Eight is dedicated entirely to the problems associated with the culture of the group, which I identified as the major barrier to success in the accreditation. The research presented in these chapters is

⁷ Further detail on my background is provided in Chapter Three.

then reviewed in Chapter Nine, which addresses the assessment of ethnographic research and the limitations of this study. The contributions to knowledge this research has made are then documented. These are in summary:

- Staff can find engaging in practice development difficult because of cultural and hierarchical divides that exist between them
- Hierarchical status within organisations can be transferred into groups initiating change, where leaders can use their positional power to coerce and force staff into becoming involved
- Some practice development units do receive additional privileges because of their accreditation status (in spite of recommendation) which can cause tension within organisations
- The absence of shared beliefs and aims within practice development can hinder the ability to become accredited
- A lack of management support of accreditation can hinder the success of practice development initiatives
- A lack of commitment to practice development can hinder accreditation.

Recommendations for practice based on the findings of this study are presented and are followed by recommendations for further research. Finally, this thesis ends in Chapter Ten with my personal reflection of the research journey as a PhD student. My feelings about presenting the account of a problematic practice development unit are detailed and the value I have gained from conducting research using ethnography, documented. To conclude, it illustrates the impact on both a personal and professional level both the concept of practice development and conducting this research has had on me.

CONCLUSION

This chapter has revealed that what will be presented over the forthcoming pages is the account of a unit undergoing practice development accreditation. Additionally it has revealed that the practitioners within this unit experienced problems due to a variety of leadership and cultural issues.

The key terms of both 'practice development' and 'accreditation' were also defined in this chapter in preparation for the rest of the thesis, which explores how the participants of this study engaged in them. Prior to the views of practice development and accreditation of the participants being presented, the view of both practice development and accreditation presented in published peer-reviewed literature is explored. This is achieved in the following chapter.

CHAPTER II

LITERATURE REVIEW & RESEARCH AIMS

INTRODUCTION

The purpose of this chapter is to provide an overview of the literature through highlighting the central debates and preoccupations found within it. First, however, it explores the role of the literature review in ethnographic research. This is in order to allow the strategies I used to obtain literature to be placed better in context. The central issues in the literature are then outlined and followed by important issues which have not yet been addressed within it. Finally, this chapter ends by documenting the production of the three research aims that guided this study, which emerged as a result of the issues which have been neglected in the literature.

ROLE OF LITERATURE REVIEW IN THIS STUDY

I began this research by reading articles colleagues classified as seminal in practice development⁸ and I allowed these texts to signpost me to other literature on the subject. It became increasingly evident when reading this material that recent practice development literature placed emphasis on gaining accreditation and particular prominence was placed on the notion of culture; yet what actually happens during the accreditation process and the role culture plays within this were not detailed. After reading approximately twenty articles, the research aims

⁸ It will be documented in Chapter Three that I did not have a background in health care, which was the reason the opinions of colleagues in the health care profession were sought at this time. My motivation for undertaking this research as I do not have such a background, is also detailed in Chapter Three.

which guided this study were generated; to investigate practice development accreditation by studying a unit undertaking this process, to examine the culture of a unit during accreditation and to portray a multidisciplinary account of practice development. It was at this point I ceased reading practice development publications and concentrated on finding a theoretical framework and research method which would be enable me to research these aims. It will be outlined in the next chapter how and why symbolic-interpretivism and ethnography were selected, but prior to this it is critical to note that while investigating the methodology it became evident that literature reviews are not recommended before time is spent in the field within ethnography. It was for this reason all reading of practice development literature was placed on hold until fieldwork had been conducted. Figure 2 illustrates my PhD journey chronologically and highlights when the initial reading of the literature began, when it was ceased and when the review was conducted in this study (over two years after it began)⁹.

⁹ It is acknowledged in qualitative literature that research is often presented as a linear process which was conducted in a simple and straightforward process in the 'write up' despite it rarely being conducted in this way (Freshwater and Rolfe 2001).

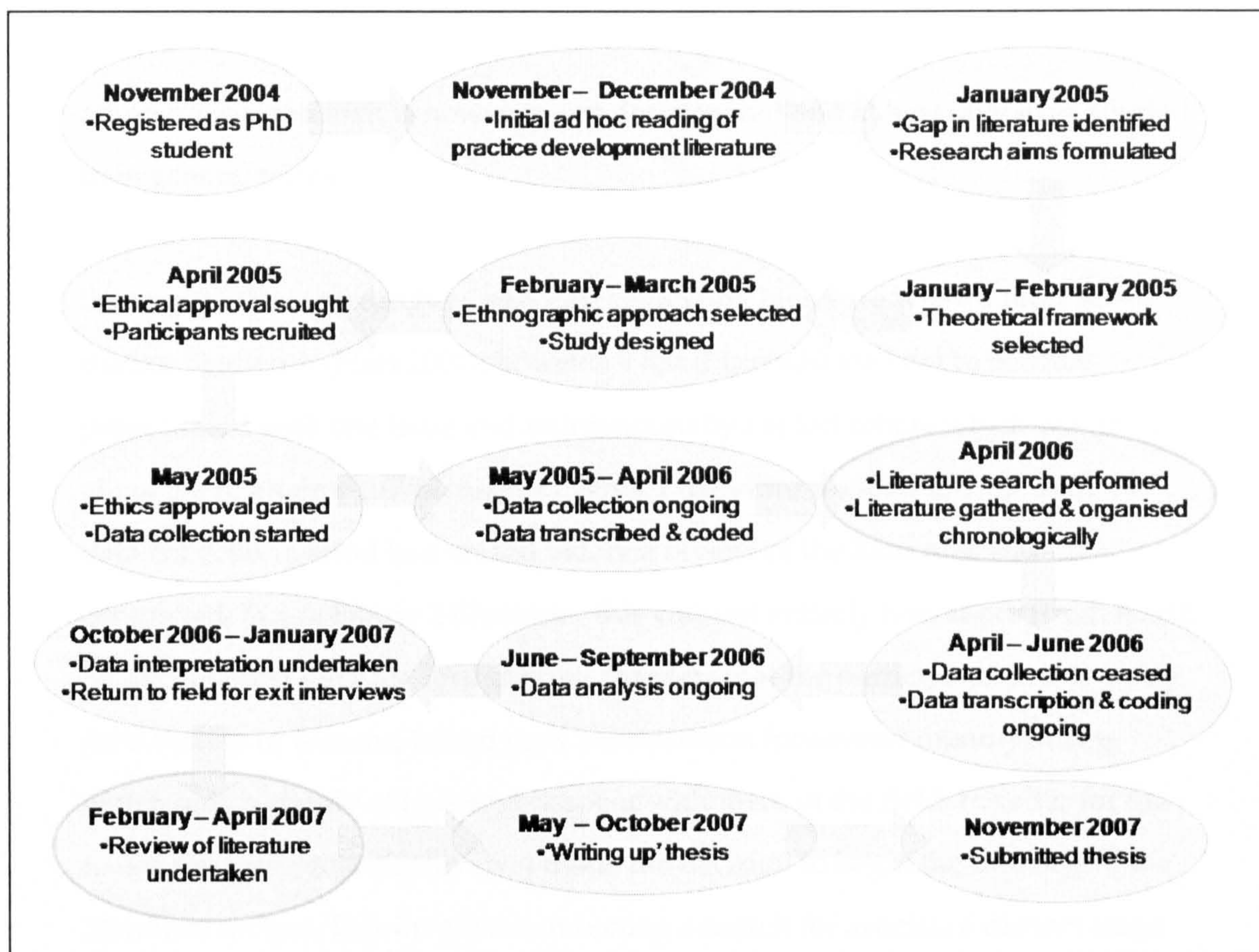


Fig 2. The PhD Journey

Indeed, while reviewing literature on conducting ethnographic research, it became apparent that initial literature overviews (which I had already undertaken) are conducted prior to collecting data in order to establish a gap in knowledge which research can then be designed to fill (Rock 2007). A full review of the literature however, is not conducted until data collection has at the very least commenced, in order to avoid apriori assumptions that could influence which aspects of data are collected (Fetterman 1998). Additionally, reviews are not conducted prior to entry into the field because many researchers using this method believe literature contains different issues to those found in the real world of the research site and so is not relevant for their study (Agar 1998). At what point specifically the literature review should be undertaken in

ethnographic research is however, not documented and at best only ever alluded to in general terms.

Some qualitative researchers advocate reviewing literature when a topic arises during fieldwork (Hart 2001); however I felt this could lead me to become preoccupied with one issue and unintentionally neglect others which would not allow me to attain a full picture of events. I therefore decided to wait until the data collection period had ceased before a review of the literature was conducted; but as Figure 2 illustrates this was not entirely how it occurred. It will be documented over the forthcoming chapters that the participants in this study, for a variety of reasons, halted their accreditation for several months during which only a couple of hours were spent with them in the field. In order for me to use my time most effectively, I made the decision to begin the first half of the literature review. This involves conducting a search for articles; a distinct stage from a review of them, the latter of which was conducted after data had been completely collected and analysed. The literature search stage of the review involved conducting database searches in order to gather articles and once these articles were obtained they were then stored until all stages of data collection had ceased so as not to influence this. It was only after this time that the review was started, however it is placed chronologically first in this thesis as the review merely confirmed my initial reading – that there is an absence of information on what exactly occurs during accreditation, that the role of culture is not explored and also that there is a lack of multidisciplinary perspectives of practice development within it. These three areas will be explored over the remainder of this chapter where the practice development literature is documented, however prior to this the strategies employed for obtaining articles which formed the review are discussed.

LITERATURE SEARCH

As the research aims focused specifically on investigating practice development accreditation by studying a unit undertaking this process and examining the culture of a unit during accreditation, I wanted to ensure I obtained articles that focused solely on the concept of practice development and not change in health care in general. To discover which databases would be most effective in obtaining such articles, I consulted with three subject librarians who recommended using the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Medline databases. The CINAHL database was used to search five hundred and twenty journals on nursing and health, using the search terms 'practice development' which I stipulated had to be in the title of the article (to ensure they specifically related to this concept). The search was not limited to any dates of publication (and so searched from 1981 onwards) but as translation of papers would not be feasible due to financial limitations, the language of articles was restricted to English. A total of two thousand, six hundred and eighty six articles were found using this database, however the majority of these had been generated because they contained either the term 'practice' or 'development' somewhere in their title – as opposed to appearing consecutively which would have denoted the concept of practice development. I subsequently searched these results manually for articles featuring the terms 'practice' and 'development' consecutively in their title and as a result the number of relevant articles was reduced to one hundred and sixty seven.

The Medline database searched over two hundred UK health and medical journals using the exact same keyword terms, again with the dates of publication unlimited (and so searched from 1966 onwards) but the language of articles restricted to English. Three hundred and sixty seven articles were generated as a

result, but as with the CINAHL database search, the majority of these articles contained either the term 'practice' or 'development' in the title but did not refer specifically to the concept of practice development. The results generated by the Medline search were therefore also searched manually for papers containing the words 'practice' and 'development' consecutively in the title, which left a total of eighty articles. Fifty of these however, were duplicated in the CINAHL search and so were eliminated which left a total of one hundred and ninety seven articles to be obtained and reviewed; the former being conducted prior to leaving the field and the latter once data collection and analysis were completed.

It became evident when reviewing the literature however, that while 'practice development' appeared consecutively in the title of some articles, not all of them referred to it as a concept, but rather to developing practice in general with no theoretical basis underpinning it. A total of twenty two articles fell into this category and so were eliminated from the review, as I intended to only examine practice development as a concept. A total of one hundred and seventy five articles were reviewed for this research which were organised chronologically to ascertain when the concept emerged in the literature and to trace its growth in popularity. Figure 3 illustrates the published practice development literature from this search, which highlights its increasing popularity.

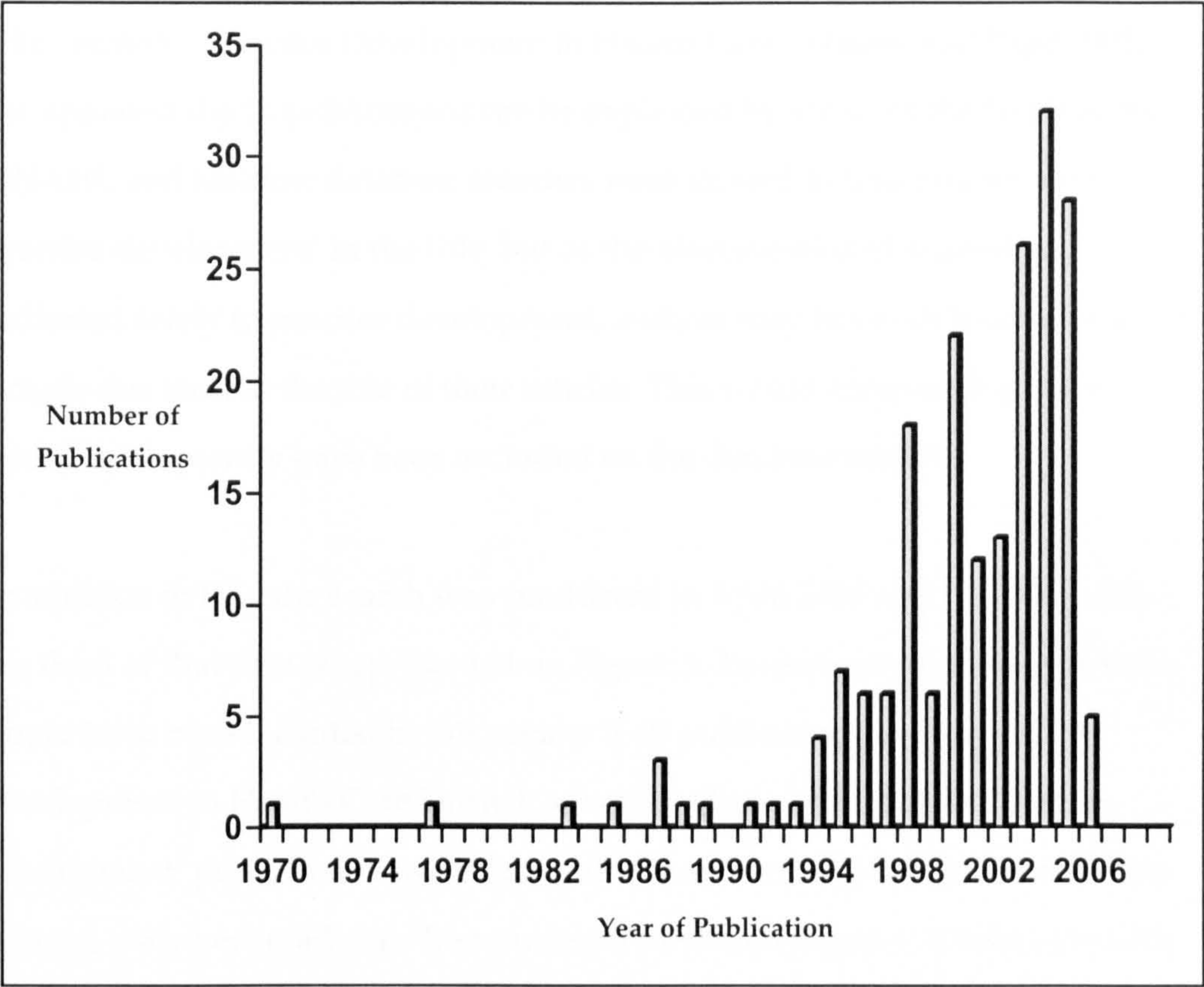


Fig 3. Practice Development Publications

Figure 3 demonstrates that practice development emerged as a concept in 1970, but literature was not regularly published on this subject until the late 1990s. This is most likely attributable to the government’s modernisation agenda, which promoted many of the principles of practice development (as outlined in Chapter One). It also indicates that more practitioners began to undertake practice development as a response to this agenda and subsequently published their experiences of it. Figure 3 illustrates that practice development publications peaked in 2004, but then appear to decrease after this which indicates that its popularity declined in recent years, however this is not the case. In 2001, the

esteem given to practice development spurred a journal dedicated entirely to it to be created – ‘Practice Development in Health Care’ (Hamer and Page 2002). The apparent dip in publications can be explained by virtue of the fact that the CINAHL and Medline database searches were limited to find articles with ‘practice development’ in the title, but as the aforementioned journal was dedicated solely to practice development, authors may have felt it unnecessary to include this term in the title of their articles. This would mean such papers would subsequently have been excluded on the database search.

In addition to this, the search was conducted in April 2006 and therefore only one third of that year is represented on Figure 3. To discover how many articles would have been included in this review if all publications in the Practice Development in Health Care journal, as well as those articles with ‘practice development’ published between May and December 2006 had been taken into account, a further small scale literature search was conducted. A total of twelve such articles were discovered, which when incorporated into Figure 3 shows only a very small decrease in practice development publications, demonstrated on Figure 4.

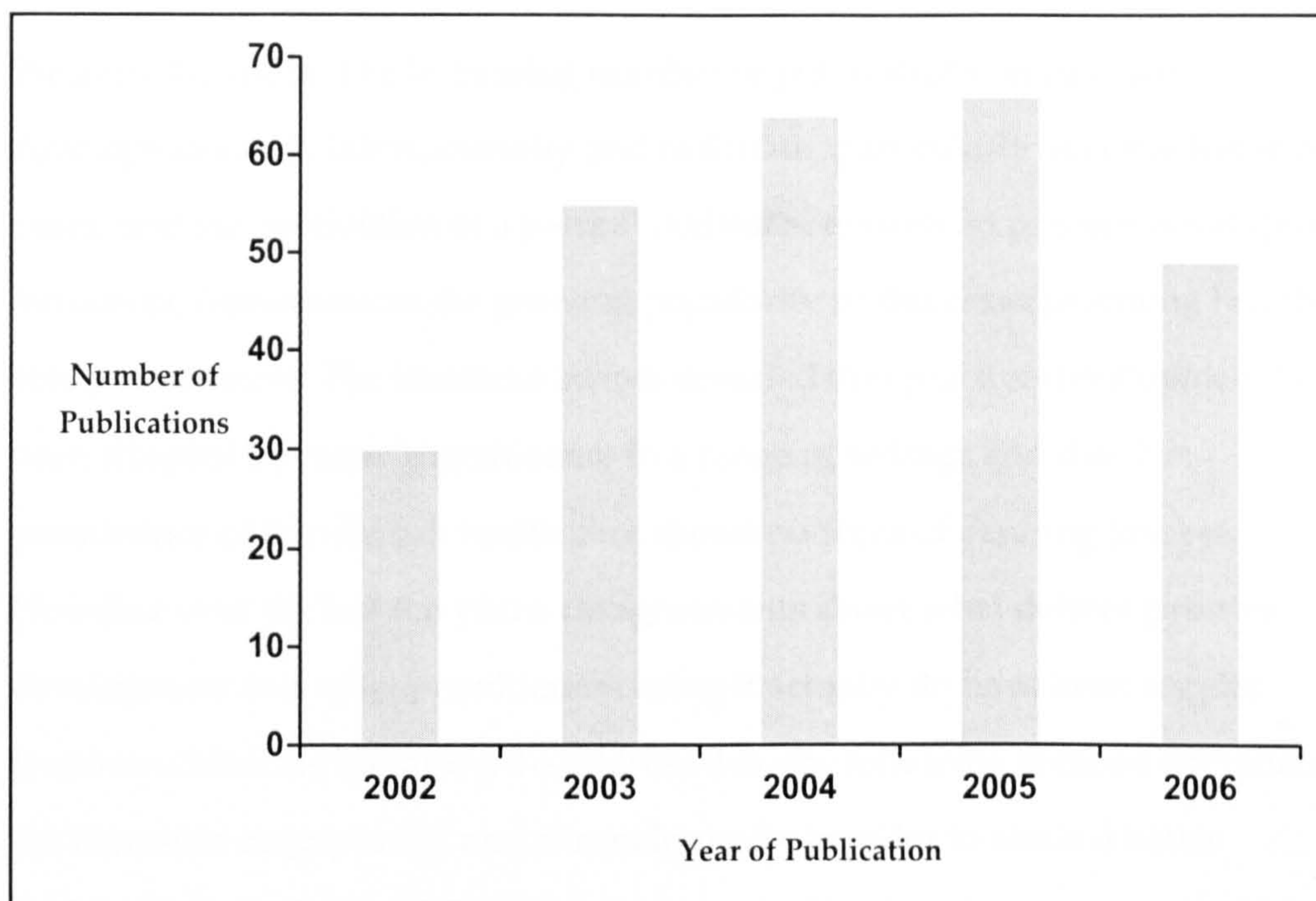


Fig 4. Practice Development Publications 2002 – 2006

The increasing popularity of practice development among international health care practitioners became evident during the review, where many authors stated the success of practice development reported by British health care practitioners within the literature had inspired them to engage in it themselves (i.e. Barrett et al 2005). The first international reports of initiating practice development came from America (Cambron and Cain 2003), but the majority of international publications on this subject have emerged from Australia and New Zealand. These articles primarily document the increasing popularity of practice development in Britain and report the current debates and trends within this area (i.e. Newton and McIntyre 2000). To recognise the contribution international practitioners are beginning to make in the subject of practice development, a regular feature has been commissioned in the Practice Development in Health Care journal since March 2007 which disseminates the work of developments in

Western Australia. The increasing number of publications on practice development both internationally and in Britain, particularly over the last seven years, and the production of a journal dedicated entirely to practice development initiatives, demonstrates the growing popularity of this concept among health care practitioners. The literature search revealed that practice development has been adopted by many practitioners in a range of settings and that the prominence of it in British health care shows no signs of expiring just yet. However over the last ten years, disagreements about what defines practice development and what practitioners using it actually do have been regular features within the literature. To address this, the following sections document the literature conceptually and chronologically in order to attain a better understanding of these debates.

PRACTICE DEVELOPMENT LITERATURE

The focus of practice development in the literature has changed during the fifteen years it has featured in health care journals, which reflects its evolution as a concept over this time. Literature published in the early 1990s focused on highlighting the fact that practice development was becoming utilised in health care and the positive results this was having in practice. During the mid 1990s, as the frequency of articles published on it began to increase, the literature focused on the work performed by 'practice development nurses'. Between 1997 and 2000 a major change occurred, where rather than centring on the work and role of practice developers, the literature focused on clarifying practice development as a concept. As part of this shift in focus, research was conducted in an attempt to clarify practice development and differentiate it from other similar change strategies. From the year 2000 onwards the literature in general still focused on

clarifying practice development but it also emphasised its value in health care through a host of articles authored by practitioners who had undertaken it themselves. The most recent literature – from 2003 onwards – has focused on promoting the idea that undertaking practice development needs to be done in a more rigorous and systematic way than it had been previously and accreditation is cited as being a key way to achieve it. Practice development literature has therefore evolved in three stages over the last fifteen years:

1. Clarification of practice development as a concept
2. Establishing practice development work
3. Practice development accreditation.

These stages are now explored more in depth over the following sections of this chapter.

Clarification of Practice Development as a Concept

The ambition to clarify practice development emerged as a response to articles between 1997 and 2004 where the majority of authors publishing their experiences made reference to the confusion over the term practice development (e.g. Sams 1998, Page and Hamer 2002) . Practice development has been defined in the literature in a variety of ways; with some authors emphasising the facilitation, evaluation and research aspects of it (Kitson 1994) and others highlighting the importance of empowerment, facilitation and the need to create an open culture when introducing change (McCormack et al 1999). Other definitions emphasise the importance of professional development, commitment and incorporation of service users perspectives into practice development (Garbett and McCormack 2002a), while others define practice development as

dynamic in its nature, highlighting it as a synthesis of approaches to change, placing value on innovation in practice (Page and Hamer 2002)¹⁰. The lack of consensus over its definition is primarily attributable to the common confusion between practice development and other similar change initiatives, as I discovered when reviewing the literature. Many of the articles which claimed to report practice developments, did in fact report nursing development (i.e. Gerrish 2001) and while practice development emerged from the work of nursing development units in the 1980s as outlined in Chapter One (Williams et al 1993); as Figure 5 demonstrates they are two distinct concepts, primarily differentiated by their perspective on multidisciplinary team working:

Nursing Development Units	Practice Development Units
The unit is nursing-led and profession focused in determining best practice	The unit is practice-led and patient focused in determining best practice by all disciplines
The clinical leader must be a nurse and clinically based	The clinical leader does not necessarily have to be a nurse, although they must be clinically based
Develops a research-based approach to nursing practice and involves MDT in research, although usually nursing-led	Develops a research-based approach to clinical practice by all professions. Engages in collaborative research sharing ownership for development
Defined clinical setting usually one ward/unit, not more than two. Static workforce which is allocated to that ward/unit	Defined clinical setting may be larger than one or two wards as members of MDT spend equal time in other wards
Staff in the ward/health setting share a vision and philosophy and are at the same stage of development	Staff within the four wards share a vision and philosophy and may be in slightly different stages of development
Acts as a change agent for nursing practice, disseminating its work within and outside of the organisation	Acts as a change agent for professional, clinical and therapeutic practice, disseminating its work within and outside the organisation
The aims and objectives if the NDU are fully documented, agreed and reviewed by nursing staff	The aims and objectives of the PDU are fully documented, agreed and reviewed by the multidisciplinary team

Fig 5. Different Focus of Practice Development and Nursing Development (adapted from Williams et al 1993:27).

¹⁰ The cited definitions of practice development from these authors can be found in Appendix One.

The terms 'nursing development' and 'practice development' were used interchangeably in much of the British literature for around seven years, which indicates that the transition from nursing to practice development was a gradual change and not a specific response to one definitive piece of legislation or policy. A similar trend occurred in the international literature (i.e. Nuccio et al 1996); indeed the Antipodean literature in particular, despite having reported embracing the popular British definitions of practice development (i.e. Darbyshire et al 2005), often referred to it as 'clinical practice development'. It was claimed this occurred in order to differentiate developments in the clinical setting from those in education and business (Goldman 2002). However, most descriptions of clinical development as described by such authors are actually more consistent with nursing development as they omitted any reference to a multidisciplinary approach to changes – the primary differentiating feature of practice development (i.e. Newton and McIntyre 2000). From 2002 onwards, in keeping with the British literature, this focus changed and later articles referring to 'clinical practice development' did embrace the multidisciplinary nature and focus of practice development.

Practice development was also used interchangeably with another term in the literature – 'professional development'. This mainly occurred during the 1990s (i.e. Gustin and Mains 1998) and eventually ceased after several prominent articles were published which acknowledged that professional development was an attribute of practice development, but the two concepts were distinct (Cowman et al 2000). These articles define professional development as relating to the progress of individual knowledge, skills and values, and practice development defined as the utilisation of professional development to provide high quality patient care (Mallett et al 1997). The confusion over these two terms

ceased altogether around the year 2000 after research results from studies that sought to clarify the term practice development were published, which ultimately differentiated practice and professional development (Unsworth 2000). These research reports acknowledge that practice development incorporates other 'eclectic' approaches to change and development (Carr 2005) and that aspects from a variety of change strategies have been synthesised to create the concept of practice development (McCarthy 2005). As these research reports played such a seminal role in practice development and are the predecessors of all future research into practice development – including that reported in this thesis – they are explored more thoroughly in the following section.

Research to Clarify 'Practice Development'

The plethora of literature published in the late 1990s which confused practice development with other similar change strategies (i.e. Glover 1998) inspired four pieces of research which intended to clarify this concept. The first of these attempted to define practice development by inquiring about the duties of professional and practice development nurses and collating a list of responsibilities from this, which were then used to define practice development work (Mallett et al 1997). Thirty-three such professional and practice development nurses responded to a survey as part of this research, which requested they selected from a list of duties and aspects which they felt reflected what were or should be included in practice or professional development nurses roles¹¹. A total of thirty duties were identified by these nurses which ranged from teaching to developing information leaflets for patients. However, the results

¹¹ This list was comprised by the researchers based on what they felt may be involved in these roles.

presented in this research do not accurately reflect the roles of practice development nurses alone. It was outlined earlier in this chapter that practice and professional development have distinct aims and differing strategies are therefore required to accomplish them. The results of this research consequently do not demonstrate accurately the work of practice developers. Additionally, respondents to the survey were asked to select their role attributes from a predetermined set and it is not clear whether the respondents believed this list to be sufficiently comprehensive or whether they were given the opportunity to suggest additional attributes. A further criticism of this research is that it targeted nurses only, not a multidisciplinary array of practitioners. This further reflects the researchers' confusion over the terms professional and practice development; as while practice development emphasises a multidisciplinary approach to health care, professional development does not. The results of this research, therefore, are not an accurate reflection of the roles, responsibilities and duties practice developers fulfil.

A second research project was also conducted to clarify practice development, as it was still poorly articulated in the literature which was reportedly frustrating for the many practitioners engaging in it (Unsworth 2000). A concept analysis of practice development was performed as part of this research using medical, nursing, accountancy, social work and counselling literature to discover how practice development was defined. This resulted in the identification of the following eight key attributes of practice development:

- facilitation through an identified or appointed source
- a planned systematic change
- the utilisation of evidence

- response to identified client need
- improvement of services to the client
- improvement of professional role or skills
- improvement to the business, professional or organisation
- improvement of the effectiveness of service

Each of these attributes have been identified in various practice development papers; however I found the incorporation of accountancy literature in this research problematic. Consultation of sources outside of the primary field of study in which a term is ordinarily found is advocated in concept analysis (Rodgers 1989). However, as the aim of this piece of research was to improve the lives of health care practitioners engaging in practice development by providing a definition of it, I believe consultation of only health care literature would have been more appropriate. The context of service provided to clients in accountancy, or indeed in education, politics or law or any other field, is distinct from providing a service to patients and their families in health care and as such it will have different implications for the users of it. Because of the incorporation of the accountancy literature in the concept analysis, I believe this research failed to generate a comprehensive definition of practice development as a health care strategy.

Two years later a further concept analysis was conducted which again aimed to clarify the term practice development as it had continued to be used inconsistently within the literature (Garbett and McCormack 2002a¹²). This differed from the previous research as it also incorporated interviews and focus

¹² Also reported in Garbett and McCormack (2002b) and McCormack and Garbett (2003).

groups with practitioners using practice development. One hundred and seventy seven articles were analysed for the concept analysis, twenty-five clinical nurses were interviewed about their experiences of engaging in practice development¹³ and sixty practitioners participated in focus groups to explore the concept of practice development as part of this study. The results from all of these methods were collated and presented as four summary statements which were said to define practice development. These statements share similarities to those discovered in the concept analysis conducted two years previously (undertaken by Unsworth 2000), which would suggest that these are an accurate reflection:

- practice development is a means of improving patient care
- it transforms the contexts and cultures in which nursing care takes place
- it is important to employ a systematic approach to effect changes in practice
- various types of facilitation are required for change to take place.

These attributes appear to have been insufficient however, as Hanrahan (2004) reports that practice development was still unclear within the literature, which led this author to conduct a further concept analysis. The number of articles assessed and the sources of these are not documented in the paper¹⁴ but the outcome of this review was the identification of two attributes of practice development: an identified patient need and a demonstration that improvement in practice is needed. However, the two previous concept analyses (Unsworth 2000, Garbett and McCormack 2002a) both identified 'facilitation of change' as a

¹³ Reported previously in McCormack and Garbett (2001).

¹⁴ As with the previously reported concept analysis, this literature may have included articles from the field of accountancy and counselling.

key feature of practice development and so it is surprising that this research did not also discover this. In addition, the two attributes identified from this research are consistent with a multitude of other change strategies – such as Service Improvement (McSherry and Kell 2007) – and therefore does not distinguish practice development from these. This definition is as a result far from distinctive or definitive.

While the flaws of these four research projects have been highlighted, the most obvious flaw of them all – to me as an outsider to health care engaging in practice development for the first time – was their failure to encompass a multidisciplinary perspective. They all highlighted the importance of this in undertaking practice development and indeed multidisciplinary team working is cited as the defining feature of this approach in most practice development literature, yet the role and opinion of a range of professionals is absent in research. The majority of literature as a whole instead focuses on the work and experience of practice development from a nursing perspective and this is explored more thoroughly over the following section.

Establishing Practice Development Work

The majority of practice development literature in general relates to specialist practice development nurses, who by publishing their work aim to illustrate their roles and responsibilities (i.e. Stickley 2004), or their experiences of occupying a practice development role (i.e. Cro and Green 2001). Research has been conducted in this area; with one survey issued in order to identify the actual work undertaken by practice development nurses (Kitson and Currie 1996) and several other research projects which aimed to ascertain potential problems when utilising practice development in a health care setting. One such

project conducted a focus group with practice development nurses, who as a result claimed the ambiguity of the term practice development hindered their ability to utilise it in their work (Clarke and Procter 1999). Another piece of research into establishing practice development work issued a survey to practice development nurses, which as a result revealed that an absence of practical organisational support made it difficult to implement it in practice (Booth et al 2003). A further piece of research combined telephone interviews, focus groups and a concept analysis of the literature in order to clarify the qualities and skills needed to occupy practice development roles¹⁵ (McCormack and Garbett 2003). However these research projects, as with those conducted into clarifying the term of practice development, all fail to address the roles of non-nurses in practice development. The literature acknowledges multidisciplinary team working as the definitive feature of practice development, yet the roles, attributes and opinions of non-nursing professionals are absent.

The work of nurses employed in specific practice development roles was the focus of research and literature prior to the year 2000, but after this time the focus of it adjusted slightly. Indeed, it was no longer those occupying specific practice development roles who published their experiences of utilising this strategy, but rather nurses encompassing practice development in addition to their normal roles within health care who were writing about their experiences of it. These articles centre around reporting practice development projects which the authors executed and so they outline the project undertaken, the evidence behind its implementation and report the effectiveness that undertaking practice

¹⁵ This research found that practice developers should be affective, motivated, empathetic, experiential, cognitive, political, communicative, facilitative, clinical and have vision. They should promote and facilitate change, translate and communicate, respond to external influences, provide education, put research into practice and perform audits (McCormack and Garbett 2003).

development has made in their capacity to provide care. The projects which are the focus of these articles all specifically relate to the context in which they were implemented and so are of use to other practitioners providing care in similar clinical settings. The projects include the management of leg ulcers (Samad et al 2002) and the development of a support group for patients who have gained weight after taking anti-psychotic medication (O'Melia et al 2004). They have emanated from a wide range of clinical care environments such as cancer care (Krishnasamy et al 2001), psychotherapy services (O'Melia et al 2004), gerontological nursing (Coffey 2005), mental health services (Jackson et al 1999) and district nursing (Redworth et al 2001). These articles reflect the wide utilisation of practice development in a range of health care settings, but once again there is a distinct absence in reported accounts by doctors, consultants, physiotherapists, occupational therapists or other members normally present in a multidisciplinary health care team who would have helped implement practice development.

The change in authorship of practice development literature from practice development nurses, to nurses engaging in practice development in addition to their ordinary roles and the increasing number of practitioners reportedly using it, led demands to be placed on having practice developments formally recognised. Accreditation has been cited as an appropriate and effective way to achieve this and this subject is explored further in the following section.

Practice Development Accreditation

Several articles published from 1999 onwards acknowledged the process of practice development was unclear and advocated a more systematic approach to undertaking it. These papers however failed to adequately detail the basis for

their claims, provide sufficient evidence on the process of practice development nor specify exactly how – in practical terms – practitioners can undertake practice development in a more systematic way. Figure 6 below summarises these papers and their criticisms.

Author & Year	Title of Paper	Method	Key Findings	Critique
McCormack et al, 1999	Towards practice development—a vision in reality or a reality without vision?	n/a	Practice development should be undertaken using a critical social theory approach	Methodology, background or basis for claims not stated
Manley and McCormack, 2003	Practice Development: Purpose, methodology, facilitation and evaluation	n/a	Practice development should be undertaken using a critical social theory approach'	Methodology, background or basis for claims not stated
Barrett et al, 2005	Systematic processes for successful, sustainable practice development	Action research & interviews	Practice development need to adopt a systematic approach to change	Insufficient information on methodology, participants or on authors' position to practice development
Carr, 2005	Practice development: 'Plausibility', 'doability' and 'outcome' issues	Realistic evaluation, action research, & interviews	Proposes 'tools' to structure practice development as a learning process	Insufficient information methodology, participants. Insufficient evidence of tool having been tested or its outcomes

Fig 6. Practice Development Process Literature

As a result of this emphasis on practitioners to undertake practice development in a more systematic way, accompanied by a lack of information on how practically to achieve this, external accreditation has been promoted. Accreditation has been endorsed in the literature (e.g. Chin and McNichol 2000) as a key way to formally acknowledge practice development work and as a result the number of units seeking this has grown at a phenomenal rate (Totterdell 2004). A number of accreditation schemes are available in health care, such as Kings Fund, Investors in People, Charter Mark and Total Quality Management and are popular as they acknowledge areas of good practice. However, as documented in Chapter One, practice development accreditation is currently only available from four British universities; who have thus far collectively granted accreditation status to over one hundred and ninety units. Yet only thirteen articles have been published which make any reference whatsoever to the accreditation system and only six of these actually discuss the accreditation process itself. The majority of these six articles outline only one of the accreditation programs; providing information such as how criteria for accreditation were established (McSherry et al 2003), or the chronological scale of accreditation (Chin and McNichol 2000). Little is known therefore, about what actually occurs during this process. Reports praise accreditation as making a 'significant and valuable contribution' (Chin and McNichol 2000:9) on national, organisational and individual levels and it is credited with accompanying a multitude of benefits in practice:

[Accredited units] find it easier to both recruit new staff and to retain their existing staff after they have gained accreditation. Patient complaints often decrease as the service is more explicitly focused upon their needs and wishes...staff in PDUs become solution-focused rather than problem-orientated and...the culture is such that it enables the talents and skills of everyone to flourish and grow. Moreover, job

satisfaction of the staff who have enabled these patient focused innovations to be put into practice has increased enormously (Totterdell 2004:140).

It has been claimed that accreditation transforms traditional power hierarchies (Walsh and Walsh 1998), empowers less senior members of staff (Kirby 2000), creates a positive attitude in employees which inspires them to embrace their work with enthusiasm and commitment (Williams et al 1993) and empowers service users, all without the use of any additional resources¹⁶ (Totterdell 2004). Accreditation has been called a journey of personal, professional and practice development which equips health care practitioners to respond to and influence 'the challenges and changes that health care is facing globally' (Chin and McNichol 2000:1) and as such several accredited units have achieved national recognition for providing excellence in care (Kirby 2000). To successfully achieve practice development, it has been suggested that a critical social theory approach should be adopted as it enables a range of developmental and research approaches to be utilized in order to identify and address constraining factors which hinder change and creativity (McCormack et al 1999). This clearly is essential when implementing accreditation, as this is cited within the literature as a key way to transform health care cultures that are conventionally resistant to change into open and supportive spaces (Walsh and Walsh 1998)¹⁷. The concept of culture is noted in virtually every article published on practice development, yet the role of culture within this is not detailed in any of these papers.

¹⁶ McSherry and Bassett (2002) are the only authors to imply that practice development does require additional resources.

¹⁷ This culture change is also a requirement of accreditation (McSherry et al 2003).

Surprisingly, given the increasing numbers of practitioners seeking accreditation, only one piece of research has been conducted into it. This research sought to assess a team of practitioners embarking on an accreditation scheme, using a Team Climate Inventory Tool (TCI) which required forty four Likert statement tests to be created. These were then submitted to the members of the group to complete, the responses of which enabled the strengths and weaknesses of the team to be evaluated (Walsh and Walsh 1998). This research project found the group under study needed to improve their strength as a team (by undertaking team building exercises) before they progressed onto the accreditation program¹⁸ and on the basis of this, the group withdrew from the scheme and - for various reasons - did not reapply at a later date. The results of this research highlighted that teamwork is critical in successfully implementing practice development; however detail on how teams achieved this relationship in their experiences of practice development is not documented in the published literature. This inspired one of the three research aims of this thesis - to investigate practice development accreditation by studying a unit undertaking this process; which would allow these relationships to become transparent.

CONCLUSION

The review of the literature presented in this chapter has demonstrated that practice development is an expanding subject which has not only begun to saturate the British health care system but is increasingly becoming a 'familiar term' in Australian and New Zealand health care (Walsh et al 2004). Publications have so far focused on clarifying practice development as a term, establishing the

¹⁸ Despite the potential value the TCI could provide to accreditation, it has thus far not been incorporated into any of the accreditation programs.

work of practice developers and reporting successful practice development projects. Several pieces of research have been conducted into clarifying the term 'practice development' by primarily performing concept analyses of published literature, but also by issuing surveys, hosting interviews and holding focus groups.

It has been documented in this chapter that accreditation is cited as a key way to formally acknowledge practice development and as a result the number of units registered on accreditation programs is increasing (Cambron and Cain 2004). However, it has also been demonstrated that few articles have been published on the area of accreditation at all. Published literature has so far focused on the 'formal' aspects of practice development by defining it as a concept and highlighting the value of undertaking it, but there is a noticeable absence of the 'informal' aspect of practice development. Figure 7 illustrates the different focus of these two areas.

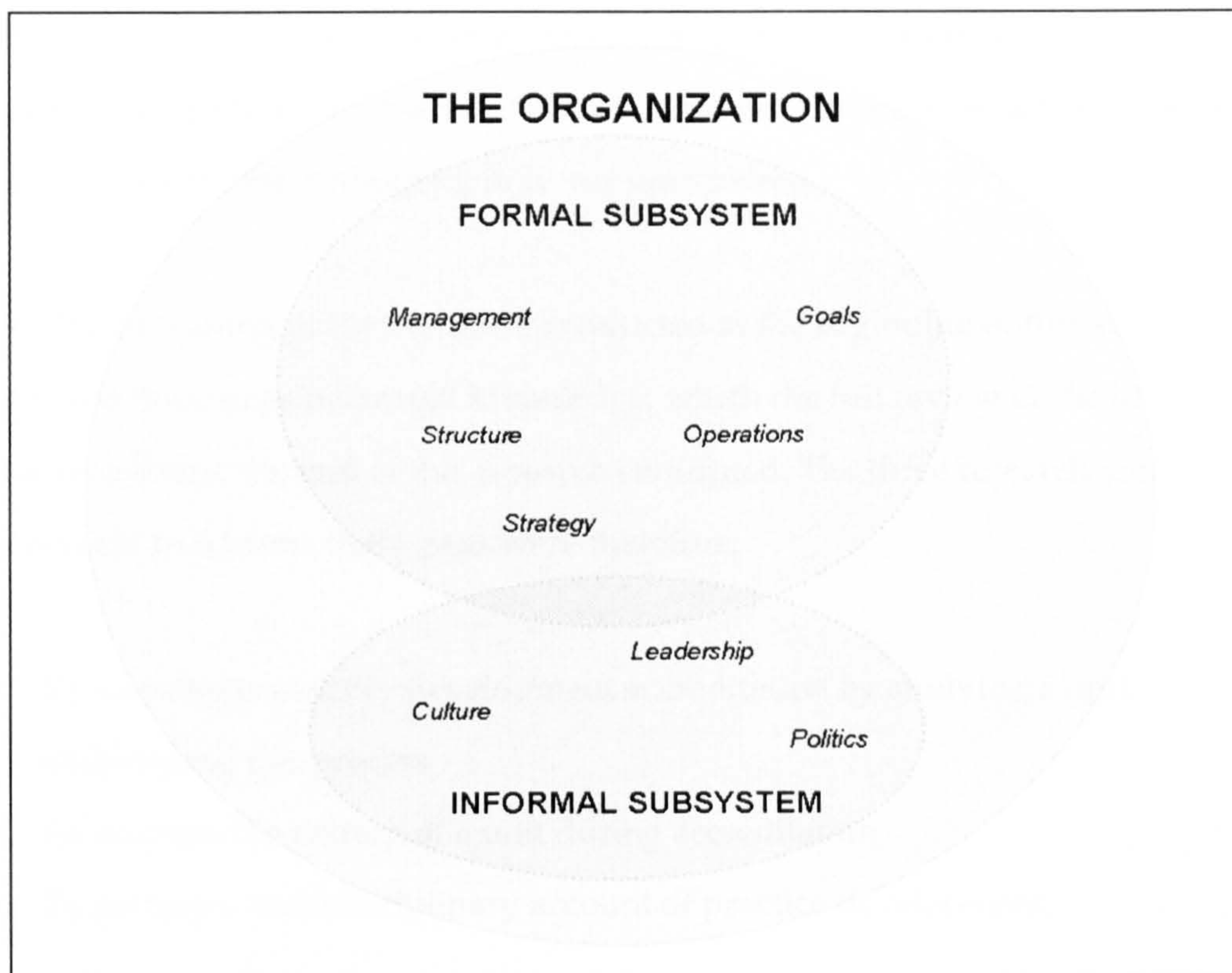


Fig 7. Formal and Informal Aspects of an Organisation (adapted from Senior 2002)

Indeed, while the subject of culture is heavily emphasised within the literature - with almost every article making reference to it (e.g. McCormack et al 1999) - information on how culture is defined and the role it plays in practice development is not explored. It was this absence which generated the first two of the three research aims which guided this study; to investigate practice development accreditation by studying a unit undertaking this process and to examine the culture of a unit during accreditation.

It was also highlighted in this chapter that there is a distinct absence of multidisciplinary voices within practice development literature, despite the multidisciplinary focus of practice development being its differentiating feature.

This prompted the third research aim of this study - to portray a multidisciplinary account of practice development - as the experiences of non-nursing practitioners engaging in it was unexplored.

The initial reading of the literature conducted at the beginning of this study revealed three gaps in current knowledge, which the full review of the literature conducted near the end of this research confirmed. The three research aims generated to address these gaps were therefore:

- To investigate practice development accreditation by studying a unit undertaking this process
- To examine the culture of a unit during accreditation
- To portray a multidisciplinary account of practice development.

The following chapter explores how these aims guided the research documented in this thesis by addressing how the theoretical framework and method which enabled these to be most appropriately investigated were selected.

CHAPTER III METHODOLOGY

INTRODUCTION

This chapter details how the theoretical framework of symbolic-interpretivism was selected to address the three research aims of this study. The first half of this chapter documents the concept of symbolic-interpretivism (a branch of symbolic interactionism) and why this perspective was most appropriate for investigating the research aims. The second half addresses the method symbolic-interpretivists use to conduct research – ethnography – by outlining this approach and how it is used to investigate issues. This chapter details the theoretical aspects of both symbolic-interpretivism and ethnography in preparation for the proceeding chapters, which will document how these were employed in practice to conduct this research.

SYMBOLIC INTERACTIONISM

The research aims of this study demanded a theoretical framework which would enable the examination of a group process, of culture, and would allow a range of perspectives to be presented. Because of the particular focus on culture, a qualitative approach was most suitable. In selecting the approach, a range of perspectives were investigated and their benefits and weaknesses for addressing the research aims were assessed.

Grounded theory could have been a suitable approach for this study but as it was not an aim of this research to generate a theory (which is the primary aim of grounded theory) this perspective was not selected. Phenomenology could also

have been selected to guide this research; however its focus on the individual made it less appealing. This is because practice development is a group process and often involves a large number of practitioners, and therefore a framework that is attentive to the interactions of groups rather than individuals was required. A case study perspective was also a suitable framework to meet the aims of this research; however this approach would place too much emphasis on the type of care provided by the group under study (i.e. paediatric, renal or cardiology). As it was the intention of this research to examine the process of practice development and not the type of care provided, this perspective was not selected. A range of approaches was therefore suitable for this research based on its aims: to investigate practice development accreditation by studying a unit undertaking this process, to examine the culture of a unit during accreditation and to portray a multidisciplinary account of practice development. However, from assessing the approaches I found symbolic interactionism was better suited as a theoretical perspective than any other for achieving the aims of this research. The reasons for this will become further evident over the remainder of this section where this approach is detailed.

Symbolic interactionism was founded in the 1920s at the American Chicago School of Sociology and emerged from philosophical perspectives such as American Pragmatism, Intersubjectivity, Hermeneutics and Sympathetic Introspection. Symbolic interactionism is based on three principles; that humans act towards things based on the meanings they hold for them, that humans inhabit two worlds – the natural world where they act on instincts and the social world where symbols exist in order to give meaning to objects – and lastly it is the interpretation of meaning which makes humans distinct and social creatures (Cohen et al 2001). This perspective states that humans make sense of their lives

by drawing on a common set of symbols and interacting with other humans. This perspective therefore focuses on the interrelatedness of mind, self and society in action (Liamputtong and Ezzy 2005), expressed through language which humans utilise in order to engage in the social processes of constructing reality (Tietze et al 2003). Symbolic interactionists claim that mind, self and society are rooted in, and sustained through, interaction which is only possible through the use of shared symbols¹⁹ which are expressed through language (Prus 1996).

Symbols are 'signifiers', developed because one stimulus has preceded another so regularly that the first stimulus has become a signifier for the second, and as a result the reaction which would be granted to the second stimulus is given to the first (Baron and Byrne 2003). Symbols are therefore signs created through the production of associations which are learned and shared within a group context but that have no natural connection to the entity they signify. Symbols are in this sense unlike natural signs such as smoke, which because of its long history of being accompanied with a blaze is classified as a sign for fire. We do not require to actually view flames in order to believe it exists, smoke is sufficient for this as years of human experience has taught us smoke and fire are linked. Symbols have no such natural connection to what they signify, but are learned in the exact same way (Charon 2004). For instance if I inform a colleague at work that I am 'experiencing problems with my mouse' she will visualize a small plastic piece of IT equipment because the word 'mouse' is a shared symbol within our social group which represents a piece of computing equipment. If instead of being based in an academic office, I worked in a veterinary surgery and informed a

¹⁹ The symbols are defined as shared because they stimulate in the person using the symbol the same response which is stimulated in the person to whom it is directed (Hewitt 2000).

colleague there that I was 'experiencing problems with my mouse' then the shared understanding of the term in this context would most likely be more associated with a long tailed rodent. The actual term 'mouse' has no natural association with either a piece of IT equipment nor a rodent and as such it is an abstract concept; symbols such as these are used 'at a distance' from the entity they signify in order to provide a cultural shorthand to the range of beliefs, values, experiences and emotions the users have²⁰. Symbols also refer to non-tangible abstract concepts, such as 'love' or 'care' that are not grounded in actual entities (Hewitt 2000). This can be demonstrated by the fact that when most cat owners are asked about their pet, they visualize their feline and experience a flush of the emotion. This could be happiness at the memory of relaxing with the cat, anger at the feline for having killed a bird or even sadness if it has recently died, which is all prompted from simply hearing the word 'pet'.

Symbolic interactionism was chosen to guide this study because of its focus on the interactions of people within groups to create meaning. However more specifically, I wanted to focus on practice development accreditation - a process undertaken only within an organisational work environment - and so a theoretical framework which would particularly account for issues associated with undertaking change in an organisation was desirable. The symbolic-interpretive perspective is the application of symbolic interactionism into an organisational context and addresses many issues which only arise within a work environment (Hatch and Cunliffe 2006) and was therefore selected to guide this study. The following section explains this perspective and highlights the areas of focus within it.

²⁰ Symbols can therefore not guarantee shared responses because of their dependency on the cultural context in which they occur (Hewitt 2000).

SYMBOLIC-INTERPRETIVISM

Symbolic-interpretivism emerged in the 1980s, inspired from the work of earlier ethnographers conducting research in work environments such as Goffman (1959) and Geertz (1973). This perspective, as described by Frey and Sunwolf (2004) suggests that, as in symbolic interactionism, groups are socially constructed through symbolic activities, and so symbolic-interpretivists aim to understand how members of a group within an organisation use symbols. As symbolic activities are the primary means through which members interact to create a shared reality that binds them together as a group, symbolic-interpretivists also examine the effect the use of symbols has on processes and outcomes at individual, collective and relational levels (Frey and Sunwolf 2004). Symbolic-interpretivists focus on culture and meaning and seek to understand how groups change over time (demonstrated by the symbolic practices group members engage in), which means this perspective is particularly apt for the study of practice development accreditation (Hatch and Cunliffe 2006).

Figure 8 ²¹ illustrates the focus of study within the symbolic-interpretivist perspective, which centres around the ways group members create meaning and the role this meaning-making plays in the workplace (Hatch and Cunliffe 2006).

²¹ As this model was created by the authors Frey and Sunwolf (2004) the explanation of it is also based on their paper, in which the diagram can be found.

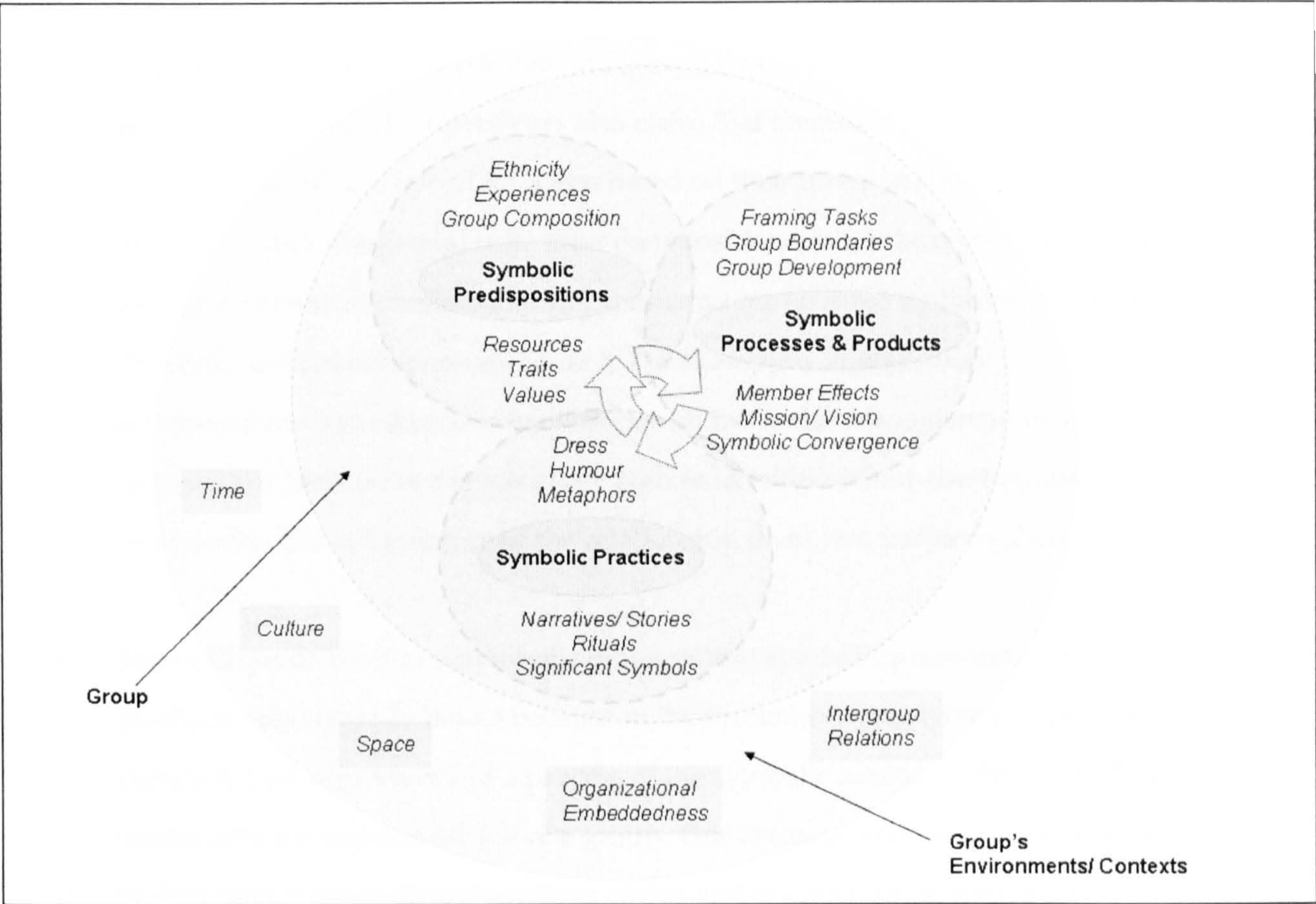


Fig 8. Symbolic-Interpretive Focus of Study (Frey and Sunwolf 2004:285)

The symbolic-interpretive perspective focus is on the macro-level, achieved by observing the identity and culture²² of groups, represented on Figure 8 by the circle entitled ‘symbolic processes and products’. Members of a group engage in symbolic practices when they interact with each other, such as reciting stories

²² Culture defined in the symbolic-interpretive perspective refers to the shared thinking, behaviour and beliefs of members which are expressed through interactions, which are constructed through the interpretations members make of events unfolding around them; allowing them to create collective meaning (Marquis and Huston 2006). In this perspective culture is not something an organization has but rather something an organization is (Scott-Findlay and Esterbrooks 2006). This is explored further in Chapter Six.

and using metaphors and this is a particular area of focus in symbolic-interpretive research, represented on Figure 8 by the circle entitled 'symbolic practices'. Symbolic-interpretivists also claim that members of a group have tendencies to behave in certain ways, based on their interpretation of the actions of others within the group, from their own position within the organisation, and also on personal and historical past experience; represented by the circle entitled 'symbolic predispositions' on Figure 8. For example a Trade Union representative is predisposed to conflict with the senior management in an organisation because of the roles they both hold within it and also because historically, this is the nature of the relationship these two positions share.

Symbolic predispositions, symbolic practices and symbolic processes and products are integrally linked because in the symbolic-interpretive perspective, culture is both a product and a process of the symbolic practices which transform continually throughout the life of a group. This is represented by the dashed and broken lines surrounding these three circles and the overlap between them and arrows among them on Figure 8. These three elements are also contained within a wider circle representing the group as a whole within the organisation, which also has a permeable boundary illustrating that the group is embedded within the multiple contexts of time, space and culture - all of which influence internal group dynamics and force groups to interact with other individuals and groups within the wider environment (Frey and Sunwolf 2004).

Organisations are viewed as arenas of power in the symbolic-interpretive perspective, expressed through organisational politics, control and conflict within which symbols are utilised to transform existing power relations (Hatch

and Cunliffe 2006)²³. However, while attempts are made to transform power relations through the use of symbols, the instigators of this are unable to control the interpretation of symbols by others who create their own meaning as they interact with it themselves (Hatch and Cunliffe 2006). Symbolic-interpretivists investigate the multiple interpretations of symbols that exist within a culture, paying close attention to the process of 'meaning-making' group members engage in (Parker 2000), which is achieved by examining stories, symbols, power structures, hierarchical structures, control systems, rituals and routines found within a group (Johnson and Scholes 2006). It is for this reason symbolic-interpretivists use ethnographic research methods to investigate organisations, as ethnography enables the social construction of a group to be examined by observing a group over time (Frey and Sunwolf 2004). Additionally, ethnography is selected because of the focus within the symbolic interactionist perspective on Geertz's (1973) metaphor of the theatre.

This metaphor is used to explain the symbolic-interpretivist view that organisational life mirrors theatre life, as actors²⁴ within them both draw on words, scripts and prompts to engage in 'role performances' which they use to portray their identity and intentions to an audience in order to control the impression they will form about them (Sandstrom et al 2003). This is particularly important in health care organisations as practitioners have to portray the role of competent, caring, knowledgeable and sensitive actors. They are not being false in doing so, rather they are forced to maintain a 'mask' because of their position

²³ This is particularly relevant for the study of practice development as this strategy attempts to adjust power relations in order to create empowerment among staff.

²⁴ The term 'actor' is used here in the sociological sense. This is defined as "entities that do things" (Latour 1992:241); that is engaged in action. It is not used in the theatrical sense of being fictional.

as health care workers, irrespective of the way they may actually feel about a patient or how they feel about problems they experience in their own personal lives²⁵. The theatre metaphor states that, just as in a theatre, organisations consist of a 'front stage' and 'back stage'; the front stage is where the public face of the organisation is seen and impressions are managed by the actors and audience, all of whom perform in order to maintain it. For example, The Ivy restaurant in London has a public image as an exclusive restaurant which serves excellent food and boasts a superb wine selection and as such attracts celebrities and millionaires. Employees at The Ivy maintain this image by providing good quality service, producing fine food and becoming educated about wine and the customers who dine there perpetuate its image by agreeing that the food, wine and service is superb and that The Ivy is an exclusive venue to dine at. But as in the theatre, organisations have a 'back stage' where the true opinions are revealed about the actors' values and beliefs. In The Ivy, this would be a staff room where waiters and chefs take breaks together and describe the food as pretentious, the wine as over priced and the customers as pompous.

The front stage of an organisation is the 'overt' aspects; visible on a superficial level through the examination of its goals, strategies and management structures. The back stage alternatively is the 'covert' aspects, where informal leadership structures are revealed and the creation of symbols reflect the values, attitudes, beliefs and politics of the organisation (French and Bell 1999). It was outlined in the previous chapter (which examined the practice development literature) that publications on this topic have so far only focused on the overt aspect of practice development. The application of symbolic-interpretivism through ethnographic

²⁵ A direct example of this applied to the participants of this research can be found in Chapter Seven.

research methods in this study subsequently permitted an examination of the unknown, covert aspects of practice development. This will become apparent throughout the following chapters, however prior to this a definition of ethnography and how it was used to research this area is detailed.

ETHNOGRAPHY

Ethnography was utilised as the method to investigate the research aims of this study as, literally translated as a 'portrait of people' (Harris and Johnson 2000), it permits the study of cultural behaviour (Cresswell 2007) and reveals the structures and interactions of a group and the meaning those within it give to their actions and interactions (Holloway and Todres 2005). This is achieved by uncovering the 'backstage' elements through participant observation²⁶.

Ethnographers use their unique position as both an insider and outsider within a group to document both the emic (insider) and etic (social scientific view) perspectives, which allows the culture of a group to then be presented to other outsiders (Prus 1996). It is because of ethnography's ability to reveal the routine and covert practices within groups that it is classified as the most effective approach to the study of work and organisations (Smith 2007) and why it was used in this research. Few ethnographies in the field of health care exist (confirmed by O'Reilly 2005), but it is however receiving increasing recognition for its value to this field (Roper and Shapiro 2000)²⁷.

²⁶ Participant observation is defined and explored in the next chapter.

²⁷ Ethnographic research which has been conducted in health care focuses on the experiences of patients (McCoy 2005), with few on the culture of health care workers (confirmed by Hodgson 2000).

Ethnographic research is inductive in nature and is purposefully flexible in its design as it is normally selected to research areas where little knowledge exists. Ethnography therefore needs to remain flexible in order to respond to emerging issues and investigate new areas of interest which arise as the study progresses (Burgess 1995). Creating rigid hypotheses would force the researcher to investigate issues only pertaining to this in their study, consequently leading to new lines of interest unrelated to the hypotheses which arise to be disregarded. This would not permit an accurate study of the culture. It is on this basis that research aims are adopted in ethnographic research studies, and is the reason the research aims outlined at the end of the previous chapter were not refined or developed into a hypothesis.

Ethnography, along with much qualitative research, is criticised for its failure to be representative of all similar phenomena or for its aim to be generalizable (Myers 2000). Results from ethnographic research are not generalizable or representative because the symbolic-interpretive perspective states that events are the products of interactions between specific actors, each influenced by their own personal experiences and histories and conversing in a specific juncture in time and space (Frey and Sunwolf 2004). These events can therefore never be replicated or be representative of the phenomena; it is the interactions of actors which cause outcomes, not a specific formula of a series of events and so the findings from such research cannot be generalized. Instead of making findings generalizable, the results of much qualitative research aim to be 'of relevance' to others undergoing similar experiences (Hammersley 1998), which is also the aim of this research. This study is not representative of what occurs to all groups undergoing practice development accreditation, but rather the many issues the participants experienced in this study will be faced by other groups in other

settings. The findings are therefore intended to be of relevance to other groups undertaking similar change initiatives.

In addition, ethnographic research is criticised because researchers are selective when observing and interpreting their data (Hammersley 1998). However, it is not possible for any researcher to be omnipresent when gathering data and therefore what is observed or recorded is selective in any research. For reasons which will be outlined over the following chapters, in this research I was granted only limited access to participants and observation was therefore clearly limited, but in order to avoid selectivity over what was observed on these occasions a Dictaphone was used to capture all verbal communication. The interpretation of data in this study was also selective (as in any research) as it was guided by the theoretical framework selected. Areas of focus which feature heavily in other theoretical perspectives, such as capitalism in a Marxist framework, are not focal issues in the symbolic-interpretive perspective and so were not addressed. Rather, the aspects outlined in the first half of this chapter and represented in Figure 8 were used to interpret the data collected; details of exactly how this was achieved is documented in later chapters of this thesis along with how data was collected. Prior to this, in order to fulfil the aims of this chapter as stated in its introduction – to detail all theoretical aspects of ethnography– the strategies employed to assess ethnographic research are addressed.

Strategies to Assess Ethnographic Data

Research has traditionally been assessed using positivist notions of internal and external validity, which consider whether the researcher has caused the predicted outcomes of their research and if so whether this causal relationship can be generalized to other areas (Whittemore et al 2001). Some ethnographers have applied this reasoning to ethnographic research (i.e. Denzin 1978 and Goetz

and Le Compte 1984), however this has been rejected by all symbolic interpretivists and most ethnographers (as positivist research and ethnography are opposing methodologies). Positivist researchers create situations in which to investigate phenomena, whereas ethnographic researchers investigate situations which they have had no control over, as social actors have created them through their interactions (Prus 1996):

Ethnography has struggled for decades with positivist criteria for reliability and validity, because the methods, field conditions and objectives of ethnographic research do not lend themselves to the same kinds of detachment and control over practice
(Le Compte and Schensul 1999b:272).

Cultural context, past experiences and identity are not taken into account when using traditional methods of assessing validity, yet these are cited as critical aspects to investigate within the symbolic-interpretive perspective and indeed as will be documented in later chapters, all three played a crucial role in the way I was able to collect, analyse and interpret data in this research. Most ethnographers agree that the application of traditional frameworks found in the natural sciences to investigate humans in their natural environment is therefore inappropriate. Ethnographic research is instead recommended to be assessed on ethnographic reliability, member verification, the contribution it makes to existing knowledge and reflexivity²⁸. Ethnographic reliability refers to the extent to which the finished ethnographic text accurately represents the social phenomena to which it refers. This is judged on three criteria – plausibility, credibility and evidence (Hammersley 1998). To accomplish the first of these, the reader must assess whether what is documented seems plausible, given existing

²⁸ These issues are addressed again in Chapter Nine after the study has been documented and findings presented.

knowledge on the subject area (Hammersley 1998). It was documented in Chapter Two however, that little has been published on the practice development accreditation process and so in order to overcome this, the findings are compared to literature on change, leadership and culture in general to discover whether the experiences were typical of a group undergoing a change process. This clearly does not appear until the final chapters of this thesis however, and so this criticism is reviewed again in the penultimate chapter to ensure this has been sufficiently addressed.

If claims made in ethnographic studies are not sufficiently plausible, their credibility is then assessed, which is achieved by taking into account the process used to produce the evidence: that is, that the researcher collected the data and that it was analysed methodically (Golden-Biddle and Locke 1993). It will be documented in the following chapter that few guidelines on how to collect data using ethnography exist. When I first began this research, I was therefore unsure of how the data would be analysed and so it was for this reason I kept detailed notes on how I collected and analysed data, which will be documented later in this thesis. Extracts from observations and participant accounts are used throughout this research to support statements and thereby address this criticism; the incorporation of direct quotes is used to expose the relationship between the source of evidence and claims made. This is further supported by the documenting of a clear audit trail which details how fieldnotes were produced, how data was transformed into analytical categories and how this was interpreted to create the findings of this research. Detailed notes were kept on the entire research and the analysis process to ensure this criticism was addressed. The audit trail is cited as a key criterion for assessing ethnographic research (Savage 2000). Its purpose is to enable the reader to confirm the findings

presented and as such it is argued by many authors that qualitative studies should be assessed on whether the researcher within the text made their 'practices visible and, therefore, auditable' (Sandleowski 1993:2). The audit trail is described by Lincoln and Guba (1985) as necessary in order for the reader to 'ascertain whether the findings are grounded in the data... to reach a judgment about whether inferences based on the data are logical [and]... to make an assessment of the degree and incidence of inquirer bias' (Lincoln and Guba 1985:323). It consists of several elements which must be present in order for a text to claim credibility. These are:

- A description of the design with the aims and intentions of the research
- A record of the methods and procedures
- An explanation of the sampling process
- A description of the data collection and analysis process
- A record of decisions about ethical issues
- Excerpts from the data (Holloway 1997:26)

These criteria are all achieved within this thesis, which will become evident in the forthcoming chapters. It is impossible to assess whether credibility through the audit trail has been achieved in this early section of the thesis and therefore the credibility of this study will be addressed again in the penultimate chapter.

A further problem within ethnographic research is the possible misinterpretation of events, conversations or actions (which exists in any research) and it is for this reason regular interviews were held with participants to clarify interpretations of incidents and opinions. It is also possible that participants could have experienced the 'Hawthorne Effect' whereby they change their behaviour

temporarily when they are being observed (Mangione-Smith et al 2002). However, the symbolic-interpretivist perspective claims actors continually change their behaviour depending on whether they are acting in the 'front' or 'back' stage areas (Sandstrom et al 2003) and so this criticism is therefore dispensed. Finally, if claims of an ethnographic text are neither plausible nor credible, the reader is asked to assess the evidence presented (Hammersley 1998). It is for this reason the data collection, analysis and interpretation processes are explicitly documented in the following chapters of this thesis which will demonstrate how each of these were conducted.

Member verification is also often used to assess ethnographic studies, however disagreement exists as whether to conduct this or not. Verification is achieved by ethnographers returning to the field of study and presenting findings to participants in order for them to determine whether the account depicted by the ethnographer is accurate of the experiences they encountered (Fine et al 2007). While some authors have called member verification a 'crucial test' for ethnographic accounts (Hammersley and Atkinson 2007), this is not the position of symbolic-interpretivists as they aim to present multiple experiences, voices and realities of a group. This means participants will almost certainly be unfamiliar with some aspects of the account depicted by the ethnographer and will claim that it does not represent their own personal experience precisely. Some ethnographers have also criticised member verification as it is believed participants can forget powerful emotions they once experienced that are documented in reports, or they may forget things they said or did as it is difficult to return to the mind set of several months or even years earlier (Sandelowski 1993). This leads some participants to state that the account presented is not an accurate one of their experiences (Sandelowski 1993). I therefore did not intend,

nor at any time actually conduct member verification because it was not advocated by the theoretical framework selected for this study, because I wanted to portray a multi-vocal account of the accreditation and because I recorded most contact with participants using a Dictaphone and so I was confident the stories and emotions I recorded were accurate at that time.

Unlike member verification, an issue agreed upon among ethnographers is that research should be assessed on the importance of their topic and the contribution they make to existing knowledge (Hammersley 1998) - which are notably also key requirements of a PhD thesis. This study was designed with the intention of producing valuable contributions to knowledge and the subject of accreditation selected in particular, because of its increasing importance. The previous chapter illustrated the growing popularity of accreditation and highlighted the gap in existing knowledge on this subject, thereby demonstrating the importance of accreditation. The valuable contributions to knowledge this research has made are documented in the later chapters of this thesis and so this issue is revisited in the penultimate chapter.

A final strategy to assess ethnographic research is to address the issue of reflexivity, whereby researchers highlight the self-awareness of their role in the study and how they have contributed to the research (Hatch and Cunliffe 2006). Reflexivity is given prominence within the symbolic-interpretivist perspective as this position claims it is impossible for ethnographers to remain 'outside' of data, because the ethnographer is the tool through which the research is conducted and data collected. We naturally carry assumptions and values as humans and these influence the way ethnographers collect data, which is why symbolic-interpretivists advocate attentiveness to researcher reflexivity (Hatch and

Cunliffe 2006). Some ethnographers however, omit their identity from research either in an attempt to present themselves as objective social scientists (Kleinman and Copp 1993) or because they believe providing personal details will lead the reader to compartmentalize the ethnographers identity and place certain political assumptions associated with these on them (Cresswell 2007). Symbolic-interpretivists alternatively, draw particular attention to identity and believe it is an inseparable part of interactions and so as ethnographers must interact and engage with participants to obtain data, their identities are a contributing factor to the findings 'How the researchers position themselves within the context, process and production of the research, is of central importance in understanding the perspectives of the people being looked at' (Bannister et al 1995:37). It is equally important however, not to overindulge in reflexivity as it can overshadow the findings of the research 'as the Fijian said to the New Ethnographer "that's enough about you, let's talk about me"' (Stacey 2005)²⁹. I maintained reflexivity through this research and kept notes on this during the period of data collection. Additionally, to address this criticism further the following section makes my personal background and history explicit, which illuminates my potential influences and preferences within this research – but not to excess.

The Research Tool: Corrina

As is apparent from the front of this thesis, my name is Corrina Dickson. I am a white female of medium build, standing five feet and five inches tall without shoes, with blue eyes and shoulder length blonde hair. I was born in Newcastle

²⁹ This quote comes from Marshall Shalin, an ethnographer who conducted research on Fijians. He became increasingly frustrated with the self indulgence of many ethnographers who spent too much time documenting themselves, and too little documenting their participants.

upon Tyne, England in the summer of 1981 and raised there my entire life alongside my elder brother by our parents, who have now been happily married for almost thirty years. I was fortunate enough to have a very happy childhood, holding a close relationship to my extended family and in particular my grandparents who I spent a great deal of time with. To this day I still enjoy a good and close relationship with my family, despite living over three hundred and fifty miles away from them. As for the academic side of my childhood; I hated my school but stayed on because of my many good friends there. I disliked it so much because I always struggled to keep up in class and I found the rules of my strict all-girls catholic state school (such as 'no nail varnish') inane. I was nevertheless a well behaved student, never having received a detention or played truant. Despite my dislike for school, my parents encouraged me to stay on for A -levels, concerned I would be too distracted at college; I did stay on but my aversion grew as I was predicted two D's and an E at A-level. Having detested school so much and believing my predicted grades proved that learning was definitely not my forte in life, I did not seriously consider going to university. However on the day of my A-level results, I surprised my parents, teachers and indeed myself by achieving three grade B's and I began to feel my dislike of learning may well have been a result of the school, and not an inherent personality trait.

I had a subsequent change of heart about learning and called the University of Newcastle a few weeks before the beginning of term to find out whether they had space on any courses available. The first they mentioned was 'Sociology and Anthropology' and although I had no idea what either was, I told them I would take it immediately - a decision I have never regretted. I really enjoyed university and found myself able to flourish academically when given the opportunity to

study in my own way. I enjoyed it so much that I stayed on after graduation to take a Masters degree in 'Sociology and Social Research Methods'. After I graduated for the second time, I knew I wanted to remain in the academic setting and endeavoured to pursue a career as a social researcher. I had spent around six months looking for a suitable research post but had been unable to find many that really excited me, until I came across an advertised position for a combined research assistant and PhD student post at Bournemouth University. The advertisement stated the topic would be 'Practice Development' and after a week investigating what practice development was, I was further intrigued and applied. I was thrilled when I was offered an interview and ecstatic when I was offered the position. The subject of the PhD was predetermined as being on the subject of practice development, but as I designed and implemented every stage of it, I always felt ownership and control over the whole process.

So this is my life academically so far – having spent almost the entire period in full time education. However, I feel it's also important to show that I have not been a student to shirk the responsibility of getting a job as some may think; indeed I have also actually been in paid employment continuously since the age of fifteen. My first job was for the Department of Work & Pensions (DWP) where I worked every summer, Easter and Christmas vacation period until the age of twenty-one and continued to work there for the entire year that I was studying my Masters degree full-time. From the age of seventeen I also worked part time in a range of jobs such as a sales assistant in a variety of shops, a telephone sales advisor, a waitress and bartender. During term time I would go to school or university during the day and attend my other jobs in the evenings and on weekend, but in holiday times I would work at the DWP during the days and at my other jobs in the evenings and on weekends. I have always enjoyed working

in roles where I have direct contact with other people as I like working in sociable environments. The roles I have chosen to occupy and the subjects I have selected to study reveals information about the kind of person I am, the life choices I have made and my background so far, yet they do not give sufficient detail about my personality - what I am passionate about and what 'makes me tick'. To reveal this information I was reliably informed (as having never used one myself) that to 'really get to know someone' on a dating internet site, producing a list of likes and dislikes can reveal a great deal about a person's personality and so it is for this reason the remaining paragraphs of this section are dedicated to it.

I am a curious person, desiring to know how everything 'works' and as a result I like to learn about all kinds of things - from the construction of cranes to the philosophy of existentialism. I prefer reading books to watching films as I find it extremely difficult to sit both still and quiet for two hours when in the company of other people. My favourite genre of film and book is comedy; my preferred authors being Terry Pratchett and Barbara Pym and favourite film of all time Monty Python's 'The Life of Brian' (possibly attributable to my catholic upbringing!). I love to watch documentaries and docu-soaps on TV, particularly those focused on physiology as I like hearing about and watching real life stories. But what I hate to watch, read or listen to is anything science-fiction related.

I take pleasure in physical exercise, mainly walking and more recently completing assault courses; I also like mental workouts which is why I complete a crossword and Sudoku puzzle at least once a day. I am member of the National Trust and love to visit historical sites and I like to travel abroad. I am most in my element however, when surrounded by friends and family and I love being in

social situations. Second to this, I also really like to sleep (around nine hours per night or I am a little grumpy), to eat (but definitely not cook) and partake in self indulgent shopping sprees for shoes and clothes.

I have been a devout vegetarian for the last 16 years because of my love for animals and I would describe myself as a humanitarian and pacifist. Although I am not religious myself, I am happy that other people have faith they can take comfort in. I do not smoke and I am a virtual teetotaler, instead my vice being anything sweet and edible - in particular Yorkie chocolate bars which combine both of these elements.

So this is me - Corrina the research tool - in a nutshell. Documenting information about myself and my background allows readers of this text to pigeon-hole me and have my possible tendencies and prejudices drawn and assumed, thereby completing the symbolic-interpretive aim of having readers involved in the meaning-making process (Tietze et al 2003). I refer back to this information at several junctures to illustrate how these prejudices and preferences have affected decisions or thoughts when conducting this research. This is primarily achieved in the proceeding chapter which documents how data was collected using ethnographic research techniques.

CONCLUSION

The concept of symbolic-interpretivism was introduced in this chapter alongside documenting how it was the most appropriate theoretical framework to investigate the research aims of this study set out in Chapter Two, as it focuses on the multiple perspectives within organisational groups, how meaning is

created and how culture evolves. It was also established that symbolic-interpretivists conduct research using ethnography because of its ability to access the 'backstage' aspects of a group and enabling multiple perspectives to be gained within it.

It was the aim of this chapter to address theoretical aspects of both the selected guiding philosophical framework and method. It is for this reason the criticisms of ethnography (its inability to be generalizable and the issue of selective observation and interpretation) and the strategies to assess it (by addressing reliability, member verification, its contribution to knowledge and reflexivity) were documented. As part of reflexivity, this chapter ended by providing personal information on who I am and my background. This is to avoid presenting myself as an objective social scientist (Kleinman and Copp 1993) and in order for the reader to place their own political assumptions on me as a research tool, based on my personal details (Cresswell 2007). Addressing the theoretical aspects of symbolic-interpretivism and ethnography in this chapter allows the following chapter – which documents the practical undertaking of these – to be placed in context.

CHAPTER IV DATA COLLECTION

INTRODUCTION

This chapter addresses the practical application of ethnography as used in this research. It documents how participation observation was undertaken, including detail such as the length of time and intensity of fieldwork, how observations were selected and the difficulties I encountered when using this method for the first time. This chapter also documents how fieldnotes were used in this research and presents how and why interviews were utilized as part of this study.

The ethical considerations which influenced the design of this research and the subsequent data collection processes are discussed within this chapter and are followed by an outline of the additional unanticipated ethical dilemmas I faced as part of this research. These issues include the significance of the body in participant observation, the experience of becoming an insider among the participants and the many 'disconcerting experiences' I encountered conducting research in a health care environment.

PARTICIPANT OBSERVATION

Participant observation is the primary technique for collecting data in ethnographic studies and is given particular prominence because of its ability to access to the 'backstage' aspects of a group. Participant observation is literally the study of participants, which is achieved by noting verbal and non-verbal interactions, the environment in which interactions occur and the relationships between participants. The intensity and time of participant observation varies in

ethnographic studies, with some researchers living among participants day and night for many months (i.e. Evans-Pritchard 1937), others sporadically revisiting the same research site for many years (i.e. Nancy Scheper-Hughes 1993) and others still observing only certain events, finding it impractical to live among participants, such as Humphreys (1975) who studied cottaging³⁰ in the late 1960s. The extent of observation is dependent on both the nature of the study and the feasibility of the research setting (Cohen et al 2001) and for this research, approval was sought from the local research ethics committee who placed conditions on when I was able to observe.

The ethics committee felt it would be inappropriate for me to be based in a health care setting on a daily basis as I did not have a health care background and instead stipulated that I should visit the research site to conduct observation only when a practice development related meeting, event or interview was to be held. As the intention of this research was to investigate the accreditation programme, and not to follow the general everyday lives of practitioners in a health care setting, I had no objection to this decision and agreed to progress in this way. Retaining an 'outsider' perspective by not being based at the research site or taking an employed position there actually offered me many advantages, which I was able to discover later. For example, the participants in this research divided into groups based on their professional and hierarchical identities (which will be explored later in this thesis) and not being given a professional role among them allowed me to avoid being allocated one of these identities. This was particularly advantageous, as it will be documented later that barriers to each of the groups existed based on position and so remaining outside of this allowed me to move

³⁰ Cottaging is the practice of homosexual sexual acts in public toilets (Humphreys 1975).

freely between the different groups, which I would not have otherwise been able to do.

Observation was conducted over twelve months and after a further six month break away from the field I revisited the main participants to conduct final interviews. This eighteen month time frame was selected on the basis of the average length of time³¹ taken to complete the practice development accreditation programme. The first twelve months of accreditation focuses on the team who have attended the practice development induction days at the university returning to their health care environment and acquainting their colleagues with the ideology of practice development and process of accreditation. During this time projects to improve practice are undertaken and attempts to transform the culture are instigated. These developments are recorded in the submission document which is usually compiled in the final six months. The aim of this research was to focus on the group processes of becoming a practice development unit and not the production of the submission document (which is ordinarily undertaken by one practitioner) and I therefore deemed the first twelve months of this process to be the most critical and decided to spend this time conducting observation. The period selected for observation in ethnographic research is dependent on individual ethnographers, with some having spent three weeks observing (Ritzenhaler and Perterson 1956), others three months (Taylor 1991) and some nine months (Van Maanen 1983). The length of time spent observing is primarily dependent on the funding ethnographers can gain to conduct their research, which was also a constraint in this research. The funding for my PhD was restricted to three years which meant

³¹ This estimate was provided by the consultants of this programme at Bournemouth University.

I would be unable to observe a group until the accreditation was completed if they exceeded the eighteen month period. I did not find this problematic however, as it is commonly reported that fieldwork always could be conducted indefinitely, as groups continually evolve and so 'fieldwork is never done, it is just terminated' (Fetterman 1998:125).

Participant observation was conducted between May 2005 and June 2006, during which over forty four hours of meetings and interviews containing over fifty different practitioners experiences were recorded on a Dictaphone. However, in actual fact the total number of people I interacted with and number of hours I spent with participants was far greater than this, as while I used a Dictaphone to record the 'practice development' aspects of meetings and interviews, conversations before and after this about other matters were not recorded (one such conversation lasted over sixty minutes). In addition, I spent four full eight-hour days at the research site when canvassing for interviewees and I turned up on five separate occasions for meetings which were subsequently cancelled and so time was spent conversing with the participants who also showed up, which is not included in this total. The time spent exchanging emails and talking on the telephone is also not included in this total, nor were the two practice development 'workshop' days hosted by Bournemouth University and two days of practice development induction hosted by the core group which I attended with the participants. The total number of hours spent collecting data with the participants was therefore far greater than the forty-four hours captured on the recording, and the number of participants I interacted with far greater than fifty.

The primary interactions observed were those between the main participants – 'the core group' – who held weekly one hour Wednesday lunch-time meetings to

discuss practice developments and the accreditation as a whole. The other most frequently observed interactions in this study were those held between members of the core group and their staff to discuss specific projects to aid practice development. These lasted approximately forty minutes and were held sporadically – sometimes four in one week and other times one in nine weeks. A Dictaphone was used to record meetings to ensure all practice development information was captured, but also to enable me to focus on the non-verbal aspects of interactions which allowed further insight into the use of symbols and the power relationships. Before any meeting began, the participants were asked to sign a consent form which granted me permission to use any information for this research and to record the meeting using a Dictaphone (a copy of this consent form can be found in Appendix Four). Meetings were always held in one of two designated rooms at the research site, inside of which chairs were arranged in a circular shape. I would sit within the circle alongside participants although unlike them, I did not contribute verbally to the meetings aside from the rare occasions when I was asked a direct question. I did not remain silent before and after meetings however, where I would chat with participants to build rapport.

I found observing participants extremely awkward when I began this study, as it was the first time I had used this technique to conduct research. Prior to entering the field, I had consulted several ethnographic texts for advice on how best to conduct participant observation, some of which recommended limiting eye contact with participants and showing only a 'moderate degree of interest' (Sanger 1996:91) of interactions. It was on the basis of this information that I made the decision to always sit away from participants and remain silent when in their company, (aside from greeting one another) before I started to collect

data. However, it became obvious on my very first day of entering the field that this was not going to be possible. My first experience of observing participants was during two 'away-days' which were arranged by the core group (the main participants) to introduce their staff to the philosophy of practice development and to establish projects to undertake as part of this. These days were held away from what would be the normal research site in a large conferencing suite several miles away. I believed this presented me with a key opportunity to physically remove myself from the other participants on the days, confirming to them that I was more of an observer than participant. However, when I arrived at the first of the away-days, before I could begin to explain to the core group how I would be observing, I had a name badge stuck on my jumper and was herded into 'Group C'. As this was only my second meeting with the core group³² and my first time collecting data in this way, I did not have the confidence to tell them this was not what I had in mind and so continued in my role as a Group C member. Thirty attendees aside from the core group were present at the first away day, all of whom treated me with cautiousness and suspicion as I had not been formally introduced to them. I had the feeling they viewed me as a rather unpopular member of staff who did not have any friends to hang around with on the away day which was the reason why I spent most of the time on my own. Because of this I decided to be more assertive at the next away day (where I would meet another thirty members of staff) and inform the core group that I did not want to be allocated to a group but rather I wanted to observe from the sidelines. By the time of the second away day I had recited many times how I would phrase my request to the core group however before I could start and with a distinct sense of Déjà Vu, I had a name badge stuck on my jumper and was steered straight

³² The first was the occasion when they volunteered for this study, which is documented later in this chapter.

into Group C once more. Lacking the confidence again to protest, I instead decided to embrace my position as a Group C member and use the opportunity to discover how the attendees felt about the practice development process so far.

This clearly meant I could not avoid eye contact or act only 'moderately interested' in events and interactions as some texts (i.e. Sanger 1996) had advised and so I became concerned that I was not conducting participant observation correctly. I subsequently searched for other ethnographic accounts which may have detailed similar problems and was relieved to discover that in fact many ethnographers advocate the development of relationships with participants in order to obtain information (i.e. de Munck 1998). I was however wary of developing any close relationships with participants, in case this would later place me in a compromised position should I need to document information which would show them in an unfavourable light. How I maintained a balance in this relationship to enable me to attain information but at such a distance to ensure I could report all of this, is documented in the last section of this chapter where I outline my experiences as an insider.

My difficulties with participant observation as it is presented within the literature have been outlined in this section. A further tension existed however, between portrayals of participant observation in the literature and my own experiences - this related to the concept of participant observation itself. Several different categories of participant observation have been documented; Gold (1958) for example claims ethnographers can adopt one of the following observational styles:

- Complete participant: where the researcher becomes a member of the group and conceals their role as a researcher from the participant
- Participant as observer: where the researcher becomes a member of the group and reveals their role as a researcher to the participants
- Complete observe: where the researcher remains hidden from view or when in public arenas does not make participants aware that they are being studied
- Observer as participant: where the researcher sees their primary role to observe but participate as and when they desire

Adler and Adler (1994) alternatively claim ethnographers take one of three stances in participant observation. Firstly, they adopt either the position of a complete member researcher (where the researcher conducts fieldwork at a site where they will be or are already a member), an active member researcher (where the researcher participates in group action but does not commit to the values of the participants) or that of a peripheral member researcher (where the researcher develops the perspective of an insider without participating).

I did not find any description in the literature, however, resonated with my own experiences of participant observation. I found the notions of the complete observer and the complete participant unethical and in my case impossible to achieve as I was not based full time at the data collection site. Becoming a participant as observer or observer as participant would also have been impossible for me as I was not based at the research site for significant periods of time and the latter along with the role of the active member researcher was undesirable as I did not wish to influence the course of events by participating in this way. I found the role of a complete member researcher unsuitable as I did

not have experience of working as a health care professional, nor had any intention of doing so as part of this study. I also could not claim to have adopted the role of a peripheral member researcher as it was the intention of this research to explore a multitude of roles and voices; as will be revealed in later chapters, these perspectives were often contradictory and therefore no 'typical' perspective of an insider existed.

My tension with this role led me to adopt the label of 'non-participant observer' to describe my role in the field– as I primarily wished to observe participants and consciously did not partake in activities. However, I acknowledge that tension around this term exists. O'Reilly (2005), for instance argues that in becoming a participant the researcher must become involved with participants, take a subjective view and immerse themselves in the field. Alternatively, to be an observer the researcher attempts objectivity and consciously maintains a distance from the participants. These two roles are clearly impossible to achieve simultaneously and it is for this reason the term 'participant observation' has been referred to as an oxymoron by authors such as O'Reilly (2005). Yet in the absence of a more suitable term, it is how the one which I have selected to describe my role.

This chapter has so far demonstrated the tensions I experienced using the primary data collection technique in ethnography – participant observation. Other strategies for gathering data were used in this study, however and my experiences of engaging with these are outlined in the following sections.

FIELDNOTES

Fieldnotes are the written aspect of observation and are used to bridge observed interactions and the ethnographic finished product³³. Described in the literature as 'the brick and mortar of an ethnographic edifice' (Fetterman 1998:114) they are of central importance in ethnography. Yet despite this, fieldnotes are shrouded in mystery, being referred to as 'the secret papers of social research' (Van Maanen 1988) within the literature, with only two one-page examples having been published (Rapport 1991, de Munck 1998). As most ethnographic texts do not include examples of their fieldnotes or discuss what was recorded in them, opinions on what fieldnotes are vary widely (Sanjek 1990). Some authors describe them as 'literally those notes written by a researcher while in the field' and others refer to them as an ongoing field journal where impressions, working hypothesis and initial ideas are recorded (Schwandt 2001). Others still describe fieldnotes simply as any notes documenting conversations and observations, including diagrams, charts and lists taken whilst data collecting (Fetterman 1998).

The reluctance to include fieldnotes in ethnographic texts is attributed to attempts to preserve the privacy of participants (as they contain original names, making them more easily identifiable), attempts to protect the privacy of the researcher (as they reflect their personal thoughts and emotions) and also because of their complex nature as they represent a limbo between reality and the ethnographic production, between memory and publication, between a researcher's training and their professional life (Jackson 1990). As a result of the secrecy over fieldnotes, novice ethnographers have difficulty in deciding what to

³³ Which in this case, is this thesis.

write about (Le Compte and Schensul 1999a) and I was no exception as I became a 'data collecting omnivore' (Spindler and Spindler 1992:55) at the beginning of my fieldwork. I wrote as much as I could about the experiences of data collecting; including the smells (olfactics) and noises of the research site, clothing and physical appearance (such as uniforms), the physical layout, patients, group interactions, relationships, the subject of meetings and non-verbal communication such as facial expressions (kinesics), laughter (paralanguage) and silence. The Dictaphone was able to capture the oral information in meetings and interviews, but the audio recordings were not a complete snapshot of what occurred and I found non-verbal signs, such as a roll of the eyes or a disengaged look spoke volumes about the way a participant was feeling which they did not articulate verbally. My fieldnotes therefore allowed the recordings to be kept in context.

After only one month of observing I was conscious that participants were curious about what I was jotting down in my field diary (a plain, spiral notepad), as they would often glance at it when they thought I was unaware. Although nothing secret was ever written in the fieldnotes, I did not want my writing to become a distraction and so four weeks into the study instead of making substantial notes I developed abstract shorthand as an aide-memoir of important points. For example, if the participants were annoyed by a group member called Mildred for failing to notify them that she could not attend the meeting, I would write 'anyd M' which would remind me when I left the meeting that the group had mentioned that they were annoyed with Mildred³⁴. Using shorthand coding in this way enabled me to take fewer notes, which fortunately proved much less

³⁴ There was no coding framework developed for this, rather key words were written down in an ad hoc manner.

distracting for the participants and I was easily able to retain the information behind the codes for several hours after leaving the research site. To ensure this information was retained, immediately after a meeting or interview ended I would return to my car and elaborate on each of the shorthand codes and also describe the content of discussions which occurred both before and after the meeting or interview into the Dictaphone. I would then return straight to my office and type up these notes, as I was conscious that my memory could lose certain details 'too long a delay sacrifices the rich immediacy of concurrent notes' (Fetterman 1998:114). The recordings of the meetings or interviews were then transcribed³⁵ and kept alongside a print out of the fieldnotes to ensure all information was kept in context.

The fieldnotes also record my development as a researcher as they demonstrate my initial immersion in and gradual familiarization with the research setting and my ability to theorize about events using symbolic-interpretivism³⁶. Initially my fieldnotes illustrate aspects of 'culture shock' as the sights, sounds and smells of the research site feature heavily within them³⁷; in particular confusion over the different uniforms and the physical location of the setting. However as I became more familiar in the research site and with the participants, these elements were mentioned much less so. The earliest fieldnotes do not make reference to my inclusion or exclusion as an insider into the group, but as strategies to initiate this were started over the first few months, my status of both an insider and outsider among the participants begins to be mentioned in the fieldnotes. Several months into the study as I became familiar with the research site and confident

³⁵ The strategy for transcribing is detailed in Chapter Six.

³⁶ It is acknowledged in the literature that fieldnotes are dynamic and what is recorded in them changes as the data collection progresses (Schwandt 2001).

³⁷ Examples of this are provided in the last section of this chapter.

with the technique of participant observation, my fieldnotes changed from being mainly descriptive to mostly interpretive, where I theorized on notions of identity, power structures and relationships among the participants and discuss the more covert aspects of their culture. Fieldnotes therefore played a critical role in this study as they reflected my personal development but also enabled me to capture information about relationships, sights, smells and theories which the Dictaphone could not record. Fieldnotes also provided context to the transcribed material taken from the Dictaphone and as these both were utilised to record the accreditation journey and were dependent on each other to complete the entire story I classified material from both as fieldnotes. As such, throughout the remainder of this thesis the term 'fieldnotes' refers to all of this material.

INTERVIEWS

The final technique used to collect data in this study was interviewing; which plays a critical role in ethnographic research as it allows specific questions regarding participant views to be investigated (Leech 2002). Interviews were held with a range of participants in this research, primarily among those within the core group, but additionally with staff members of both wards under study and also the practice development consultant. Senior hospital managers and the consultants based at the research site were also invited for interview; however they did not respond and therefore did not partake in this aspect of the research.

Interviews with the core group were held every three months and with the rest of the participants in the study every six months to discuss issues raised from observation. A total of forty-four interviews were held with twenty-seven different participants; the length of which varied greatly with some lasting only

four minutes and others sixty-seven³⁸. I always consulted with the core group before approaching other participants for interview as they were my gatekeepers in this research. The core group recommended the best days to host interviews to ensure I potentially had a good number of volunteers and these days were normally a Wednesday and successive Thursday. On interview days I put up posters around the research site, explaining I was looking for volunteers to be interviewed about practice development and I would wait in a private room with the Dictaphone and a stack of consent forms and information sheets (a copy of which can be found in Appendix 5). The door of the room was left open until a volunteer entered, at which point it was closed and the 'engaged' sign placed on it to ensure we were not disturbed. In order to make sure that I gained the information I required (which had arisen from observation) and to explore any areas participants felt were important which I had not anticipated, I used semi-structure interviews with the majority of participants. Spradley's (1979) recommendations for interviewing were utilised to achieve this; where I asked both 'grand tour' (Spradley 1979:86) questions which related to the way a participant felt about practice development, such as *'How do you feel about the recent changes through practice development?'* and 'mini tour' (Spradley 1979:88) questions which referred to more practical aspects and were more specific such as *'What happens in a project meeting?'*. Interviews with the core group members were much less structured however, as I not only had more time allocated to spend with each of them³⁹ but also because they were the main participants in this study I had more questions about how they viewed the process.

³⁸ The length of time an interview took was dependent on the amount of information volunteered by the participant.

³⁹ Other participants I interviewed had not scheduled time to do so and therefore had to wait until they completed their duties or were on a break before being interviewed.

As rapport, described by Patton (2002) as being maintained through body language and eye contact, plays a critical role whilst interviewing, I chose not to make fieldnotes during interviews which allowed me to fully engage with participants and listen for any new pieces of information I could then ask them to elaborate on. I conducted core group interviews on separate days as they were often lengthy and were quite exhausting for me and so I was able to make fieldnotes after each one by returning to my car and speaking these into the Dictaphone. However this was not possible when I interviewed other participants as I often interviewed several per hour with only a short space of time in between. It was impractical to return to the privacy of my car to speak observational notes into the Dictaphone after each meeting, but it was also undesirable to do this in the interview room in case I was overheard. So instead I allocated myself a five minute break between interviews where I would keep the engaged sign on the door and I would make detailed written fieldnotes. As with all other fieldnotes, these were also typed up within a few hours of leaving the research site, after I returned to my office and were then kept with the transcript of the interview.

This chapter has thus far documented how data was collected: by spending hundreds of hours interacting with and observing participants, by keeping detailed fieldnotes and by conducting regular interviews. Figure 9 demonstrates this process as it was undertaken in this research. Given the personal and intense nature of ethnographic research, it is perhaps unsurprising that there are several ethical issues to consider when conducting this type of study. These are outlined in the following section.

STAGE 1	Initial Reading of Literature
STAGE 2	Determined Research Aims
STAGE 3	Ethical Approval Sought
STAGE 4	Negotiated Access to Field
STAGE 5	Ethical Approval Secured
STAGE 6	Entered Field
STAGE 7	Observations & Interviews Conducted
STAGE 8	Exited Field
STAGE 9	Data Analysed & Interpreted
STAGE 10	Final Exit Interviews
STAGE 11	Literature Review

Fig 9. Stages of Research

ETHICAL CONSIDERATIONS

Ethical considerations in ethnographic studies differ slightly from most other forms of research because of the methods used to gather data. Unlike other methods, ethnographers often witness illegal behaviours, or observe large numbers of people in the course of their research; many of whom (despite ethical guidelines to attain this) are not asked for their consent⁴⁰ (Le Compte and Schensul 1999c). While it is impossible to predict ethical issues which may present themselves prior to data collecting in the field as part of ethnographic studies (as the research site and participants are often unknown until this

⁴⁰ In my own research I inadvertently observed the interactions of car parking attendants, shop workers, patients, families and cleaners at the research site by virtue of the fact of being present there.

begins), five considerations have been suggested to address ethical issues when conducting ethnography. These are as follows:

- Special care should be taken when researching vulnerable populations
 - Participants should know who will be conducting the research and how to get in contact with the researcher
 - Consent must be gained and participants should understand what will be done with research
 - The privacy of participant must be protected
 - Protection from unnecessary risks from participating in the research must be given
- (Le Compte and Schensul 1999c).

The first of these refers to the issue of protecting vulnerable populations. This research sought to follow practitioners undertaking practice development accreditation; a group not classified by the ethics committee who granted permission for this research as 'vulnerable'. However as ethical approval was sought when the research site was still undecided, the ethics committee did place the condition that I was not to have contact with potentially vulnerable groups such as patients, should they be present at the research site. The second and third listed considerations were addressed by attaining written consent and the third and fourth by addressing the issue of anonymity. The issues of consent and anonymity are expanded on and discussed in the following two sections.

Attaining Consent

This section documents the considerations around consent from the list on the previous page; these are that participants should know who will be conducting the research and how to get in contact with the researcher and that consent must

be gained and participants should understand what will be done with research. To gain participants in this research, three sampling strategies were adopted. Firstly, an opportunistic sampling approach (Miles and Huberman 1994) was taken to recruit participants; fulfilled by my appeal for a group to take part in my research at a Bournemouth University practice development accreditation induction workshop (as I was aware that all delegates could be potential participants in this research). Secondly, a purposive sampling approach (Patton 2002) was taken to attain participants, as I required a group who were undertaking the practice development accreditation scheme, and those attending the workshop were committed to this process. Thirdly a convenience sampling approach (Colman 2001) was taken as participants volunteered to take part in this research – and this element is particularly important with regards to the ethical considerations of this study.

The main participants – the core group – volunteered to be involved in this study after I made a short presentation on a practice development induction programme which they, along with several other units, attended at Bournemouth University in April 2005⁴¹. As soon as they volunteered to be involved, I posted information sheets and consent forms to them and asked for all employees based at the research site whom I may have contact with during the course of the study to read and sign them. Once the study began, new staff were also given consent forms and information sheets to ensure I had the permission of all staff to be involved in the accreditation.

⁴¹ Further details on this are provided in the following chapter.

The information sheet documented that participation in this research was entirely voluntary and that participants were free to withdraw from it at any time. My personal email and postal addresses were provided in this sheet along with my telephone number, to enable participants to contact me to discuss the study further or ask any questions or withdraw their participation from the research. I was not contacted by any participants who had questions about the study, nor did anyone based at the research site refuse to take part or withdraw their participation. The information sheet also notified participants that information gathered from their meetings and interviews would be used to form part of my PhD thesis, would be submitted for publication in peer-reviewed journals and would be presented at conferences. The information sheet stated that I would provide participants with a summary of the research findings if they wished and so they were asked in interviews and meetings (and the core group several times by email and post) if they would like to receive such a report. No participants asked for this which is not an unusual occurrence in ethnographic research where it has been reported that participants are often uninterested in results 'research participants might not care, one way or the other, about the research which the researcher has so assiduously undertaken' (Van Den Hoonaard 2003:148). A summary of the research has been produced in the event a participant asks for this at a later date and a copy of this can be found in Appendix Six.

As stated earlier, written consent for this research to be conducted was obtained from all employees I may have immediate contact with at the research site. The ethics committee who granted permission for this research to be undertaken (the letter confirming this can be found in Appendix Seven) stipulated that each time I met with any participant, they needed to sign a consent form. This would

ensure ongoing consent from the participants and also would remind them that I was there to conduct research. As I met with the many core group members up to three times per week for twelve months, this created a great deal of paperwork and participants were often confused as to why they had to repeatedly sign these forms. However, this became a ritual of my spending time with participants and I felt it was a useful exercise because it reminded participants that what they were to discuss was being noted and recorded for use in my research study. The consent form explicitly asked for participants to grant me permission to use a Dictaphone to aid me in capturing conversations and no participants ever refused to have this used. It was reiterated when they signed the consent form however, that if they later changed their minds about having their opinions recorded, they should contact me and I would erase their statements from the research. The consent forms were deemed essential by the ethics committee, but the signature of participants present in a meeting or an interview on these clearly has implication for anonymity. This issue is addressed in the following section.

Anonymity

This section addresses anonymity from the previously listed issues of considerations in ethnographic research (page 75); these are that the privacy of participant must be protected and that protection from unnecessary risks from participating in the research must be given. As with most ethnographers I had to obtain ethical approval for this study to take place, a process which places importance on participant anonymity in research. Precautions were taken to try and ensure this happened, but complete participant anonymity is extremely difficult in ethnographic research 'While anonymity is a widely-held goal in research-ethics review policies, it is ... a virtual impossibility in ethnographic research' (Van Den Hoonaard 2003:141). The anonymity of participants is

difficult to maintain in ethnographic research as reports need to describe events or participants in detail to give readers a sense of the group under research. Trying to do this without providing some markers which could disclose those under investigation is almost impossible (Le Compte and Schensul 1999c).

I could not guarantee in my own research that the participants within the research site would not be able to identify one another. I did however endeavour to ensure that those outside of it did not recognise the group from my reports and this was achieved by giving pseudonyms to the participants and the research site. It was made explicit in the participant information sheet that pseudonyms would be given and anonymity to those outside of the research site would be achieved by doing so:

All details such as the organisation name and names of the participants will be changed. Any personal details that could make someone identifiable to people outside of the organisation, will be changed

(Information Sheet, Appendix Five).

In the interest of protecting the anonymity of the participants of this study, the letter of approval from the local ethics committee granting permission for this research to proceed has certain details removed. Bournemouth University currently has units seeking accreditation from a variety of regions - Kent, Hampshire, Dorset, Wiltshire, London and Northern Ireland - and revealing the name of the local ethics committee would reveal the locality of the research site and could make participants more easily identifiable. To help protect the anonymity of participants such details were therefore eliminated. To ensure as few people as possible ever encounter the fieldnotes, recordings or transcripts

taken as part of this research (which all contain original names), this material was never shown or given to any other persons and has been kept in my personal locked filing cabinet at my university office. At the end of this research project, this material will then be handed to the department administrator who will place it in secure storage for five years, after which it will be destroyed in accordance with Bournemouth University regulations (Institute of Health & Community Studies, 2004).

It was stated at the beginning of this section that a further concern to address when conducting ethnographic research is that participants encounter no unnecessary risk for participating in it. This was achieved by keeping personal details about the participants' private lives confidential. It will be documented in the following section that the core group often told me in private many details about their personal lives. This information could make them more identifiable and may have ramifications within their personal lives if it was published and so it was for this reason all pieces of information about the participants personal lives were erased from this research. Additionally, participants often made statements which may potentially have placed their employment in dispute, which would be followed by a request from them for everyone to keep the information confidential. This was always maintained to ensure participants encountered no risk to either their personal lives or professional careers as a result of partaking in this research. Aside from the ethical considerations recommended to address when conducting ethnographic research from the literature, I found other issues important to contemplate when undertaking this kind of study. These are as a result of the personal and intensive nature of ethnography and are detailed over the next section.

ISSUES IN DATA COLLECTION

There were three main issues I encountered when observing the participants; these centred around the significance of the body, becoming an insider and disconcerting experiences I stumbled upon at the research site. These issues are all unique to the method of data collecting through ethnographic research and as will become apparent, all provided me with a 'rites of passage' as a novice ethnographer.

Significance of the Body

The body and physical appearance of the researcher plays a key role in ethnographic studies as the ethnographer is the research tool, which is why my physical appearance was outlined in the previous chapter. All bodies have a multitude of cultural codes inscribed on them and as a white, English female this could have been problematic had the participants been of a different gender or race to me. However the core group and indeed the majority of the participants were all also white, English and female, with many of them similar in age which helped my ability to fit in with the group. This was further assisted by virtue of the fact that the core group were a range of different weights and heights, making my own physical build relatively insignificant. Being able to physically fit in with a group aids the researchers ability to bond with them, demonstrated in several pieces of research which illustrate that 'people prefer others who are similar to themselves in physical attractiveness' (Locke 2003:285).

As alluded to earlier in this chapter, I lacked confidence at the beginning of this study as this was my first experience of using ethnography. As a result I sought advice from ethnographic texts and on the recommendation of several authors (i.e. Sanger 1996 and Hammersley and Atkinson 2007) I tried to further 'blend in'

with participants by mirroring their clothing. While their uniforms varied somewhat, they all consisted of either full length trousers worn with a tunic top or polo shirt, or a plain calf-length short-sleeved dress. The participants also all adhered to a dress code of minimal jewellery, flat shoes and hair tied back or in a short crop. Because of this I never wore a skirt above calf-length, instead opting for the majority of the time to wear black trousers and a plain black jumper. I also ensured my hair was always kept tied back, that I wore only minimal make up and was jewellery-free whenever I met with the participants. My attempts to blend in by mirroring their clothing were scuppered however, on one occasion when a meeting was called at short notice. In order to attend it I had to get to the research site immediately, meaning I did not have time to change my clothing, hair or make up. When I arrived at the research site my hair was down as I did not have a tie for it, I was wearing a bright turquoise skirt and white cardigan (a far cry from the usual black ensemble), I had on eye shadow and lipstick and had forgotten to take out my long earrings. I was struck by the brightness of my outfit as I stood in stark contrast to the participants in their uniforms when I arrived and I was concerned at drawing so much attention to myself. However I was surprised by the positive response from the participants, who informed me how 'refreshing' it was to see someone out of the usual NHS uniform and wearing so much colour.

Revealing my personality through my dress and showing myself as a person and not just a researcher in this meeting became a key bonding moment between myself and the participants, who I felt warmed to me as a result. After this I wore my normal attire whenever I met with them and this continued to strengthen our bond, illustrated by my fieldnotes which are scattered with comments regarding

my appearance “*they liked my eye shadow*” (02.09.05 Fieldnotes⁴²), “*and she said ‘oh you’ve got those lovely shoes on again’*” (08.09.05 Fieldnotes). The significance of the body and how it is used has been explored in some ethnographic texts which I read before undertaking this research. However, I found the direction of these texts to blend in with participants by mirroring their dress (i.e. Sanger 1996, Hammersley and Atkinson 2007) actually prevented bonding with the group in this research and in fact it was expressing myself through my clothes and standing out - not blending in - which allowed me to attain insider status. This position of insider came with its own array of problems however, which is explored in the following section.

Becoming an Insider

The ease at which I became an insider among the participants in this research was to a great extent attributable to the core group who from my first meeting with them were warm and welcoming towards me, including me in conversations and jokes. I made them aware from the beginning that my knowledge of health care was limited because my background was in social science and so in the early days of data collection, the core group explained many health care terms and phrases to me. They also explained the current political climate in the wider organisation, for example on one occasion they were discussing water-coolers which had been placed on each ward within the research site. Aware that I would not understand the significance of this, the participant sitting next to me explained the long struggle employees had faced with their senior managers to have water-coolers purchased. She informed me that a new manager had recently taken over and had immediately purchased the

⁴² This refers to information obtained from fieldnotes created on this date. How data was analysed is documented in Chapter Six.

water-coolers to send out a strong visual message about her newly attained position. The core group were always willing to help me obtain information I required and when they learned after several weeks that I wanted to copy all of their documentation, without me even requesting so they would email me documents and photocopy their notes for me. They were also completely supportive when I asked to interview other staff and even gave employees time off from their duties to partake in these.

I felt truly established as an insider once the core group began to tease me when in meetings, as they did this with each other; my delight at being included in their banter is evident throughout my fieldnotes "*I really am feeling like a part of their group*" (03.08.05 Fieldnotes). I was assured I had achieved insider status among the core group, as they would discuss personal pieces of information about themselves (which included general issues such as marriage, children and family) but also during individual interviews, pieces of very sensitive information. The participants differed in the amounts of personal information they shared with me, one of the core group for instance revealed intimate personal details about her private life to me for over an hour after a meeting one day, during which I barely spoke as she clearly wanted to discuss herself at that time. Other participants used what I termed 'exchanging techniques' where they revealed a personal piece of information about themselves and then provide a verbal cue for me to reveal something personal about myself in exchange (usually in the form of a question such as "*Have you ever had something similar happen to you?*"). I always provided the information they requested as I was conscious of the importance of self-disclosure in developing trusting relationships with participants (Rickards and Clark 2006):

when investigator and participant build a trusting relationship together they create a safe and open environment in which the voices or opinions and views of the participants emerge in an authentic way (Le Compte and Schensul 1999a:12).

It was also the revelations about other participants' personal details which led me to believe I had achieved insider status. The core group discussed in front of me confidential information about staff during recordings (they were aware they were being recorded as had signed a consent form for this at the beginning of each meeting and the Dictaphone was placed in a visible position) which was often preceded by the phrase '*this is confidential*' (08.12.05 CG meeting⁴³) or '*this is in confidence*' (01.02.06 CG meeting). The core group trusted I would keep information they requested to remain confidential as such and this trusting relationship indicated that I was viewed as one of them. This was confirmed by a close friend of one of the core group who revealed a private piece of information about the core group member when I inquired of her whereabouts. The member of staff informed me where she was and revealed the level of trust needed to do so '*She doesn't want any of the staff at the hospital to know, but I know she won't mind me telling you because she really likes you*' (26.10.05 Fieldnotes).

I enjoyed the status of being an insider among the core group, but I equally enjoyed my position of remaining simultaneously an outsider, which was possible by virtue of the fact that I was not based at the research site (and so remained outside of the tensions and relationships there). Fieldworkers who conduct research in health care settings by working as an employee have revealed tensions over the dual role of health care professional and researcher

⁴³ This refers to information obtained from a core group meeting held on this date. A full explanation of how data was analysed can be found in Chapter Six.

(i.e. Borbasi et al 2005). These ethnographers reported experiencing a sense of conflict as they felt their loyalties were divided at times between these roles, which often were situated at odds to one another (Savage 2000), a problem I had the advantage of avoiding. As I had no previous experience of working in health care, I did not approach the research site with any position on the hierarchical scale, which enabled me to access a range of staff I otherwise may not have been able to had I been given a occupation. I did not arouse suspicion conducting interviews as I was an outsider and so clearly had no ulterior motive to the questions I posed and I was able to ask about anything without 'stepping beyond' my status, which as a low-grade employee I may have been chastised over. My non-health care background served further benefit as I was able to engage in the research site with 'fresh eyes'; learning the language, hierarchical system, professional divisions and rules of interactions for the first time. Ethnographers with an established health care background would have been unable to recognise many of the issues which were so obvious to me:

Insiders may see the problems and have ideas on how to correct them, but they don't necessarily see the root cause because they are looking through their organisations cultural lenses. They don't question the system; they are totally entrenched in their organisational routines and just accept the way things are

(Klein 2004:10).

I valued the friendship the insider status I attained with the core group, however as detailed earlier I was conscious that this could cause complications if it was extended into my private life. I was particularly concerned that if I developed a close friendship with any of the participants either in or outside of the research setting, I would find it difficult to write anything which could show them in an

unfavourable light if I needed to (a tension also experienced by Taylor 1991). The opportunity for expanding my friendship in this way with several of the participants was presented on a few occasions, in particular after I moved to a property closer to the research site. Because most of the participants lived nearby to my new property (as it was closer to their place of work), I often saw them in the same restaurants or shops. One prominent example occurred early in the study when I was in the bread aisle of my local supermarket and I caught a glimpse of the back of one of the participants. I was awash with concern over whether to speak to her or not, as I was anxious she may have felt that I had placed myself in a friendship role to her away from the research site. I made the decision not to speak to her as this would be a definite form of action and I instead hid in the jam aisle for five minutes to avoid her seeing me and to make sure I would not be placed in any further predicaments. A further example of my friendship quandary with the participants occurred approximately four months into the study when a participant invited me to visit her new house, which was situated quite literally around the corner from where I lived. I got on very well with the participant and I would have liked to see her home, but not wishing to potentially sacrifice the research study by building a friendship in case I needed to report unfavourable information about her, I fabricated an excuse as to why I was unable to visit.

While I chose not to extend my friendship with the participants beyond the site of this study, I found spending so much time with them, sharing in the highs and lows of their accreditation journey and having had them participate in my personal journey as a researcher, left me with a strong bond to them. This was particularly poignant with the members of the core group and my final interview

with them before leaving the research site for a six month period was sad and emotional:

'I know I will really miss Kate and Jenny, they are so lovely. It has been very emotional saying our farewells, as this could be the last time we see each other' (06.06.06 Fieldnotes).

Gallmeier (1991) has suggested that field researchers often experience such difficulties when disengaging from participants, which makes the process of exiting the field equally as significant as gaining entry to it (Gallmeier 1991). This was certainly the case in my experience but while I was saddened at exiting the field after a twelve month period, knowing I would return to interview participants at the end of the eighteenth month was reassuring. During this period I was able to come to terms with the fact that I would see the participants only one last time, when I returned. Reducing the contact I had with the core group through email and telephone calls over these six months allowed me to gently disengage from them and although the final interviews with the core group were still sad, this emotion was less strong than at the previous interviews. It was this gentle separation from the participants that made me feel finally felt ready to accept I was leaving them for the last time. Struggling over my identity of being both an insider and an outsider was emotional and often uncomfortable; however there were many more experiences which invoked these emotions during this study, as the following section illustrates.

Disconcerting Experiences

I was completely unprepared for the many emotional difficulties I encountered as a result of data collecting in a health care research setting, as ethnographic texts had not previously reported similar issues. When I first began to collect

data I would arrive for a meeting or interview fifteen minutes ahead of schedule to give myself sufficient time to set up the Dictaphone, pull the consent forms and information sheets out of my bag and position myself in a good place to watch and listen to interactions. However a series of 'disconcerting experiences' which occurred from three months into the study, forced me to no longer arrive so early and instead wait in my car until two minutes before the scheduled start time of the meeting or interview. The first of these disconcerting moments occurred in August 2005 as when awaiting the core group to arrive for a meeting, I overheard an elderly female patient sobbing and crying to go home:

"As I walked to the meeting room, an elderly female patient was whimpering and crying; she was breaking her heart and sounded exhausted. She wasn't aggressive or violent like some of the other patients; just utterly sad. She kept saying gently 'I just want to go home. Please let me just go home'. She sounded so distressed and desperate, and I felt so helpless. No staff went to comfort her the entire time I was there which was absolutely crushing. I really wanted to go and see her, hold her hand, console, reassure her; I really wanted the nurses to do this for her. But they didn't and I didn't dare, with visions of the ethics committee reminding me that I am not to have contact with the patients. So instead she was left to cry alone, probably feeling terrified and lonely and I feel terrible for that" (03.08.05 Fieldnotes).

This incident caused an unexpected emotional dilemma for me as I struggled with my desire to go and comfort the patient as a fellow human being, but knowing as a researcher I was not permitted to do so. I knew that I may have scared or confused the patient by going to see her and so this was the deciding factor why I did not visit her, however I found myself surprisingly angry that the staff did not go to comfort her either⁴⁴. The proceeding weeks presented other

⁴⁴ The distress I felt and emotional link to the patient was most likely a result of the close relationship I shared with my own grandparents (as detailed in Chapter Three), which possibly made me more sensitive to incidents such as these with older patients.

distressing incidents; one where I had to helplessly watch as an elderly man struggled to get himself to the toilet and another where a nurse became irritated with an elderly male patient who was having difficulty taking a drink. A further incident I witnessed was an elderly female patient frustrated to the point of tears that she could not reach a book she wanted to read and having her calls for assistance ignored by the staff. After these, I experienced one more troubling incident which pushed me to my limit and led me to make the decision to no longer wait in rooms at the research site for the fifteen minutes period prior to meetings or interviews. This incident involved a female patient and is best described by the following extract taken from my fieldnotes:

"An elderly lady emerged from bay C – she was ghostly pale and had a tiny frame. Her hair looked unkempt and she was wearing a thick jumper, skirt and tights, despite it being really hot today; she looked in need of some good TLC. She shuffled towards me and I could hear the ethics committee ringing around my head again, telling me that I mustn't have contact with patients so I tried not to make eye contact with her and instead rooted around in my bag, pretending to look for something. She neared closer and closer and closer until she was virtually touching my toes and as I looked up she was staring right at me. I said 'Hello' and desperately searched for a member of staff to take me away from the situation, worried that this could jeopardize my study - but no one was around. An uncomfortable silence ensued so I broke it by saying 'Were you on your way to watch some Telly?' and beckoned her towards the TV opposite, hoping she would leave so I was no longer in this predicament. She asked me 'What are you here for?' and I told her I was there to see the Sister. After a few seconds she turned around and grabbed hold of something protruding from her bottom, under her skirt, and said to me 'This is making me feel really uncomfortable. Feel it, it's horrible. It really hurts me'. I realised that what she was holding was her huge incontinence pad which looked like a duck tail poking out from under her skirt and out of her tiny frame. It looked damn uncomfortable and I was overcome with a rush of sympathy for her (where is the dignity in this?). I said to her 'Oh I'm not a nurse, I can't, I'm sorry' and after a few minutes she shuffled off somewhere and I was relieved But then she returned. She asked me to take her to bed and I explained again that I wasn't a nurse, while scouting the ward

frantically for someone to take her to bed - but no one was around. After a few more seconds she stared dead straight right into my eyes again, but this time she looked different; her eyes were wide and pupils smaller and she looked absolutely terrified – literally like a rabbit caught in headlights. She asked ‘What was I doing again?’ and looked so frightened. She clearly had no recollection of where she was, what she was doing and who I was. I’ve seen this terrified look before, and I felt so helpless” (02.09.05 Fieldnotes).

While I was obviously troubled by these experiences as the extracts from my fieldnotes show, I did not witness anything out of the ordinary or what could be classified as terrorizing - no war or murder like some ethnographers do.

Ethnographic texts are often the product of researchers who have witnessed horrendous events, such as the ritual sexual abuse of children (Herdt 1993) and purposeful child neglect and murder (Scheper-Hughes 1993). Ethnographers seek to study human life which is in fact distressing and troubling and so these emotions and experiences have to be encountered. Ethnographic research is a powerful emotional journey where the researcher develops friendships and associations, but also has to hold back from influencing the natural series of events, just as I had to by not assisting patients. It is only through this journey that ethnographers are able to produce the rich narrative accounts and unique insights into how cultures work and so I therefore view the disconcerting experiences I encountered as a ‘rites of passage’ in becoming an ethnographer.

CONCLUSION

This chapter has documented why ethnography is selected as the research method for symbolic-interpretivists (because of its ability to access the backstage areas of a culture) and also how data was collected for this study. Details of how and when observation was conducted and the advantages of using this technique

as a non-health care professional were discussed. How and why fieldnotes were taken and their reputation as the 'secret papers' of research were explored, alongside details of how, when and why interviews were conducted in this research.

Finally, this chapter concluded by detailing the issues I faced when using ethnography for the first time as part of this study. These issues included how I learned to use my body as a way of bonding with participants, the dichotomy I experienced at being both an insider and outsider to the group and the disconcerting encounters I faced when conducting research in a health care environment for the first time. This chapter addressed the practical aspects of how data was collected as part of this research in preparation for the following chapter, which documents with whom and where data collection took place.

CHAPTER V

THE RESEARCH SETTING

INTRODUCTION

This chapter introduces the research setting and participants of this study. It begins documenting the research site by detailing its history, physical layout and surrounding area and outlines the core group and other significant figures in this study. My initial meeting with the participants and my first experience of visiting the research site is also documented and described in detail. Finally, this chapter ends with an overview of the series of events which unfolded over the twelve months spent in the field with the participants. Providing this information and setting the scene of the research enables the proceeding chapters of this thesis, which discuss these factors in more detail, to be better placed in context.

TEMPERLEY HOSPITAL

This study took place in a picturesque ancient market town located in a semi-rural region of England called Temperley, which had a small population (almost forty-five thousand people) of an equal number of males and females living in the town. The majority of Temperley residents were over the age of fifty, white, Christian and were born in the UK⁴⁵ (2001 Census Data). Because the majority were over the age of retirement, almost a third of residents described their general health as poor with many of them requiring treatment for illnesses associated with ageing (2001 Census information). The only hospital in the town of Temperley was the research site for this study – Temperley Hospital – which was a small building with just two-hundred beds to accommodate admitted

⁴⁵Only eighteen hundred residents of Temperley were born outside of the UK (2001 census data).

patients. Originally built as a workhouse in the 1800s, it was later used as a military hospital during the first and second world wars and was the main hospital for the surrounding towns up until the mid-1990s, when a large hospital – Whitemead – was built in the next town. Because most patients received treatment at Whitemead, in 2005 Temperley Hospital was renamed as Whitemead's rehabilitation directorate. As a result the majority of wards at Temperley were transformed to become entirely rehabilitation focused and so this study focuses on two wards within Temperley Hospital – Willow ward and Oak ward – which were rehabilitative. Patients receiving treatment on Oak and Willow wards were all over sixty years old and had been admitted after enduring either a fall or stroke. However as the majority of residents in the town of Temperley were elderly, and consequently so were the majority of patients, most of the patients also suffered from varying forms and severities of dementia.

Oak and Willow wards were situated next to each other with only a small room dividing them, as Figure 10 shows. They were almost identical in layout and therefore had the same capacity for patients (Figure 11 shows the floor plan of one of the wards) and the two wards treated patients with the same needs, using a similar staff quota. Situated next to Oak ward, represented by 'E' on the Figure 10 was an already accredited practice development unit – Elm Ward – who first began the accreditation program with Bournemouth University in June 2003. Elm ward successfully attained accreditation status within eighteen months and had maintained this ever since. Having documented the locality of this research, attention is now given to the key figures within it.

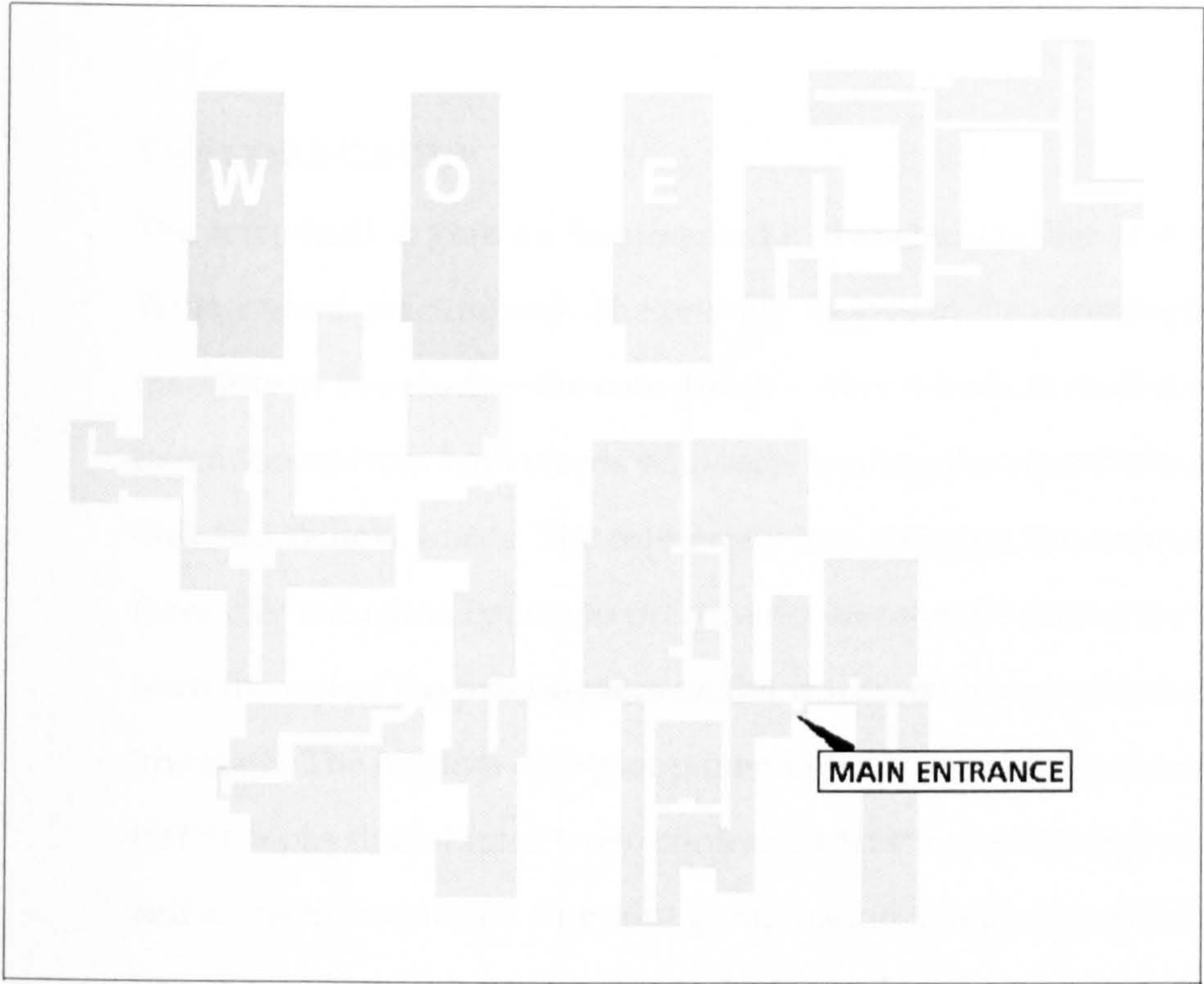


Fig 10. Temperley Hospital
Floor Plan

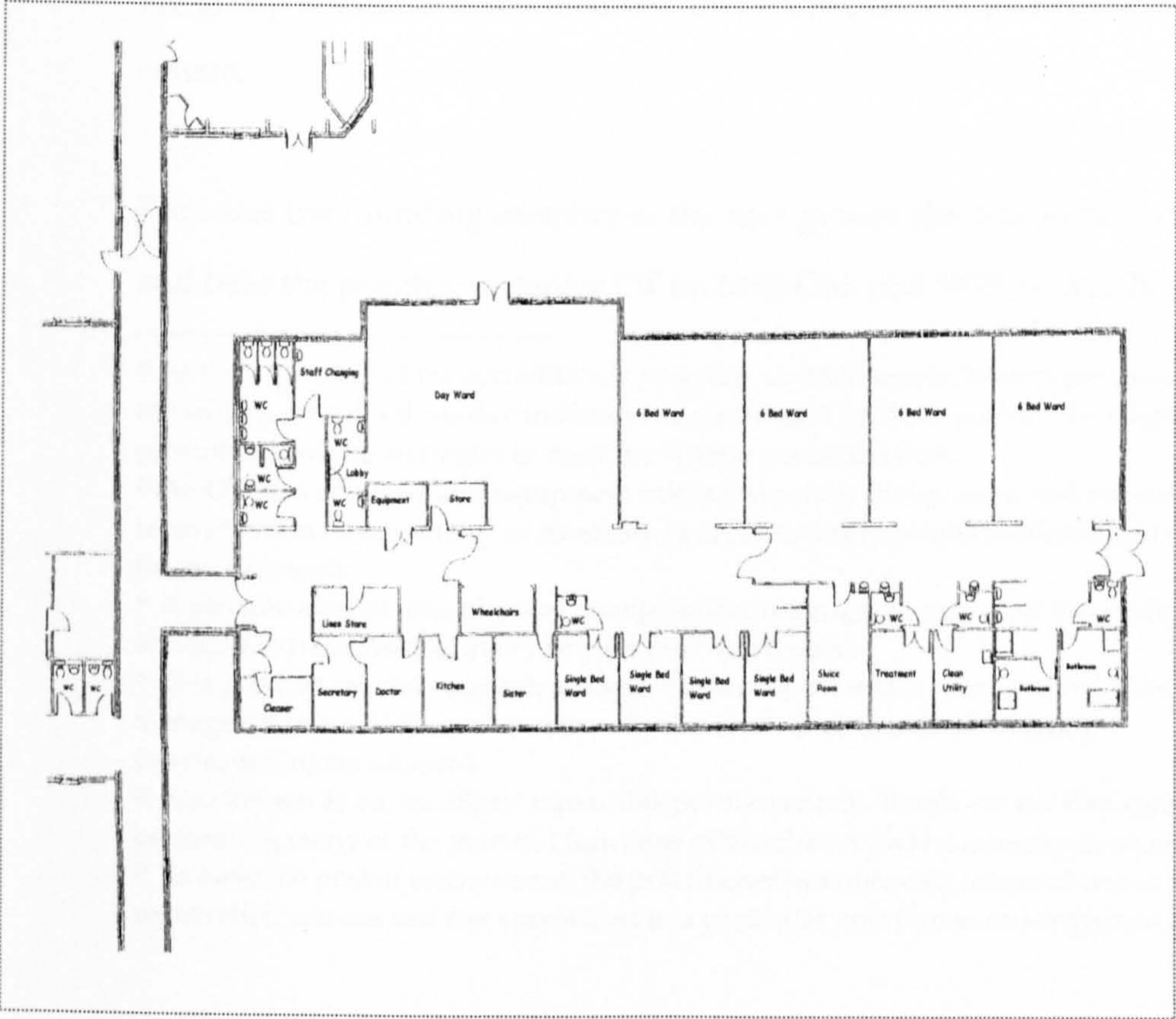


Fig 11. Layout of Oak Ward

THE CORE GROUP

The accreditation journey documented in this study is that of the Oak and Willow ward practitioners. The primary figures in the accreditation and therefore in this study – the core group – were a team of multidisciplinary practitioners from both wards who were leading the accreditation attempt on Oak and Willow wards. The core group had attended Bournemouth University's three day induction course to practice development⁴⁶ and so are differentiated from the rest of the practitioners on the wards, who are collectively referred to as 'the staff'. The original core group members were an occupational therapist (OT⁴⁷), a physiotherapist⁴⁸, two clinical leaders⁴⁹, a health care assistant (HCA⁵⁰) and a practice educator. The core group membership underwent several changes however, which will be documented later in this chapter. One change was the recruitment a new member – a senior staff nurse⁵¹ – who was the only person in the group not to have attended the university practice development induction course.

Kate was the founding member of the core group; she was in her late twenties and held the position of senior OT on both Oak and Willow wards. Kate had

⁴⁶ At the beginning of the accreditation program, up to five practitioners per group undertaking the scheme attend a three day induction course hosted by three practice development consultants, where strategies to meet the criteria are established.

⁴⁷ An OT uses activities and equipment involved in daily living, work and recreation to assist recovery from illness, injury or disability in order to improve independence and the quality of life (www.oed.com).

⁴⁸ A physiotherapist uses physical manipulation, massage, exercise and the application of heat and light to treat disease, injury or pain (www.oed.com).

⁴⁹ This position requires assuming responsibility for the entire ward and involves a more managerial role which consists more of paperwork than 'hands on' nursing (www.nursingnet.uk.com).

⁵⁰ Also known as an 'auxiliary' nurse, this position entails 'hands on' nursing care and performing many of the practical functions of ward work (www.nursingnet.uk.com).

⁵¹ To have the post of senior nurse, the practitioner has normally attended one or two post-registration courses and has specialized in a particular area (www.nursingnet.uk.com).

been a student at Temperley Hospital nine years prior to obtaining this role and returned to the hospital as a fully qualified practitioner in 2003. As an OT, Kate worked for the Therapy Department at Temperley Hospital, which meant she was present on the wards when treating patients but she was not permanently based there. Rather, lunch breaks and the completion of paperwork would be undertaken in the Therapy Department's allocated office situated at the opposite end of the hospital to Oak and Willow wards. Jenny, another core group member was also in her late twenties and had worked at Temperley Hospital for several years, holding a senior physiotherapist position on both Oak and Willow wards. Similarly, Jenny worked for the Therapy Department and so would return to her allocated office when not treating patients.

Margaret was another founding member of the core group – she was in her early forties and occupied the clinical leader position on Oak ward. By 1995, Margaret had worked on both Willow and Oak wards as a staff nurse and had worked on other departments within Temperley Hospital, but in September 2004 she returned to Oak ward to assume the clinical leader position. Occupying the reciprocal position on neighbouring Willow ward was Christine, a clinical leader in her late forties. Christine had joined Temperley Hospital in June 2004 where she worked on Willow ward as senior nurse, however after only a few days in this position the clinical leader of Willow ward took leave due to an illness, which left Christine in charge as the 'acting clinical leader'. After several months it was announced that the original Willow ward clinical leader would not be returning and Christine was given this position permanently. Working alongside Christine on Willow ward was a further core group member Anna, a senior HCA in her late thirties, who had worked at Temperley Hospital since 1999.

The last member of the original core group was Angela (in her mid-fifties) who had been employed as a practice educator since 2002. Her role was established to support student nurses on placements and therefore was a joint appointment between Temperley Hospital and the local university. This meant Angela was not permanently based on either Oak or Willow ward, but rather in an office at the other end of Temperley Hospital. Finally, Emily was the only member of core group who joined later and was not involved in the accreditation from the beginning. Several months into the accreditation Emily, a senior staff nurse in her late forties who was based on Oak ward, was asked to join the core group. She had been employed on Oak ward since November 2004 but prior to this she had worked as a staff nurse on Elm ward for five years and so had already been part of a successful practice development unit accreditation before. The core group were at the very centre of this research, but several other key figures are featured heavily throughout this thesis because of the pivotal roles they played within the accreditation attempt; these are detailed in the following section.

Other Key Figures in this Study

The first key figure outside of the core group who played a critical role in the accreditation was Theresa, the practice development consultant allocated to the core group by Bournemouth University. She was employed by the university to guide and assist the core group through their accreditation, providing up to thirty hours of support to them at their request. The core group contacted Theresa if they encountered issues or problems which they were unsure of how to overcome. She would arrange meetings with them at the hospital to discuss possible solutions and after which she would produce a 'visit report' which was submitted to the University as a record of the group's progress. Theresa became a practice development consultant after successfully leading a development

accreditation herself whilst working as a directorate senior nurse at a local hospital. She had worked with over eighteen units seeking accreditation since taking on this role in 2002, many of which - like Oak and Willow wards - contained multiple teams within them⁵².

Other significant figures in the core group's accreditation journey were Abigail - the general manager of Temperley Hospital - and Rosemary - a senior clinical leader - who were collectively referred to as 'the management team' or 'the management'. Both Abigail and Rosemary joined Temperley Hospital in October 2005 and therefore had not been involved in arranging the funding for the Oak and Willow ward accreditation; however they did subsequently play a key role throughout the rest of the accreditation journey as the following chapters will demonstrate. Two additional significant figures in the accreditation were Helen and Megan. Helen (in her mid fifties) had worked at Temperley Hospital for several years on many different wards after returning to it from pursuing her career in a nursing home. She replaced Christine as the clinical leader on Willow ward in January 2006 on a temporary contract and was assisted by Megan, a senior staff nurse in her forties. Megan had worked at Temperley Hospital since 1997 having originally been employed as an HCA, however during this time she successfully became qualified as a nurse and was temporary seconded at the same time as Helen to lead Willow ward.

The roles of the core group members, the relationships between them and the other significant participants (illustrated in Figure 12) played a critical role in the accreditation, which the forthcoming chapters will demonstrate. Prior to this,

⁵² For example, one practice development unit Theresa facilitated had thirteen teams within it.

having introduced the research setting and the key figures within the accreditation so far in this chapter, my first encounters with both of these is now presented.

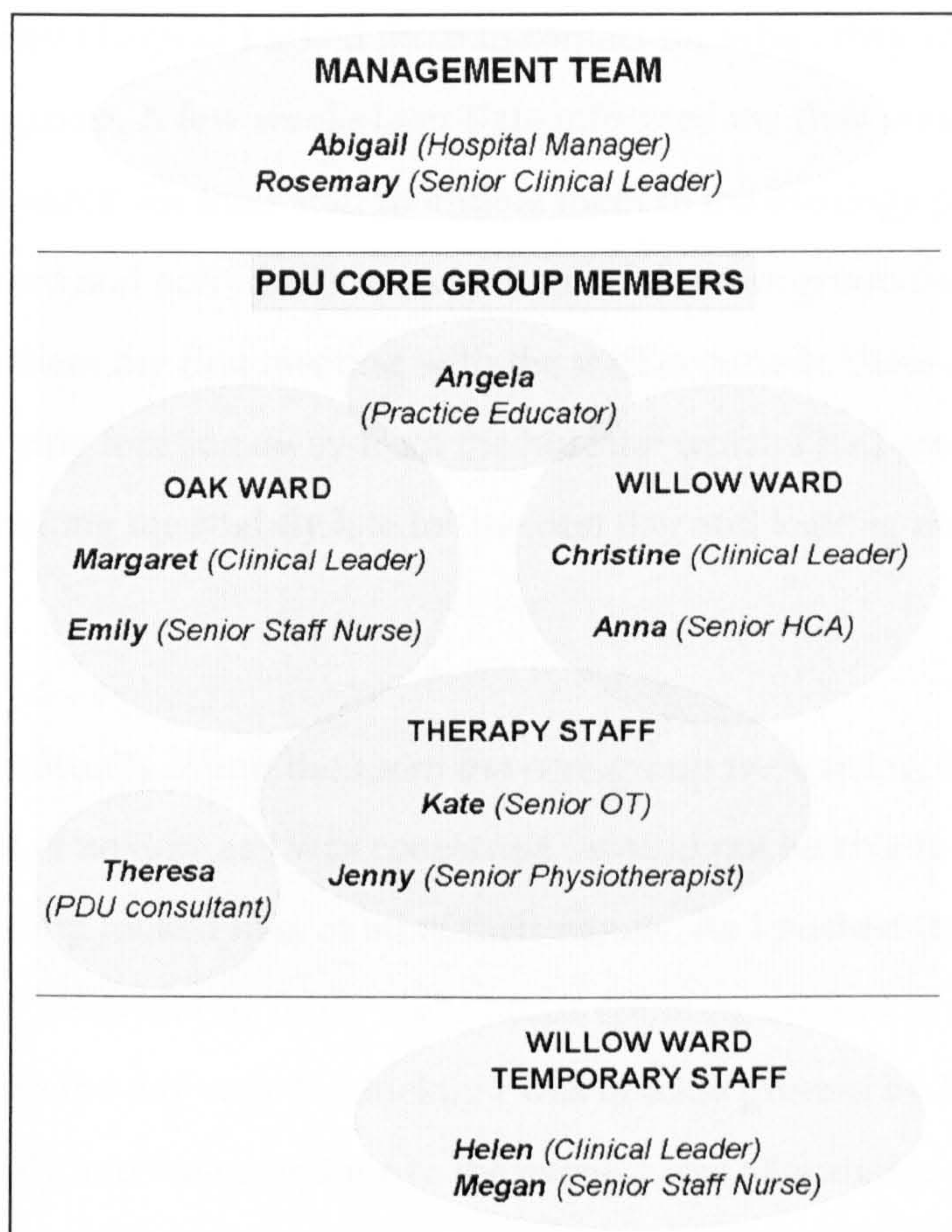


Fig 12. Key Figures in the Oak & Willow Ward Accreditation

FIRST ENCOUNTERS

My first meeting with the core group occurred on the practice development accreditation induction days hosted by Bournemouth University in April 2005. Several groups of practitioners who were beginning their accreditation attended these days and this was therefore selected as the canvassing for participants to be involved in this study. I gave a brief presentation of my proposed research to the

attendees on the first day and requested if any groups were interested in participating to contact me. I received an email the next day from Kate, who representing the core group volunteered to take part. After sending additional information sheets about my proposed research and consent forms to the group at Temperley Hospital I asked them to contact me when they were next going to meet as a group. A few weeks later Kate informed me they would be holding two 'away-days' for their staff to initiate them to the ideology practice development and accreditation and I assured the core group I would be present, which is where my first meeting with the staff occurred. These days were held in a conferencing location away from the hospital which I had great difficulty in finding, making me slightly late for the first day and leaving me flustered on arrival.

When I eventually found the room the core group were using, I was hit with a sharp bout of anxiety as I was concerned I would not be able to remember what the core group looked like, or all of their names. As I pushed the door to the room open I was met by thirty-eight heads spinning around to see who the latecomer to the day was, but luckily I was quickly greeted by Kate who was very friendly and welcomed me to the event. I was allocated to 'Group C' for the day and it soon became apparent that my group was divided into two cliques (which I later learned was based on whether they worked on Oak or Willow ward) and not being a member of staff myself, I was left to float around between the divided group. The staff in group C rejected all of my attempts to socialize with them and indeed Margaret's (who was leading Group C) efforts at making the two groups socialize with each other. The second away day organised by the core group, which was identical in set up and held for those members of staff who could not attend the first, was much the same as the staff were equally as

reluctant to socialize with me or each other and were again divided into two cliques. However I was more prepared for this having experienced it on the previous occasion and so I tried much harder during this day to learn about the reasons behind their divide. At the end of this second away day Kate informed me the core group had arranged a meeting the following week back at Temperley Hospital and it was attending this meeting where I first encountered the research site.

I arrived for the meeting forty-five minutes early, as having never visited the town of Temperley before and therefore having no idea of how long it would take me to find it, I had set off far too early. When I arrived at Temperley Hospital I pulled my car into a free space in the car park and waited there until a more reasonable time to arrive on the wards for the meeting. The hospital was much smaller than I expected and looked quaint; it was old and small for a hospital with well kept greenery surrounding it. I was nervous as I waited for time to progress so I could move into the hospital; having not seen the core group in their uniforms before I worried whether I would recognise them among the crowd of other people wearing the same outfit. I rehearsed their names and tried trying to visualize their faces to ease this, I tested my Dictaphone four times to ensure it was working and I triple checked I had sufficient and additional information sheets and consent forms. Making myself increasingly nervous waiting in my car with dreaded thoughts of the Dictaphone failing to work and my inability to remember who the core group were - despite still being twenty minutes too early - I decided to head for the meeting which I had been told would be held on Oak ward.

As I passed through the automatic doors of the Temperley Hospital main entrance I was bombarded by signs instructing all visitors to 'use the provided alcohol gel hand wash'. I of course obliged, but as I did so the gel flew out of the pump and left me with a smear down the front of my top. I scraped as much as I could off my black jumper and began to move into the hospital. Only a few steps away I spotted a small cafeteria and as I was both very early and nervous, I decided to make use of it. I purchased a Yorkie bar to comfort myself and give me a burst of energy and a can of Coca Cola to wet my throat which was dry with anxiety. After consuming them both in a matter of minutes I proceeded to find Oak ward and was amazed that despite the hospital being small, it seemed to be a labyrinth of corridors, receptions and doors with a notable absence of signage. Several wrong turns later I eventually found an arrow directing toward Oak ward, but as I walked past it to reach my goal I was hit with the most rancid smell of what can only be described as a warmed concoction of cabbage and faeces. As I breathed it in, I felt my stomach lurch with the Yorkie bar and can of Coca Cola I had just consumed. I felt as though I might actually be sick, but the prospect of returning to the labyrinth of corridors to find a toilet in which to do so was not appealing and as time was ticking by, I instead decided to hold my breath and hurried to reach Oak ward. I was horrified to discover that the putrid smell was actually emanating from the ward itself and as I entered it I was astounded that the staff seemed unaffected by it - a smell so strong and repulsive that I actually thought I may have been sick. While I attempted to relax myself and ask one of them for directions to the meeting room, I was amazed to hear the staff discussing what they were intending to eat for lunch. I was utterly horrified however, as a small trolley with a squeaky wheel was pushed past me by a small lady in a pink uniform and I realised that the rancid smell of cabbage and faeces was the patients lunch.



Figure 13. A Hospital Lunch (photographed August 2005)

Margaret emerged at this point from her office located to the right of where I was standing; she greeted me and we walked together to the meeting room and I was relieved that the door was closed so I no longer had to smell the stench of lunch. As the core group filtered into the room one by one, they appeared relaxed, excited and happy. They looked very different in their uniforms as I had previously only seen them in their own clothes, but as there were only seven of us in the room my concern over not being able to recognise them among others in the same uniform was quashed. The core group were energetic and excited at the meeting and I found it captivating to watch. They appeared to be progressing with the accreditation at an incredible speed and I found their enthusiasm for practice development contagious. This excitement and speedy progress lasted for only a matter of weeks however, as problems among the core group, the staff and their managers began to emerge.

The following section illustrates this as it is a synopsis of the core group's entire twelve month accreditation journey. This is a summary of the series of events which occurred during my time data collecting with the group and features at this point in the thesis because appreciating the course of events and their chronological order is critical for later chapters to fully understood. Indeed Chapters Seven and Eight explore the leadership and cultural issues the core group encountered thematically, not chronologically and so this synopsis allows these issues to be better placed in context. The following section therefore is not the 'findings' of this research, but rather background information provided to enable the remainder of the thesis to be better understood.

SYNOPSIS OF THE ACCREDITATION JOURNEY

The accreditation journey documented in this research began in May 2005 as this was when I attended the core group's two away-days arranged for the staff of Oak and Willow wards to initiate them into the philosophy of practice development accreditation. The staff who participated in these away-days were both night and day shift nursing staff, with one member of the therapy team (out of a possible five) and one consultant (out of a possible three) also in attendance. I noted after these days that while the core group were excited and enthusiastic about the accreditation, the staff appeared less so, seeming reluctant to work together and expressing a negative attitude towards implementing changes. After the away-days the core group held a meeting where their excitement about the forthcoming changes was clear and they reported making fast progress, with one practice development project having already been implemented and the

steering group⁵³ almost established.

In June 2005, the core group were still enthusiastic about the accreditation, as most practice development projects were underway, the steering group had been established and the presentation which they would give to them written. The core group had placed a funding bid during this month to purchase equipment for one of their projects and two of the members had visited an already accredited unit at a local hospital to gain insight into how the process worked. Two other members of the core group attended a practice development event, organised by Bournemouth University for all of their units who had either successfully attained or were undertaking accreditation and it appeared that socializing with other units perpetuated their enthusiasm. Projects were still proceeding well in July, where a multitude of meetings to discuss and organise these had been held. The core group received the news during this month that the funding bid they had submitted was successful and they would receive all of the money they requested, which further added to their high spirits. Even amongst all the progress and enthusiasm however, it was slowly becoming evident to me that the accreditation was creating a huge amount of additional work for the core group and in particular for Christine who was leading most of the projects that had been progressing.

At the start of August 2005, a senior staff nurse from Oak ward – Emily – was invited to join the core group, which she accepted. Emily brought fresh enthusiasm to the group, but even with this cracks in the core group were

⁵³ Groups undergoing accreditation must establish a 'steering group' which has key stakeholder representation. The purpose of the steering group is to ensure the aims and activities of the unit undertaking accreditation remain in line with local and national objectives, by providing them with direction and support.

beginning to develop. Angela stopped attending meetings and the core group were overwhelmingly concerned that projects were taking longer to complete on Willow ward than on Oak and that the Willow ward staff were not participating in projects to the same extent as those on Oak ward. The core group felt Christine's attention was being diverted from the accreditation because of problems she was experiencing on Willow ward, yet the nature of these problems were not revealed at this point. Jenny and Kate were beginning to feel frustrated at undertaking the majority of the organisational work and written aspects of the accreditation because of the other core group members refusal to help. Partly attributable to all the tensions among them, during this month a major disagreement erupted between the members of the core group over a project entitled 'staff rotation' - with some believing the project would be beneficial for the staff and others that it would cause resistance, uproar and turmoil. The divide in the core group was worsened during September where the Willow ward core group members' attendance at meetings began to dwindle. The Oak ward members of the core group discussed their frustration over this and the general lack of staff attendance at practice development project meetings. They were also frustrated that some projects were unable to progress as they were still awaiting the funds to be given to them from the bid they had successfully won several weeks earlier.

In October 2005, after eight weeks of absence, it was confirmed that Angela had left the core group because of a new position she had taken within the hospital. Morale was extremely low among the remaining core group members due to the loss of Angela and what they deemed as her useful links with the university but also because of the clearly ever increasing divide between the Willow ward and Oak ward members of the group; which was illustrated by the comment that

Jenny, who was described as the most vivacious of the group, was extremely low. The continuing distraction of the Willow ward members of the core group - who were preoccupied with the still undisclosed problems on their ward - eventually led the practice development projects on there to grind to a halt. By November, morale was at an all time low as the Willow ward core group members failed to attend most arranged meetings. The entire core group did attend a practice development dissemination day hosted by Bournemouth University for their units however, as they hoped it would reinvigorate them but in actual fact it only served as a painful reminder to them of how little progress they made. The mood was worsened still when the core group learned that their management team had withdrawn the money they secured in a funding bid and allocated it to a different ward within the hospital. By mid-November projects ground to a complete stop as the staff and the core group failed to attend meetings. Because of the lack of progress made and poor attendance, the steering group meetings which had been arranged many months previously were cancelled. The problems Willow ward were experiencing were finally revealed during this time to Theresa and I; these were due to twenty-five serious official complaints from patients and their families about the poor standard of care on there. These complaints placed the entire future of the staff on Willow ward in jeopardy as the management team debated how best to address the problems.

In December 2005, the core group were told that the management team were moving Christine to a different ward within the hospital and so she would no longer be a core group member. This caused them to feel anxious, as they were concerned that the new leaders who were to be placed temporarily onto Willow ward – Helen and Megan – may be unreceptive towards the accreditation. The core group were nevertheless hopeful that Willow ward would be able to get

back on course towards accreditation, as the remit Helen and Megan had been given by the management team to improve Willow ward was in keeping with their aims for developing the ward. The core group decided to officially halt all progress on practice development until they could meet with Helen and Megan to discuss the possibility of their participation in the accreditation, which they were able to do in January 2006. Helen agreed to continue accreditation on Willow ward in the meeting which was held at the beginning of the month, but she failed to attend any subsequent meetings with the core group throughout the rest of my time with them. This left the core group frustrated as they could not understand her lack of involvement when the remit she had to fulfil fitted in so well with their own ambitions for Willow ward. A disagreement occurred in this meeting between Helen and Anna, which resulted in Anna handing in her resignation from the core group⁵⁴ which worsened the morale of the group even further.

The frustration over the lack of involvement by the Willow ward leaders and staff continued into February 2006, where the core group discussed discharging Willow ward from the accreditation altogether and continuing it forward with Oak ward alone. With little progress being made in projects and many important decisions regarding the future of the accreditation to be made, the steering group meeting arranged for February was also cancelled. The core group confessed to having lost their motivation for continuing accreditation by the end of this month which persisted into February, where the uncertainty over whether to continue accreditation with Willow ward continued. A series of meetings were arranged to discuss this, one of which was with the management team who confessed that

⁵⁴ The reasons for this are detailed in the forthcoming chapters.

because of the specific remit given to Helen and Megan to rectify the problems on Willow ward, proceeding accreditation without them would be the best course of action. The core group then met with Theresa to announce their decision to continue the accreditation with Oak ward alone, but after reviewing the reasons for originally seeking a joint accreditation for both wards with Theresa, they reviewed their decision again and decided to proceed the accreditation with both wards. They arranged a meeting with their managers and Theresa to discuss this further, during which their management team agreed to support whatever decision they made but confessed still feeling it more appropriate to attempt the accreditation without Willow ward. It was at this point in the accreditation journey – June 2006 – that my fieldwork ceased. As I left the hospital, the core group were dreading the prospect of trying to initiate practice development again on Willow ward because of the difficulties they had previously experienced trying to do so and a final decision of how to progress had still not been reached.

CONCLUSION

This chapter introduced the research setting, participants and the journey of accreditation the core group undertook in order for following chapters to be placed in context. It began by documenting the town of Temperley, its hospital and the two wards – Oak and Willow – which were the research setting for this study and the main figures in the accreditation – the core group, their managers, the practice development consultant and the new Willow ward leaders. My first encounters with the core group, the staff and Temperley Hospital were documented, which was followed by a synopsis of events which unfolded during the accreditation. This provides the background for the forthcoming

chapters – the ‘findings’ – which further explore and elucidate the problems and issues the group faced. However prior to this, how the data collected from this research was analysed and interpreted to reach these findings must be presented; and this is achieved in the following chapter.

CHAPTER VI

ANALYSIS & INTERPRETATION

INTRODUCTION

How the data collected through the methods outlined in the previous chapter – participant observation, fieldnotes and interviews – were transformed by the analysis process to generate the findings presented in Chapters Seven and Eight is detailed in this chapter. The first section of this chapter addresses the analysis of collected data, the strategies utilised to do this and the rationale behind this selection. An audit trail of exactly how the analysis was performed is provided, which demonstrates how I transformed a collection of observations and recordings into a refined set of complete findings which achieved the research aims. These were to investigate practice development accreditation by studying a unit undertaking this process, examining the culture of a unit during accreditation and portraying a multidisciplinary account of practice development. The audit trail provides details of how data was transcribed and coded and topics collapsed to achieve two central themes which explained why the accreditation attempt of the participants was unsuccessful; leadership and culture.

The second half of this chapter addresses how data was interpreted using the selected theoretical framework which guided this entire study, symbolic-interpretivism. How the data was analysed and interpreted is presented in this chapter in preparation for those which follow, where issues and problems around leadership and culture uncovered by this process are documented.

ANALYSIS IN ETHNOGRAPHIC RESEARCH

It is not documented within symbolic-interpretivist literature how data should be analysed. Rather as ethnographic research methods are advocated in this approach, it is implicit that strategies within ethnography should be used to analyse this material. However, no established method of analysing data collected through ethnographic research techniques exists (O'Reilly 2005). Some ethnographers report 'feeling' for themes by continually re-reading their fieldnotes (Colaizzi 1978) and others instead opt to use computer software packages such as 'Ethnograph' (Dohan and Sanchez-Jankowski 1998) which highlight key terms from inputted fieldnotes. However, neither of these techniques appealed to me, as while the computer packages saved time I was concerned they removed words and phrases out of context creating 'disembodied research discussions' (Hoskins and Stoltz 2005). I also believed 'feeling' codes from the data lacked rigor as readers would not be able to follow an audit trail demonstrating from where findings had emerged. I subsequently developed my own analysis strategy whereby I manually searched for key topics from fieldnotes and transcripts just as a computer package would, but I was able to ensure these were kept in context by reading them as complete documents and in chronological order (as the timing of events was imperative to understanding why certain issues arose). Conducting the analysis manually instead of by computer packages was extremely time consuming, but offered the advantage of allowing me to become completely re-immersed in the data; reliving the experiences and emotions the participants underwent during the accreditation. It was through this process I was able to compress the twelve month accreditation journey into several weeks' worth of re-reading and re-experiencing the journey to code, analyse and interpret it; this being described as the ultimate aim of ethnographic analysis (Roper and Shapiro 2000).

While some ethnographic texts have alluded to their analysis strategies by stating they either felt for codes or used a software package outlined earlier in this section, most do not document in any way how fieldnotes were analysed to create a final ethnography (Roper and Shapiro 2000). This is surprising given that analysis and interpretation is described as 'the raison d'être' of ethnographic research (Hodgson 2000). The reason for this could be attributed to the secrecy surrounding fieldnotes as documented in the last chapter or because analysis of ethnographic data is not a linear process (Hammersley and Atkinson 2007), but is instead 'tangled up' with every stage of the research process⁵⁵ (O'Reilly 2005). Evidently however, themes, ideas and patterns 'do not just emerge magically from fieldnotes' (Le Compte and Schensul 1999b:46) as appears to be the case in some ethnographic texts and it is for this reason I wanted to make my own analysis strategies explicit. While no 'checklist' from any one source was used for the analysis in this research, two texts did influence its design. The recommended elements of analysis⁵⁶ contained in Brewer (2000) and instructions of how to draw patterns and themes from data found in LeCompte and Schensul (1999b) were drawn upon for guidance during the analysis stage of this research.

The actual analysis of data was divided into two stages; the first performed during my time in the field and the second once I had left, which Figure 14 illustrates. The coding of data and drawing of themes was withheld until after time in the field had ceased, as it could have blinded me to new lines of inquiry which may subsequently have arisen (Rock 2007). The aspect of analysis

⁵⁵ The reason being that data collection and analysis are extremely time-consuming processes, and for time and logistics, the two are difficult to perform simultaneously (Hammersley and Atkinson 2007).

⁵⁶ These are data management (organizing data into manageable units), coding (indexing data into categories and themes), qualitative description (identifying key events, people, behavior, etc) and establishing patterns in the data.

performed during time in the field was the transcription of recorded material, performed in order to prepare data to be coded and themes drawn, which was executed after exiting the field. This allowed me to make best use of my time as it ensured data was ready for analysis as soon as data collection had ceased.

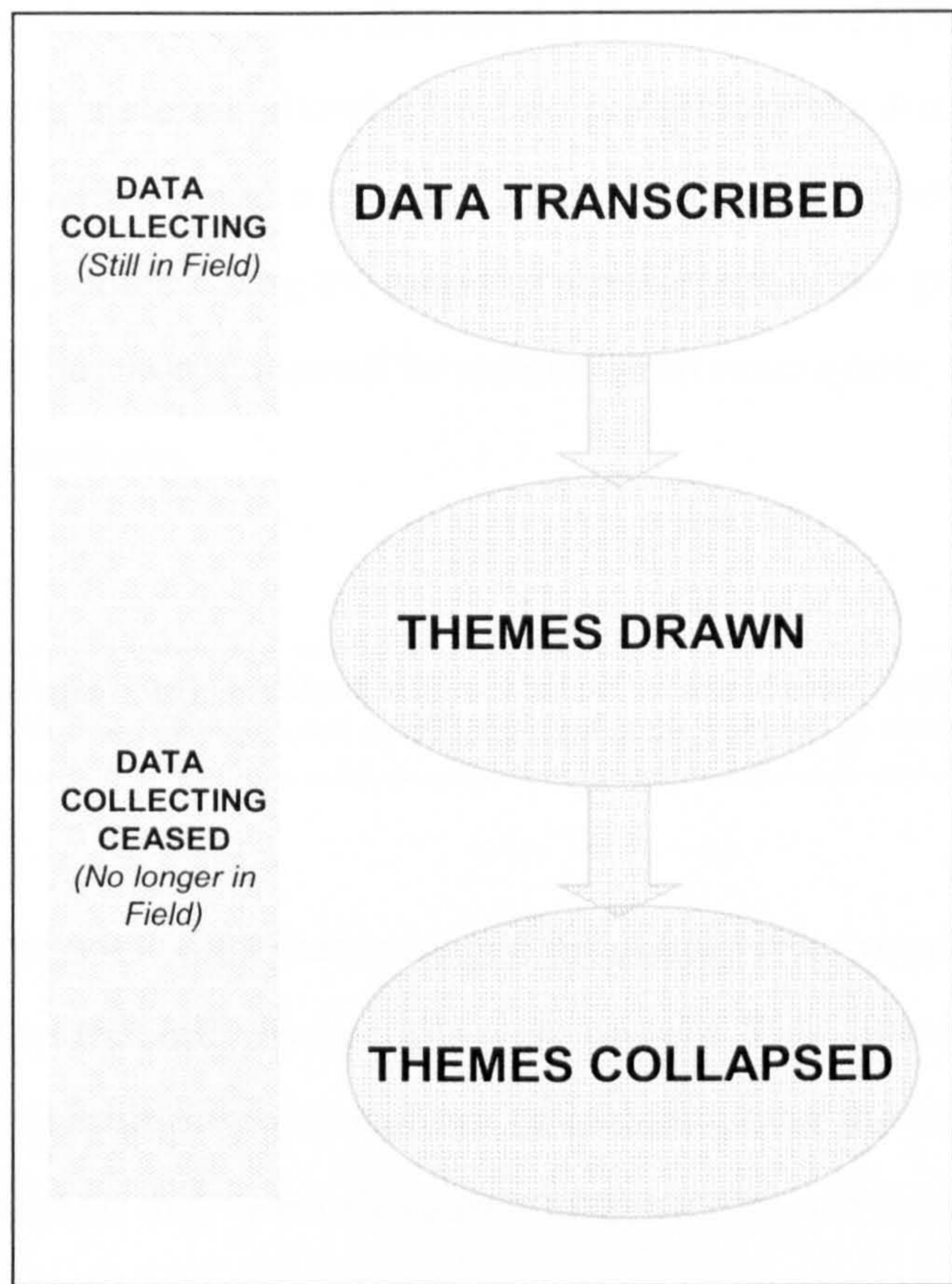


Fig 14. Stages of Data Analysis

Transcribing Data, Drawing Topics & Collapsing Themes

As documented previously, over forty hours of recordings were captured during this study and most of which were of meetings where between three and nineteen attendees were present. Performing verbatim transcription of this material would have been problematic due to the number of people present. The numbers meant that recordings consisted of multiple conversations, a multitude

of unfinished sentences, lots of speaking over each other and almost continual interruption. Additionally, as Dictaphones are only just starting to be utilised in ethnographic research⁵⁷ the transcriptions of events such as meetings are not commonplace and ethnographers instead rely on roughly drafted notes or memory for what issues were discussed. I therefore developed my own system of transcribing material whereby I would paraphrase the discussion, creating bullet points which noted topics and speakers. When a sentence appeared to stand out as encompassing the mood or atmosphere of the group it would not be paraphrased but would instead be written as an exact quote, as the following extract demonstrates.

- Jenny asks if they should pull Willow ward off the accreditation 'until they can sort themselves out'. She said they can't run an efficient ward at the moment 'let alone try to get PDU status'

Recorded interview data was managed differently from recordings of meetings due to the fact that only two people were present. This meant there were no interruptions, multiple conversations or speaking over the top of one other. As they were shorter they were also easier to transcribe and because I was asking specific questions (as opposed to in meetings where I would not speak) I required precise answers, which I wanted to record exactly. Interviews therefore were transcribed verbatim, with pauses, conversation fillers and broken sentences all noted ⁵⁸.

⁵⁷ Indeed I found only one ethnographic report which claims to have used a Dictaphone in a similar way, however this does not detail the analysis strategy of this material (Arber 2006).

⁵⁸ In preparation for the second stage of analysis, transcripts were kept with their corresponding fieldnotes which documented emotions and non-verbal communication, allowing me to keep them in context.

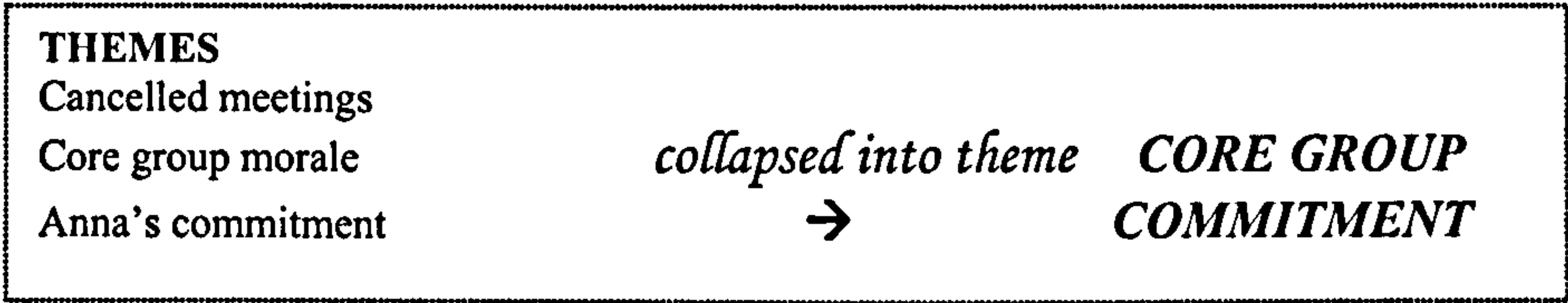
The transcripts or fieldnotes were then read line by line to identify topics of conversation. These topics were written alongside their corresponding line or lines (a strategy advocated by Cresswell (2007) for use within qualitative research). The following extract demonstrates this strategy and a full transcript of a meeting transcribed using the method documented earlier in this section, with topics identified on it can be found in Appendix Eight.

Expelling Willow Ward	Jenny asks if they should pull Willow ward off PDU ‘until
Jenny’s Leadership	they can sort themselves out. She said they can’t run an
View of PDU	efficient ward at the moment ‘let alone try to get PDU status’

Topics and their corresponding line or lines of text were then extracted from the transcriptions or fieldnotes and grouped together in Word documents thematically. The date and source of the text were identified (i.e. fieldnotes, core group meeting or interview) and placed after each extract to ensure they were kept in context. Over three hundred and eighty pages of material was produced using this method, within which hundreds of topics were identified. Many of the topics were similar (often simply worded differently) and so this material was then reduced by collapsing similar themes together. For example, all topics regarding the need for management support were gathered together under the heading ‘need for management support’ thereby creating one large theme⁵⁹. The pages of collapsed themes were then divided into two groups, based on whether they related to my personal experience of data collection or to practice development and accreditation. Themes relating to my personal experiences of data collection (totalling 35) were not analysed further but incorporated into

⁵⁹ Themes are therefore the exact meaning implied or inferred from words, behaviours or events categorised under ‘topics’ (DeSantis and Ugarriza 2000).

Chapters Four and Five of this thesis which documented how I conducted this research, as they were not related to the aims of this study. Themes relating to the process of accreditation and practice development were analysed further. One-hundred and twenty nine had been ascertained after the collapsing of similar themes and I then sought to identify patterns which linked these together to gain a better understanding of their relationships within the accreditation process. Related themes were then grouped together under more encompassing headings which included all of the themes, these headings were for example ‘core group commitment’ and ‘management support of core group’⁶⁰. The box below illustrates this and Appendix Nine demonstrates fully how all one hundred and twenty nine themes were collapsed in this way.



Twelve themes were ascertained through this process which encompassed all topics identified from the analysis of material collected from the field as part of this research. These encompassing themes were:

- Distribution of work within the core group
- Core group shared beliefs & aims
- Commitment of core group members

⁶⁰ This strategy is similar to thematic analysis, which has been used in ethnography before (Mahoney 2001), however I decided not to use thematic analysis in this research as it combines emerging themes from data collection with those found in the literature to produce its findings (Aronson 1994). I wanted to ensure the results of my analysis emerged only from the data, not from the literature and so this approach was not adopted.

- Management support of the core group
- Restricting & forcing staff involvement
- Core group vs. The staff
- Willow ward vs. Oak ward
- Clinical Leaders vs. Core group
- Nurses vs. HCAs
- Nursing Staff vs. Therapists
- New staff vs. Old staff
- Day staff vs. Night staff

Patterns between these themes were sought to understand how they were related. I identified the first five as relating to leadership – both of the core group and that of the staff (this theme be explored in Chapter Seven) and the latter seven to cultural divisions which were based on both hierarchical and professional identity (this theme be explored in Chapter Eight). However these two notions were not mutually exclusive and most issues within them were related to both to some degree; which is confirmed by the symbolic-interpretivist perspective which claims culture and leadership are intertwined⁶¹. In order to discuss these themes which are the basis of the ‘findings’ of this chapter more easily, these were divided based on whether they fitted more into leadership or more into culture. Figure 15 demonstrates how all of the encompassing themes were collapsed under the headings of leadership and culture and this diagram provides the basis of the following two chapters which will first address leadership and then culture.

⁶¹ As the symbolic-interpretive perspective states culture is in part determined by leadership and that leadership is in part defined by culture (Rickards and Clark 2006).

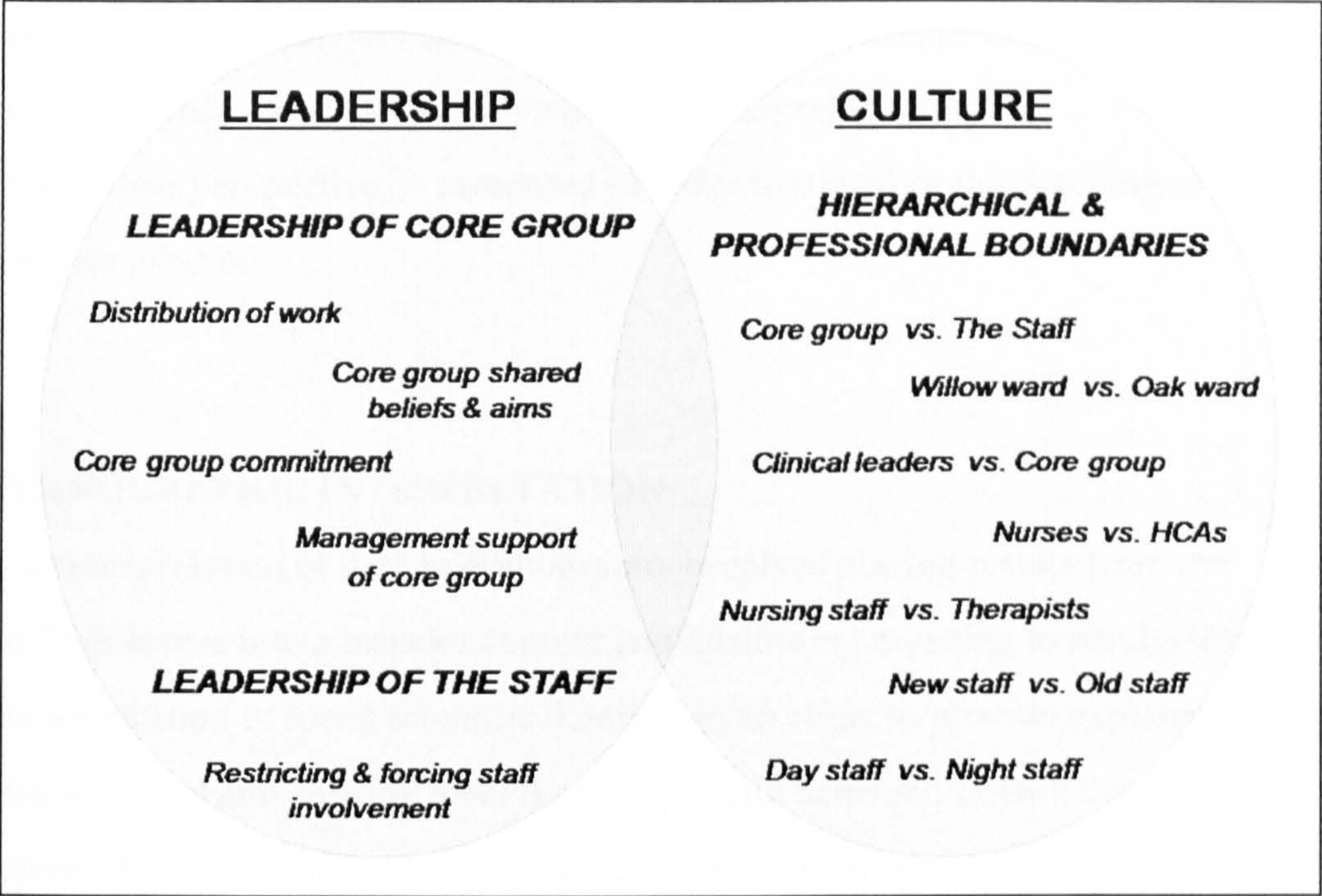


Fig 15. Issues which Prevented Successful Accreditation (ascertained from analysis)

Chapter Seven will address the problems associated with leadership uncovered in this study which prevented the accreditation from being successful; these include the support of the core group by their managers, the leadership among the core group and the leadership by the core group of their staff. Chapter Eight explores the cultural barriers to the accreditation attempt which prevented it from being a success that were based on hierarchical and professional boundaries which existed among the participants. The leadership issues are documented prior to the cultural issues, as these were the most apparent reasons which could be recognised by those within and outside of health care as causing difficulties within the accreditation. The cultural issues discovered which posed a barrier to accreditation are discussed secondly, as although they were obvious to me as an outsider to the health care profession, most of the participants seemed unable to identify these as a key reason for its failure. Prior to

documenting the barriers based on leadership or culture, how these two themes and the actions associated with them were interpreted using the symbolic-interpretive perspective, is presented in order to complete the detailing of the analysis process.

ETHNOGRAPHIC INTERPRETATION

The interpretation of data in ethnography involves placing results from the analysis stages into a broader context and attributing meaning to results through the application of social scientific theories, in an effort to provide explanations on an individual and cultural level (Le Compte and Schensul 1999b). Symbolic-interpretivism was selected as the guiding theoretical framework for this entire research (as outlined in Chapter Three) and subsequently the results of the analysis were interpreted using this perspective. To summarize, the elements of focus within the symbolic-interpretive perspective are:

- Symbolic predispositions: the tendencies people have to behave in certain ways, based on their interpretation of others and indeed their own past experiences (Frey and Sunwolf 2004).
- Symbolic practices: stories, narratives and metaphors which all demonstrate that group members are engaging in symbolic practices (Frey and Sunwolf 2004).
- Symbolic processes and products: the identity and culture of a group (Frey and Sunwolf 2004).
- The group as a whole: which is embedded in multiple contexts of time, space and culture, which all influence internal group dynamics (Frey and Sunwolf 2004).

- Power relations: relationships within the group expressed through organisational politics, control and conflict (Hatch and Cunliffe 2006)
- Multiple interpretations of symbols within the group (Johnson and Scholes 2006).

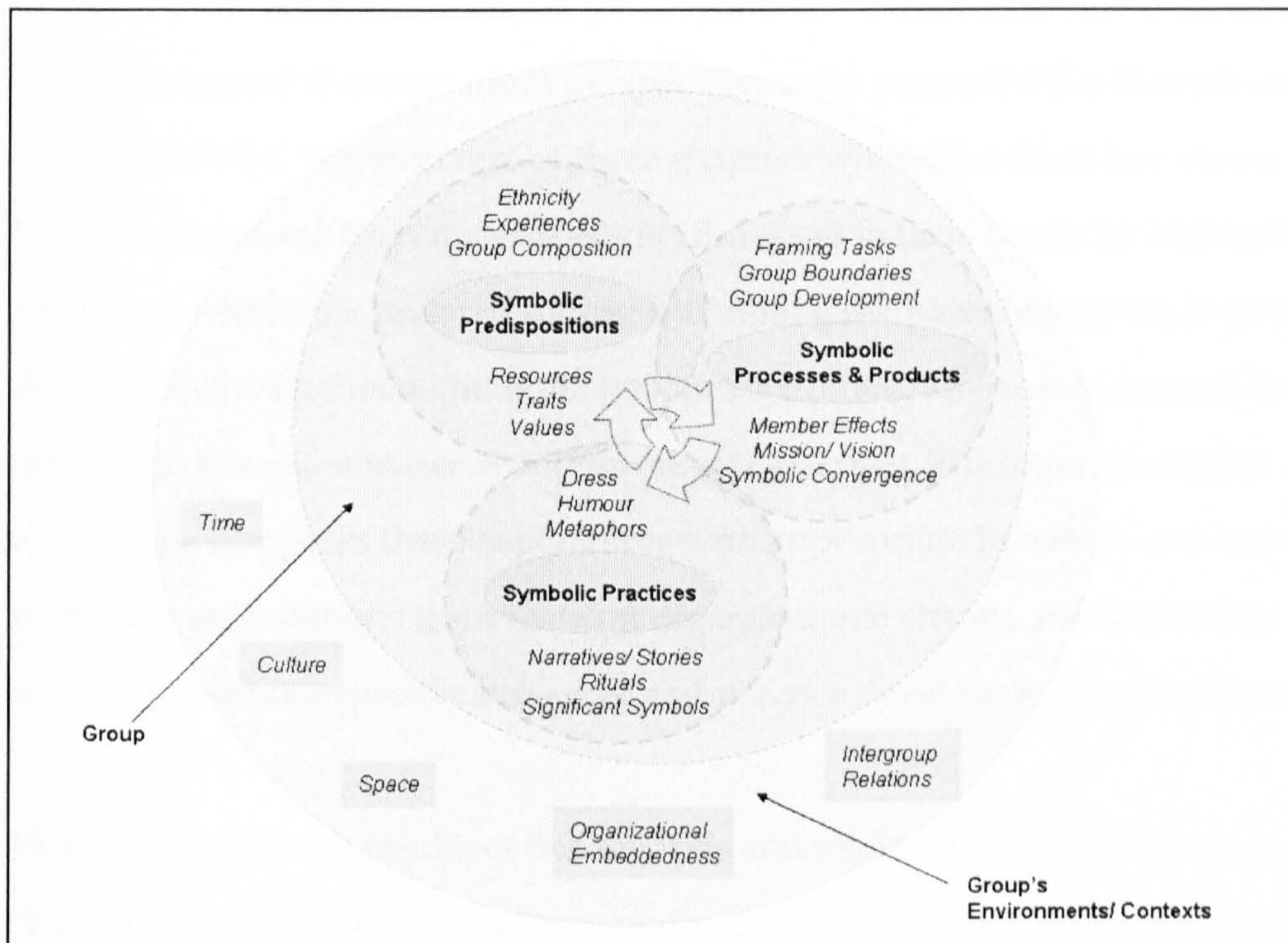


Fig 16. Symbolic-Interpretive Focus of Study (Frey and Sunwolf 2004:285)

Interpretation was accomplished by construing events, actions, conversations and explanations revealed under the themes 'leadership' and 'culture' ascertained from the analysis of data in light of the symbolic-interpretive core elements of focus as outlined above. Relevant literature to 'leadership' and 'culture' (such as that in the field of organisational change) was utilised to examine to findings, which enabled me establish whether the findings confirmed

or invalidated current knowledge on these issues and whether any new knowledge had been generated⁶². The 'interpretation' of the data in this research was therefore the application of symbolic-interpretivism to the results obtained from the analysis stage, in order to explain events and actions thereby generating findings. These findings were then compared with relevant literature, as will be demonstrated in the following chapters which enabled both the emic (insider) and etic (external interpretation) perspectives to be presented (Le Compte and Schensul 1999b). The structure of these chapters will reflect these two views. Each theme gained from the analysis is addressed in turn, firstly by highlighting its context within the research setting and among the participants; the beginning discussion of each theme therefore includes a rich narrative using extracts from fieldnotes, interview material and meeting transcripts. The latter discussion of each theme compares these experiences with appropriate literature and includes references and citations from relevant organisational change and leadership texts, symbolic-interpretive literature and practice development publications.

However, before the results of this analysis and interpretation processes are documented in this way in the two 'findings' chapters which immediately follow, the main themes which shape these are defined from the symbolic-interpretive perspective; leadership and culture.

Defining Leadership

Leadership is a subject which has been explored from countless perspectives (Northouse 2004) and as a result a multitude of competing views of what it is

⁶² The symbolic-interpretive perspective was successful in identifying and addressing all of the issues under the two main headings of leadership and culture but had it not, other compatible theoretical frameworks would have been utilized in addition (as advocated by Hammersley and Atkinson 2007).

(Marquis and Huston 2005) and what makes leaders effective exists (Grint 2005). Commonly within this, the concepts of leadership and management are confused, leaving the relationship between the two greatly debated. Some theories claim management - which focuses on small scale, localized changes, seeks to maintain the status quo and controls staff by giving rewards to those who follow rules - is the opposite of leadership - which embraces change, seeks to create radical organisational change⁶³ and directs and focuses staff rather than control them (Grint 2005, Halbestram 2006). Other theories claim no such divide between leadership and management exists and as such they can be effectively combined in one individual (Burnes 2004). The symbolic-interpretivist perspective explains the wide variety of opinions on leadership by virtue of the fact that leadership is a symbol, and as such it is interpreted in different ways depending in which social group it is being discussed:

It is much like the words *democracy*, *love* and *peace*. Although each of us intuitively knows what he or she means by such words, the words can have different meanings for different people

(Northouse 2004:2).

The symbolic-interpretive perspective takes an alternative approach to previous literature on leadership and management by claiming the relationship between the two should not be the focus of debate, rather it should be on the relationship between leader and follower (Rosenbach and Taylor 2006). This perspective states leadership is a transactional group process that develops between the would-be leader and others who share in their goals (Ridgeway 2003), making leadership inextricably tied to group membership (Van Knippenberg and Hogg 2003) and existing in a duality; as there can be no leaders without followers and

⁶³ A table demonstrating the differences between the two concepts in more detail can be found in Appendix Ten.

no followers without leaders (Goffee and Jones 2006). Leadership is therefore not a set of formal responsibilities as other perspectives have claimed but rather the 'management of meaning' (Rickards and Clark 2006) whereby the actions of leaders are conscious and sub-conscious attempts to interpret and shape situations in an effort to influence the interpretation of reality for their followers (Rickards and Clark 2006). This is achieved by leaders promoting their 'vision' which is a critical aspect in facilitating elements such as empowerment⁶⁴ in followers (Halbestram 2006).

Symbolic-interpretivists define vision as an easily communicable, memorable achievable, simple, imagined concept of how an organisation could and should look (Burnes 2004)⁶⁵. Leaders utilise vision by defining the purpose of the group and providing members with a frame to interpret the current and future action undertaken to alter its future (Tietze et al 2003). To successfully create a vision which will inspire and motivate a group, leaders must connect with their follower's values and beliefs thereby becoming 'culturally literate' (Tietze et al 2003). The vision must encompass the cultural beliefs, values and goals of the group as it is this – and not the use of rules and procedures – which is the control mechanism for the organisation and the 'glue' which binds the interaction of leaders and followers together (Halbestram 2006). This is only achievable however, if the vision holds meaning for those working within the group (Tietze et al 2003); indeed, while leaders 'manage' culture, they are also symbols themselves (representing meaning that followers attribute to them) and so are

⁶⁴ Empowerment in the symbolic-interpretive perspective is defined as a psychological state which invokes in the individual a sense of personal power and the freedom to use this power (Lashley 2001).

⁶⁵ Vision is generally poorly articulated in the literature, usually being confused with strategic initiatives, which means it is presented as a combination of general concepts and ideas, usually in the form of a mission statement (Thornberry 2006).

consequently also managed by culture (Hatch and Cunliffe 2006). As a result, a symbiotic relationship exists between followers and leaders which is why the symbolic-interpretive perspective advocates a 'shared leadership approach' to change, which promotes the full inclusion and cooperation of followers in creating organisational change (Goffee and Jones 2006). Shared leadership is defined as follows:

The transference of the leadership function among team members in order to take advantage of member strengths (e.g. knowledge, skills, attitudes, perspectives, contacts, and time available) as dictated by either environmental demands or the developmental stage of the team. Within environments using shared leadership, the leadership functions are transferred among team members dependent on the type of skills needed at each juncture of the team's development or driven by the demands of the situation

(Burke et al 2003:105).

The shared leadership approach is also advocated within practice development literature, because of this focus (Chin and McNichol 2000). To achieve this, groups of independent actors need to become linked because of their desire to attain a shared, common goal (Northouse 2004). They need to coordinate their activities in order to accomplish these goals and so shared attitudes, mutual support and empowerment are essential in order to be successful (Seibert et al 2003). The symbolic-interpretive perspective pays particularly close attention to the social interactions within a shared leadership approach (Pearce and Conger 2003), emphasising issues of power and power differences (Snyder and Kivinieme 2001), as people never communicate as equals within organisations (Parker 2000).

Defining Culture

As with the term leadership, a multitude of definitions of culture exists; most of which view it as something an organisation has. However symbolic-interpretivists again take a different view, instead claiming culture is not something an organisation has, but rather something an organisation is (Parker 2000). It is defined as the basic assumptions a group share, that have been learned as the organisation has solved problems of internal integration and external adaptation; the successful strategies of achieving this are then taught to newcomers as the correct way to think and feel in relation to such problems (Schein 2004). In this perspective, culture is constructed through the interpretations individuals within it make of events as they unfold, as this enables collective meaning to be created among its members. Culture consequently refers to the shared thinking, behaviour and beliefs of group members, expressed through their interactions and use of symbols (Marquis and Huston 2006). It is for this reason particular attention is given within symbolic-interpretivism to the rituals, values and beliefs which tie a group of individuals together in a coherent whole (Schein 2004).

Rituals, behaviours and languages must be shared among the members of a culture, however individuals within it do not need to agree with them. Indeed cultures are spaces where human diversity and a shared sense of belonging is integrated and expressed in a multitude of ways; much in the same way that when sharing a meal with friends - even though the same ingredients have been used to create the dishes - everyone enjoys it in a different way, with some people eating more, others less and some preferring certain dishes to others (Hatch and Cunliffe 2006). Culture is consequently viewed as a struggle for hegemony, where subgroups compete to define the purpose of organisation

using culture as their means of control (Parker 2000). Meaning is shaped, manipulated and changed to legitimize particular purposes and actions over others within organisations (Tietze et al 2003), making culture an ongoing social construction (Parker 2000). How the various groups within the Oak and Willow ward accreditation used culture to create conflict with one other and the role leadership played in attempting to adjust this is outlined over the following two chapters.

CONCLUSION

The analysis and interpretation strategies employed in this research were documented in this chapter. An audit trail of analysis was detailed to demonstrate exactly how the analysis was performed to reduce the vast amounts of raw data collected through ethnographic research techniques to uncover two main themes 'leadership' and 'culture'. How issues relating to these two themes were interpreted using symbolic-interpretivism were detailed and the main areas of focus within this perspective - symbolic predispositions, practices, processes and products, the wider context of the group and power relations and multiple interpretations - were highlighted. Finally, definitions of the main themes – leadership and culture – were explored from the symbolic-interpretive perspective in preparation for the following two chapters which addresses the varying issues associated with these which hindered the participants of this research from successfully attaining practice development accreditation status.

CHAPTER VII

LEADERSHIP OBSTACLES TO ACCREDITATION

INTRODUCTION

This chapter addresses the leadership issues and problems which proved to be major obstacles in gaining successful accreditation that were uncovered through the analysis and interpretation of collected data, as outlined in the previous section. The structure of this chapter follows the sphere of 'leadership' on Figure 17, addressing each of these issues in turn.

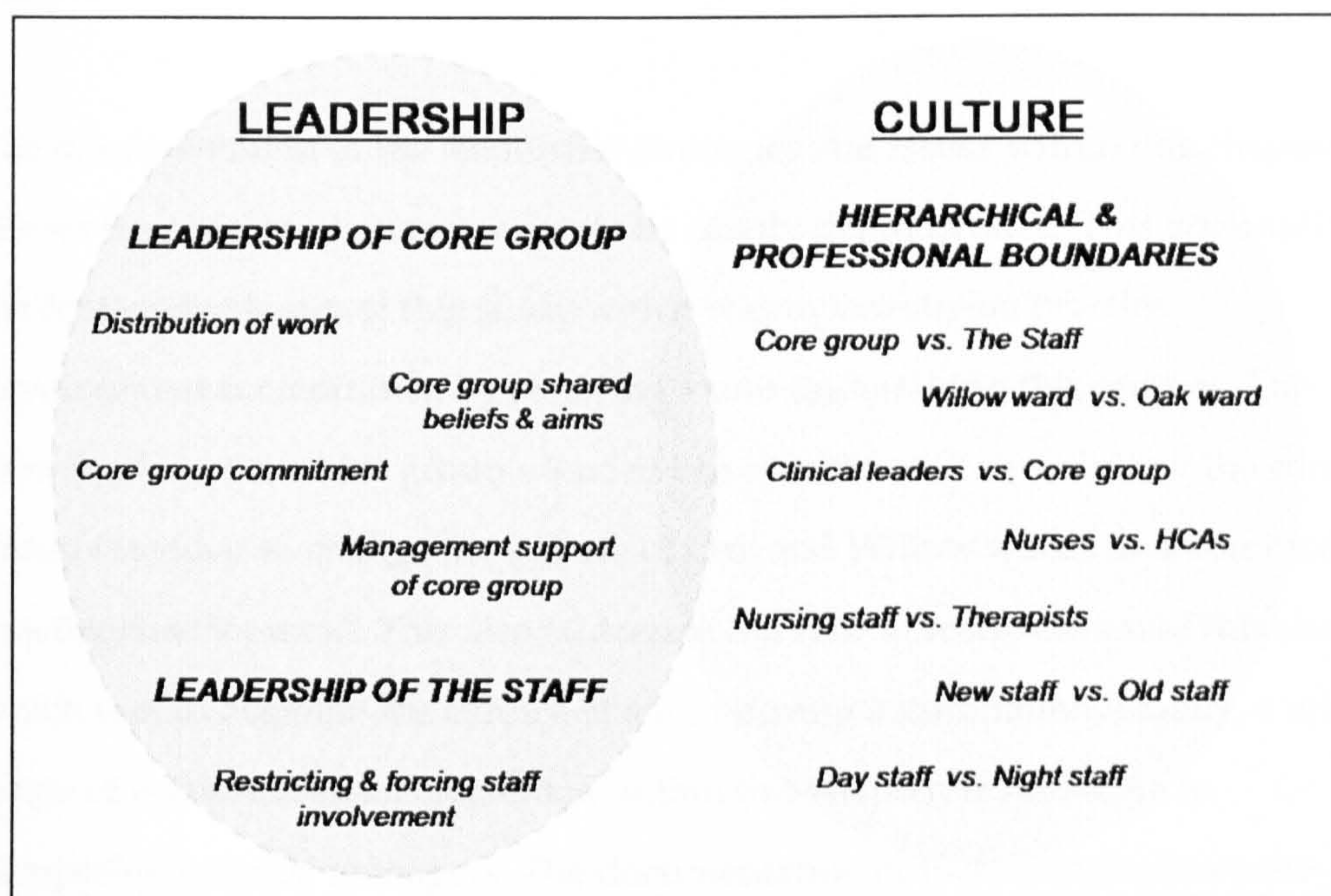


Fig 17. Leadership Issues which Prevented Successful Accreditation (ascertained from analysis)

The first half of this chapter focuses on the leadership of the core group, represented in the top of Figure 17, and addresses the issues within this. These are the problems caused by an uneven distribution of work, an absence of shared beliefs and aims, a lack of commitment and the difficulties caused by the

management team's lack of support. The second half of this chapter addresses the core group's leadership of the Oak and Willow ward staff, represented at the bottom of Figure 17 and how this hindered their ability to become successfully accredited. The relationship which existed between the core group and the staff is documented and a discussion of the leadership style taken towards them is provided. Examples of how the core group both restricted staff involvement in the accreditation and then forced them into complying through manipulation and coercion are provided and further illustrated by an in-depth case example of this.

The documentation of the leadership strategies and issues within this chapter allows the process of accreditation to be clearly demonstrated. This accomplishes the first research aim of this study which was to investigate practice development accreditation by studying a unit undertaking this process. The examination of the core group's leadership over the staff reveals how the core group intended to change the culture of Oak and Willow wards to accommodate practice development. This also addresses the second research aim of this study which was to examine the culture of a unit during accreditation. Finally, a wide range of perspectives are presented within this chapter; from HCAs to Temperley hospital managers. The documentation of these views allows the third research aim – which was to portray a multidisciplinary account of practice development – to be achieved.

LEADERSHIP OF THE CORE GROUP & DISTRIBUTION OF WORK

To summarise information detailed in Chapter Five about the core group, when

they began their accreditation journey in May 2005, they did so with six members – Kate (a senior OT), Jenny (a senior physiotherapist), Margaret (Oak ward clinical leader), Christine (Willow ward clinical leader), Anna (senior HCA on Willow ward) and Angela (practice educator). However, the group was expanded in August 2005 as Emily (senior staff nurse on Oak ward) joined, but was reduced again as Angela resigned in September 2005 and Christine in December 2005. The core group's attempt to recruit the temporary Willow ward leaders Helen (clinical leader) and Megan (senior staff nurse) failed and the number of core group members was reduced further still in January 2006 as Anna also handed in her resignation. The evolution of the core group plays a critical role in the journey of accreditation and so while references are made to 'the core group' throughout the following chapters, this often comprised of different members. For this reason, dates are provided after quotations or reported incidents in order to gauge which members were in the core group at that time.

An examination of the core group first begins with an exploration of the leadership roles and task allocation among them. These two themes although represented separately on Figure 17 have been combined in this section because – as it will shortly be revealed – they were seen as a representation of one other by the core group and so are best understood in relation to each other.

The core group initially adopted what they described as a shared leadership⁶⁶ approach within their group, as advocated by practice development literature. This caused several members (such as Jenny and Kate) to feel “*uncomfortable*” as

⁶⁶ No conversations to clarify what was meant by this were observed however.

they were concerned the group could become a “*free for all*” and lack direction (25.05.05 *Fieldnotes*); nevertheless they still found it preferable to having only one leader as concerns were raised that some members of the core group would dominate others because of their “*strong personalities*” (25.05.05 *Fieldnotes*). However, while the core group believed they were using a shared leadership approach, they failed to fully understand what this entailed as Kate – the founding member of it – was ‘nominated’ from the first day as the sole leader. This was possibly because Kate demonstrated her leadership skills on numerous occasions – “*Kate appears to be leader of the core group*” (25.05.05 *Fieldnotes*) – and seemed confident, competent and organised; ensuring tasks were fulfilled such as completing documentation, or arranging meetings “*at the meeting next week I’m just going to push for it to be written up*” (18.10.05 CG meeting). The core group were content initially with having Kate as their leader, referring to her strength on several occasions and affectionately calling her “*the centre of the PDU group*” (10.08.05 *Steering group meeting*)⁶⁷. Kate however, was a reluctant leader⁶⁸ and disliked holding this role, but the absence of a single more suitable leader in the group kept her in this position. Kate’s uncertainty over leading the core group led to Jenny and Margaret sharing⁶⁹ this role with her (although this was never verbally acknowledged but evident through their actions) and within a couple of months of the accreditation, the three seemed confident and solid in their new roles:

⁶⁷ ‘PDU’ stands for practice development unit and is the name the core group used to refer to both themselves, and the process they were undertaking.

⁶⁸ The reasons for which are discussed in Chapter Eight.

⁶⁹ Sharing leadership in this respect does not refer to the shared leadership approach, as the latter can only be achieved when all members of the group share in the leadership role, which was not the case among the core group.

"Kate is pretty much the backbone of the core group, followed closely by Jenny and Margaret. Lovely as they are, Christine and Anna don't organise anything and Angela just has to take minutes" (14.09.05 Fieldnotes).

Theresa (the practice development consultant) noted the powerful alliance of Kate and Jenny in particular and believed their relationship was critical to the entire success of the group *"I'm fairly confident that they'll finish [the accreditation] unless the OT and Physio leads go"* (15.09.05 Interview). As time progressed, it became evident that Theresa's concerns were well founded, as on the rare occasions that Jenny and Kate were unable to attend a meeting, the remaining core group members would not proceed in their absence. Jenny was a strong leader alongside Kate, as they mirrored each other's attitudes, values and beliefs and were close friends outside of work because of these similarities. Jenny and Kate worked to organise core group meetings (*i.e. 07.09.05 CG meeting*), delivered every presentation during their accreditation (*i.e. 25.05.05 Fieldnotes*) and between them completed all written aspects of this work (*i.e. 19.10.05 Fieldnotes*). Jenny chaired all core group meetings from August 2005 onwards, where her joint leadership role with Kate was evident in the language she used *"What we thought we would do today..."* (03.08.05 CG meeting) – using the collective 'we' to refer to Kate and herself. Jenny played an instrumental role in keeping core group meetings focused, as she always reined conversations back to the subject of accreditation when they were diverted (09.08.05 CG meeting) and on the odd occasion when she was unable to gain control of the conversation, she and Kate would continue talking about it until the others in the group redirected their attention back (28.09.05 CG meeting). Jenny also addressed the emotional welfare issues of the group, inquiring how the others were feeling about developments – *"How is everyone feeling about their projects?"* (28.09.05 CG meeting) – by helping to solve any problems they were experiencing with implementing practice

development (28.09.05 CG meeting), by resolving disputes which arose between core group members (18.10.05 CG meeting) and generally in raising the morale of the group (i.e. 28.09.05 CG meeting).

As with Jenny, Margaret also assumed her leadership position alongside Kate in the core group because of their shared values, beliefs and attitudes, which Margaret believed made them a powerful team *"I think if you look at Kate and Jenny and me, we're quite focused and strong about where we want to be and how we're going to get it"* (24.11.05 Interview). Margaret's leadership role centred around liaising with authority figures, where she utilised her contacts both within and outside of Temperley Hospital to help her in the accreditation. She arranged meetings with senior management and other key people within the Trust (07.09.05 CG meeting) regarding their accreditation and liaised with the leaders of successful practice development units in the region (15.09.05 CG meeting). Margaret admitted that she had influenced Kate's decision to initially take the sole leadership role of the core group, because she herself had only just accepted the Oak ward clinical leader position and felt it would be too much work for her to take on. As she became more settled in her role however, Margaret said this was no longer the case – *"it's not like that anymore"* (24.11.05 Interview) – and expressed her desire to lead the accreditation alone on several occasions.

Jenny, Kate and Margaret shared the leadership role among them, making best use of individual strengths – Margaret was relied upon to take the lead in arranging meetings with management and other senior figures as she had the best contacts, Jenny took the lead when emotional issues needed to be addressed and morale raised and Kate lead throughout, taking control of the group as a whole by continually steering it in the right direction and keeping it focused. The

other members of the core group accepted Kate, Jenny and Margaret's leadership as they abstained from attending meetings with senior figures (10.11.05 *Fieldnotes*) and actually turned to Kate, Margaret and Jenny for leadership. The Willow ward members of the core group frequently asked for direction – "*What am I supposed to be doing again?*" (18.10.05 CG meeting) – and sought 'permission' from them over tasks – "*Can I write that project up when I come back from my holidays?*" (02.11.05 CG meeting). This however caused conflict, as Jenny and Kate believed they had adopted a shared leadership approach with the entire core group and did not acknowledge that they were in fact leading it, which often caused them to become frustrated with the attitude of the others. This caused a breakdown within the core group as Kate and Jenny awaited the rest of the core group members to assume some leadership responsibilities, while they awaited direction to act from Kate, Jenny and Margaret.

One of the primary sources of tension related to the confusion over leadership within the core group, centred around task allocation and the distribution of work. Tasks were not delegated by Kate or Jenny because of their belief that they were engaging in a shared leadership approach; which they felt was not conducive to delegating work, believing instead that each member should voluntarily assume responsibility. The others in the group awaited direction from Kate, Jenny and Margaret as they felt they were leading the group and so did not offer to undertake any tasks, instead opting to wait to have duties designated to them. As a consequence, Kate and Jenny undertook the majority of practice development work themselves, such as organising meetings, preparing documentation, organising away-days, creating information boards for Oak and Willow wards, managing correspondence and completing the submission document (25.05.05 CG meeting). Margaret assumed responsibility for organising

meetings with senior management and external people, but she did not partake in the *"donkey work"* (02.03.06 Interview) which was all left to Kate and Jenny.

As the core group began to experience problems and morale started to flag, Kate asked others for help to write the submission document but no-one volunteered and as a result it was left to Kate and Jenny to complete. This worried Theresa – *"You seem to be taking on too much my friend"* (28.09.06 CG meeting) – who expressed her concern on many occasions that a small minority of the core group were undertaking the majority of accreditation work (10.11.05 CG meeting). This situation however, continued for several months where each time help was requested by Jenny or Kate, eye contact from the rest of the group was avoided (28.09.05 CG meeting) or someone would *'volunteer'* Kate or Jenny to undertake it (17.08.05 CG meeting). When Christine or Anna were eventually asked directly by Kate and Jenny to book a room for a meeting and type up a letter, they claimed to not understand what they were being asked to do and so the responsibility to complete this once again fell onto Kate and Jenny (28.09.05 CG meeting). It eventually became an expectation that Jenny and Kate would complete all of the mundane aspects of the accreditation, which was clear when the core group met with their senior management team to discuss Helen and Megan's potential future in the accreditation. During this meeting they were informed the new Willow ward leaders would not partake in any aspects of accreditation work other than initiating projects on the wards (01.02.06 CG meeting), which meant Kate and Jenny would still be responsible for completing the majority of practice development work. Theresa felt was an important decision for them to contemplate as she was aware of their already heavy accreditation workload *"you guys need to look at whether you are prepared to take on the responsibility of writing it"* (29.03.06 CG meeting). Kate and Jenny agreed with Theresa and felt it

was unfair that they would be responsible for completing the entire documentation side of the accreditation - *"We can do all the boring admin jobs, but that's the problem; I think we've been doing loads of stuff like that and no one else does their share and we get frustrated"* (02.03.06 CG meeting) - and they believed this also fundamentally compromised the principles of practice development, which they felt required those initiating changes to be responsible for documenting them:

"I think that if we keep Willow ward going, the whole documentation of the whole thing will be just on Margaret, myself and Jenny which is really unfair I think. And it's not the whole point of the process of accreditation ... the whole writing up but will have to come from them [Megan and Helen] because it's them doing it on the ward" (02.03.06 Interview).

All members of the core group were unhappy with the distribution of work; with some believing it was badly organised and others that they had an unfair share of it. As a consequence they all felt it would be more appropriate for a single leader to take charge of the core group. Margaret for example felt a single leader would ensure continuity of changes on both Oak and Willow wards *"You can't implement change with two different people implementing it cos it just doesn't get done the same way...it needs one person to really coordinate it"* (05.06.06 Interview). Anna believed a single leader was needed to organise the core group:

"You do need someone to blend us all together and collate ideas ... [and] guide us, because obviously if it's unstructured, it's going nowhere ... I think it will come to the point where they will need someone to lead it forwards. It's nice to have informal chats, but when it comes down to it they've got to collect the information and get it into a worthy document – they will need somebody to lead through that" (09.05.06 Interview).

Kate maintained throughout the accreditation process that a single leader of the core group was needed, believing this would *"drive it forward"* and provide a

strong leadership base *"I still think that you need one particular person to lead and we don't have that. We haven't had that one lead and I think that's where it probably hasn't helped"* (02.03.06 Interview). This view was surprising, given Kate's past experience of accreditation which began when she joined Oak ward in 2003. The clinical leader at that time⁷⁰ was embarking on practice development accreditation for the ward and had taken on the leadership position of the core group to do this, however she left the ward ten months later to take up a position elsewhere in the hospital. The accreditation completely collapsed as a result because the rest of the core group were unsure of how to take over her leadership role *"when she left, it rapidly started to disintegrate"* (18.07.05 Interview). Theresa was aware that this was often the case in practice development accreditation, which is the reason she initially advocated a shared leadership approach (15.09.05 Interview); however five months into the accreditation she, along with the Temperley Hospital managers agreed that a single leader of the core group was essential to prevent it falling apart (10.11.05 CG meeting). Kate believed the single leader should be a member of the nursing staff and in a hierarchically superior position of power and not a therapist as she was⁷¹ *"Jenny and I said from that time [the beginning of the accreditation process] you have got to have a clear leader, whether that be the clinical leader, the Sisters or the managers"* (28.06.06 Interview).

Kate acquired the position as leader of the core group by emergent leadership⁷² as the others supported and accepted her 'leader-like'⁷³ behaviour (Northouse

⁷⁰ Margaret's predecessor.

⁷¹ The reasons for this are explored over the forthcoming chapters.

⁷² This is opposed to leadership which is 'assigned' from a formal position in an organisation (Northouse 2004)

2004) and admired her enthusiasm for practice development (Ridgeway 2003). However her clear reluctance to take on this role had caused the others to feel anxious and when the founding leader of a group does not appear confident in their role, other strong members step in to share (or usurp) the leadership position, which was demonstrated by Margaret and Jenny's assumption of a joint leadership role (Schein 2004).

The uncertainty, confusion and frustration over the distribution of work among the group caused tension and conflict and while the symbolic-interpretive perspective advocates a minimal level of conflict within groups (in order to strengthen decisions⁷⁴), disputes over the distribution and allocation of work are classified as 'dysfunctional'. This is because they create uncertainty around individual task roles, which ultimately prevents the group progressing toward their goal (Robbins and Judge 2007). Conflict around task allocation among core group members during accreditation has not yet been documented in literature, but clearly plays a major role in how it progresses. The uncertainty over the completion of tasks led the core group to believe a single leader would be more appropriate, however Oak ward's initial accreditation attempt failed when a sole person led the group, which is precisely why the shared leadership approach is advocated in practice development literature (White 2005). The dissipation of change initiatives after a leader leaves, which was seen in the Oak ward original accreditation attempt, indicates that 'true' change was never actually achieved; meaning any success during this period was accountable to employees following the instructions issued by a charismatic leader:

⁷³ Leader-like behaviour emerges from the individual members of the groups' social schemas of how leaders think and act (Ridgeway 2003).

⁷⁴ This is explored further in Chapter Nine.

New ideas lasted only as long as someone did the pushing. As soon as the champion for these new ideas left, the change initiative dissipated. This may be short-term change, but it isn't true change. True change occurs when ideas or concepts become embedded in the underlying assumptions about how work is done. True change means the new ideas become institutionalized and are no longer dependent on a change agent or champion to support them

(Klein 2004:1).

True change can only occur if followers recognise a genuine need for change, when they achieve a sense of ownership over changes and when they re-examine the assumptions which led them to behave in certain ways originally (Klein 2004). While it is certainly more evident that true change has not been achieved if a single leader leaves an initiative (as it collapses), the shared leadership approach is equally as unlikely to achieve true change but because others exits to continue the initiative forward, this is not so evident. One possible solution to resolve this would be to establish a series of successors who are genuinely committed and dedicated to the goals in order to ensure leadership continues if the lead figure resigns. This is recommended in criterion four of the Bournemouth University practice development accreditation scheme framework (Bournemouth University 2007) and more on this proposition is outlined in Chapter Nine. The absence of genuine committed members of the core group in this accreditation also caused significant problems, which the following sections illustrate.

CORE GROUP SHARED BELIEFS & AIMS

The entire core group began the accreditation with a collective belief of the need

to create a new identity for Oak and Willow wards, which they viewed as a “dumping ground” (25.05.05 CG meeting) for patients who had a variety of complex needs which they could not address “It’s a mish mash of everything that’s left over and you don’t know where to put people” (03.08.05 Interview). The core group wished to create an identity as a specialist rehabilitation unit which they hoped would “raise the profile” (09.05.05 Fieldnotes) of Oak and Willow wards and ensure they were no longer sent ‘inappropriate patients’ (25.05.05 CG meeting) from the nearby larger hospital, Whitemead. The core group believed if Oak and Willow wards underwent the accreditation process together, a shared ideology and collective consciousness would be created among the staff over both wards. The core group wanted to strengthen this bond by physically joining the two wards and met with an architect and senior managers on several occasions to discuss the feasibility and financial implications of doing this (17.08.06 CG meeting). To cement the new identity of the wards the core group wanted to rename the would-be unit with a more rehabilitative title, which they hoped would raise awareness within the hospital and the wider Trust of their purpose (28.09.05 CG meeting).

The core group’s desire to create a new identity was also in part determined by their aspiration to separate themselves from the already accredited unit at the hospital - Elm ward - which was situated directly next to Oak. Elm ward had a high profile throughout the hospital and was renowned for providing excellent quality, patient centred and innovative care (10.08.05 CG meeting). The core group found separating themselves from Elm ward problematic, however as many of the projects they undertook as part of the accreditation were identical to those Elm ward had successfully implemented; which made them often feel as though they were ‘copying’ their ideas (10.11.05 CG meeting). Several members of

staff on Oak and Willow ward had also previously worked on Elm ward and often made references to its more effective systems, which irritated the core group:

“Patricia bought a wad of paper on protected meal times [and] then started waffling on about ‘Elm ward this’ and ‘Elm ward that’ so I said ‘Well we’re not Elm ward, do we have to do it the way they did it?’” (25.05.05 CG meeting).

The core group believed Elm ward received privileged treatment as they thought they were allocated additional funds from the hospital budget because of their practice development unit status - *“Everyone thinks ‘Elm ward, wow’ so they get all the charity funds” (12.10.05 Interview)* – and they felt Elm ward in general received more recognition, attention and praise than any other wards *“they just get so much credit all the time and you always hear about them being a PDU” (31.05.06 Interview)*. The core group’s belief that Elm ward received preferential treatment was heightened several months into the accreditation, as money from a funding bid the core group won was withdrawn by their management team and allocated to Elm ward to complete some of their ongoing practice development projects *(02.11.05 Fieldnotes)*.

While united in their desire to create a new identity as a rehabilitation unit, the core group were not agreed on how to achieve this, which Theresa had noted *“they seem to working slightly at a tangent to each other ... [and] are not clearly going in one direction” (15.09.05 Interview)*. This did not particularly concern her early in the accreditation however, as she explained this was often the case when practitioners first create a core group. Several months into the accreditation, the core group members had grown even further away from reaching a consensus on

how best to attain their goal, which then became a more serious concern for Theresa. Anna for instance, was strongly opposed to starting a project which involved rotating the Willow and Oak ward staff around the wards (19.10.05 CG meeting) but Theresa hoped the negativity demonstrated by some members of the core group towards certain projects would eventually become a positive influence, as it would ensure they had fully debated the appropriateness of their actions:

“They’ve got an extreme cynic in the group, which actually is quite useful because if you can take them with you – once you’ve actually converted them to the idea – they can become powerful. But it’s a lot of hard work ... I think that person will bring up the sorts of issues that staff will bring up and it’s really good in a way to have somebody like that to temper the enthusiasm ... she will sort of dampen down some of the wilder excesses of the others which is in some ways a useful role” (15.09.05 Interview).

The core group were unable to overcome their disagreements regarding some projects however, and the continual disputes had a negative impact on their ability to progress in the accreditation. Disagreements were heightened as problems surrounding the complaints on Willow ward worsened, as Christine in particular became unhappy with some of the suggested ideas for improving practice, which she felt were distracting her attention from addressing the ward complaints. The inability to resolve disputes significantly lowered the morale of the core group who reported feeling “stressed” and “disappointed” at being unable to move the accreditation forwards (25.11.05 Project meeting).

The disagreements also demonstrated that the group differed significantly over what they believed practice development entailed and signified. The original core group members had all attended the three day induction course hosted by

Bournemouth University and so it would be anticipated that their understanding of the practice development philosophy would be somewhat similar. While they did all agreed that practice development was a framework to achieve higher standards of care (i.e. 20.07.06 *Interview*) through team development (i.e. 10.01.06 *CG meeting*) in a continuous process (i.e. 10.08.05 *Interview*), they differed on all other aspects of it, most likely attributable to their personal experiences of engaging with it. Christine and Angela for example, believed practice development required significant amounts of *"extra work"* (24.10.05 *CG meeting*) but Kate and Jenny fundamentally disagreed, claiming the developments they were undertaking through accreditation should be part of everyday practice *"PDU isn't doing anything differently to what you normally would do, it's just providing evidence to it"* (10.01.06 *CG meeting*). Kate and Jenny focused more on the aspects of practice development associated with providing evidence and evaluating change - *"evaluation and producing evidence is the fundamental part of PDU"* (31.05.06 *Interview*) - whereas the rest of the core group paid little attention to this. Angela was alone in prioritizing the need for changes to be patient centred (18.07.05 *Interview*), as the others in the group believed that accreditation was more to praise staff for their good work *"for nurses to take some credit really for what they're doing, cos they slog their guts off"* (20.07.05 *Interview*). Some core group members viewed practice development as primarily a multidisciplinary initiative (18.07.05 *Interview*), but others believed it was something which should be nurse led - *"I think it should be more nurse not therapy led"* (19.10.05 *Interview*) - and while some core group members felt *"getting other peoples view into place"* (18.12.05 *CG meeting*) was a key aspect of practice development, others were more concerned with putting their own ideas into action:

"If you really sort of want to be underhand about it you can sort of make a few suggestions to staff about things that you would like to happen and wait for them to come back with it being a good idea from them" (05.06.06 Interview).

Finally, the core groups' individual experiences of the accreditation process led them to each have a different opinion of practice development, as it was called *"a fantastic concept"* (08.12.05 CG meeting) and *"a fab idea"* (24.11.05 Interview) by some, but *"slightly confusing"* (12.10.05 Interview), *"easier said than done"* (02.03.06 CG meeting) and *"a headache, the whole bloody thing"* (28.06.06 Interview) by others.

While individuals interpret information and create their own symbols and meanings as a result of this (Hatch and Cunliffe 2006), it would be expected that the group's definitions of practice development would not be quite so polarized, which indicates that they were not united in their beliefs and aims for the accreditation. Organisational change literature claims that disagreements such as those experienced by the core group are not uncommon, as initially groups are merely a collection of individuals within which each member brings their own cultural frame⁷⁵. As such to begin with there is often little consensus among the group until they can forge a collective sense of mission and common experience which will then enable them to understand each other's needs, values and goals (Schein 2004). As outlined previously, disagreements between group members are advocated from the symbolic-interpretive approach (Baron and Byrne 2003) and Theresa had also hoped this would have strengthened the core group as a team, because once the opposing members are convinced of the necessity of

⁷⁵ Humans understand cultural texts (such as language and behaviour) through 'frames' which consist of what they already know about the text and other texts like them and as such they are approached with certain expectations. When people find themselves in new situations, they draw on knowledge of similar experiences to get by (Tietze et al 2003).

projects they can become strong allies⁷⁶ for them (Yukl 2006). However the core group's overall inability to overcome their differences indicates that they were not united in their values and beliefs and as a consequence their disagreements only further weakened the group's structure (Baron and Byrne 2003).

The core group were all united however, in their aim to differentiate themselves from Elm ward which is a natural part of group formation, as group members must realise that they cannot become a replica of another group (Schein 2004). This leads the group to actively create their own identity by distinguishing themselves from others (Frey and Sunwolf 2004). However, the core group's disdain for Elm ward was more than just to distinguish themselves as a group; they were in fact harbouring a deep dislike for Elm ward. Practice development literature advocates the sharing of information and knowledge between accredited units to enable them to more effectively problem solve (Sheehan and Hayles 2006), which the core group's attitude to Elm ward directly opposed. Units are expected to use no additional resources to become accredited in order for initiatives to be easily transferable by others (Totterdell 2004) and once accredited this should continue, with practice development unit status bringing no additional resources or favoured treatment (Chin and McNichol 2000). But as in the case of Elm ward, accredited units are often viewed as elitist and 'a protected minority of day dreamers' permitted to 'carry out their pet projects' (Page 1998b:76). The rivalry between Elm ward and the core group was partly attributable to the fact that health care practitioners are continually competing for a limited pool of resources which necessarily causes competition (Sullivan and Decker 2000). This was escalated in this instance by the management team

⁷⁶ Resistance is an indicator of strong values, which can serve as a source of commitment when opponents are converted to supporters (Yukl 2006).

who allocate funds successfully gained by the core group to Elm ward for their practice development projects.

The core group had a great deal in common with Elm ward – they were implementing similar projects, creating practice development within the same hospital and many of their staff had experience of working on both wards. Yet when the core group were in need of advice, they sought the opinion of practice development leaders at other hospitals rather than walking fifteen steps next door to Elm ward, which I often found surprising *“They really resent Elm ward, which is just bizarre. I thought the whole point of practice development was sharing ideas and information”* (17.08.06 Fieldnotes). The rivalry with Elm ward emerged primarily from the fact that it did receive additional resources and preferential treatment because of its accredited status. Practice development literature has so far not documented that some accredited units are indeed privileged by receiving additional resources, which causes tension between them and other departments within the same hospital but this research has uniquely revealed this.

The importance of shared values and beliefs when undertaking change initiatives is key, as while a shared goal is essential, agreement on how to achieve this goal must be likely to be achieved. Anna fundamentally disagreed with the proposed staff rotation project⁷⁷ and it was highly unlikely she would ever have changed her mind, irrespective of information presented in support of it, and the rest of the core group were equally as unlikely to change their decision to proceed with the project, irrespective of information Anna presented contrary to this. A

⁷⁷ Her reasons for which are detailed later in this chapter.

loggerhead situation was subsequently caused which was eventually only resolved when Anna resigned from the core group. The disputes caused by a lack of shared beliefs and values led to the commitment of some core group members to dissipate, which further hindered the accreditation process as the following section will illustrate.

CORE GROUP COMMITMENT

A lack of commitment by some core group members was the source of many disputes among the group; commitment was best mirrored by attendance at the weekly lunchtime core group meetings, which were held to discuss the progress of developments and to highlight any areas of concern during the process. When the accreditation first began, attendance at meetings was almost one hundred per cent (illustrated in Appendix Eleven), with core group members even coming in for meetings on their day off (22.06.05 CG meeting). However, as the core group began to collapse because of the problems on Willow ward, the attendance at meetings by some members dwindled which frustrated those who attended regularly. This was particularly evident on one occasion where Kate, Jenny and Anna collectively vented their annoyance with the rest of the core group as they had failed to notify them that they would not be attending the meeting, making Anna, Jenny and Kate feel their time had been wasted *"I come in on my days off for these meetings"* (19.07.05 CG meeting).

Inevitably, every member of the core group missed a meeting at some point during the accreditation process but non-attendance at meetings was at its height around the time of the steering group meetings, despite many of these having been arranged months in advance. When the date of the steering group meetings

neared, most of the core group announced they could not attend for various reasons and the meetings consequently had to be cancelled (*i.e. 18.10.05 CG meeting*). Non-attendance at practice development project meetings also mirrored the declining commitment to the accreditation, with on one occasion – despite their previous annoyance at fellow core group members for failing to attend meetings without notifying them – Kate, Jenny and Anna all missed a project meeting they were due to attend. All three were on their wards at the time of the meeting but did not show up to it and failed to inform Christine - who was hosting it - that they would not be attending (*07.09.05 Project meeting*). Despite this one occasion, Kate and Jenny were the two most dedicated members of the core group, reflected through the fact that they attended the majority of meetings. However Margaret believed on occasion they had allowed their personal lives to interfere with their accreditation responsibilities. Both Jenny and Kate were undergoing major changes in their personal lives which Margaret believed distracted their attention and weakened their commitment to the accreditation, which had caused a lull among the core group (*10.11.05 Interview*). Jenny and Kate conversely, believed it was Margaret and Emily who failed to demonstrate sufficient commitment to the accreditation, which they believed should have been demonstrated by showing enthusiasm and energy for practice development on Oak ward:

“The clinical leaders need to be more responsible for it and be enthusiastic and having PDU boards everywhere and just drumming it in...at every ward meeting, just kind of be the one encouraging it and enthusiastic and I don’t think that’s happened” (28.06.06 Interview).

When core group members were interviewed about their level of commitment they would often blame time pressures for their lack of involvement; Christine

for example announced *"I don't have time to do PDU projects"* (19.10.05 CG meeting) and Anna claimed she was also *"too busy"* to be involved in the accreditation (19.10.05 CG meeting). Anna's lack of time for practice development was a source of frustration among the others in the group, as while she had implemented one of the projects quickly her failure to document the changes she made and evaluate this – which she excused by saying she *"had other things to do"* (19.10.05 CG meeting) – annoyed the others. The core group believed the documentation side of projects was the simplest and quickest aspect of practice development to complete, and so did not understand Anna's reluctance to conclude the project by achieving this last aspect of it.

Anna and Christine's lack of commitment to the accreditation was clear by their deficient awareness of key pieces of information. For example, after four months and many core group meetings they believed Angela was a practitioner who wished to become a steering group member, utterly unaware that she was in fact a core group member (17.08.05 CG meeting) which was the reason she had been attending weekly meetings. They also thought the first steering group meeting was a gathering of people who were interested in becoming involved in the accreditation, when in actual fact the membership of the steering group had been decided weeks earlier and the steering group meeting they attended was the first official one (17.08.05 CG meeting). Anna and Christine were also completely unaware that two of the largest projects they were supposed to be involved in had merged to form one large project almost a month after this had been done (19.10.05 CG meeting). Finally their lack of awareness over key accreditation issues was clear as they told the others in the group they had implemented the

protected meal times⁷⁸ project for two meals per days instead of the agreed one as they thought this was what they were “supposed” to do (19.10.05 CG meeting).

As the problems on Willow ward escalated with more complaints, Christine “completely lost interest” (10.11.05 CG meeting) in the accreditation and her commitment to it finally expired when she learned that she would be moving wards. Anna felt the repercussions of Christine’s mental withdrawal from the accreditation and she felt uncertain about the future of practice development on Willow ward, which she believed prevented her from demonstrating commitment to it “I want to wait and see what’s happening on my ward before I get involved” (19.10.05 CG meeting). When Christine was replaced on Willow ward by Megan and Helen several weeks later after the problems caused by a clear absence of commitment, the core group acknowledged that gaining this from the new leaders was imperative (08.02.06 CG meeting). On their first meeting with Helen and Megan, the core group were impressed with the interest in the accreditation they demonstrated; Helen in particular who had emphasised her desire to “fire the staff up” (20.01.06 CG meeting) on Willow ward. The core group believed this was confirmation of their commitment to the accreditation, which was confirmed by Theresa who commented “It sounds like you want to lead Willow ward through a bit of the PDU journey” and was informed “Oh absolutely” (20.01.06 CG meeting) by Helen. However, Helen was not genuinely committed to the accreditation, as she did not attend any subsequent meetings and failed to communicate any further with the core group about it. Megan unlike Helen, told the core group from the second meeting she attended with them that she could

⁷⁸ Protected meal times is the closing of a ward to visitors and other staff within the hospital whilst meals are being served in order for nursing staff to focus on assisting patients who need help to eat, and to enable more uninterrupted, quality time to be spent with patients.

not commit to the accreditation *"I can't be committed cos in six months I might not be there"* (06.03.06 Interview). Megan felt her limited time on Willow ward (due to being only temporarily seconded) meant she would not reap the benefits of practice development initiatives and so was therefore reluctant to participate *"we'll be long gone by then"* (20.01.06 CG meeting). Megan admitted she would be more likely to be committed to the accreditation if she was to be offered a permanent position on Willow ward but needed assurance that she could see the process through until the end before this could happen:

"At the end of the six month secondment are they actually going to say 'Well stay for another six' or are they going to restructure the management yet again, you know? Who knows what they've got in mind. So do I actually get stuck into all this work? I'm stuck between the devil and the deep blue sea at the moment" (06.03.06 Interview).

Theresa was frustrated by Megan's attitude as she believed a significant amount of accreditation work could be achieved in the six months Megan would be on Willow ward *"But that's saying that you can't be committed to improving the ward, and you clearly are, and you might not see the end of it, just contribute"* (01.03.06 CG meeting). While the core group were able to empathise with the position Megan and Helen were in – *"they're not committed because of the job they're in, being that it's only a temporary thing"* (05.06.06 Interview) – they were nevertheless frustrated that the accreditation could not move forward on Willow ward until they gained their commitment *"we need to know how committed Helen and Megan are, or else it just won't work"* (01.02.06 CG meeting). With a clear lack of enthusiasm for the accreditation shown by Helen and Megan, after several weeks the core group believed the only way they could move forward was by requesting their managers force them to become committed to it:

“They need to rein Helen and Megan in and make them part of our PDU structure ... if we get the right support from Abigail and Rosemary, and they need to look at what we’re doing, then they will be forced to be committed” (08.02.06 CG meeting).

Commitment to practice development is cited as a fundamental necessity of core group leaders within the literature (Bowles and Gallie 1998), which the core group agreed with. The participants all doubted each other’s commitment to the accreditation, which they claimed was the primary cause of their inability to proceed; as demonstrated within this section Margaret doubted Kate and Jenny’s, Kate and Jenny doubted Margaret and Emily’s, Margaret, Kate and Jenny doubted Christine and Anna’s and Anna, Margaret, Kate and Jenny doubted Helen and Megan’s. The lack of commitment to the accreditation was clear by the resignation of Angela, Christine and Anna and the failure of Megan and Helen to join the core group at all. All five claimed at the start of their accreditation journey that they were committed to practice development, yet their actions contradicted this, which signifies an espoused-inferred beliefs gap⁷⁹. While they wished to give the impression that they were interested in working towards accreditation, their absenteeism from meetings and developments would suggest otherwise.

Megan felt unable to commit to the accreditation because of the short time she was contracted on Willow ward. This is in keeping with some organisational leadership literature, which claims change needs at least three to six months before it is accepted and so ‘change should never be attempted unless the change agent can make a commitment to be available until the change is completed’

⁷⁹ Espoused beliefs intend to give a positive impression to an audience, and inferred beliefs are deducted by researchers from behaviour in an interpretation of a person’s action (Martin 2001).

(Marquis and Huston 2006:173). This however has implications for the constantly changing environment of health care, which Theresa acknowledged in her response to Megan, as it is an environment rarely conducive to having facilitators of change see initiatives through from beginning to end. Symbolic-interpretivists support this view and recognise that culture change is in fact a slow process and as such the reality of one change agent throughout this process is virtually impossible (Halbestram 2006). Additionally, as creating true cultural change takes a great deal of time - in direct opposition to Margaret's view of Jenny and Kate - symbolic-interpretivists advocate leaders must maintain outside interests in order to sustain their motivation and energy during periods of change. Equally as leaders need to use their own motivational levels to restore motivation in their employees and become role models in practice during periods of change, the symbolic-interpretivist perspective would support Kate and Jenny's view that Margaret and Emily's absence of this hindered the accreditation:

Power and energy go hand in hand. Effective leaders take sufficient time to unwind, reflect, rest and have fun when they feel tired ... developing outside interests are important so that other resources are available for sustenance when political forces in the organisation drain energy

(Marquis and Huston 2006:313).

Commitment to a group and its goals is essential in a shared leadership approach, as group members must have confidence in each others commitment because when a changeover of leadership occurs (to utilise each member's strengths), group members should trust sufficiently in the new leaders' commitment to its success (Burke et al 2003). Additionally, as no permanent single leader exists in a shared leadership approach, exchange tactics which are

ordinarily utilised by leaders cannot be used (Seibert et al 2003) and so the success of the group is therefore dependent on individual commitment to goals, rather than the result of guidance and direction by a leader (Rickards and Clark 2006). An apparent lack of commitment makes others in the group reluctant to follow guidance given by that member (Burke et al 2003) and this would certainly have been the case had Christine or Anna been given the opportunity to assume a leadership role within the core group. The lack of commitment by the core group members was therefore a key barrier to the accreditation being a success. Applying the symbolic-interpretive perspective to the problems related to commitment documented in this section – more specifically whether instigators of change should be present from its beginning to end – raises a new issue for accreditation. Practice development is called an ongoing and continuous process (McCormack et al 1999) and so necessarily can never have one single practitioner to see this through from beginning to end, as no end exists. Practice development can therefore never be achieved by one leader and so effective succession planning – through selecting several genuinely committed and dedicated practitioners – is the potential solution to this problem, which is explored in Chapter Nine.

The issue of commitment explored in this section raises new questions for accreditation; practice development units comprise of several departments, units or wards (Allsopp 1998), which may have influenced the Oak ward members of the core group to continually try to gain accreditation with Willow ward. Yet Anna and Christine both admitted at various points they did not believe seeking accreditation was in the best interests of Willow ward and Helen and Megan's reluctance to become involved implied they shared a similar view; but the Oak ward members of the core group continually pressed them for their commitment

irrespectively. Accreditation therefore should perhaps not be limited to multiple units, as this may have given the Oak ward members of the core group the confidence to proceed without the clearly reluctant Willow ward. The literature has neglected to document resistance to practice development from the leaders of other units – such as Helen and Christine – but this evidently played a major role in this accreditation. To gain the commitment of the Willow ward leaders, the core group turned to their management for support and the relationship between them and their management team is discussed in the following section.

MANAGEMENT SUPPORT OF CORE GROUP

The core group were aware from the start of the accreditation that they would need to gain the support of their management team, as many of the changes they wished to implement would affect other departments within Temperley Hospital and would therefore need authorization. To aid this, the core group invited their managers – Abigail and Rosemary – to join the steering group, which they both accepted. After the first steering group meeting the core group were elated by the support their managers had vowed to give them, with Abigail in particular having appeared excited by the changes the core group suggested (10.08.05 *Fieldnotes*). The core group were further impressed when they approached Abigail for her help in completing the business aspects of the submission document as she told them that she would be “*happy to help*” (28.09.05 CG *meeting*) in any way she could. The core group met with Abigail several weeks after this to discuss possible funding for physically linking Oak and Willow wards, which she agreed to and even arranged a meeting between the hospital architect and the core group to discuss plans to implement it (22.09.05 CG *meeting*). Rosemary also demonstrated her support for the accreditation, as she

often informed the core group of forthcoming conferences relevant to the projects they were implementing and she reassured them that she would fund attendance (02.11.05 CG meeting). However, the core group felt the support from their managers had begun to dwindle as the problems on Willow ward emerged, and the relationship between them became particularly strained during November and December 2005, as a result of the management's interference in core group projects.

One such instance was Abigail's reallocation of the money the core group successfully secured through their bid to the already accredited Elm ward (02.11.05 Fieldnotes), which was particularly infuriating for the core group as Abigail did not inform them that she had done so, but rather Margaret had discovered this only by reading the Trust's monthly magazine. The core group confronted Abigail about her decision and she reassured them that she would give them money from the hospital budget to pay for their project equipment; however as this never actually materialized the core group seriously doubted the sincerity of her support. They were also annoyed when they were informed only two days before it was scheduled to be held, that neither Abigail nor Rosemary could attend the second steering group meeting which had been arranged several months earlier, despite numerous reminder emails sent to them in the preceding weeks. The prioritization of other engagements above the accreditation made the core group question the sincerity of their manager's support (08.12.05 CG meeting).

The relationship was at breaking point after Abigail and Rosemary decided to "hijack" (24.11.05 Interview) the core group's staff rotation project. This project was designed by the core group to rotate the staff of Oak and Willow wards

among the two wards in order for the staff to gain an understanding of how they both worked. The management team announced they would be rotating the staff between Oak and Willow ward in a meeting the core group arranged to discuss the future of the accreditation (18.12.05 CG meeting), during which Abigail and Rosemary made it clear they would not be consulting the core group over it. This frustrated the core group as they felt their ownership of the project had been lost and in an attempt to regain some degree of control over it, Margaret informed their managers in a subsequent meeting that they wished to put the project “on hold” (20.03.06 CG meeting) until the issues on Willow ward had been resolved and the support of Helen and Megan had been gained. However her opinion was dismissed and she was told it would continue irrespectively. The core group were further infuriated when Abigail and Rosemary informed them they would be rotating staff for a period of three months and not two weeks as the core group had intended (20.03.06 CG meeting). This confirmed to them that the managers were using the accreditation as a method to isolate negative members of staff rather than, as the core group had claimed to want to achieve, to help staff bond together and to enable them to become familiar with both wards for when they became a unit:

“The senior management team would like to see it as a vehicle to see how many people are functioning. I wanted to go for one month and I got pushed to two and then it got changed to three months behind my back, which I wasn’t too happy about” (05.06.06 Interview).

The atmosphere between the core group and their managers was worsened from December 2005 onwards when the strategies to improve the care on Willow ward were discussed, as the core group felt they were being “kept in the dark” about the plans (08.12.05 CG meeting). Rumours began to circulate, with some reports

claiming Willow ward would be completely closed down and others that the Willow ward staff would all be redeployed elsewhere in the Trust (08.12.05 CG meeting). The uncertainty over the future of Willow ward made the core group feel it was impossible to implement projects as part of the accreditation, as they mostly required joint changes over both wards (08.12.05 CG meeting). In mid-December 2005 the management team finally announced their decision over Willow ward – to replace Christine with Helen and Megan from different wards within the hospital for a six month trial period. The core group were informed of their decision only a few weeks before it was due to be implemented and their lack of consultation over how this would impact the accreditation frustrated the core group *“They’ve made these decisions behind closed doors”* (08.12.05 CG meeting). After this was announced, the core group arranged a meeting with their managers in which Abigail reassured them she would encourage Helen and Megan to continue with the joint accreditation (01.03.06 CG meeting). However, when the core group met with Helen and Megan for the first time in January 2006 to discuss this, it was evident that Abigail had not done so, which the core group felt was once again reflective of lack of support *“it feels like our views have just been disregarded”* (08.12.05 CG meeting).

They described feeling *“disillusioned”* (01.03.06 CG meeting) by Abigail and Rosemary who they believed had *“made it clear”* (08.12.05 CG meeting) through their actions that practice development was not a priority for Willow ward, which made them angry and feel disregarded *“They’ve just gone ahead and changed things and I feel quite short changed by it all”* (08.12.05 CG meeting). When it became clear to the core group several weeks after first meeting with Helen and Megan that they were uninterested in pursuing the accreditation, they asked Abigail and Rosemary who would be replacing these leaders on Willow ward after the

secondment. However the most information the core group were given was that their managers had “big plans for [Willow ward] next year” but no details could be given as to what these may be (29.03.06 CG meeting). The core group eventually felt unable to continue with a joint accreditation between Oak and Willow ward until they knew the plans for the future year as they did not want to initiate changes that would only be removed with the arrival of another new leader:

“This Trust has so many secrets, you know? How could you ever actually have any projects under the guidelines of the Trust agenda when you don’t actually know what the Trust agenda is going to be, or what is going to be instigated? It’s rubbish. The nursing managers need to be in there and understanding what it’s about - it’s not just a paper shuffling exercise, it’s actually something really important and valuable. I just don’t think they realise that, especially about how much we need to know about where the actual rehab directorate is going and all that kind of stuff in order to do PDU. Otherwise you’re doing projects for what? They could all be completely different in two months time” (28.06.06 Interview).

The core group instead decided to separate the accreditation which would enable Oak ward to continue towards it alone. They were aware that this may have some financial ramifications and so sought approval for this from Abigail, who informed them that she believed this was the best course of action (08.02.06 CG meeting). The core group then met with their practice development consultant Theresa to announce their decision to proceed the accreditation with Oak ward alone, but after Theresa spoke with the group and helped them remember the reasons why they sought a joint accreditation originally, the core group revised their decision again. They then approached Abigail with their final decision – to continue the accreditation with both Oak and Willow wards as originally planned – and seemed to have a renewed energy from discussing this with Theresa. However, they were disappointed by Abigail’s negative reaction as she

voiced her concerns that Willow ward would ever be able to achieve a sufficiently high standard of care to gain accreditation status and that the two wards would have to develop at different rates because of the specific remit which needed to be completed on Willow ward (01.03.06 CG meeting). Abigail nevertheless agreed to support their decision in principle, although the core group doubted the authenticity of this and so asked Theresa to attend a subsequent meeting with their management team to highlight the benefits of a joint accreditation. During this meeting however, it instead confirmed that their concerns over the reality of Abigail and Rosemary's claims of support were well founded, as Rosemary told them she was concerned how Willow ward – which had *"always been known as a failing ward"* (29.03.06 CG meeting) – could successfully gain recognition in a scheme which demonstrated excellence in care:

"It's an anomaly to talk about practice development when the numerous complaints Willow ward have received about basic care and the attitude of staff and negativity and nurses not caring is so horrendous When they aren't even doing basic care, to talk about practice development is concerning" (29.03.06 CG meeting).

The management team nevertheless reassured the core group that they would support whatever decision they made with regards to the joint accreditation – whether to proceed with Oak ward alone or not – despite their misgivings (29.03.06 CG meeting). But the core group felt to ensure the success of the accreditation, their managers needed to *"play a bigger role"* (08.02.06 CG meeting) and offer more than just verbal support. As the months passed this failed to occur, leaving the core group disillusioned once more:

"Our managers say 'Oh great, PDU' but none of them seem to want to be a part of it" (01.03.06 Interview)

"The management are saying 'Oh yeah, great idea' because it gives the hospital more status. They see the words of it, but that's it. They don't particularly want to get involved in the process" (02.03.06 CG meeting).

The core group also became increasingly concerned, because of their management teams clear disbelief in practice development, that Willow ward's participation in the accreditation would be withdrawn by Abigail or Rosemary if the remit was not fulfilled, or worse still the entire accreditation itself could be halted if they believed it was not beneficial, which the core group felt powerless to stop:

"They decide that you can do these things and set up these things – the people up in the offices – but then ultimately when it comes down to it, they are making all the decisions, regardless of what you're doing and how much effort people have put into it on the wards" (31.05.06 Interview).

Management support of change initiatives is critical (Gerrish 2001) and group's undertaking change need both support initially to undertake change initiatives, but also to be granted a degree of independence by their management to enable them to implement changes, without having to constantly seek permission (Page 1998a). The core group evidently did not achieve this as Abigail and Rosemary did not grant them permission to begin the accreditation in the first place (as they had not yet taken up their positions within the hospital), but also the core group failed to achieve a degree of independence as they had to ensure their managers were members of the steering group to make certain their proposed changes would not be hindered.

Groups initiating change need to have sufficient resources allocated to them by their managers to enable their success (Yukl 2006), yet it is acknowledged that while teams are often encouraged to begin change initiatives, they are not given additional resources to support them which makes achieving change incredibly difficult 'the best goals, team members, and commitment will not mean much if you have no money, equipment or supplies to accomplish that goal' (Northouse 2004:214). However, practice development literature actually states that changes should be undertaken without any additional resources (Page 1998a), which raises concerns over the feasibility of achieving this without additional assets. The core group were successful in securing money from a funding bid which they wanted to use to purchase equipment for their practice development projects, which would mean that they would not have received any additional resources from their organisation to complete the accreditation. The removal of these funds by Abigail demonstrated that not only had the core group attempted to achieve accreditation without additional resources from their managers, they also actually had any potential resources removed from them. As a result they were unable to continue with several projects that required this equipment, illustrating how critical additional funds within accreditation are. The withdrawal of this money also placed considerable strain on the relationship between the core group and their management team, along with other incidents outlined in this chapter, which all contributed to the eroding degree of trust between them. Avoiding secrecy, which could have been achieved by the management team informing the core group of the decision to remove their funds and informing them of Willow wards future plans, is recognised as a key feature in building and maintaining a trusting relationship during periods of change, which is imperative to success. Some authors have emphasised the need for total transparency (i.e. the need for bad news as well as good to be shared) in

order to achieve this (Rickards and Clark 2006), even if some information cannot be shared for legal reasons, providing this is explained it will not have a negative effect on the trust relationship (Rickards and Clark 2006).

The core group's belief that they were unable to proceed with the accreditation until they had sufficient information regarding the future of Willow ward contradicts practice development literature, which advocates a flexible approach to implementing changes. This is because organisational change is inevitable and reports exist of units having successfully achieved practice development under almost constant organisational change (Page 1995). However for the core group, the uncertainty they faced over the future made them feel continuing projects was a waste of time as they suspected Willow ward may have been closed in the near future, making their efforts futile and so clearly disparity exists between reports in the literature and this core group's experience.

The multitude of issues the core group faced during their attempts at becoming an accredited practice development unit, associated with leadership problems have been explored over this first half of this chapter. Problems over a lack of clear core group leadership, failure to achieve shared beliefs, values, commitment and management support all served to prevent the accreditation from being successful. However one of the other major barriers associated with leadership to the success of the accreditation, was the core group's leadership of the staff. This is explored over the remainder of this chapter, beginning with an outline of the staff's reputation.

LEADERSHIP OF THE STAFF

The staff on Oak ward were described as a group who worked reasonably well as a team (10.11.05 CG meeting) and the ward as generally being a “nice ward” (26.08.05 Interview) by the core group and the management team. The Willow ward staff alternatively were described as having a “shocking reputation” (08.03.06 Interview) as “chaotic” (16.12.05 Interview), and the ward in general as being “dysfunctional” (01.03.06 CG meeting), “pretty horrendous” (01.03.06 CG meeting) and having “deep rooted problems” (29.03.06 CG meeting). It was claimed by the core group that Willow ward had suffered from a lack of good leadership which was reflected by, and in part attributable to, the high turnover of clinical leaders it had (ten in as many years). The HCAs on Willow ward shouldered most of the responsibility for this as they were said to “rule the roost” (10.11.05 CG meeting) which “any clinical leader will find challenging” (08.12.05 CG meeting). The staff on Willow ward were described as having “a lot of attitude” (10.11.05 CG meeting) which the core group described as “hard done by” (08.12.05 CG meeting) and “downtrodden” (08.12.05 CG meeting). Their managers said the Willow ward staff lacked any “initiative” (01.03.06 CG meeting), “enthusiasm or understanding” (29.03.06 CG meeting) and refused to “stick to boundaries” (20.01.06 CG meeting) – instead immediately “overstepping them” (20.01.06 CG meeting). The standard of care on Willow ward was deemed as inappropriate and inadequate (10.01.06 CG meeting) by the core group and the management team, to such an extent that staff there could not be trusted to execute basic care tasks (01.03.06 CG meeting) and needed to be “spoon-fed” (20.01.06 CG meeting) instructions on how to do their job, which was the reason the ward had received so many complaints. The staff were described by Abigail as lacking any responsibility or ownership over their care (02.03.06 CG meeting) and instead of being genuinely committed to their work, were simply “a group of people who turn up and go home again” (29.03.06 CG

meeting) and who *“didn’t care”* (06.03.06 Interview) about their work. The standard of care and staff attitude on Willow ward were recognised as longstanding problems – *“that is the way Willow ward have always been”* (29.03.06 CG meeting) – and attributed to *“the culture and philosophy on the ward”* (29.03.06 CG meeting) by the management team who believed it would be a major challenge to change.

Despite the core group and managers acknowledging that the Oak ward staff had a better attitude than the Willow ward staff, they were all treated in the same way throughout the accreditation. The core group’s negative view of the staff led them to adopt a controlling leadership style, which was often reflected in the language they used when discussing them:

“we need to make them more proactive” (15.09.05 Project meeting)

“it’s all about pushing them” (08.09.05 CG meeting)

“we need to hammer it into them” (22.06.05 CG meeting)

“it’s about chipping away at them” (10.01.06 CG meeting)

“we need to retrain their mentality” (03.08.05 CG meeting)

“just force it on them” (22.06.05 CG meeting)

“it’s really about breaking their mentality” (12.10.05 CG meeting).

The core group sent out a clear message to the staff that they were the leaders of the accreditation and the staff were followers, as on the away-days the core group did not partake in any ‘icebreaker’ or ‘teambuilding’ sessions with the staff, but rather divided themselves physically and stood at one side to *“observe”* (09.05.05 Fieldnotes) their interactions. The staff were disgruntled about the core

group's lack of participation and made several derogatory comments about this to one another such as *"Why do we have to do these stupid exercises and they get to just stand there"* (09.05.05 *Fieldnotes*). The staff were divided by the core group into small teams on the days and were told these would be led by a member of the core group. I was in Margaret's group for both days and watched as she exercised an autocratic leadership style⁸⁰ over her group (09.05.05, 20.05.05 *Fieldnotes*). Margaret's desire to have correct answers to the questions she posed led her to ignore many suggestions her team made, dismissing them as the *"wrong answer"* (09.05.05 *Fieldnotes*) or as *"too negative"* (20.05.05 *Fieldnotes*). This was most obvious in an exercise where Margaret asked the group to *"name the assets of the ward"* (20.05.05 *Fieldnotes*); as she was unsatisfied with the lack of answers from her team, Margaret told them that resource nurses were an invaluable asset on both Oak and Willow wards and wrote this as an answer on her flipchart. With her back turned to write on the chart, one member of the team spoke out claiming they were unaware what a resource nurse was, let alone who they were or what they did on the wards and so they clearly were not an asset. The others in the group murmured agreement but Margaret argued against their view, until one of the team announced she was indeed the resource nurse on Willow ward, thereby proving the point the others had made – that it was not common knowledge who the resource nurses were. In spite of this, Margaret would not erase 'resource nurse' from her list of assets as she personally still felt that they were (20.05.05 *Fieldnotes*). Throughout the days, Margaret disagreed with many ideas for projects staff in her team said they would like to undertake as part of the accreditation, such as eliminating the 'bibs' patients had to wear at meal times because they were undignified (09.05.05 *Fieldnotes*). Margaret instead

⁸⁰ Appendix Twelve defines a range of leadership styles.

wrote her own ideas for projects on the chart, such as changing handovers⁸¹, rearranging the sluice room and physically joining Oak and Willow wards, which she then presented to the larger group later as being suggestions from her entire team (09.05.05 *Fieldnotes*).

Margaret was not alone in ignoring the staff's suggestions from the away-days, as while the rest of the core group did write down project ideas from their teams such as improving communication and aiding techno-phobic staff to overcome their fears (09.05.05 *Fieldnotes*) – both of which were deemed as 'essential changes' that needed to be implemented immediately by staff – these were never started back on the wards. The core group instead implemented the projects they felt were most important and prioritized those projects which contributed to policies soon to be introduced by the Trust, such as staff appraisals (08.12.05 CG *meeting*) and discharge planning (25.01.06 CG *meeting*) when they returned to the wards. As soon as they returned from the away-days, the core group delegated jobs for these projects to the staff, without them being present or consulted (25.05.05 CG *meeting*). This did make some members of the core group feel slightly uncomfortable, such as Jenny who implied she wished to take a 'joint decision making' leadership approach⁸² believing staff needed to be consulted about participating in it *"it's all about them as well and what they think and decide to change cos there's no point in us telling them what to do"* (10.08.05 *Steering group meeting*). These concerns soon dissipated however and the core group confirmed that staff were to be used as a tool in the accreditation process – *"We need to make sure we get what WE want"* (22.06.05 CG *meeting*) – declaring on many occasions

⁸¹ A handover is a way of communicating patient developments during the last shift to staff starting the next shift. This can be done by holding a meeting, using a tape recorder or producing it in written form.

⁸² Appendix Twelve defines this leadership style.

that the role of the staff was to implement tasks delegated to them by the core group. This was a view the staff were well aware of *"It's all very well for Anna and Co. cos they just swan off to meetings and don't actually do anything"* (25.08.05 Interview). The core group believed their own role was to supervise staff implementing projects, evaluate changes and produce the written work needed for the submission document (10.08.05 Steering group meeting). The language they used to talk about the staff reflected their view that they were instruments to be utilised in completing projects:

"You can give them jobs to do" (25.05.05 CG meeting)

"You can tell them 'you go and find that out'" (25.05.05 CG meeting)

"We can allocate them jobs to do in projects" (22.06.05 CG meeting)

"The staff can do all the work changing things for you" (10.01.06 CG meeting).

The core group view of the staff is significant as it affected both the leadership style taken over the staff and the way the staff reacted to this. Symbolic-interpretivists claim humans act on how they imagine others view them; based on Cooley's (1902) notion of the 'looking glass self' which claims the imagined reflection of ourselves is provided by others (McIntyre 2006) – that is, the 'I' is drawn from the 'generalised other' (Knights and Wilmott 2000) – and so the expectations people hold for each other play a vital role in guiding how they perceive themselves. The expectations we hold about people can cause them to behave in ways which confirm our original beliefs, thereby producing a self-fulfilling prophecy (Knights and Wilmott 2000) and so the core group's perception of the staff as incompetent, lazy and unable to develop commitment

or empowerment, led them to treat them as if this was true (examples of this will be provided over the remainder of this chapter). It was a result of the core group's opinion of them that the staff felt unable to develop ownership or empowerment, just as the core group had predicted. The view leaders hold of their staff is therefore critical, as it determines how staff are treated (Paton and McCalman 2000); that is when staff are perceived as 'set in their ways' and can only change if they are rewarded to do so, then they are treated sternly and rewarded when they obey instructions (Marquis and Huston 2006). If staff are not seen as a competitive threat, then leaders will more often than not dominate them (Rickards and Clark 2006), which is precisely what happened between the staff and the core group.

Leaders need to hold a positive opinion of their staff (Marquis and Huston 2006) as they must trust and have confidence in their ability, in order to invoke feelings of empowerment (Yukl 2006) in a transformational leadership approach, which is advocated in practice development literature (McCormack and Garbett 2003). Equally, a sense of distrust and a lack of confidence in staff's ability will hinder their capacity to become empowered. A closer inspection of the leadership style the core group took of the staff, caused by the opinion they held towards them, is demonstrated throughout the remainder of this chapter by documenting examples of how they both restricted and forced the staff to be involved in practice development.

RESTRICTING & FORCING STAFF INVOLVEMENT

As the core group viewed the staff as instruments and not partners, in the accreditation they were not included in most meetings and the core group

controlled information passed on to them from these. No meetings were held for staff to disseminate information beyond the initial away-days and the high turnover of staff since the away-days contributed to the general staff opinion that no one understood what the accreditation was about - *"I don't even know what PDU means"* (15.12.05 Interview) - how it worked, why it was in place and how they as individuals fitted into the new changes it would bring:

"If you're coming in to something new like myself, its very difficult to grasp what it's all about and say 'I'm prepared to work with this and to work towards this goal'... It's like anything in life: if you understand things and they are explained to you, then you're more likely to give them a go" (16.12.05 Interview).

Anna and Emily were the only two members of the core group who acknowledged that the absence of information filtering down from core group meetings had caused a barrier to emerge between them and the staff. Anna informed the core group that staff had told her they could not understand why changes – which they viewed as simple to implement such as changing the way handovers were given – could not be done immediately without having to establish project groups, gather evidence, document it and consult with the core group (25.05.05 CG meeting). This was further illustrated in the 'protected meal times' project, where the Oak and Willow ward receptionists did not refuse visitors and other staff entry to the wards, or ask callers to telephone back after lunch time as they had been instructed to do by the core group (19.10.05 CG meeting). The receptionists did not attend the staff away-days which introduced them to the concept of practice development and so did not understand the aim of it. As the rationale behind the protected meal times project was not explained to them, nor were they involved in either the planning or implementation of it, the receptionists did not understand why they needed to close off the ward and

consequently did not assist in this and continued instead in their normal practice. The staff's lack of understanding over the rationale behind changes was also particularly evident during the implementation of a project which encouraged patients to walk to the day room for their breakfast rather than be served it in bed. The core group believed doing this would give the patients more independence and speed up their rehabilitation, but this had not been explained to the staff who were unable to see the benefit of making these changes and subsequently disagreed with the project:

"I think it's really wrong...why is it good? Why is it good to get somebody out of bed at half past seven? Cos they're sat there all day in a chair and then they go back to bed in the afternoon, and I think that's no good" (15.12.05 Interview).

Emily believed the staff lacked understanding about what practice development was and what it would mean for them because of the absence of information from the core group *"it doesn't mean anything to them, it's just a word" (05.06.06 Interview)*. Several members of staff corroborated this view, revealing during interview that until they could not see how practice development could make changes to improve the wards, it was irrelevant to them *"The theory behind it, you see 'The Practice Development Unit' wonderful! But it's not happening; and until it happens it means nothing" (15.12.05 Interview)*.

Despite Anna's cautionary words to the core group to provide staff with more information, and Emily's concerns over the lack of understanding about the accreditation shown by the staff, no strategies to improve the flow of information to them were implemented. The staff identified the lack of information as a key hindrance to their ability and desire to become involved in practice development:

"I get the impression that no one really understands it and nobody properly wants to get involved. But I think that's because no one knows really what they're expected to do" (15.12.05 Interview).

"It's about communication. It's about feeling that your viewpoint is valid as well, you know? ... Morale is quite low at the moment, you know? I think it's down to communication - it comes down to forums where people can say things" (16.12.05 Interview).

While the majority of the core group were withholding information and discussing how staff could be utilised to achieve developments in practice, the strain of the problems on Willow ward began to show in Christine's leadership *"I don't think now is a good time for PDU" (18.07.05 Interview)*. Indeed, her leadership of the accreditation virtually ceased, which reflected her view that practice development could not contribute to improving Willow ward. Christine's floundering commitment concerned the core group as they believed because she was *"not in a happy place" (26.08.05 Interview)*, her negativity towards the accreditation would engulf the Willow ward staff, forcing practice developments to eventually cease. The core group believed they needed to take a leadership role on Willow ward as Christine was *"not a strong leader" (10.11.05 CG meeting)*, but these ambitions were quashed as their management team announced the decision to draft in two leaders from elsewhere in the hospital onto Willow ward.

Helen's style of leadership was described by the core group as *"old school" (09.05.06 CG meeting)* and *"dictatorial" (02.03.06 CG meeting)* as she did not advocate equality in multidisciplinary working, instead believing that *"clinical leaders rule the roost" (08.02.06 CG meeting)*. The majority of the core group felt Helen would not listen to advice or suggestions to improve practice from them – *"I can't see her accepting things being done by certain members of the team" (01.03.06*

CG meeting) – let alone the staff. The core group feared that Helen would be unable to accept suggestions or tasks undertaken as part of practice development by them or the staff at all. This was confirmed by Helen who confessed that she had become short tempered when staff suggested changes to her (10.01.06 CG meeting) and admitted her reluctance to give staff any control over implementing changes autonomously *“I don’t want ... them making changes independently”* (10.01.06 CG meeting). Helen stated she did not trust staff to complete basic care tasks which the core group claimed resulted in Megan and Helen undertaking the majority of work on the wards themselves (29.03.06 CG meeting). Both the core group and Theresa felt this style of leadership compromised the principles of practice development and leadership in general *“leadership skills are about enabling other people, not doing it all yourself because if you do everything for other people, they just sink again when you’re not there”* (01.03.06 CG meeting). The core group believed they had taken a different leadership style to Helen’s claiming they had given the staff a *“responsibility”* (29.03.06 CG meeting), permission to *“lead changes themselves”* (01.03.06 CG meeting) and the opportunity to independently *“develop their practice”* (08.02.06 CG meeting). The following sections and chapters will illustrate that in fact the core group did not achieve this and far from having a different leadership style to Helen, Margaret in particular, despite of her protests, did treat staff in the same way:

“I don’t like to be the kind of manager that’s a dictator. I like to make sure that any changes that in making generally are OK with the majority – or at least a few, depending on the change. But I do like to at least try and consult with people” (05.06.06 Interview).

Margaret and Helen demonstrated the use of similar managerial strategies to obtain results, as Helen claimed to use a *“drip feed”* (20.01.06 CG meeting)

technique in which she would subtly suggest changes she wanted staff to implement and then waited for them to present the idea back to her as if it had been their own ward and would *“act surprised”* (20.01.06 CG meeting) when the staff announced their ideas. Margaret did not openly admit to having used this technique but she did allude to this on several occasions, as the following quote illustrates:

“If you want to be underhand about it, you can sort of make a few suggestions to staff about things that you would like to happen and wait for them to come back with it being a good idea from them, so it becomes an idea from them” (05.06.06 Interview).

Margaret and the core group genuinely believed that they had adopted a different leadership style over the staff to Helen. The following case example highlights this was not the case and that the core group were equally as controlling over the staff on both Oak and Willow wards.

Case Example: Using Practice Development to fulfil Personal Agendas

The project which best illustrates the core group's control and coercion over the staff and how they used the accreditation to fulfil their own personal agendas was entitled 'staff rotation'. This was proposed as a project from the very first day of the accreditation. It aimed to continually rotate two staff members from Oak ward and two from Willow ward for a fortnight to enable the staff to gain a better understanding of how both wards worked; thereby making adjusting to the other staff and routines easier when they would eventually become a joined rehabilitation unit. The core group claimed this experience would aid the staff in getting to know one another better, thus strengthening their bond as a team when they became a unit. However, while these were the reasons given to the staff for this project, the members of the core group each revealed their own personal agenda behind its implementation during interviews. Margaret confessed she had wished to rotate staff between Oak and Willow wards for many years because of what she viewed as an uneven distribution of 'good' and 'bad' staff between them. She expressed her relief at being given the opportunity to implement this after many years of attempting to have it authorised:

"I said this when I came here eight years ago as a D grade, what we need to do is work across the two wards; swap the staff and swap ideas ... and now we are doing it" (03.08.05 Interview)

Margaret was often frustrated that delays to the project's implementation were caused because of the need to discuss it as a core group and design its implementation. Margaret expressed her desire to take on a clinical leaders position which would cover both Oak and Willow wards, as it would enable her to implement the project more quickly:

"If I became leader of them both, I would mix up the staff across the two straight away. I wouldn't do this "Oh we'll rotate a couple of staff a week at a time". I would be 'Right - you, you and you over there'" (24.11.05 Interview).

Jenny on the other hand hoped rotating staff between Oak and Willow wards would allow them to observe different routines and working practices,

which she hoped would then give staff sufficient confidence to return to their ward with ideas on how to improve practice, gained from observing another. Jenny anticipated this would aide staff in gaining a sense of ownership and empowerment over their work (20.01.06 CG meeting). Kate had different expectations for the rotation project, believing the reallocation of 'bad staff' from Willow ward temporarily onto Oak ward was the only solution to "overcome the problems on there" (12.10.05 Interview) - namely the poor attitude most of the staff expressed. Kate hoped this redistribution would break down the negative power alliances that existed among the Willow ward staff, but would also improve the relationships between the staff of Oak and Willow wards, subsequently strengthening their bond as a rehabilitation unit (12.10.05 Interview).

Unlike Jenny, Kate and Margaret, Anna did not see any benefit whatsoever in rotating staff between Oak and Willow wards and argued against it whenever the subject was raised (28.09.05 CG meeting), unconvinced of the reasons given by the core group, which were to socialize the staff and to give them knowledge of both wards (03.08.05 CG meeting). Anna was aware of the staff's views of this project, which was evident from the first time it was raised on the away-days, where I noted "the staff seemed very hesitant about pursuing this" (20.05.05 Fieldnotes). Anna explained to the core group that staff were reluctant to rotate because they felt comforted on their own ward with its familiar layout, routine and patients (19.10.05 CG meeting). Emily corroborated Anna's view (yet only voiced her concerns during interview) as she recognised the staff's resistance to the project and admitted she thought it would be a mistake to pursue it (16.12.05 Interview). But Margaret disagreed, believing the resistance to the project was insufficient reason for it not to proceed, as resistance was an inevitable aspect of any change process "That's always the way; you always get a core group of people who will push for change and those who will sit on the back of it" (24.11.05 Interview). Every member of the core group acknowledged that staff were opposed to the rotation project, yet they continued to plan for its implementation regardless (28.09.05 CG meeting).

Jenny suggested involving those staff members who were most unhappy with the project in its design and implementation, which she believed would allow the core group to better understand the source of the staff's discontent and provide them with the opportunity to address their concerns. As Anna

was most aware of staff opinion, Jenny asked her if the core group would be successful in getting any staff involved in the project, but Anna said this would be highly unlikely as the staff felt they would be unable to influence the project at all⁸³ - *"They feel it's just going to happen anyway" (02.11.05 CG meeting)*. The staff during interview echoed Anna's suspicions, as each of them expressed feelings of powerlessness in preventing the project from being implemented *"I don't want to do it really, but if you've got no choice then you've got no choice really" (26.08.05 Interview)*. Many of the staff were so opposed to the project they threatened the core group members with their resignation, should they be forced into participating *"I've said to them if they put me on Willow, I'm going to leave" (15.12.05 Interview)*. They informed me during interviews of their reasons for their reluctance to rotate between the wards, which was just as Anna had thought - that they preferred the familiarity of their own ward *"It's not a very good argument; I just don't want to. I like working on this ward. I like it. This is my ward" (15.12.05 Interview)* and found the prospect of interacting with a new team on another different ward uncomfortable *"Everyone is dreading swapping wards" (16.12.05 Interview)*. The staff felt uneasy because of the uncertainty of the leadership style, the schedule and the location of items on other wards, which they felt undermined their confidence as professionals *"It deskills you having to say 'where does this go?'. It undermines your confidence" (15.12.05 Interview)*. The staff claimed if the core group decided to proceed with the project in spite of their views, they would fight against it *"There will be resistance from all of us" (15.12.05 Interview)*. This project caused great unrest and invoked strong negative feelings in the staff, which eventually led to the rotation project becoming representative of the accreditation as a whole; making the term 'PDU' synonymous with the rotation project and the negative emotions associated with it:

"People have said to me 'Oh, you haven't signed up for doing PDU' and I say 'What is it?' and they say 'They're trying to get Willow and Oak to change their staff'" (26.08.05 Interview).

A few members of staff expressed their misgivings about the project to their clinical leaders, but were informed that as they were employed through the hospital and not by the individual wards, if the Trust required

⁸³ Possible reasons for this are outlined in the next chapter.

them to work on another ward, then refusal to do so breached their terms of employment and could lead to a dismissal (16.12.05 Interview). The staff as a result believed the accreditation was merely a managerial exercise in which they had no option but to take part, again reaffirming Anna's view:

"It's taken out of our hands really... They've decided themselves that this is what's going to happen and we haven't got a say... You shouldn't be forced into something that you don't want to do - that you feel strongly about - but we haven't got a choice" (15.12.05 Interview).

The core group - without consultation or involvement from them - decided to begin rotating staff in January 2006 and aware that considerable backlash would occur when this was announced, the core group emphasised that Anna's presence would be critical at this meeting as she was *"a strong member of Willow ward"* (07.09.05 CG meeting). They hoped Anna could persuade the staff to view the project positively; however Anna resigned from the core group before this meeting was arranged. Instead of proceeding with a meeting to announce the project, the core group attached a notice to the practice development information boards on both wards to declare when it would be started (a copy of this can be found in Appendix Thirteen).

RESTRICTING & FORCING STAFF INVOLVEMENT CONT.

Staff attendance at several project groups which had previously been good - *"lots of people involved in this project"* (27.08.05 *Fieldnotes*) - began to dwindle after the publicizing of the staff rotation project (18.10.05 *CG meeting*) and eventually ceased altogether (08.12.05 *CG meeting*). This concerned some of the core group members who found the lack of attendance *"really worrying"* (08.12.05 *CG meeting*) and *"a serious problem"* (22.10.05 *CG meeting*) and became embarrassed by the staff's resistance to participate in projects *"I don't really want to write 'attendance is poor' in the minutes"* (03.08.05 *CG meeting*). Several other members of the core group however rationalized the staff's actions by claiming the projects they had chosen all required major changes to the ward and its routine, which necessarily meant heavy consultation with the core group would have been needed to implement them anyway (10.11.05 *CG meeting*). Some of the core group were unconvinced by this attitude, instead rationalizing their absence as a result of the core group's apathetic attitude to the meetings (which were frequently cancelled) - *"if the core group can't be bothered to meet half the time, then how can we expect the staff to?"* (07.09.05 *Interview*) - and because of a lack of encouragement to attend meetings (28.09.05 *CG meeting*).

Irrespective of the varying reasons the core group gave for the lack of attendance, they were in agreement that action needed to be taken to involve staff more and several strategies were developed to do this. Firstly the core group *"nominated"* (03.08.05 *CG meeting*) staff they thought would implement projects well; these were both friends of the core group members (22.06.05 *CG meeting*) and influential members of staff from both wards (03.08.05 *CG meeting*) - a move advocated by their accreditation consultant Theresa *"you can start...picking people on Willow ward to be involved"* (01.03.06 *CG meeting*). Secondly, the core group

agreed to announce to the staff that it was compulsory to be involved in at least one project for the accreditation (09.08.05 CG meeting). Thirdly the core group named staff who had attended any project meeting previously on practice development information boards located on both wards, which they hoped would make those staff members named less likely to withdraw (07.09.05 CG meeting). Lastly after several prompts from Theresa to involve the staff more in projects, the core group agreed it was essential to hold a practice development 'information day' to introduce the concept to the large number of new staff who had joined the wards since the initial away-days (07.09.05 CG meeting). This last strategy however, was never introduced which left all new staff to Oak and Willow wards with little understanding of practice development. The other three strategies were implemented, all of which involved forcing the staff in various ways to participate in projects in an effort to encourage the rest of the staff who they felt "*probably just need a bit of jeering*" (07.09.05 CG meeting) into participating.

The core group's overruling of the opinion of staff and forcing their participation for 'their own good' was particularly evident by the implementation of a project entitled 'changing the role of the HCAs' which aimed to extend the remit of the HCAs on Oak and Willow wards into becoming more rehabilitative focused (22.06.05 CG meeting). The core group believed changing their role would emphasise the rehabilitative focus of the wards but would also enable the HCAs to spend more time interacting with patients and would boost their confidence, as their added responsibilities would demonstrate the importance of their role. The core group issued questionnaires to the HCAs to gauge how they would feel about changing their role in this way and the responses they received stated clearly that the HCAs did not wish to change their role (15.09.05 Project meeting). However, the core group believed these changes would be beneficial to the

wards and the HCAs and so pursued it regardless, convinced they would embrace their new role once it was in place (28.09.05 CG meeting).

Forcing the staff to participate in projects in such ways often made some members of the core group feel uncomfortable - *"it's like dragging people along with you"* (12.10.05 Interview) - who would then caution the others not to pressurise staff to be involved (22.06.05 CG meeting). Emily, for example said during many interviews that she wanted staff to voluntarily become *"much more involved"* (04.11.05 Interview) in the accreditation but acknowledged that in order for this to happen, they first needed more information on what the core group hoped to achieve through practice development *"it doesn't mean anything to them, it's just a word"* (05.06.06 Interview). Jenny was also particularly conscious to avoid *"pushing things on people"* (10.11.05 CG meeting) as she believed this would not create a genuine change in the attitude of staff or inspire them to become committed to the accreditation. The forceful tactics used to encourage staff into participating was not successful and so other strategies which focused more on appealing to them to become involved were implemented. As part of this, Jenny and Kate created information boards (see Figure 18) which documented the times and dates of project meetings for both Willow and Oak wards and they placed posters appealing for staff involvement in particular projects (23.09.05 Project meeting) around the wards and asked others in the core group to encourage staff to become involved in ward meetings (28.09.05 CG meeting). However these strategies appeared to have been implemented too late, as the staff rotation project had led staff to become resistant to all future practice development work and they subsequently never became any more involved in the accreditation.

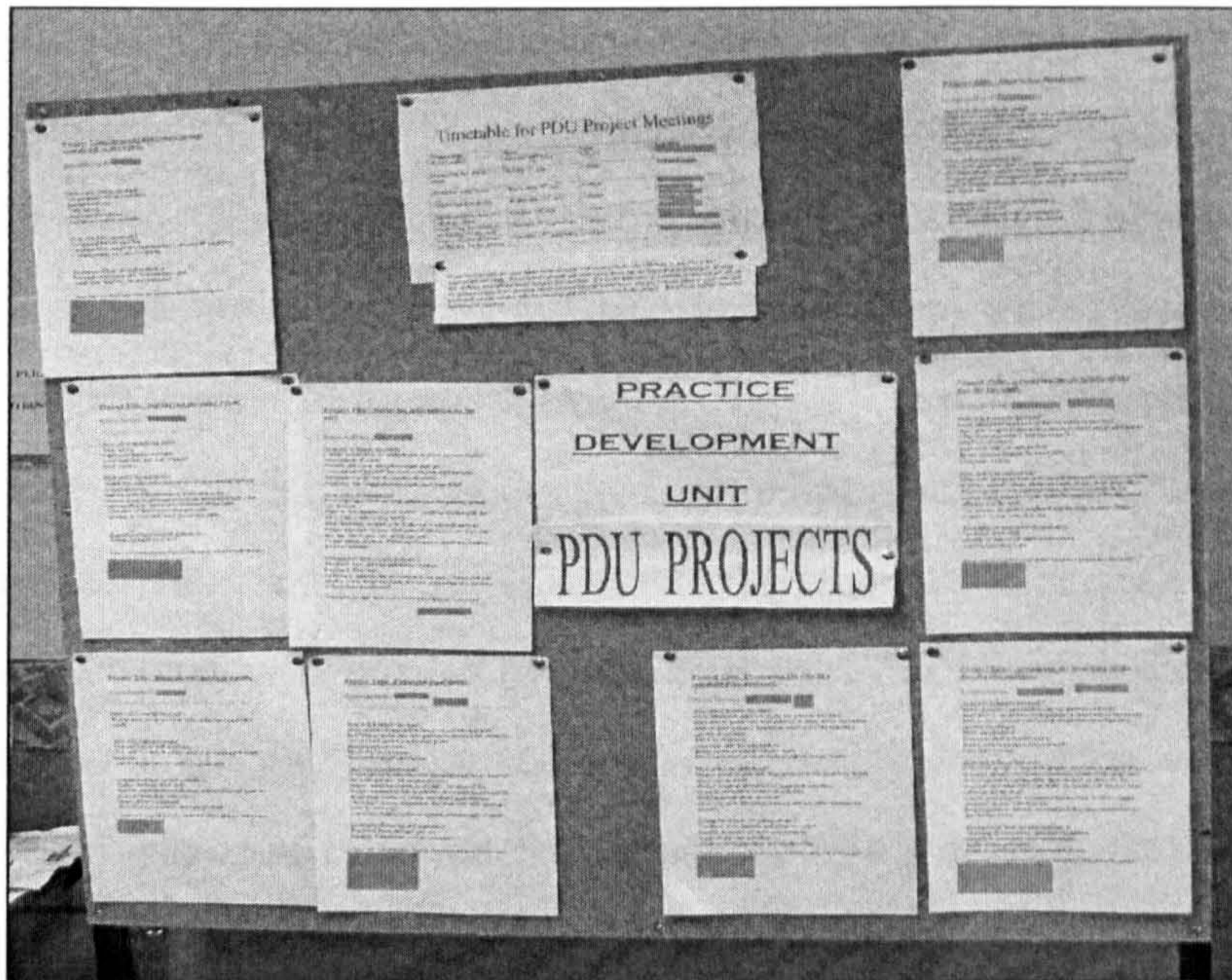


Figure 18. Practice Development Information Board

Forcing staff to become involved in practice development is in direct violation of its principles, as voluntary involvement is the only way to achieve empowerment - the key component of practice development 'the actions of empowered staff are freely chosen, owned and committed to, on behalf of the organisation without any requests or requirements to do so' (Marquis and Huston 2006:311). It is however, also acknowledged that staff involvement in practice development can be difficult (Bowles and Gallie 1998), which is perhaps the reason core group leaders from other units report having informed their staff that they must be involved in projects (Casley 1998).

Practice development advocates a transformational leadership approach, which encourages and enables staff to accomplish more than would normally be expected of them (Kirby 2000) by addressing staff need and focusing on values and emotions (Northouse 2004), through building a relationship of trust

(Rickards and Clark 2006) while being mindful of staff values, emotions and any ethical issues which may arise (Northouse 2004). To achieve this, a representative or direct democracy⁸⁴ approach to leadership must be taken whereby staff are voluntarily led as a result of the positive emotional responses invoked in them by their leader⁸⁵ (Goffee and Jones 2006). Forcing staff to participate in projects demonstrated that this was not the leadership approach taken by the core group nor is it taken in many empowering change strategies, where the rhetoric of 'handing down power' is often preached yet decisions made by staff are in actual fact blocked or ignored (Senior 2002). Forcing participation is more indicative of a 'top down leadership' approach, characterized by leaders pursuing initiatives which are seen as counterproductive or contrary to the interest of the staff at the time of their implementation⁸⁶ (Goffee and Jones 2006). Rather than adopting the transformational leadership approach which the core group should have done, they instead demonstrated autocratic and technocratic⁸⁷ leadership styles; overruling staff opinion, coercing and forcing them to participate in projects (Halbestram 2006).

The core group exercised the power they attained by their leadership of the accreditation, through introducing initiatives which fulfilled their personal agendas. This caused the trust between the staff and the core group to erode

⁸⁴Leaders are nominated to act on behalf of the staff and hold the post for a specific period of time, or for as long as they command the support of the group they represent in a representative democracy approach. In direct democracy, all members of the group have an equal right to rule and are involved in decision making (Senior 2002).

⁸⁵ These are individual feelings that they are significant, that they matter to the leader, feeling a sense of community and a 'buzzing feeling' of excitement and challenge (Goffee and Jones 2006).

⁸⁶ As opposed to in hindsight.

⁸⁷ Power is held by an individual or small group and supported by control over resources in an autocratic leadership approach and power is exercised through the use of knowledge, expert power and the ability to solve relevant problems in the technocratic leadership approach (Senior 2002).

(Hatch and Cunliffe 2006), which led to resistance to the changes and opened 'the psychological floodgates to anxieties of the deepest kind' (Rickards and Clark 2006:133). The staff resisted contributing to projects as a result, which is the reason practice development literature advises leaders to avoid making decisions 'behind closed doors' (Allsopp et al 1998) - the core group failed to do this particularly in projects such as 'staff rotation'. The core group also tried to secure staff involvement by using 'influence tactics' which are actions undertaken with the intent to change the attitudes, behaviours and beliefs of others (Robbins and Judge 2007). While influence tactics secure compliance in change initiatives, those adopted by the core group made it unlikely that genuine commitment to the accreditation could be developed (Van Knippenberg and Hogg 2003):

It has been demonstrated that some tactics (consultation, inspirational appeals, and rational persuasions) are most likely to produce commitment in the target of influence, whereas others (pressure, exchange, coalition, and legitimating tactics) are more likely to produce only over compliance or even resistance

(Seibert et al 2003: 177).

Margaret insinuated to the staff that they could face redundancy if they did not comply with the rotation project (05.06.06 CG meeting), which gained only compliance, not commitment as the staff did not internalize any new values. The threat of redundancy illustrates Margaret's use of her hierarchical position as clinical leader to demonstrate that the project was in accordance with hospital policy. Making such threats to gain compliance is a 'legitimacy' or 'pressure' influence tactic (Van Knippenberg and Hogg 2003), but using power and authority as the 'driving force' behind the changes is recognised as a key barrier to the acceptance of change by staff, who have no option but to comply (Tebbitt 1993). The core group also appealed for staff involvement by emphasising

government policy on 'best practice' thereby aiming to show that their requests for staff to comply with projects were reasonable. This is classified as a 'rational persuasion' influence tactic, which is used to ensure staff cannot comfortably object to participating in changes (Robbins and Judge 2007). One example of this occurred in the project which changed the morning routine for patients, who instead of being given breakfast in bed as the routine stood, were encouraged to walk to the day room to eat. The staff were later told that this would aide patient rehabilitation (08.09.05 *Project meeting*) and as the purpose of the ward was to do this, the staff found it difficult to legitimately justify why they would not partake in it.

A third kind of influence tactic adopted by the core group is known as 'inspirational appeal' which was evident by the posters created to involve staff in the 'changing the role of the HCAs' project (Robbins and Judge 2007). The poster stated 'HCAs – We Need You!' which the group hoped would highlight the HCAs important role in the success of the wards (26.09.05 *Project meeting*), thereby attempting to gain emotional commitment to accreditation by appealing to their beliefs, needs, hopes and aspirations. A similar influence tactic they used was 'personal appeal' which was demonstrated by their attempts to gain the support of their friends for projects (22.06.05 *CG meeting*). Finally, the core group used 'coalition' influence tactics by their attempts to enlist the influential members of staff to undertake projects in the hope this would inspire others to become involved (03.08.05 *CG meeting*). I identified a further influence tactic, not recognised as such in the literature but clearly utilised by the core group to control the staff, which was the withholding of information. Knowledge and information about the accreditation and the decisions being made within it were not disseminated to staff – recognised a strong contributor to the resistance of

change, as a lack of information destroys trust and makes understanding and accepting change difficult (Bates 2000). It perpetuates fear over changes and causes suspicion as to the motives for their implementation (Lashley 2001) which leads to changes being automatically resisted (Paton and McCalman 2000):

People abhor 'information vacuums' and when there is no ongoing conversation about the change process, gossip usually fill the void. These rumours are generally much more negative than anything that is actually happening

(Marquis and Huston 2006:180).

Leaders must contain ambiguities which perpetuate and cause anxiety by sharing information through 'upwards communication'⁸⁸ (Rickards and Clark 2006). A lack of information perpetuates fear over the new changes, and suspicion over the motives for implementing them (Lashley 2001), which is the reason practice development literature emphasises the importance of holding information sessions for staff (Chin and McNichol 2000). It has been acknowledged that holding such sessions is difficult to achieve in practice because of time pressures (Page et al 1998), however the consequences of not providing staff with information, as this study has shown, is very damaging. Most of the core group were unaware that staff found it difficult to accept changes because of the lack of information. Information about changes being implemented is critical as people need to understand and see the need for changes themselves in order to embrace them 'It is only after the light bulb has gone on, revealing that something is wrong or missing, that people become open to alternative explanations' (Klein 2004:43). It is the sharing of a belief that a justifiable and urgent need for change exists and agreement over the proposed

⁸⁸ This is where leaders share the rationale behind why they want to implement changes, which enables staff to become partners in the changes (Potter and Rosenbach 2006).

changes between followers and leaders, which enables change to be successfully achieved (Schein 2004).

The staff associated the accreditation with the negative emotions they experienced at being forced to participate in the staff rotation project. The symbolic-interpretivist perspective views culture change as only possible by the development of shared meaning, expressed through language. The word 'PDU' encoded cultural attributes, values and ideals of the group (Tietze et al 2003) and the disparity between the core group's view of accreditation (as a strategy to improve the wards and their reputation) and the staff's view of it (as a 'paper exercise' implemented by their managers) demonstrated that the term did not successfully encode shared values and ideals (Schein 2004). A positive shared meaning of the term 'PDU' was unattainable because of cultural frames that were created by the core group's actions, which led it to be associated with negative experiences. This was illustrated by Theresa's advice to the core group to cease using the term 'PDU' altogether in order to gain staff support in making changes and to overcome their resistance to accreditation. Forcing staff to comply with changes they feel uncomfortable about often leads them to adopt more of an 'anti' position than they first had, known as 'polarization' (Brewer 2003). This makes staff less committed to the change initiative, making empowerment an impossibility and dysfunctional conflict a more than likely outcome (Baron and Byrne 2003). It is suggested in one piece of literature that staff can view practice development as something that is done 'to them' rather than 'by them' – quite possibly because of such actions (Sheehan and Hayles 2006). The core group failed to recognise that their domineering behaviour made the staff reluctant to participate.

The staff claimed that interacting with a new team on an unfamiliar ward was uncomfortable for them, which was the reason given as to why they did not want to partake in the 'staff rotation' project. However this is indicative of 'espoused beliefs' as their concern over rotating wards may have been less attributable to a disrupted sense of ownership over the care they provided or the comfort of a familiar system, but rather they had a 'fear of the unknown' – uncertain of how they would be treated on the other ward. We develop self-identity through a sense of how others see us ('the looking glass self' as outlined earlier in this chapter) and as a result when the other person in an interaction is unknown, anxieties and tensions associated with this uncertainty is significantly increased (Schein 2004). According to this theory, some of the more influential members of staff would have been reluctant to rotate wards because they would then need to readjust their 'sense of self' as powerful and influential, because they could not be certain that the staff on the other ward would view them as such. This uncertainty causes resistance, which the core group failed to appreciate.

The project entitled 'changing the role of the HCAs' aimed to transform the identity of the HCAs by developing, adjusting and extending their role; however changes which disrupt a sense of identity or rearrange professional boundaries cause resistance as these are the strategies through which people can know who they are (Schein 2004). Changing professional roles causes conflict as it threatens our sense of self and causes new 'rules' of behaviour to be learned which is difficult as we are conditioned to accept and follow the rules and procedures associated with such roles throughout our the majority of their working lives (Rickards and Clark 2006). The implementation of changes to identity require a long period of adjustment (Sandstrom et al 2003), which the core group did not grant the HCAs.

From a symbolic-interpretive perspective the reactions of the staff should have been anticipated, because the introduction of unfamiliar and new systems cause stress as they involve breaking well established frames⁸⁹. When staff are unable to use their existing frames to understand new systems they are left feeling frustrated and stressed, which was made particularly worse in this case as the nature of health care work requires staff to 'surface act' thereby intensifying their feelings of stress (Robbins and Judge 2007). Surface-acting occurs when staff have to restrain their true feelings of unhappiness about a change in system to hide these in front of their clients; which for the staff of Oak and Willow wards was a dissatisfaction about having to rotate wards, but at the same time having to repress these to present the image of a caring, focused and attentive practitioner to patients and their families. Research has shown that suppressing true feelings at work in order to conform to rules of behaviour is extremely stressful and can lead to depression in staff (Robbins and Judge 2007), but can also cause 'indifference' or 'withdrawal' (Lashley 2001). This is the action of staff mentally distancing themselves from changes as a means of self protection, where compliance is attained but genuine commitment not (Knights and Wilmott 2000). Doing so however, is incredibly destructive as the workplace is the very site where the sense of self is socially constructed and maintained and therefore cannot be escaped (Knights and Wilmott 2000). The core group implemented changes which affected the identity of the staff (such as changing the role of the HCAs) because they believed it would be beneficial to them, without contemplating the impact this could have on the staff. The implementation of such projects, which were used to fulfil the core group's personal agendas, raises a new issue for practice development and change in general, as some literature

⁸⁹ Which is eased by adequate education and training (Robbins and Judge 2007).

has claimed staff are naturally cynical of leader's motives when any change initiative is implemented (Dean et al 1998). Indeed some practice development authors have claimed that if initiatives benefit the leader as well as the organisation in general, then they are misconstrued as being coercive:

I think it would be quite difficult to "get away with" an action that was clearly only serving one's own interests in an organisation, but people are often accused of doing just that when their actions benefit both themselves and the organisation

(White 2005:226-7).

However, using participant observation in this research provided a unique insight and enabled me to understand the intentions of the core group. It is because of this that I am able to conclude that in this case, projects were implemented to meet the core group's own agendas. They implemented the staff rotation project because they believed it would serve the 'greater good' of the organisation by redistributing 'problem' staff and encouraging staff to work more effectively as a unit, despite their knowledge of how unhappy staff were about doing so. Organisational change and leadership literature has so far provided many stories of leaders who claim to be engaged in empowerment strategies but who use change to meet their own agendas (Hatch and Cunliffe 2006) and this research has also confirmed this.

Finally, the core group's poor leadership over the staff was partly attributed to their often uninspiring and dispassionate style, which has been shown to hinder staff willingness to adopt new ways of working (Totterdell 2004). In particular, Christine's clear lack of interest in practice development had a negative effect on the staff, as leaders who project unhappiness or negative feelings towards changes cause their staff to feel de-motivated and lethargic and stimulate a low

sense of morale among a team (Marquis and Huston 2006). If a leader does not have sufficient courage, energy or desire to try and achieve goals, staff will lose their faith in their leader and the initiative, which in this study was demonstrated by Anna's difficulty as a member of Willow ward to continue with the accreditation as a result of Christine's attitude (Thornberry 2006) 'It is particularly important to have passionate, inspirational leaders in PDUs, in order to encourage others in what are often new ways of working' (Totterdell 2004:139).

CONCLUSION

The many issues associated with leadership the core group encountered during their accreditation journey were explored over this chapter. This began with an overview of the relationships among the core group and how the leadership of this group was confused; with some members believing they had adopted a shared leadership approach, others that they had a single leader and others still that the core group had three leaders. It was documented that the confusion over the leadership caused general unrest and led to disagreements over the distribution of accreditation work. It was also demonstrated that the absence of a genuine belief in practice development caused the commitment of some core group members to dissipate, making the goal of attaining accreditation of a joint unit impossible. The ramifications of the absence of shared beliefs in, and commitment to, practice development have not been previously addressed in the literature⁹⁰. The ethnographic approach taken in this study to investigate practice

⁹⁰ This is evident in Appendix 14 which illustrates the themes generated in this study and appropriate comparative literature used to interpret them. This Figure demonstrates that many

development accreditation by studying a unit undertaking this process and to examine the culture of the unit during accreditation, has therefore provided new knowledge in this area.

The problems over a lack of practical support from the Temperley Hospital managers for the core group was also documented in this chapter. Practice development literature emphasises the support needed from senior managers (Walker 2003); however this research is the first to highlight the result a perceived lack of support has on practitioners undertaking this change initiative. In particular the secrecy from Abigail and Rosemary over the future of Willow ward made the core group believe their efforts of implementing projects would be pointless, yet practice development literature has emphasised that initiatives should be sufficiently flexible to adapt to the continual changes which occur in practice. This research has therefore raised a new debate over the practicalities of instigating change within dynamic working environments, thereby contributing to knowledge on this subject.

The relationship between the core group and their managers was strained because of the additional resources and privileged treatment Elm ward received which was outlined in this chapter. This is avidly discouraged within practice development literature, yet as this research has uniquely been able to document by using ethnographic research methods, is something which can, and does occur.

themes which emerged from this research have not been attended to in the literature, such as the leadership of practice development core groups, within practice development literature.

The leadership style the core group took toward the staff was also documented in this chapter, which showed that practitioners instigating practice development can control and coerce staff into participating in projects. Within leadership and organisational change literature, many stories of empowering change initiative leaders demonstrating this attitude exists and the use of participant observation in this study has allowed this - and the various influence strategies and controlling mechanisms used to aid it - to be confirmed. Practice development has not yet broached the issue of leaders controlling staff in such ways and so again this research has been able to make a valuable contribution to knowledge. Additionally, literature has only documented either the leader or follower perspectives in empowerment change initiatives, but the application of the symbolic-interpretive perspective – with its emphasis on multiple views and experience within a group – has allowed both the leader and follower perspectives in leadership, empowerment and change to be presented in this chapter; thereby adding to current knowledge.

Finally, it was documented that the absence of effective transformational leadership – critical in any empowering change initiative – prevented the core group from gaining the support of the Oak and Willow ward staff in their accreditation, which hindered its potential to be a success. This chapter has addressed the leadership barriers to the accreditation that existed among the participants in this study, but a second barrier also existed. This was attributed to the culture of the participants where barriers were created based on professional and hierarchical roles, as the following chapter will illustrate.

CHAPTER VIII

CULTURAL OBSTACLES TO ACCREDITATION

INTRODUCTION

The culture of the health care environment in which this research was conducted posed a major barrier to the possibility of practice development accreditation ever being a success. This chapter documents how this was the case and therefore achieves the second research aim of this study, which was to examine the culture of a group during accreditation. My position as an outsider to health care, accompanied by the utilisation of participant observation enabled me to gain a unique insight into the culture of Oak and Willow wards. I discovered that the barriers surrounding professional and hierarchical identities prevented the staff and core group from working as a multidisciplinary team to implement practice development. This chapter explores the various subgroups within 'the PDU', illustrated in Figure 19.

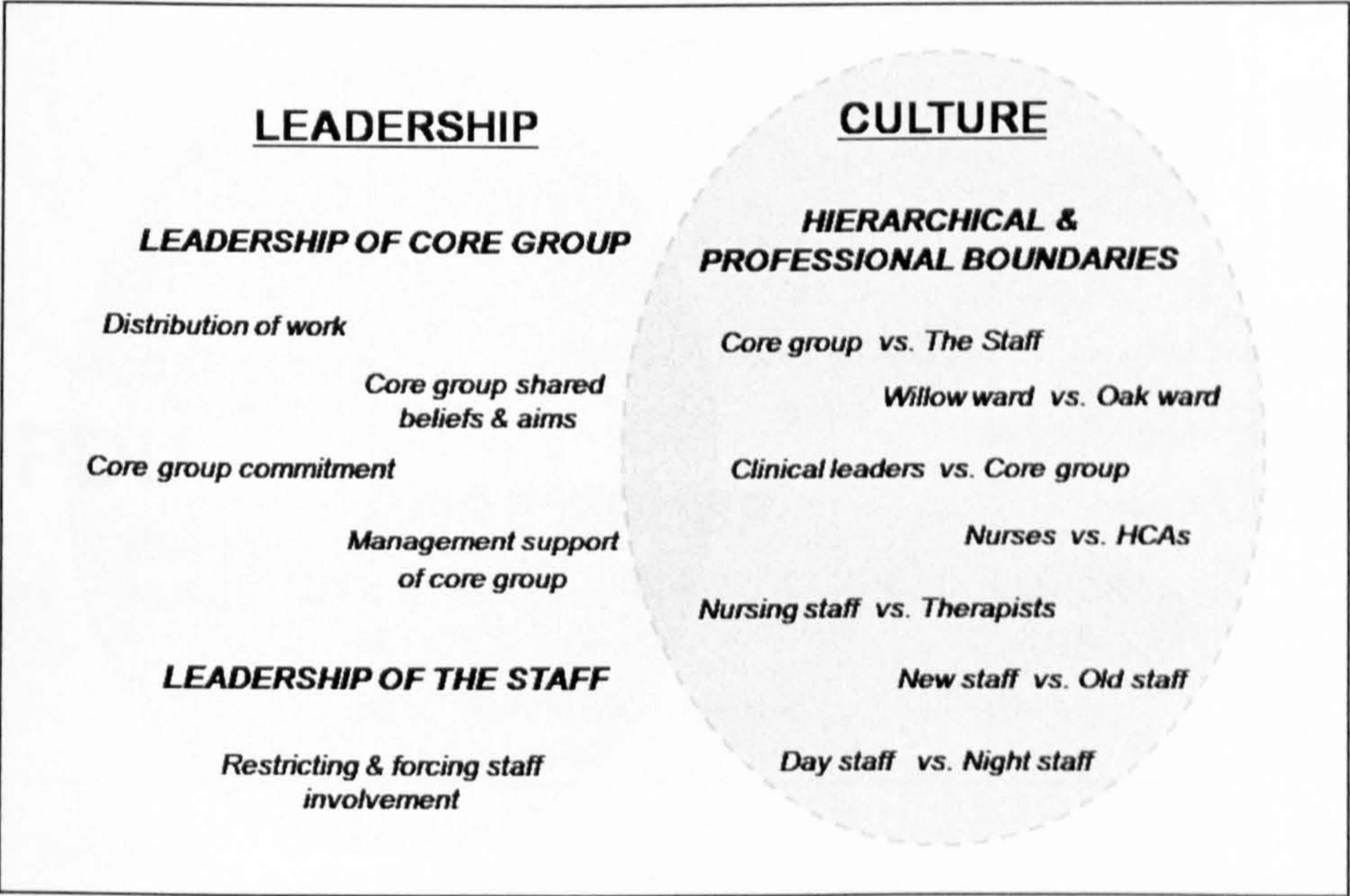


Fig 19. Cultural Issues which Prevented Successful Accreditation (ascertained from analysis)

PROFESSIONAL & HIERARCHICAL DIVIDES

The professional and hierarchical identities of the core group and staff were at the root of most of the disagreements between and among them. I identified more than forty subgroups within 'the PDU' but the largest and most prominent of these are explored in this chapter. As it will be documented, the staff and core group made clear divides between themselves and each other by contrasting their own roles with that of others based on Oak and Willow wards. The subgroups documented in this chapter therefore emerged from my interpretation of the participant's identities and interactions and these subgroups are documented on Figure 20.

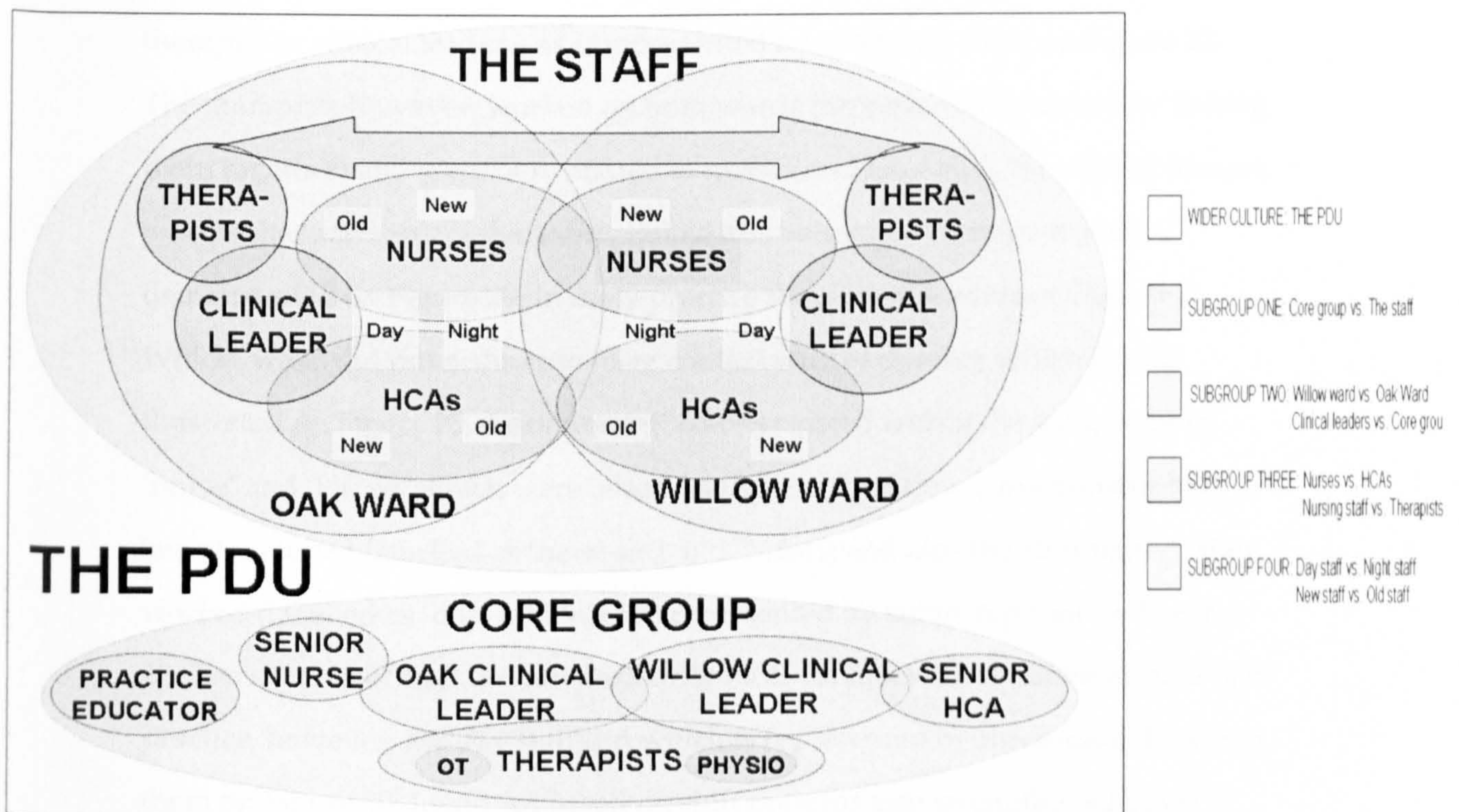


Fig 20. 'PDU' Subgroups

The lemon coloured background represents the wider culture in the accreditation – the ‘PDU’ – consisting of both the staff of Oak and Willow wards as well as the core group. The largest subgroups within the ‘PDU’ were ‘the ‘staff’ and the ‘core group’ (subgroup one) and these two were divided based on hierarchical status. The subgroup entitled ‘the staff’ is addressed first; this subgroup included all staff involved in the accreditation, but within it two further primary subgroups existed based on which ward staff were employed on – Oak or Willow (subgroup Two). There was a degree of overlap between the wards however, which was based on the professional boundaries of ‘nurses’ and ‘HCAs’ as illustrated on Figure 20.

Further divisions existed between the staff based on their job role – nurse, HCA, therapist or clinical leader – as is represented by subgroup three on Figure 20. The therapists however, worked on both wards (represented by an arrow linking them together) and were only related to nurses and HCAs via the clinical leaders, who as the managers of the wards linked all professional groups together, demonstrated on Figure 20. In daily practice the clinical leaders of Oak and Willow ward did not ordinarily have contact with each other which is also illustrated on Figure 20. Additional divisions existed within the subgroups of ‘nurse’ and ‘HCAs’ which were based on the length of time a practitioner had been employed (labelled as ‘new’ and ‘old’⁹¹ staff) and also the shift pattern they worked (labelled as ‘day’ and ‘night’) represented by subgroup four on Figure 20. The night shift staff did not ordinarily have contact with the clinical leaders in practice, however, the day staff did which is represented by the overlap between them on Figure 20. Identities based on shift patterns also strengthened other

⁹¹ Old refers not to age, but to length of time spent on the ward. Old staff were those who had worked on the ward for eighteen months or longer.

groups, as the day shift nurses and day shift HCAs formed a distinct group from the night shift HCAs and night shift nurses, represented by their overlap on Figure 20.

The second major subgroup in the PDU entitled the 'core group' is now addressed; several more subgroups existed within this, where the clinical leaders were at its centre, represented on Figure 20. The senior nurse from Oak ward (Emily) formed a subgroup with her Oak ward colleague, clinical leader Margaret within the 'core group'. Similarly the HCA from Willow ward (Anna) formed a subgroup with her Willow ward colleague, the clinical leader Christine, within this. The OT (Kate) and physiotherapist (Jenny) combined their normally separate professional identities, to become represented as one profession - the therapists - who were linked to both clinical leaders, represented by their overlap on Figure 20. The practice educator of the core group (Angela) however, was not based on either Oak or Willow ward and had no colleagues in a similar position which left her isolated within the 'core group', illustrated by her physical divide from the others on Figure 20.

The links and divides that existed between, among and within the subgroups of the 'core group' and 'the staff' played a critical role in the failure of the 'PDU' to become accredited. These relationships are explored over this chapter where the conflict that existed between the core group and the staff, the staff of Willow Oak wards, the clinical leaders and the rest of the core group, nurses and HCAs, nursing staff and therapists, day staff and night staff, old⁹² staff and new, is addressed.

⁹² As explained previously, 'old' refers not to age but to length of service on the wards.

SUBGROUP ONE: CORE GROUP vs. THE STAFF

This section focuses on the divide which existed between the core group and the staff represented by subgroup one on Figure 20, which was based on the core groups use of their hierarchical status they attained through their professional roles on Oak and Willow wards, to control and coerce the staff into participating in the accreditation. This was documented several times in the last chapter, for instance it was highlighted that the staff had their employment placed in jeopardy if they refused to rotate wards as part of a practice development project, which created tension and made them feel powerless *"Nobody is happy about it, but it's totally out of our hands"* (15.12.05 Interview). The core group used their hierarchical status to take over the ownership of the accreditation from its start and their possession of it was demonstrated through the language the core group used - *"we need to give staff a vision of what projects we're doing"* (25.05.05 CG meeting) - and also by that of the staff *"They're trying to get both wards to change over staff"* (15.12.05 Interview). It was for this reason staff believed practice development could only be implemented by hierarchically senior figures *"It's only the leaders that have time to do PDU"* (25.08.05 Interview), which Theresa recognised and drew to the attention of the core group on many occasions *"They'll think 'Oh they're having a meeting and it's really nothing to do us'"* (10.11.05 CG meeting). Anna joked after one such comment *"if we wanted to include the staff, they would be here"* (28.09.05 CG meeting) and although she was only teasing, her statement reflected precisely how the staff felt about the core group and the accreditation.

Angela was concerned over having a core group consisting of hierarchically senior members from the outset, as she feared the accreditation would be seen as *"something solely for the management"* (18.07.05 Interview). Emily also had similar

doubts and believed the hierarchical membership of the core group violated the fundamental principles of practice development *"The core group is just made up of senior people. I think it's all a bit remote. It's meant to be bottom up"* (05.06.06 Interview). Others were less concerned however and believed it was not the status of the core group which caused a barrier to staff involvement but rather the perception of the staff that it was only hierarchically superior figures who could make changes within a health care organisation *"I think there is an inbred culture that clearly the person that can sanction these changes is the person in charge of the ward"* (24.11.05 Interview). The Oak and Willow ward staff disagreed with this view and felt it was precisely the core group's hierarchical position which hindered their ability to become involved in, or take ownership of, any aspect of the accreditation:

"They pay no attention ... I'm only an HCA at the end of the day and if you come up with an idea and put that idea forward, you can guarantee that it won't happen, it won't work. If you're unhappy with things and you try and change it, they say 'No'- it's the same with most of the wards I've worked on" (15.12.05 Interview).

"There's limits; you can come up with all of these ideas, like I've said before; unless you can find the right person to come behind you [she shrugged her shoulders]. Especially at HCA level, we can't do a great deal. We can try and push the right people, but if the right people don't do their part, then we're fighting a brick wall" (15.12.05 Interview).

The core group controlled staff involvement through their status, by legitimizing the implementation of rigid bureaucratic procedures which staff with ideas for projects had to undertake in order to receive permission from the core group to implement them. One staff nurse – Naomi – explained in an interview how these processes had discouraged her from initiating a project she wanted to start, which she had previously successfully implemented on the last ward she was

employed on (25.08.05 Interview). Naomi designed and instigated a 'red tray scheme' after hearing about it through a nurse friend; this scheme highlights patients who needed assistance to eat at lunchtime by having their meals served on a red tray instead of the standard grey one, thereby making it instantly noticeable to the nursing staff. This saved time as patient notes did not need to be consulted to ascertain who required help to eat by every member of staff and contributed to higher standards of care as those who needed help were ensured to get it using this system. Naomi found this project easy to implement on her last ward and had found it enormously effective and beneficial for the patients, which was why she volunteered to design and implement it as part of the accreditation. Naomi was however informed by the core group that this would not be as simple to implement on this occasion as it was on her last ward, as she would have to arrange a series of meetings with other interested staff from both Oak and Willow wards, liaise with internal and external agencies and departments about it, gather evidence from journal articles to justify its implementation and decide how it would be evaluated. Lacking in confidence to approach staff from other wards, arrange meeting rooms, to host a project discussion group, liaise with agencies, consult journals and design evaluation strategies, this entire process daunted her. She confessed feeling too deterred by the bureaucratic procedures in place to implement the project, and as a result she abandoned the idea:

"On my last ward, I put it on the computer, bought the trays and came out with the posters and whatever, and just got on with it straight away. There wasn't any, you know, 'You've got to do it with this'" (25.08.05 Interview).

The core group's control over the staff during the accreditation by their hierarchical position was evident again in a project Anna had persuaded her

friend Kerry – an influential HCA – to undertake. This project aimed to rearrange the sluice rooms on Oak and Willow wards, as the lack of order in them slowed staff when trying to find equipment and resources and while Anna had discussed with her the changes Kerry wanted to make to the sluice room, she granted her the autonomy to implement them alone (11.08.05 *Project meeting*). Kerry made the changes to the sluice room immediately which impressed most of the core group who admired her enthusiasm; however Margaret was not pleased with the changes.

Margaret subsequently sought Kerry and informed her that the sluice room was not satisfactory and instructed her on how it needed to be rearranged. Kerry felt embarrassed and disheartened by the negative feedback she received from her efforts and felt Margaret had completely over-ridden her decision; she concluded that staff involvement in the accreditation would be unappreciated (11.08.05 *CG meeting*). Kerry did not want to make the changes to the sluice room Margaret had ordered and instead resigned from not only the project but from all practice development initiatives “*There was so much disgruntledness I just crossed my name off and said I wasn’t doing it anymore*” (25.08.05 *Interview*). Kerry then informed the other staff about her experience with the core group which had a major effect on them, as every member of staff told me of Kerry’s story during interview “*Kerry resigned from the PDU because she got negative feedback*” (15.12.05 *Interview*). The staff informed me of Kerry’s bravery at undertaking projects for the accreditation which the rest of the staff did not want to, her eagerness and goodwill at helping the core group by doing so, the effort she put into rearranging both sluice rooms and lack of appreciation and disapproval she received for doing so, which they attributed to her status as a less senior member of staff (15.12.05 *Interview*). Kerry’s experience reminded many of the staff of their own personal experiences

of previous change initiatives, where empowerment was promoted but never achieved, leaving many of them cynical about change processes as a whole:

"I'm a bit of a cynic, you know? Will it work? You see I've had similar things in jobs before where there has been lots of talk but not a lot done so perhaps I'm a bit sort of on the cynical side ... I have had places where they say 'Oh yes, we're going to do this and we're going to do that' and nothing ever came; nothing ever changes so it was more of a paper exercise than anything else" (25.08.05 Interview).

The core group's use of their hierarchically superior roles on the wards to force staff into being involved in the accreditation caused the term 'PDU' to become synonymous with the negative feelings these instances invoked. This was so prevalent that Theresa believed the only way practice development could continue on Oak and Willow wards was if the term 'PDU' was no longer used, as it would be too difficult to eliminate the negative connotations it had gained (08.12.05 CG meeting). Theresa told the core group that the staff would begin to "turn off" when 'PDU' mentioned and suggested instead using terms such as "improving the ward" to gain the support of staff (08.12.05 CG meeting):

"I would almost not say anything about PDU, but say 'We need to improve the ward' and get them on board that way and not talk about 'PDU' too much because 'PDU' might put them off" (29.03.06 CG meeting).

Additionally Theresa felt the hierarchical status of the core group was a major factor in the lack of participation from the staff in the accreditation and so she continually encouraged them to hand ownership to the staff. Theresa was concerned that without involvement and ownership over developments, the staff would be unable to become empowered and the accreditation would fail (29.03.06 CG meeting) *"If they can see themselves as valued, and as part of that change*

decision, the more likely they are to be on board" (05.06.05 CG meeting). Theresa saw the reluctance of Megan and Helen to become involved in the accreditation as a key opportunity for one of the lower hierarchical members on Willow ward to join the core group. She believed that if ownership and empowerment could be attained by a low-ranking employee in the core group, then other staff would be encouraged to do likewise (29.03.06 CG meeting). However the core group said this would be unable to occur as Helen had an autocratic style of leadership and would be uncomfortable having subordinate members of staff in control of any changes, as she herself had confessed *"I don't want lots of things happening when I don't know what's going on"* (01.03.06 CG meeting).

Theresa was correct to be concerned over this, as it has been documented that staff must to be sufficiently involved in change procedures in order for them to recognise a need for change (Klein 2004). Without involvement in initiatives, staff cannot develop a sense of ownership over their work which subsequently hinders their ability to become empowered⁹³ (Lashley 2001). Indeed empowerment can only occur when staff have the opportunity to learn, explore, be creative and make the most of their talents (Marquis and Huston 2006). The symbolic-interpretive perspective claims ownership over ideas by all members of staff is critical in creating cultural change (Klein 2004) and practice development literature corroborates this, stating ownership over changes is crucial (Walsh et al 2004) to achieve the aim of staff empowerment (Casley 1998) and to create innovation in health care teams (Walsh 1998). It has been documented that obtaining staff ownership over changes has been difficult in practice development (Sheehan and Hayles 2006), which has been attributed to high staff

⁹³ Empowerment is defined as having a sense of personal power and the freedom to use this power in the symbolic-interpretive perspective (Lashley 2001).

turnovers and general staff attitude (Gerrish 2001). While both these elements played a role in the Oak and Willow ward staff's ability to gain a sense of ownership, as it was documented throughout the last chapter, it was the core group's exercise of power which also hindered this.

Organisational change literature has recognised the difficulty at attempting to initiate change strategies that endeavour to empower staff, when pressure to do so is from hierarchically superior positioned leaders 'It's difficult to create less hierarchical systems by relying solely on hierarchical leaders' (Pearce and Conger 2003:25). This is due to the status given to leaders in organisations 'We adorn our leaders with the status and trappings of position. And yet much leadership literature today is about dissolving the barriers between levels in an organisation' (Smith 2007:24). Only one article has previously hinted that selecting senior staff to become core group members may cause difficulties in developing staff ownership over changes; yet it fails to state what these problems may be or how they could be overcome⁹⁴ (Sheehan and Hayles 2006).

The core group utilised a range of powers they attained through their hierarchical position on the wards (legitimate, expert and informational⁹⁵) which the staff felt caused a barrier to their involvement. The relationship between the core group and the staff from the wards, based on hierarchy and position was continued into the accreditation where the core group were leaders and the staff

⁹⁴ Rather this article claims that choosing hierarchically senior staff to be core group members is not in the 'spirit' of practice development.

⁹⁵ Legitimate power is the ability to influence others because of socially proscribed roles which give legitimacy to one's influence. Expert power is the influence a person has because of their expertise; others feel they must obey the expert because of their expertise. Informational power is the control over information people retain which grants them an advantage over others (Snyder and Kivime 2001).

followers. Despite the clear block in initiating an empowering change strategy from a position of authority causes, some authors have admitted that they themselves as practice development core group members did not overturn nor ever intended to overturn, the hierarchical structure of their group as it would an 'enormous task' (Allsopp et al 1998:18). These reports also imply that, just as the core group in this study, some leaders of practice development have forced projects onto staff and restricted what they were able to change 'PDU leaders needed to be clear about what was negotiable and what was not' (Allsopp et al 1998:18). Clearly some core groups are reluctant to give a degree of ownership to staff, which is a recognised behavioural pattern within the symbolic-interpretive perspective. This view states many people in hierarchically superior positions begrudge sacrificing a portion of the power they have accumulated within an organisation (Robbins and Judge 2000), which is corroborated by organisational change literature which states those in senior positions have acted as a barrier in attempts to empower other staff for this exact reason (Lashley 2001). This has been implied in only one piece of practice development literature so far:

I was surprised to find myself feeling slightly uncomfortable and maybe even threatened by this staff and patient empowerment as I had been much more used to a hierarchical methods of care delivery
(Casley 1998:162)*.

Leaders often feel at the start of an empowering change initiative that creating democracy and handing ownership of changes to staff is good in theory but the realities of doing this in practice prove difficult, with some leaders believing it affects their image 'it can make you look weak and slow things down' (Rickards and Clark 2006:118). This was certainly the case with the core group in this

* This is a quote taken by the author from a senior member of staff within a practice development unit and is not the author's personal opinion.

research and in particular Margaret who stated her frustration over delaying implementing the staff rotation project on many occasions.

The core group also demonstrated exercising the power they had gained from their hierarchical position by insisting staff followed a rigid procedure if they wanted to implement a project of their own, illustrated by Naomi's experience of trying to implement the 'red tray scheme' (25.08.05 *Interview*). Forcing the staff to seek permission if they wanted to instigate projects only increased the dependency of the staff further on the core group, making the possibility of developing ownership over the changes even more unlikely (Robbins and Judge 2007). The symbolic-interpretivist position emphasises that less adherence to written procedures during times of cultural change is required (Halbestram 2006), with some authors claiming all bureaucratic constraints should to be removed (Yukl 2006) in order to remain flexible to staff need and to enable them to develop ownership and empowerment (Halbestram 2006). Anna attempted this in the sluice room project, as while she met with Kerry to discuss ideas for redesigning it, she allowed Kerry to design and implement changes independently (11.08.05 *Project meeting*). Anna hoped that the freedom given to Kerry in this project would enable her to become a 'change champion', inciting motivation and excitement for practice development among the rest of the staff (Sheehan and Hayles 2006). However, Margaret's intervention in the changes Kerry made hindered this, as she did not allow the 'empowered' Kerry to address the sluice room problems as she saw fit; such actions demonstrate a lack of trust in staff and reasserts hierarchical positions of power and control (Lashley 2001).

Kerry's recalling of her negative experience when implementing the project to her colleagues created an 'organisational story' which is used to highlight important events in an organisation's lifespan. Such stories are known by a large number of people within the organisation (Johnson and Scholes 2006) and are told to new members of staff to demonstrate the 'rules' of behaviour⁹⁷ (Martin 2001). Kerry's story captured the central message of the accreditation – that the hierarchical divide between staff and the members of the core group replicated the relationship between them on the wards; that while the core group claimed to wish to empower staff by having them contribute to changes and develop ownership over their practice, in fact any decisions the staff made were ultimately dependent on the approval of the core group. Organisational stories play an instrumental role in developing resistance to changes (Tebbitt 1993) and this was evident in the accreditation. After Kerry's story was spread, the staff subsequently refused to partake in the accreditation; a decision based on the perceived injustice Kerry had faced 'Stories of injustice or oppression, if told and shared by organisational members, can also serve as acts of resistance' (Hatch and Cunliffe 2006:267).

Kerry was an influential member of staff⁹⁸ and her story enabled her to create the meaning of 'PDU' for the other staff and frame its future on Oak and Willow wards (Tietze et al 2003). Naomi's experiences of being hindered in the accreditation because of the bureaucratic restrictions over implementing a red

⁹⁷ These stories are representative of the 'unmanaged organisation' - the terrain in every organisation which cannot be managed; described as a 'dreamworld' where emotions prevail over rationality and pleasure over reality. Organisational stories are attempts to recreate reality poetically; which means they are not 'facts' but individual products of experience (Gabriel 2000).

⁹⁸ While managers are generally the most influential members of the organization (because power structures make them the most obvious and visible source and as a result they are most likely to be obeyed) symbolic-interpretivists recognize that hierarchically low members often have a great deal more power among staff with whom they share a common bond (Baron and Byrne 2003).

tray scheme also shaped the meaning of 'PDU', as did the staff's own previous experiences of change as they applied their own frames to interpret the accreditation (Tietze et al 2003). Past experiences have an important effect on subsequent predispositions towards events (Frey and Sunwolf 2004) and because symbols are created from learning based on association⁹⁹ any 'empowerment' strategy for many of the staff was synonymous with just another management fad.

The core group were unprepared for staff to redefine 'PDU' in their own terms and struggled to win back the dominant discourse¹⁰⁰. This caused a continual vying for power which created a battle between the core group (who wanted to have their definition of 'PDU' accepted) and powerful members of staff (who wanted to define 'PDU' as a management strategy). The symbolic-interpretive perspective recognises that leaders often lose control over their construction of the meaning of symbols and feel frustrated at not being able to control the cultural process that enable their staff to construct and create their own interpretations of it (Hatch and Cunliffe 2006), which in this case was the symbol of 'PDU'. The staff were successful in achieving the dominant discourse and so 'PDU' for them was defined as a managerial controlling technique. This definition was confirmed on many occasions, but in particular during the staff rotation project where staff were threatened with unemployment if they did not participate; a technique often used by managers in change initiatives as when

⁹⁹ As explained in Chapter Three, when one stimulus regularly precedes another, the first may become a signal for the one that follows after and as a result we acquire the same reaction to the first stimulus as the second (Baron and Byrne 2003).

¹⁰⁰ Discourses reflect institutional values and beliefs as they define who can speak, when that person can speak and what they can speak about (Tietze et al 2003).

they are faced with resistance, some managers suggest to rebels they have the right to exercise power over them in such ways (Sandstrom et al 2003).

The core group's emphasis to the staff that they had to participate in the accreditation reasserted that they were in the authoritative position, but this only widened the gap between those in the powerful position (the core group) and those who had to obey (the staff) even further. It is recognised within cultural change literature that forcing staff to become involved in change initiatives by using hierarchical status in this way will only ever create resistance (Seibert et al 2003) and rather than adopting these strategies, leaders must instead hand over a portion of control to their staff and permit them sufficient responsibility, authority and power to complete tasks (Klein and Lundin 1999)¹⁰¹. However it is also reported that many leaders find delegating work incredibly difficult¹⁰², yet this is critical if staff are ever to gain a sense of ownership over changes. This was certainly the case with the core group (except Anna on one occasion) who did not delegate work to the staff without giving them explicit and detailed instruction on how to accomplish it (Yukl 2006). Their inability to hand over control meant the core group overlooked members of staff with ideas and passion for projects which could improve practice, such as Naomi who wanted to implement the red tray scheme.

Practice development articles mostly report that the leaders of these initiatives are hierarchically senior members of staff (i.e. Williams et al 1993), yet none

¹⁰¹The correct amount of responsibility and ownership is dependent on individual staff, as delegation has the potential to be unempowering if employees lack the necessary skill and knowledge to complete the task.

¹⁰² Yukl (2006) reports that 70% of managers find delegation difficult because mistakes may be highly visible, the task in question may be particularly important, and because the manager or leader felt they could complete the task better than their staff.

report any difficulties associated with this, such as a lack of involvement or ownership. This is surprising given the obvious impact this had among the participants in this study, however the absence of such reports could be attributed to the fact that the articles which make reference to practice development leaders, are mostly authored by the hierarchically superior staff occupying these roles, who may be unaware of their impact on others and of their own inability to delegate. It is for these reasons the symbolic-interpretive perspective claims change strategies which aim to empower within hegemonic cultures do not serve the best interests of those they claim to empower, but rather serve to benefit those already occupying powerful positions by maintaining power and control (Tietze et al 2003):

Even though hegemonic practices proclaim the value of autonomy, the use of velvet language of participation, involvement or empowerment, they are ideologically engineered to benefit only the interests and goals of managers and owners

(Hatch and Cunliffe 2006:267).

Some literature however, has challenged this view and claimed empowerment can still occur even when relational aspects of power remain traditional and choice for staff is limited, as a sense of value and meaning can still be established with effective training, communication, a reciprocal trust relationship and a genuine recognition by leaders that their employees are a crucial contribution to the success of the organisation (Lashley 2001). Within this, staff need the opportunity to determine their own roles, accomplish work that is meaningful to them and be able to influence important events, which will enable them to gain a sense of empowerment (Yukl 2006). However as documented previously, the Oak and Willow ward staff did not receive adequate training or communication

and trust dissipated as a result of the core group's use of influence tactics. The restrictions over the implementation of projects they were interested in by staff and the control over changes staff made within projects, demonstrated that the core group did not give staff the opportunity to determine their own roles or accomplish work that was meaningful to them. The division of the core group and staff based on their hierarchical identities created a major barrier to the success of the accreditation. Outlined in the following section are the two second largest subgroups – that of Oak and Willow wards, which were contained within the group of 'the staff' – and how identities based on working on these wards caused a hindrance to the accreditation.

SUBGROUP TWO: WILLOW WARD vs. OAK WARD

Divides existed among 'the staff' based on whether they were based on Oak or Willow wards, as illustrated on Figure 20. It will be documented in this chapter that many other divides existed between and among these, but affiliations to Oak or Willow ward were the strongest¹⁰³. It was documented in Chapter Five that the two wards were virtually identical; with a similar layout, comparable staffing quotas and caring for the same kinds of patients. Oak ward however, did have a very small amount of extra space which was used for storing two waste bins and this extra space was a source of major contention for the Willow ward staff:

"Oh my God you must know about the big yellow bin? Every time the sluice room meeting was on they would say 'Our sluice room would be perfect if that bin wasn't there, blah, blah'" (08.02.06 CG meeting).

¹⁰³ Cultural bonds which exist within groups vary in strength, which will be demonstrated in this chapter (Brewer 2002).

The Willow ward staff believed it was this extra space which enabled the Oak ward staff to provide better care for patients and therefore allowed them to maintain a better reputation within the hospital (11.08.05 *Project meeting*). In addition to this, the Willow ward staff believed that their ward unfairly received the “worse” (15.12.05 *Interview*) patients, who required more care and attention “It’s always appeared that Willow ward has the heavier dependent patients and it’s the one that always gets closed with infections” (06.03.06 *Interview*)¹⁰⁴. The Willow ward staff were resentful towards Oak ward as they felt it received more funding¹⁰⁵ (28.09.05 *CG meeting*) and that this money allowed Oak ward to purchase newer equipment (10.01.06 *CG meeting*) which gave them an unfair advantage and enabled them to provide “better care” (11.08.05 *Project meeting*).

The Oak ward staff had an equal dislike for Willow ward, which they described as a “skanky” (26.08.05 *Interview*) place to work. They believed the Willow ward staff did not take pride in the cleanliness of their ward or in performing their duties, which they claimed was reflected in the fact that it was regularly closed with infections (26.08.05 *Interview*). The staff on Willow ward were viewed by those on Oak ward as being “set in their ways” (15.12.05 *Interview*) and unreceptive to change:

“The staff don’t get on with us, we don’t get on with them. I think the difference is that a lot of the staff there are set in their ways, and somebody else comes along and has a different view or idea and they are bitchy”
(15.12.05 *Interview*).

¹⁰⁴ Patients were in fact allocated randomly to either wards, depending on which had free space at the time.

¹⁰⁵ Which came from the donations of ex-patients and their families (28.09.05 *CG meeting*).

Being situated physically next to one another and caring for the same remit of patients had provoked competition to develop between Oak and Willow wards *"There's always been rivalry between the two wards, certainly since I've been at Temperley ... and Oak has always had the best press"* (06.03.06 Interview). Similar rivalries are reported in organisational change literature which claims a dependence on a common pool of scarce resources can provoke opposition and conflict within health care settings (Hatch and Cunliffe 2006). The physical divide between the wards was also a symbolic boundary, where member identities were created based on which side of the boundary line they fell (Frey and Sunwolf 2004). It was the constant comparison of the Oak and Willow ward staff by others in Temperley Hospital (due to their similarities) which caused them to create a boundary around staff to distinguish themselves from one another. This boundary was based purely on location and is the only division based on physicality in this chapter. Divisions based on profession and hierarchy caused more complex problems than those based on locality, as they were not as easily identifiable. The remainder of this chapter explores these divides.

CLINICAL LEADERS vs. CORE GROUP

Represented within the category 'subgroup two', identities based on hierarchical position caused conflict among the members of the core group. The hierarchical structure that existed within the wards was duplicated in the core group – where the clinical leaders were at the top of the hierarchical scale. The subordinate positions of the therapists (Kate and Jenny) the senior staff nurse (Emily) and the HCA (Anna) to the clinical leaders are each explored in this section.

It was documented in the previous chapter that Kate and Jenny held a leadership position within the core group and as they were hierarchically senior to other therapy staff on the wards, it would be anticipated that they would have felt empowered to initiate changes on Oak and Willow wards. However during interview they said that they felt unable to contribute to many of the practice development projects because of the low status therapy staff held among the nursing staff¹⁰⁶. Kate and Jenny felt they were not respected on the wards in the same way as the clinical leaders by the nursing staff – *“clinically we’re seen as therapy and possibly not the same level as the clinical leaders”* (02.03.06 Interview) – which led them to believe that it was only the clinical leaders who could facilitate and implement projects or have any control over practice developments:

“Kate and I are a bit powerless really in how PDU progresses and ultimately the decisions of what is going to happen doesn’t lie with us, which is frustrating as a core group member” (02.03.06 Interview).

Kate and Jenny held this opinion from the outset of the accreditation, claiming as therapists they would never be able to gain sufficient power over nursing staff to implement projects, which is why they felt practice development could only be led by a clinical leader *“I’ve said from the beginning that it shouldn’t be a therapist leading it, it should be a nurse”* (28.06.06 Interview). After several unsuccessful attempts by Kate and Jenny to reassert a degree of power among the nursing staff on the wards, they felt it was their therapist status which hindered their ability to make changes *“we feel completely dispelled”* (28.06.06 Interview). Because of their lack of influence, Kate and Jenny felt the only way therapists could have any influence in practice development would be through the permission of the clinical leaders:

¹⁰⁶ The relationship between therapy and nursing staff is explored later in this chapter.

"On a ward we can have an impact and help move things forward, but unless you have that right relationship with the clinical leader on the ward, it doesn't matter. We're not important and we can't influence anything on the ward if we've got a clinical leader who isn't willing to accept advice and help... the leadership of this and how it moves forward is going to come very much from Margaret and Helen ... we can't ultimately influence anything on the ward without Margaret and Helen's go ahead" (02.03.06 Interview).

The lack of power on the wards with regards to the accreditation that Jenny and Kate felt was also extended into the core group. This was worsened after they decided to base themselves more on Willow ward than Oak in an effort to encourage participation in the accreditation at the beginning of 2006, which was the same time Helen and Megan took over the leadership roles there. This caused problems for Kate and Jenny as Helen had a negative view of therapy staff, believing they lacked any responsibility on the wards. As a result, Helen refused to listen to any of Jenny and Kate's suggestions or accept their help in developing projects, which left them feeling powerless to implement changes on Willow ward or progress with the accreditation *"at this moment in time, working on the other ward disempowers me" (02.03.06 Interview).*

In a similar way, Emily was also low in the hierarchical structure of the core group despite her senior position on the wards. Her subordinate status was particularly evident when core group meetings were held, as if the ward was understaffed or particularly busy Emily was asked by Margaret (her manager on the ward) to stay and work rather than attend the meeting (10.11.05 Fieldnotes). Emily often appeared to be over-awed in the core group by the more hierarchically senior members of it, which was apparent by her reluctance to

voice her dissatisfaction with decisions made in meetings¹⁰⁷. Her low status was most obvious when the core group had dwindled to just four members.

Professionally and within the core group, Emily was less senior to Kate, Jenny and Margaret and for this reason she was not invited to meetings with senior managers to discuss the future of the accreditation along with the other three. It was her exclusion from the accreditation during this time which led Emily to admit in an interview that she did not feel in any way empowered through the practice development initiatives on Oak and Willow ward, although she had experienced empowerment previously on Elm ward during their accreditation (08.03.06 Interview).

As Megan held the same position as Emily on Willow ward, she experienced the same sense of unempowerment. Although Megan never actually joined the core group, the discussion over whether she would demonstrated her subordinate position to the clinical leader on Willow ward, which would have certainly hindered her ability to implement practice development initiatives there, had she joined. Helen's traditional view of ward hierarchy made her unreceptive to accept or support the few changes Megan had instigated on Willow ward (01.03.06 CG meeting). Megan was asked by the core group to join after it became evident that Helen was uninterested in proceeding with the accreditation, but Megan's awareness of Helen's lack of support for it and having already made it clear she would be unable to instigate changes without her agreement, Megan told the core group they would need to seek Helen's permission for her to join "you'll have to let me know what's decided, cos it's all a bit above my head really" (01.03.06 CG meeting).

¹⁰⁷ She freely voiced these during interviews.

Megan, Emily, Jenny and Kate all experienced a lack of empowerment because of their hierarchical status in comparison with the clinical leaders within the core group, but the person most affected by the hierarchical structure which was transferred from the wards was Anna. Originally selected to become a member of the core group because of her status as a powerful and influential member of staff - *"She has a lot of power, not by role position but by the way she works on the ward"* (20.07.05 Interview) - Anna felt overshadowed by her subordinate position among the others. At the very start of the accreditation Anna reported that she had achieved a sense of empowerment due to her position as a core group member and she felt the traditional hierarchical structure of the wards had been dissipated within the group:

"I wasn't treated as a second class citizen; my views were taken seriously. We were all listened to equally, it wasn't a case of 'She's only an HCA so she doesn't matter'; we were all equal ... if somebody listens to you, it makes you feel good and it really does empower you and it's motivational to know that what you're saying is being listened to. On the core group, it was really nice just feeling that I was worth something and valued" (09.05.06 Interview).

Within several weeks however, it was evident that Anna's lack of hierarchical authority had become an issue as she had attempted to implement a project but had her actions blocked by others in the hospital and consequently had to call on more senior members for assistance in completing it *"they won't pay any attention to me as I'm only an HCA"* (10.01.06 CG meeting). Anna's lack of authority within the core group was evident when disagreements occurred, as she struggled to have an equal say in the actions the core group would take *"she isn't in a position of leadership, but trying to do it"* (10.11.05 CG meeting). For example, the previous chapter highlighted Anna's opposition to the implementation of the staff rotation project, which she raised her concerns over on many occasions. These were never

taken seriously by the rest of the core group and Anna's opinion on what action they should take was overlooked (02.11.05 CG meeting), which implied her views as an HCA were not of equal importance as those of the others. Anna's lack of authority and power reached its peak when Helen joined Willow ward, as within a matter of days her autocratic leadership style caused Anna to believe Helen would be unable to accept her equal status as a core group member *"After a couple of days with them, that's when the thought processes started and I thought 'She is not going to be happy about me doing PDU'"* (09.05.06 Interview). In her first meeting with the core group, Helen openly conveyed her dislike for the changes Anna had made as part of a project she facilitated, claiming the changes Anna had made violated the principles of best practice and that she was very unhappy with them (01.03.06 CG meeting). Helen continued to express her unhappiness about the project in front of the rest of the core group during the sixty minute meeting, which left Anna feeling humiliated and compounded her belief that Helen would be unable to accept her as an equal *"the meeting that we had to discuss what we had done in the PDU, it was just so negative ... that meeting was like the straw that broke the camel's back"* (09.05.06 Interview). Anna resigned from the core group as a direct result of this meeting, explaining to the others she felt powerless to initiate changes as part of the accreditation or even to give an opinion, if Helen was also to become a core group member *"Anna felt completely demoralized and that her position doesn't count and the reason she left, she said is because she doesn't feel that she will have any influence"* (01.03.06 CG meeting).

Helen's actions caused Anna to feel she had lost any competition for influence she had and a degree of respect from the rest of the core group (Siebert et al 2003). An equal sense of empowerment is critical in a shared leadership

approach¹⁰⁸ but the fact that Anna, Emily, Jenny and Kate all claimed they did not feel they had this, demonstrates that the core group were unsuccessful in achieving this approach in the accreditation (Northouse 2004). Anna and Emily were selected as core group members because of their potential to become 'influential champions' for practice development on Oak and Willow wards, in an effort to help staff accept the new changes which would be put into place¹⁰⁹ (Klein 2004). Anna was selected for her 'personal' (Northouse 2004) or 'charismatic' (Marquis and Huston 2006) power¹¹⁰ and Emily because of her position as a well-liked and mid-range hierarchical member of the nursing team; yet neither maintained a degree of power within the core group. Emily's inability to disagree by presenting her own viewpoint in core group meetings reflected her 'status differential' which is the reluctance of a low-status member to criticize or disagree with high status members (Robbins and Judge 2007). Emily also demonstrated traits of 'groupthink' by keeping her misgivings about actions of the core group to herself (groupthink being adopted because we prefer to be part of a group, rather than the disrupting force within it). Emily's silence was judged by the rest of the group as full agreement with their decisions despite the exact opposite being true because of this (Robbins and Judge 2007).

It was clear Anna and Emily had been selected to be core group members in the hope they would be able to positively influence the other staff, and not because their opinions were truly valued. This was evident by Anna's repeated advice to

¹⁰⁸ As without a belief in another members ability, the group may be reluctant to follow guidance given by that person (Burke et al 2003).

¹⁰⁹ The symbolic-interpretive perspective claims many of our attitudes are acquired from others in a process of social learning, which means if staff were to see Anna or Emily reacting positively about the changes and developing a sense of ownership and degree of empowerment over their work, they may be likely to gain similar feelings (Baron and Byrne 2003).

¹¹⁰ This is power attained through followers, rather than a formal position as a manager.

the core group not to proceed with the staff rotation project, but the disregarding of her opinion until after the staff had 'rebelled' against it. Emily also could have played a pivotal role in the core group as she had previously contributed to the Elm ward accreditation. However, because the core group were so preoccupied with differentiating themselves from Elm ward, they failed to utilise her experience and information as a resource.

These examples illustrate how the genre¹¹¹ of the Oak and Willow wards - where nurses, HCAs and therapists exist in a subordinate position to clinical leaders - was transferred into the core group. Only one piece of literature so far has suggested that multidisciplinary care can be hindered by perceived traditional power structures within the NHS (Walsh 1998), which this research project has been able to corroborate. In addition, the traditional power structures were not only perceived among the core group, but were in fact actually prevalent. They were also rife among the staff on Oak and Willow wards, as the following section demonstrates.

SUBGROUP THREE: NURSES vs. HCAs

On Oak and Willow wards, divides existed between the nurses and HCAs based on their professional identity and hierarchical status. The majority of nurses in this study believed they were superior to the HCAs, as while they thought themselves to have a great deal of responsibility for the patients, they believed HCAs lacked this and were there *"just wipe people's bottoms and go home again"*

¹¹¹ Genres in the symbolic-interpretive perspective are types of communication which contain unwritten rules and relationships. Understanding genres allow social actors to perform in culturally competent ways and informs the way actors view social practice. They are in a constant state of flux (Tietze et al 2003).

(18.10.05 *Project meeting*). This was particularly evident in a project which aimed to improve the way handovers were given, as during the meeting for this project a senior staff nurse – Patricia – repeatedly made disparaging remarks about HCAs, despite an HCA attending the meeting (26.08.05 *Project meeting*). Patricia claimed HCAs lacked responsibility and because of this they should not be included in handovers, where information about patients was given.

The HCAs were aware of their status on the wards and all commented on this during interview. The HCAs expressed their feelings of helplessness as a result of their status, believing this would prevent their ideas for improvements being accepted among other staff on the wards. This was reflected in an interview with an HCA – Lauren – who spoke passionately about her desire to change the way soup was given to patients at lunchtime. She believed the current system of serving it in bowls made eating difficult and time consuming for most of the patients and so Lauren wanted soup to instead be served in a cup, as patients could hold these much easier which was demonstrated through the ease with which they could hold cups of tea. She thought this would enable patients to be more self-sufficient as they could feed themselves and thereby aid their rehabilitation. When I asked Lauren if she had presented this suggestion to the core group as a project, she replied it would be pointless as it was only HCAs who helped patients eat and so the idea would be dismissed because others could not see how the current system was ineffective *“bowls really just don’t work, but because they’re trained, they don’t see it cos they’re doing the drugs at that time”* (15.12.05 *Interview*).

The distribution of work between HCAs and nurses during mealtimes was a particular bone of contention, with all HCAs unhappy about having to help

patients eat their meals whilst nurses dished out medication *"it's only the HCAs that do food, which is another pet hate"* (15.12.06 Interview). The nurses were aware of the HCAs views but believed it was another, in what they saw as a long line of complaints the HCAs made *"they always complain and moan"* (09.08.05 Project meeting). A small amount of published literature exists which acknowledges disputes between HCAs and nurses based on an unclear divide of duties between them (i.e. Spilsbury and Meyer 2005), however such disputes have not yet demonstrated in practice development literature.

The HCAs felt unable to contribute to the accreditation because of their low position on the hierarchical scale of Oak and Willow wards and the nurses were unwilling to listen to the HCAs suggestions because they were perceived as being non-constructive. This demonstrated that the traditional hierarchy of the wards was a block to the accreditation as both the nurses and HCAs were unwilling to overcome their divides when faced with each other. They were however, able to temporarily put their disputes to one side and merge their boundaries when they wished to differentiate themselves from the therapy staff on the wards, as the following section illustrates.

NURSING STAFF vs. THERAPISTS

The HCAs and nurses created the subculture of 'nursing staff' in direct opposition to the therapists, as they believed that because therapists were not based solely on Oak or Willow wards¹¹² they lacked a sense of responsibility to both the patients and the other staff (18.10.05 Project meeting). The nursing staff

¹¹² As outlined earlier, therapists were based in the Therapy Department office at the opposite end of Temperley Hospital.

felt the therapists were too demanding as they created tight deadlines such as requesting nursing staff have patients ready for rehabilitation at 9 am. The nursing staff begrudged the therapists for not assisting in getting the patients out of bed and dressed in the morning to help achieve this deadline, believing the therapy staff instead spent the mornings *"hanging around waiting for patients"* (18.10.05 Project meeting). The tension between the nursing and therapy staff was most evident in the project entitled 'changing the role of the HCAs' which aimed to extend their role to become more rehabilitative. The nursing staff believed this project – which had been created by the therapy members of the core group, Kate and Jenny – aimed to provide therapists with more free time by forcing HCAs to undertake more of their duties:

"It's all very well these Physios and OTs saying 'Yes, yes incorporate the HCAs so they can do it at weekends' – what do they think we do? As if we haven't got enough ... we have not got the time and it's their job anyway which I think is being pushed onto us, yet again. And I think it shouldn't be, because they don't come and help us, they don't come and wash patients. We don't say 'We're stuck, come and give us a hand', but they expect us to give them a hand" (15.12.05 Interview).

The therapists were aware of how the nursing staff viewed them and as a consequence continually defended themselves in project meetings (26.08.05 CG meeting). Jenny and Kate attempted to bridge the gap between therapists and nursing staff by assuring them they would work with whatever systems nursing staff thought were best to improve the wards (08.09.05 Project meeting). They also attempted to improve communication and erode the divide between them by proposing the development of a space on Oak and Willow wards for therapists, which would mean they would no longer be separated when they had paper work to complete. Jenny and Kate also hoped this would demonstrate to the

nurses and HCAs that their role involved more than spending time in the gym with the patients. In addition, they announced that therapists would take more of an active role in ward duties by attending other information events such as handover meetings (08.09.05 CG meeting); yet all of these initiatives were met with scepticism and negativity by the nursing staff who did not believe in reality that any of this would be sustained (26.08.05 Project meeting). Jenny was deflated that the additional efforts she and the other therapist's made had in no way bridged the gap between the professions. Jenny rationalized the nurses unreceptive attitude to overcoming their differences and working as a multidisciplinary team by claiming different 'types' of people follow a career in nursing to therapy and those who pursue nursing are less likely to adapt to change:

"I think therapists are quite outgoing personalities who aren't afraid of having a go at things and implementing ideas and I think nurses are different to us. They're more happy to be led, particularly on this ward, so they don't, you know, often just pick up the initiative and go" (02.03.06 Interview).

This view is acknowledged within organisational change literature, where it is suggested that certain professions appeal more to some people than others. This is known as 'Personality-Job Fit Theory' and this view claims that several variables exist which determine how well suited a person's personality is to their profession, and so 'personality types' do occupy distinct job roles (Robbins and Judge 2007). The symbolic-interpretive notion of frames corroborates this, as it claims training for a career requires the shared learning of attitudes, norms and values that will eventually become taken-for-granted assumptions within each profession (Schein 2004) and because of the many sets of cultural beliefs and values which are present in a multidisciplinary team, this will have the potential

to provoke conflict (Walsh 1998). Identities are based on professional roles and those occupying positions are institutionalized in socially established set of values and ideologies, which means professional identities such as 'nurse' have a set of behaviours those people occupying this role are expected to conform to (Baron and Byrne 2003).

Jenny's view of nurses being unreceptive towards change is further corroborated by practice development literature, which has claimed that the nursing profession has suffered with a lack of teamwork (Walsh 1998) and a tradition exists whereby those who "speak out" to make changes are often persecuted (Mackay 1989:181). It is also confirmed in the literature that therapy staff alternatively, are trained to question practice and work within larger multidisciplinary teams to improve practice 'I realised that as a therapist we are expected to be able to produce an opinion right from being a student' (White 2005:230).

The nurses and HCAs were able to temporarily overcome their differences to place themselves in direct contrast to the therapists, because divides are eroded and bonds strengthened between groups who share some common links when they are faced with a different group (Parker 2003). The HCAs and nurses provided similar kinds of care and so the bond of being a member of 'nursing staff' was reinforced when therapists were present (Brewer 2003). Cultural bonds therefore vary in strength and while nurses and HCAs joined forces in the presence of therapists, they divided again depending on various other factors such as the length of time they had worked on the wards, as the following section demonstrates.

SUBGROUP FOUR: NEW STAFF vs. OLD STAFF

Divides existed on both Oak and Willow wards among the HCAs and nurses, which was based on how long they had worked there; this tension was most evident during the implementation of the 'changing the role of the HCAs' project. Jenny and another physiotherapist, Alex, led the project and informed the HCAs on Willow and Oak wards that they would provide several training sessions to explain the exercises patients could be expected to do with HCAs as part of their rehabilitation. Two of the new HCAs volunteered and attended this training, after which they were keen to initiate exercise classes on their wards. The old HCAs however, openly refused from the start to attend the training sessions because they believed exercising with patients was not a part of their role and because they felt it was unfair one HCA was allowed to "skive off" work to host the class, leaving others to cover their work *"I think it's unfair...for the member of staff who is left with all the donkey work, so I think it's really wrong"* (15.12.05 Interview). Irrespective of the old HCAs views of the classes, one of the new HCAs – Caroline – did initiate an exercise group after considerable encouragement from her clinical leader. She reported having enjoyed the interaction time with patients this had given her and that it had installed a sense of satisfaction and pride in her as she felt that she had actively contributed to the patient's rehabilitation (15.12.05 Interview). Despite the benefits Caroline felt from conducting the class, she confessed during interview that she would not host another because of the "stick" she had received from the old HCAs, who had called her "lazy" (15.12.05 Interview) for not contributing to the normal duties:

"It can't happen. It's not that I don't want it to, but you get stick; hassle, off some of the others if you're sort of sat out. Not verbal hassle, you just get this feeling ... I know it's part of the work and the rest of it – it's getting other people to understand it" (15.12.05 Interview)

The core group were conscious that the older staff's negative attitude could hinder other staff from being *"too enthusiastic"* when exploring new ideas (08.12.05 CG meeting) *"When you've got a group of people who are really used to thinking in a negative way, that will only continue to filter down"* (24.11.05 CG meeting). The differences in opinions among the old and new staff was evident in their view over the wards, where the old staff described them as *"a great place to work"* and the new staff as *"a horrible place to work"* (08.12.05 CG meeting).

The old staff were successful in constraining the behaviour of the new staff, as no subsequent exercise classes were hosted. This controlling behaviour was a result of the old HCAs limited power among other nursing and therapy staff, as power imbalances within organisations often filter down between groups and can lead oppressed groups (such as old HCAs) to punish others they have some degree of control over (Senior 2002). The older HCAs felt they had lost a portion of control over their identity because of a project which attempted to change their role, and the nursing staff in general felt a lack of control as they were informed they would have to rotate wards and fulfil other duties as part of the accreditation, or risk being sacked. This led the older staff to exercise their control over the new, enthusiastic ones:

Nurses as an oppressed subordinate group exclude other nurses who adopt different views and demonstrate intellectual abilities. Nurses who appeared to think about caring, or appeared to think at all, could be ignored and ridiculed by other nurses. Hence, perversely, the oppressed group attempts to protect itself by silencing and excluding a discourse that might enable other nurses to make a more assertive (co-operative, caring, thoughtful) contribution to health care.

(Miers1999:70).

Some staff demonstrated their 'cultural illiteracy' (Schirato and Yell 2000) by breaking the unwritten rules of their professional identity, such as Caroline who failed to realise HCAs on Oak and Willow wards did not host exercise classes as this was the role of therapists. Cultures only survive by teaching rules of behaviour to newcomers, which is achieved by the ridicule or ostracization of those who try to change these roles (Schein 2004); demonstrated in this example by the new staff being humiliated because of their enthusiasm:

Each organisation has its own culture and value system. New members must understand this culture and be socialized into the organisation if they are to build a power base. Being unaware of institutional taboos or sacred cows often results in embarrassment for the newcomer

(Marquis and Huston 2006:313).

The breaking of rules by newcomers can challenge the basic assumptions of a cultural group and bring the possibility of new meaning, which may in turn provoke a change in behaviour (Hatch and Cunliffe 2006). This is reported to having occurred in a practice development unit before (Page et al 1998), however while the new members of Oak and Willow ward may have challenged the older staff's attitudes, they were not successful in changing their behaviour. This reluctance to change action is a way of maintaining group identity; a common reaction during times of transition in organisations (Brewer 2003). The actions of the newer staff may have caused the old HCAs to reflect and realise their behaviour was in fact inappropriate as it was not in the best interests of the patients, but they did not change their behaviour as maintaining it was the only way for them to retain their group membership and identity (Schein 2004).

The new staff did not continue to challenge the behaviour of the other HCAs, because of their desire to conform. For example, Caroline was aware that the values of the old HCAs were flawed as they were not in the best interest of the patient, yet her desire to 'fit in' with them (which would retain her identity as an HCA) clouded her rationality and caused her to conform (Robbins and Judge 2007) out of an instinctual fear of rejection and desire to be liked (Baron and Byrne 2003). This ensured the HCAs maintained 'group inertia' as the old HCAs successfully imposed their norms and values to constrain the new HCAs desire to change (Robbins and Judge 2000). A divide between old and new staff in practice development initiatives has not been reported in the literature, yet evidently hindered the success of the group in this accreditation. A further issue as yet unrecognised in practice development literature is the divide between day and night staff, which is explored in the following section.

DAY STAFF vs. NIGHT STAFF

The nurses and HCAs readjusted their boundaries once again when it came to identifying themselves as either a 'day' worker or a 'night' worker. The day shift HCAs and nurses were united as directly opposed to the night shift staff as they believed they were lazy, which was an attitude also supported by their clinical leaders. Margaret claimed they did *"as little [work] as possible"* (08.09.05 Project meeting) and so had a *"pretty cushy job"* (27.08.05 Project meeting) and the new Willow ward leaders Helen and Megan also confessed to *"having conflict"* (20.01.06 CG meeting) with the night staff over of their lack of work. Kate and Jenny as therapists were unaware of this divide until the accreditation and challenged both the clinical leaders and day staff's perception of the night workers, claiming they had found the evening staff pleasant and eager to

participate in practice development on the away-days that were held in May 2005. Christine disagreed and said *"you need to work a night with them!"* (27.08.05 *Project meeting*) as this was the only way Kate and Jenny would realise how lazy they were. Because of the view the nursing staff and clinical leaders had of the night staff, they often purposely excluded them from practice development activities. For example, questionnaires which were supposed to be issued to the Willow ward night shift HCAs as part of the 'changing the role of the HCAs' project, were not given out because Anna – who was issuing them – was not on speaking terms with any of the night staff and claimed they would only give negative responses anyway (15.09.05 *CG meeting*).

The core group were presented with an opportunity to bridge the gap between the day and night staff when discussions were held over the Christmas party. However, they failed to embrace this as an opportunity and this led to four separate Christmas parties having to be held (15.09.05 *Project meeting*) as the day workers refused to work an evening shift to enable the entire night staff to celebrate together and the evening staff also refused to provide cover which would allow the day shift staff to celebrate together. A mixed party with both sets of staff was highlighted to be a good idea in theory by the core group, but they believed in reality the staff would not mix at the parties and this would lower morale and further fuel the divide *"it would be more people ignoring other people"* (15.09.05 *Project meeting*). The failure of the core group through opportunities such as these to remind all staff of their shared vision – to break down traditional barriers in order to create the best care for patients – left the staff uninspired to be a part of the changes initiated through practice development (Goffee and Jones 2006). The core group therefore only proliferated the divide between the staff; yet this behaviour is unrecognised in the literature.

In addition, divides between day and night staff in practice development initiatives have not yet been acknowledged in literature¹¹³ yet clearly they had a major impact in this research. This is discussed further in the following chapter.

CONCLUSION

Divisions which exist between and among professional groups is an underplayed topic (and indeed barely mentioned) within organisational change literature (Parker 2000) and completely unacknowledged in practice development literature; yet as this research has demonstrated these divisions play a critical role in the success or failure of change initiatives such as practice development. This chapter has illustrated the many complex and overlapping divisions based on both hierarchical and professional identity which my unique position as an outsider to health care using ethnographic research methods has enabled me to discover. These divisions were based on both physical and symbolic boundaries and incorporated deep rooted identities and loyalties – only revealed by the application of symbolic-interpretivism to this research – which has led to the generation of new knowledge in the field of practice development to be achieved.

Figure 20 illustrated the prominent divides that existed between the practitioners within the 'PDU'. The 'staff' and the 'core group' were the two major subgroups who were opposed to one another, based on hierarchical boundaries. The core group used the status they attained by their positions on Oak and Willow wards

¹¹³ This division has been noted in other nursing literature previously, which attributes this to workload distribution (i.e. Brooks and MacDonald 2000); this issue is expanded on in the following chapter.

to coerce and force staff into participating in the accreditation; yet leaders of empowering change strategies behaving in such ways (thereby hindering staff involvement) has not been acknowledged in practice development literature. Using ethnographic research techniques, I was able to observe the various controlling mechanisms the core group used and also examine the impact this had on staff trust and morale. This method also enabled me to hear the organisational stories of Kerry, Anna and Naomi who had their decisions ignored or overruled by the core group within the accreditation, which provided a unique insight into the culture of an organisation undergoing major change. This is because actual organisational stories - such as those presented here - are rarely found within the literature.

This chapter explored the subgroups within the core group itself, where it was demonstrated that the hierarchical structure from the wards was transferred into it. The clinical leaders were positioned at the top of the scale within this and as a result, the other members of the core group – Anna, Jenny, Kate and Emily – all reported feeling unempowered in their positions. The transferral of hierarchy into practice development core groups is as yet not documented in the literature¹¹⁴, yet clearly it has a major impact on the goal of empowering practitioners through this initiative.

How professional and hierarchical divides can be overcome when faced with a similar group was also illustrated in this chapter. This was the case for the

¹¹⁴ As in the previous chapter, this is evident in Appendix 15 which illustrates the themes generated in this study and appropriate comparative literature used to interpret them. This Figure demonstrates that many themes which emerged from this research have not been attended to in the literature, such as the barriers between two wards within a unit undertaking accreditation (Willow ward vs. Oak ward), in the practice development literature.

subgroups 'Willow ward' and 'Oak ward' and also 'nurses' and 'HCAs' – who were all able to merge their boundaries to overcome differences when positioning themselves in opposition to another group. The tensions that existed between the night and day staff on Oak and Willow wards were also documented, yet this has not previously been addressed in practice development literature¹¹⁵. Additionally, no articles have been authored by night staff which implies, as was the case in this study, that night staff are excluded from practice development; an issue previously not raised.

This chapter has explored the cultural barriers which prevented the participants in this study from working together to implement practice development or achieve accreditation. The previous chapter outlined the leadership issues which also similarly presented a blockade to this. Within these chapters, new knowledge has been generated in this area which will be further highlighted in the following chapter along with information on how this can be applied to the wider field of implementing change and empowerment initiatives in general.

¹¹⁵ One article has mentioned old and new staff separately, but found on the contrary to this study that these groups worked in harmony together by learning from each other (Page 1998a).

CHAPTER IX

CRITICAL REVIEW OF RESEARCH & RECOMMENDATIONS

INTRODUCTION

This chapter reviews the claims to new knowledge this research has made, which is achieved by first addressing whether the findings outlined in the previous two chapters achieve the research aims documented at the beginning of this thesis. The techniques of assessing ethnographic research from Chapter Three are then re-addressed in order to determine whether these claims are plausible; within which the valuable and original contribution generated through this research is discussed, as this is both a requirement of ethnographic research and a PhD. The limitations of this study are then documented before the recommendations for practice and for further research based on the findings in the previous two chapters are presented.

RESEARCH AIMS

The aims of this research were to investigate practice development accreditation by studying a unit undertaking this process, to examine the culture of a unit during accreditation and to portray a multidisciplinary account of practice development. These were evidently achieved, as the previous chapters have documented the accreditation journey of Oak and Willow wards, the culture of the group and the multidisciplinary perspectives within it. More specifically Chapter Four documented how a unit was selected to take part in this research, how and why ethnography was chosen as the method to follow the accreditation process and Chapter Five provided a synopsis of 'what happened' during this

journey, which was expanded in later chapters. The culture of the group undergoing accreditation was examined and explored throughout Chapter Eight in which the varying opinions of the multidisciplinary group were presented, which was additionally documented in Chapter Seven. The views of nurses, occupational therapists, physiotherapists, clinical leaders, HCAs, hospital managers and even a practice development consultant and ward clerk were all presented in this study, thereby fulfilling this aim. Indeed all three of the research aims were achieved, which was only attainable by the use of ethnographic research methods. The assessment of ethnography is detailed in the following section.

ASSESSING ETHNOGRAPHIC RESEARCH

The strategies to assess ethnographic research were outlined and discussed in Chapter Three, but many of these were unable to be documented until after both the research and findings had been presented. The first strategy required the issue of selective observation and interpretation to be addressed but as stated earlier, this research maintains to be a collection of selected observations, as it would have been impossible for me to observe all interactions. Additionally, it was specified by the local research ethics committee that I was not to be present at Temperley Hospital unless a relevant meeting, event or interview was being held, which further restricted the observation as this was only possible for several out of possibly hundreds of hours per week. During the times of observation, discussions were recorded with a Dictaphone which ensured that I did not focus on the opinion of only one of the participants in a meeting or the thread of only one conversation, as all information was recorded. Therefore, while

occasions of observation were selective, what was observed during these times was not.

The second strategy to assess ethnographic research is based on its generalizability, but as stated in Chapter Three ethnographers do not intend their research to be generalizable as data is gathered from a very specific setting. Additionally, symbolic-interpretivism was adopted as the guiding theoretical perspective of this research and this theory states that interactions are dependent on actors who all have individual and unique backgrounds and perform in a specific juncture of time and space which can never be replicated (Frey and Sunwolf 2004). Therefore what is observed is unique to the group under study. While the findings from ethnographic studies are not generalizable, as many groups share similar characteristics the findings are 'transferable' to other interactions, groups and procedures. The series of events which unfolded during the Oak and Willow ward accreditation will never be exactly replicated by another group, but some of the issues and barriers they faced certainly will. The findings of this study are therefore transferable to other groups undertaking similar empowering change initiatives.

The third method of assessing ethnography is to judge the reliability of the text; that is the extent it accurately represents the phenomena to which it refers. This is achieved through the reader's evaluation of whether what is reported seems plausible given existing knowledge on the subject. However, Chapter Two revealed that ethnographic research has not been utilised in practice development previously nor has culture or the multidisciplinary perspectives of this initiative been explored and in fact very little literature exists at all on the subject of accreditation. It is for these reasons that the findings of this research

were interpreted in light of organisational change and leadership literature which, as demonstrated over the previous two chapters, corroborated the findings. It is therefore reasonable to assume that the findings of this research are plausible, given current knowledge. However if the reader is still unconvinced of its plausibility, a second strategy to assess ethnographic findings is to consider how credible the research is. This is achieved by examining the process that produced the findings and it is for this reason Chapter Six provided details of how the data was transcribed, coded, topics collapsed and themes drawn. This demonstrated how the data was analysed to generate the findings and information was provided which explained how the symbolic-interpretive perspective was applied to interpret the data. This presented an audit trail which contributed to the credibility of this study's findings and therefore addresses this criticism.

The fourth strategy suggested to assess an ethnographic piece of research is through the conduction of 'member verification' but as outlined in Chapter Three, debate exists within the literature as whether to conduct this or not. This is because participants are often unable to appreciate the multiple perspectives presented in the final research project. Indeed, they may place less prominence certain emotions which they felt strongly at the time of data collection when it is in a finished report, or they may not wish to have unfavourable information presented of them – all of which will affect their ability to verify the research data. It is for this reason member verification was not conducted in this study.

The fifth strategy to assess ethnographic research is through reflexivity, which is necessary because the ethnographer in this type of research is the data collection and analysis tool. It was to address this issue that a description of myself was

presented in Chapter Three, which highlighted my physical appearance, history and personality; these details were also referred to at various junctures in this thesis to show how they influenced this research – such as my ease at bonding with the participants who were culturally similar to myself. The issue of reflexivity was therefore addressed and fulfilled in this study.

Finally, the sixth strategy to assess ethnographic research is the importance of the selected topic and the contribution to existing knowledge it has made, which are also the two key requirements of a PhD thesis. Existing literature on practice development was presented in Chapter Two to demonstrate accreditation and the issue of culture within this are increasingly important subjects as more units than ever are seeking accreditation. It was also highlighted that there is a distinct absence of literature on both of these subjects and in addition practice development has not been written from a multidisciplinary viewpoint, despite this being a defining feature of this initiative. The gap in literature around these areas generated the research aims which guided this research and by addressing and researching these issues, a valuable contribution to existing knowledge has been made. Additionally, an original insight has been provided into practice development through the utilisation of – for the first time in this area – ethnography and symbolic-interpretivism and by my position as a non-health care researcher. New areas of discussion not previously documented in the practice development literature – such as boundaries based on professional identity – were raised through this combination and for the first time the experiences of a failed practice development unit were presented, creating a unique and new contribution to current knowledge.

Many insights were gained as a result of this research which reflects the valuable contribution to knowledge it has made. Chapter Seven outlined the various difficulties associated with leadership encountered in the accreditation and for the first time was able to raise the issue of, and present the outcome a lack of genuine belief and commitment in the cause of practice development from its leaders has. Additionally, the difficulties associated with an absence of these elements as well as management support were for the first time demonstrated in practice development literature. This chapter also presented for the first time that staff can be coerced and forced into becoming involved in practice development, which compromises the principles of choice and ownership - critical elements in any empowering initiative. Similar experiences have been reported in organisational change literature and so this research therefore also contributes to the existing body of knowledge in this area. Chapter Seven demonstrated for the first time that although practice development literature claims units must adapt to organisational changes, the secrecy over future plans of an organisation can make this extremely difficult in reality. It also showed that while it is claimed practice development units should not receive additional privileges because of their accreditation status, some in fact do. These issues have not been presented in the literature previously, nor has differing views on practice development within one unit been acknowledged, again highlighting this study's contribution to new knowledge.

Chapter Eight explored the cultural barriers among the participants in this research which was discovered by utilising participant observation. The divisions that existed based on professional and hierarchical identities were documented and how leaders can hinder staff involvement in empowering change initiatives by use of their hierarchical status has now been illustrated

through this study. Similar reports have been reported in health care and organisational change literature and so this study has therefore been able to contribute to the existing body of knowledge in these areas by confirming this. The tensions which exists between practice development units has been alluded to within the literature but this study was uniquely able to document that this can indeed be the case, thereby making a valuable contribution to knowledge on this subject. Additionally, tensions between the multidisciplinary members of a group undertaking practice development were documented in this research, by the use of ethnographic research methods, for the first time in practice development literature.

A recognition that some staff find engaging in practice development difficult was also achieved through this research, which adds to existing knowledge on this subject. For the first time questions over the extent to which night staff are involved in practice development have been raised through this research, demonstrating its generation of new knowledge. Finally, this research documented how hierarchical status in practice can be transferred into practice development initiatives and in particular in core groups leading these changes, which are issues previously not acknowledged in the literature. This research has therefore both generated new knowledge and contributed to existing knowledge and so has made both an original and valuable contribution to not only practice development, but organisational change and empowerment knowledge in general. Before strategies to utilise this knowledge in practice are given by presenting recommendations based on these, the limitations of this study are outlined as part of the final stage of verifying the study.

LIMITATIONS OF THIS RESEARCH

This research was limited by three elements which have already been alluded to throughout this thesis. The first of these limitations is the amount of time spent in the field data collecting, however as stated earlier the time frame was selected because eighteen months is the average estimated period of accreditation. The participants in this study clearly extended beyond this but the time constraints of my PhD registration meant I would not be able to follow the core group until they either completed the accreditation or withdrew altogether. This study is therefore not an account of the complete accreditation journey (which in itself is a continual process anyway) but rather a substantial component of this.

The second limitation of this study is that it followed the accreditation journey of only one group of practitioners. While it was not the aim of this study to be a generalizable, representative, or an omniscient account of practice development units - as it is not the purpose of ethnography nor is this possible from the symbolic-interpretive perspective¹¹⁶ - this does still limit the results of this study. The findings however, were compared to other accounts in the literature to corroborate them and make them applicable to other similar settings, achieving its aim to be of relevance to other groups.

The final limitation is the number of perspectives it has been able to attain. I depended on the core group to grant permission and access to interview staff and because of this I was unable to gain the views of those with whom they did not share a good relationship. It was outlined over the previous chapters that the

¹¹⁶ As actors bring their backgrounds and cultural frames to the interactions and events are dependent therefore on a group of specific actors, interacting within a specific juncture in time and space.

night staff were excluded from the accreditation because of the view the core group held towards them and as a consequence, access to this group was problematic which meant I was unable to interview any of them. Additionally, access to certain participants was limited because of the refusal of some to be interviewed. Helen did not respond to three requests for interview and Christine and Angela did not respond to requests once they had resigned from the core group. This study was therefore limited by the availability of, access to, and willingness by participants to provide information for this study.

Having addressed the limitations of this study and the techniques to assess this research which have reviewed the findings of this study, recommendations for practice based on the findings presented are documented.

RECOMMENDATIONS FOR PRACTICE

The recommendations for practice as an outcome of this research are based around the pivotal areas which the participants of this study failed to achieve, but had they been addressed from the outset of the accreditation journey, a very different outcome would have almost certainly been achieved. These are to create a vision, overcome professional and hierarchical boundaries, produce a succession plan and understand conflict. These are not limited to the field of practice development or accreditation, but are applicable to change initiatives in any organisational environment and in particular attempts to instigate empowerment.

Create Vision ¹¹⁷

The core group had difficulty in gaining both management and staff support for practice development, which was primarily due to the fact that they failed to develop a vision of what they wanted to achieve through the accreditation. The majority of staff were unable to understand what practice development was or what accreditation would mean for them because of this, which consequently made them reluctant to partake in the process. Vision in initiating change is critical from the symbolic-interpretive perspective as it frames the future for staff in times of transition (Rickards and Clark 2006). It describes their purpose and provides them with a 'map' to interpret current actions and the overall future of the group (Tietze et al 2003). A successful vision becomes the 'glue' which binds the interaction of leaders and followers together, which creates a trusting, reciprocal relationship through which followers can become empowered (Halbestrom 2006). To successfully create a vision which will inspire and motivate a group, leaders must connect with their follower's values and beliefs (Tietze et al 2003) and so vision must encompass the cultural beliefs, values and goals of the group. It is through vision and not rules and procedures, that leaders control their followers and so creating this is critical from the symbolic-interpretivist perspective (Halbestram 2006). The criteria of the Bournemouth University and University of Leeds accreditation schemes both require groups to demonstrate vision. However the core group in this study failed to do this, and instead created a mission statement believing this was a vision – a common error made by leaders (Thornberry 2006).

¹¹⁷ Vision defined in the symbolic-interpretive perspective is an achievable imagined concept of how an organization could and should look. It is not a mission statement (Burnes 2004).

While they failed to create a vision of what they wanted to achieve collectively, many members of the core group had developed a picture of what they wanted to achieve: to become a physically joined unit in which all aspects of care delivery were rehabilitation focused and all staff specifically trained for this within it. Anna and Christine failed to understand this vision however, and as a consequence were unable to commit to the accreditation. The entire core group failed to collectively create their vision which therefore could not be relayed to staff or to the management, who were all unable to understand the purpose of the accreditation.

Vision is most effective when it is translated into a visual picture (Thornberry 2006), which the core group could have easily accomplished at the practice development induction days they attended, had they understood its significance. This in turn could have been conveyed to the staff on the away-days and the managers when they returned to the hospital. The core group could have commissioned a local artist or even a member of staff, patient or relative to depict their vision. A simple sketch or painting of the two wards joined, with the members of the multidisciplinary team working collaboratively, some holding exercise classes and patients engaging in various rehabilitative activities on this picture would have been sufficient. Placing the identical pictures on Oak and Willow ward would have ensured staff, patients, visitors, other agencies and the management team could have known instantly what the core group were trying to achieve through their projects and the accreditation. Without an understanding of the reasons why they needed to rotate wards, why their role had to be expanded and why the core group were discussing joining the two wards, the staff were reluctant to participate in practice development initiatives which caused the core group to become frustrated and start forcing them to

participate. Without a mental image of what it was that the core group were trying to achieve, the management team were unable to understand how the accreditation and the joined unit would fit into their organisational plans for the hospital, which consequently meant they placed little importance on it and did not consult the core group in decisions. A key recommendation for future practice on the basis of this is therefore for initiators of change to understand the nature and purpose of vision, which will enable them to create a clear mental image others can relate to and communicate this effectively, subsequently increasing the likelihood of their cooperation.

Overcome Professional & Hierarchical Divides

The staff and the core group were unable to overcome their professional and hierarchical divides to work together to achieve accreditation status, which was documented in Chapter Eight. The professional divides were based on role, length of time served, shift pattern worked and the physical boundary of the wards themselves. The staff defended their identities based around these as they believed they were at risk, because they did not understand that practice development did not require professional identities to be blurred, but instead for the roles of the other professionals to be understood in order to work more effectively together. A clear vision would have helped to reassure the staff that their professional identities would not be eroded, rather that the boundaries which existed between them would be.

Earlier chapters documented the ways in which the core group used their hierarchical status to coerce and control staff involvement, overrule suggestions and changes, withhold information and force them to become involved in projects. It was also demonstrated that staff felt unable to participate as equal

members in practice development because of the core group's hierarchical status, which they felt had been transferred into the accreditation where clinical leaders existed in a hierarchically superior position. The core group should have dissipated the rigid boundary based on their hierarchical status as this would have limited their desire to coerce the staff, making the staff much more likely to participate in the accreditation. A key recommendation for practice is therefore to make significant efforts to break down the hierarchical and professional boundaries – not identities – which exist in organisations when undertaking empowering change initiatives. This could be achieved by educating the leaders of these initiatives of the potential risks in not doing so, such as non-participation, resistance or even sabotage of the initiative, which would inspire them to avoid maintaining these divides through their actions.

Succession Planning

Chapter Seven explored the problems related to leadership experienced in this study and outlined the debate as to whether a single or shared leadership approach would have been more effective. A single leader would have coordinated the core group more effectively, but equally the accreditation attempt would almost certainly have ceased had only one person been leading it and then resigned. While the shared leadership approach allowed a range of perspectives to be represented within the core group, the lack of genuine commitment to, and belief in practice development from some of its members prevented the core group from progressing. Irrespective of whether a single or shared leadership approach is adopted in change initiatives, it is critical that successors to lead it are established; something recommended by the Bournemouth University accreditation programme, but which was failed to be implemented by the core group. Selecting less hierarchically superior successors

who were interested in, and committed to practice development would have sent a powerful message to the staff: that hierarchical status was not relevant in practice development. Clear succession plans would also have enabled the core group to replace members who resigned easily and the joining of a new member may have helped raise the morale of the core group during difficult periods.

The core group were not alone in feeling reluctant to hand over their control of the accreditation to the staff, as it is acknowledged in leadership literature that handing over power and control is difficult for most leaders (Lashley 2001) because it is the final 'letting go' of the ideas which have inspired them; it is therefore emotionally challenging and 'hurts like hell' (Smith 2007:91). However, it is critical to achieve as leaders who ignore succession dilemmas because of their inability to hand over control only develop further dependency from their employees¹¹⁸ (Rickards and Clark 2006), making empowerment an increasingly unlikely occurrence. The core group's inability to establish successors and let go of their 'PDU' damaged the reputation of practice development, as it became viewed as an initiative reserved for a limited group of people. On the basis of this, it is therefore a key recommendation for practice that succession planning is discussed, arranged and implemented in any change initiative and because of the emotional strain this places on leaders resigning from their position within it, sufficient support to do this also needs to be in place to ease the transition.

Understand Conflict

The previous two chapters documented that the staff of Oak and Willow wards resisted the changes implemented through practice development in a variety of

¹¹⁸ Known often as 'Queen Bee Syndrome' – cases where leaders are unwilling to teach others, and actively use behaviour that keep others from power (Tebbitt 1993)

ways. Resistance is viewed as the expression of conflict within the symbolic-interpretive perspective and this was demonstrated through the staff's implicit (by purposely ignoring information about changes) and deferred action¹¹⁹ (demonstrated through the threat of resignation if a certain project continued). Leadership and organisational change literature cites reasons for resistance to change as being a lack of trust or choice, uncertainty that the change is necessary, loss of personal security, resentment of interference, the loss of status and power, fear of personal failure and a lack of support; all of which were demonstrated by the staff in this accreditation attempt (Lashley 2001).

Symbolic-interpretivists view conflict as inescapable because it is implicit in all aspects of power and control – both of which saturate organisations (Hatch and Cunliffe 2006). Conflict is most potent during attempts to create change because cultures provide value stability, personal meaning and predictability (Schein 2004) and change disrupts these, thereby affecting the balance and identity of a group (Marquis and Huston 2006). Additionally, significant alterations to the workplace instigate feelings of 'loss' in some employees who as a result find changing a painful and difficult experience (Jones 1995). Introducing change in organisations has been likened to the stages of bereavement; these being a denial that change is necessary at all and as the changes continue, feelings of anger develop, which often leads to a scapegoat being sought to attribute blame for the change, finally resulting in resistance to changes (Yukl 2006). If the initiatives proceed however, given time, most people will eventually accept that the

¹¹⁹ Implicit resistance efforts are demonstrated through subtle tactics and demonstrate a loss of loyalty to the organization and the loss of motivation to work (Hatch and Cunliffe 2006), whereas the line between the source of resistance and the reaction to it is blurred in deferred action. For instance, minimal reaction may occur when a change is first introduced and feelings towards it are stored, but when another change is introduced the stored emotions are added to and a fierce backlash can occur as a result (Robbins and Judge 2000).

changes are inevitable and will mourn for what they feel has been lost, such as identity or routine. It is because of this reason that the symbolic-interpretivist perspective views resistance to change as a natural human reaction and not a sign of inflexibility or ignorance (Yukl 2006); yet the core group viewed the staff's resistance to practice development initiatives as precisely this. The word 'resistance' has negative connotations as it is most commonly associated with violence and hostility, which is most likely to be the reason why the core group and indeed other leaders try to ensure conflict is resolved quickly (Rickards and Clark 2006). However, symbolic-interpretivists believe it is the avoidance of conflict and not conflict itself which causes major problems (Klein 1999) and therefore a minimal level of conflict within groups is advocated¹²⁰ (Robbins and Judge 2007).

The core group were completely unprepared for the resistance they faced, despite a plethora of literature which exists that highlights that this occurs (Robbins and Judge 2000) and even recognition of it within the practice development accreditation pack issued by Bournemouth University. It is therefore a key recommendation for practice that the leaders of change must accept – as the symbolic-interpretive perspective advocates – that resistance to change will occur and plan strategies on how to address this before changes are introduced. Had the core group understood the symbolic-perspective, they could have addressed the concerns of the staff rather than trying to overpower them and overcome their resistance quickly, which consequently would have enabled them to gain the support and commitment of the staff.

¹²⁰ Attempts to work through conflict must be non-coercive as the use of influence tactics transform healthy conflict into dysfunctional conflict, demonstrated through resistance (Senior 2002).

The four recommendations for practice presented here all emerged as a direct result of the problems the core group and staff of Oak and Willow ward faced during their accreditation. As it was documented earlier in this chapter, this research has also raised several new lines of enquiry which if undertaken, could benefit practice further. These are outlined in the following section.

RECOMMENDATIONS FOR FURTHER RESEARCH

The new knowledge generated by this research has highlighted five areas where further research could be of great benefit. Firstly, the review of the literature reported in Chapter Two revealed that the multidisciplinary aspect of practice development is its differentiating and defining feature, yet it was detailed in Chapters Seven and Eight that many professional groups were excluded from the Oak and Willow ward accreditation. One of the limitations of this study was the inability to attain the views of certain professions during the accreditation – such as the night staff, porters and consultants. Further research into the roles of professionals such as these in practice development would therefore be of benefit to the current body of knowledge as it could help to clarify who is included within ‘multidisciplinary’ teams and why some groups may be specifically excluded within practice development.

Secondly, this research demonstrated that an accredited unit can be viewed as elitist by others and given preferential treatment within organisations. Further research to explore the relationship between accredited and non-accredited units would be beneficial in the area of practice development, where the sharing of knowledge between these units is promoted. Given the increasing number of

units undertaking accreditation, assessing the impact of dividing units based on this accreditation status would aid organisations in learning how to deal with these tensions.

Thirdly, this study documented the accreditation journey of a virtually all-female group of practitioners¹²¹. Alternative issues and problems may have been raised had the core group instigating practice development consisted of both male and female health care professionals. The impact of gender differences within practice development is not documented in the literature, however an exploration of this may provide critical information on power issues within this change strategy. Additionally, all-female core groups such as that in this research may benefit from a feminist perspective analysis. This would provide insight into the power structures within same-gendered groups and may enable useful insights for same-sex groups of practitioners instigating practice development.

Fourthly, this research has demonstrated how a unit can fail to successfully develop a culture which embraces change, incorporate the full professional team and incite ownership and empowerment in practitioners when utilising practice development. However, given the many successful reports within the literature of this in practice development initiatives, further research into how these elements were achieved would be of benefit to future units undertaking this. The knowledge generated from this research which highlights the potential pitfalls, combined with further research which would document how practice development can be achieved would be of tremendous benefit for practitioners undertaking this, or indeed any empowering change initiative.

¹²¹ Out of seventy-seven staff based on Oak and Willow wards, only six were male. Four of these were consultants who were not involved in the accreditation.

Finally, given that few papers acknowledge the difficulties ethnographers encounter at exiting the field when their research ceases, it is a recommendation that further research be conducted into this experience. The nature of ethnography requires researchers to intertwine their own and the participants worlds for a period of time where they become accustomed to the research site, learn new rituals, routines and languages, build relationships with participants and forge a new identity as both an insider and outsider. It was reported in Chapter Four that I found it difficult when withdrawing from the field and it will be demonstrated in the next chapter how this research experience has affected both my personal and academic life. Sudden withdrawal from the field can potentially be disconcerting for researchers and in particular novice ethnographers. Research into the strategies used by ethnographers to deal with disengaging from participants and exiting the field would be of benefit to future researchers using this method, as it would both prepare them for the difficulties this causes and provide them with mechanisms to cope with this.

CONCLUSION

This chapter has assessed the research and findings outlined within this thesis in order to apply the experiences of the group in this study to change initiatives in general and to subsequently make recommendations for leaders of change and empowerment strategies and highlight areas which would benefit from further research. This was achieved by first documenting how the research aims were fulfilled. Secondly, the strategies for assessing ethnographic research were examined and applied to this research - within which the valuable and original contribution this study has made was outlined. The limitations of this study were

also documented and after assessing the research, four recommendations for practice based on findings presented in previous chapters were established which are to create a vision, overcome professional and hierarchical boundaries, produce a succession plan and understand conflict; which are applicable for any organisation instigating an empowering change initiative. Finally, recommendations for further research on the basis of this study were presented. These are to conduct research into the roles of more professional groups within practice development, to explore the relationship between accredited and non-accredited units, to assess the impact of gender within practice development, to investigate how practice development can be successfully achieved and finally to explore the experiences of ethnographers when exiting the field.

This chapter assessed and verified this research by demonstrating its contribution to knowledge. The following final chapter of this thesis draws this study to a close, by addressing the personal development I have experienced by conducting this research and reflects on the PhD process in general.

CHAPTER X

EPILOGUE

INTRODUCTION

To conclude this research, thesis and my PhD, this final chapter begins by returning to its title and documenting my views on unexpectedly uncovering and reporting the negative aspects of practice development. This is then followed by a reflection on how I have developed as a direct result of undertaking this research and finally, this thesis ends by demonstrating how the experiences of conducting this study have already started to shape my personal and professional future.

HISTORY IS ONLY WRITTEN BY THE VICTORS

'I Bet You Wish you'd picked a Different Group' was a very carefully selected title. I did not anticipate when I began this research that the experience of the practice development accreditation process I would follow would be problematic, as failure within this had not been documented. I did not expect to observe leaders coercing staff into trying to become empowered, or practitioners who would be instantly against instigating change; but reassuring, neither did the core group. It is for this reason I believe the failure of the accreditation attempt documented in this thesis is the strength of this research, which has made a valuable contribution to practice development knowledge.

It was not my intention to expose practice development as a 'sham' or accreditation as pointless either at the beginning of this research, nor indeed at the end. In fact, I believe anyone would find it difficult to disagree with the

principles of practice development: that staff should be sufficiently empowered so they take responsibility and ownership of their care and work inter-professionally to ensure a smooth service, that service of the highest quality is provided to clients, all without the use of any additional resources. However, I believe my unintentional unearthing of practice development problematic areas and dysfunctional aspects allow practice development and accreditation to be better understood, which will enable practitioners engaging in these to strengthen and improve them; in the same way a patient must wear a hospital gown that exposes his bare bottom and makes him feel vulnerable and uneasy, but which is necessary to identify health problems by a surgeon to enable him to be treated effectively. As it is with practice development; exposing its flaws through this uneasy account does not demean its value to health care, but rather presents those promoting it with an opportunity to make improvements. The very purpose of practice development is to highlight systems or ways of working that are not effective in order to implement changes which will improve them; of which this study – albeit inadvertently – has achieved the first half. The second must come from those within practice development as it is the insider who can ‘translate the applicability of those outsider views and apply them to a specific challenge facing their workplace’ (Klein 2004:11). This research has overcome the old adage ‘history is only ever written by the victors’ and in the future will show that documenting failure as well as success can be of significant value to practice. The documented downfall of the Oak and Willow ward accreditation attempt in this research, which has contributed to knowledge, was only possible because of the utilisation of ethnographic research techniques. The impact of using this method as a novice researcher is discussed in the remaining sections.

FROM THE OUTSIDE LOOKING IN

Using ethnography in this study was my first experience of engaging with this method. The many problems I encountered as a result of this – learning how to use my body, struggling with the insider-outsider dichotomy and having to endure disconcerting experiences – were documented in this thesis and demonstrate how as a researcher I have learned to really understand and employ this method. I was slightly concerned when I started collecting data that I might miss valuable information by not being based permanently on Oak or Willow wards, but in fact I found on the contrary, and in hindsight I would have missed a great deal more had I assumed a position on the wards. Because I was not based there, I made no attempt to become an HCA, nurse, therapist, clinical leader, ward clerk or porter in this research. Had I assumed any of these roles I would have almost certainly become too embroiled in the politics of professional and hierarchical identity to gain the many perspectives of the group that I did. Joining only one professional group provides a barrier to interaction with many others in a culture and allows an understanding of only one view in a much wider group to be attained. It is for this reason I now believe it is imperative for ethnographers to research areas only outside of their own culture, for cultures to only be investigated by outsiders to them and additionally for ethnographers to avoid assuming a role within the culture that they study. These are important and valuable lessons I have learned as a professional by conducting this study, but additionally I have learned a great deal on a personal level by undertaking this study, which the following section illustrates.

REFLECTING ON THE PHD JOURNEY

Earlier in this thesis, a section entitled 'The Research Tool: Corrina' which gave an outline of my biography and personality was presented. This was in order to demonstrate how I as the research instrument in this study had influenced all elements of the data collection, analysis and interpretation process. But in the same way as a chef blunts his knife whilst preparing a meal, I as a research tool have been affected and shaped by this study

There is no one way street between the researcher and the object of study; rather, the two affect each other mutually and continually in the course of the research process

(Alvesson and Skoldberg 2000).

Now, at the end of this research and my PhD journey, I want to present not how I have influenced this study, but rather how it has influenced me. Conducting the analysis of the collected fieldnotes, recordings, transcripts and learning to understand the actions of the participants by reviewing literature and applying theories to this, caused me to reflect on how I too have been resistant to change in the past. One such example occurred when I worked as a bartender and my manager announced a new change in the routine; customers would no longer approach the bar to order meals and drinks, instead we had to go their table to take orders. This irritated me as my first thought was 'Great, even more work for me to do' but I nevertheless cooperated and kept silent about my unhappiness with the change. I served customers all that day with a sour attitude, annoyed by my manager's decision and probably ruined lunch, drinks and dinner for many people and only contributed further to the rest of my team's negative attitude. Understanding why people react in such ways to change by interpreting the data collected in this research, enlightened me to my own reasons for responding in

such a negative way. As a consequence I have adjusted my attitude and now embrace change, as I know that even if changes do create more work, providing they develop more effective systems they are worthwhile – after all, it is what I am paid to do.

Learning about the concept of practice development itself also had an impact on my attitude. Its principles – particularly instigating ideas for change from the ‘bottom up’ – inspired me as I have always existed at the lowest level in hierarchical systems and only ever received instruction to change from the top. I have never felt sufficiently confident to voice my opinion on procedures I felt were ineffective or inefficient because I believed it was not my place to do so. But reading literature which claimed that many leaders and managers advocate constructive criticism on how to improve systems, I became more confident and started to challenge aspects of my practice. One such example of this occurred when I was employed during my PhD as a ‘resident tutor’ where I was responsible for the welfare of students in a university halls of residences. As part of this role I recommended many students to a counselling service, but it was soon apparent that some students were ‘slipping through the net’ of care, as they were being refused treatment because of a bureaucratic anomaly. I was unhappy with the apparent lack of client focus and flexibility of the counselling system and so I arranged a meeting with the head of services to discuss collaboratively improving it. However, I was informed in this meeting that the current system had been ‘in place for many years’ and would be ‘too much trouble and a lot of hard work’ to change. I was undeterred and I pushed on to have it adjusted, but I was informed that to make any changes to the current system I would have to meet with the senior manager of student services; this was provided with a warning however, that this person was ‘extremely senior’ and almost certainly

would not appreciate the opinion of someone of my status. To be absolutely sure that the changes I wanted to implement would be an improvement for everybody, I liaised with the relevant people which they would affect and after attaining their approval, I met with the head of service. After presenting my case, recommending strategies for improving the services and emphasising the need for all staff who were responsible for the welfare of students from the various services to work together to achieve a better service, he agreed to change the system. I would never have made a suggestion to improve practice, let alone met with a senior figure by myself without having read inspiring accounts of implementing change in practice development literature. The confidence these stories gave me to develop my own practice, enabled me to gain ownership and empowerment over my role.

CONCLUSION

Ending this thesis with an outline of how practice development and ethnography have shaped my understanding, beliefs, thoughts and feelings illustrates how researchers are not left untouched by their experiences and that a PhD is a 'rites of passage' through which novice researchers are developed, moulded and shaped. Undertaking a PhD and sharing the practice development accreditation journey with the practitioners of Oak and Willow wards changed my entire outlook in both my personal and academic life.

Having engaged and experimented with ethnography as a methodology through this study, I am completely convinced of its value to conduct research. Culture lies behind everything - every person, situation, decision and outcome; it affects with whom and how we interact and so has significant value in investigating any

experience or phenomenon. In my future career as an ethnographer I will utilise the many skills I have gained by undertaking this research and in my personal life, I have already developed - having learned to embrace change and comfortably accept that things are adjusting, shifting and altering every second of every minute of every day; and that is not necessarily such a bad thing, after all 'A scholar who loves comfort is not worthy of the name' (Confucius).

APPENDICES

- I. Definitions of Practice Development**
- II. Varying Practice Development Accreditation Criteria**
- III. Commonalities & Differences of Accreditation Criteria**
- IV. Participant Consent Form**
- V. Participant Information Sheet**
- VI. Research Summary for Participants**
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- XI. Core Group Attendance at Meetings**
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- XIII. Poster Announcing the 'Staff Rotation' Project**
- XIV. Leadership Themes Generated & Comparative Literature**
- XV. Culture Themes Generated & Comparative Literature**

APPENDIX I

DEFINITIONS OF PRACTICE DEVELOPMENT

[Practice development is] a system whereby identified or appointed change agents work with staff to help them introduce a new activity or practice. The new practice may come from the findings of rigorous research; findings of less rigorous research; experience which has not been tested systematically or trying out an idea in, practice. The introduction ought to be systematic and be carefully evaluated to ensure that the new practice has achieved the improvements intended (Kitson 1994:319).

Practice development is a continuous process of improvement towards increased effectiveness in person-centered care, through the enabling of nurses and health care teams to transform the culture and context of care. It is enabled and supported by facilitators committed to a systematic, rigorous and continuous process of emancipatory change (McCormack et al 1999: 256).

Practice development is a continuous process of improvement towards increased effectiveness in patient centered care. This is brought about by helping health care teams to develop their knowledge and skills and to transform the culture and context of care, it is enabled and supported by facilitators committed to a systematic, rigorous, continuous process of emancipatory change that reflect the perspectives of service users and service providers (Garbett and McCormack 2002a:88).

[Practice development is a] discipline focused on the improvements of care for patients in the complex environment of real practice settings, and it is underpinned by the active engagement of practitioners, often in partnerships with others. It draws on and synthesizes a range of different theoretical disciplines and practical approaches and operates at various levels, as a means of facilitating developments in practice, theory, policy and strategy both within and from practice (Page and Hamer 2002:15).

APPENDIX II

VARYING PRACTICE DEVELOPMENT ACCREDITATION CRITERIA

BOURNEMOUTH UNIVERSITY

Each Practice Development Unit must demonstrate:

1. Information on the unit, nature of service it provides and the staff team.
2. The reasons for seeking accreditation as a development unit and how the team came to this decision.
3. A clear philosophy and vision for practice and how this relates to the delivery of care.
4. The unit's action plan and how this supports the organisations overall strategic plan.
5. Personal development plans for all the staff that link to the local health plan and identify how learning needs will be achieved, funded and evaluated.
6. A clearly identified clinical leadership structure that ensures:
 - An identified leader with clear responsibility and accountability;
 - Clear succession planning;
 - Development plans for leadership development within the unit;
 - A steering group to support the PDU and clinical leader.
7. A clearly defined communication structure to ensure effective collaboration and sharing of knowledge within the multi-agency/ disciplinary team.
8. A clear partnership, with:
 - Users and carers;
 - Other agencies required "seamless" care to the client group.
9. How a spirit of enquiry and the use of critically appraised evidence has been developed.
10. Explanation of how the delivery of care is based on evidence and represents best practice and continuing development in light of new evidence.
11. Demonstrate which areas of practice have been developed, how this links to the health plan, and what further developments are planned.
12. How the developments have been evaluated and the learning and best practice dissemination locally, regionally, nationally and internationally.
13. A clear partnership with an academic department to support research and dissemination of practice.

(Bournemouth University Promotional Material)

UNIVERSITY OF TEESSIDE

1. Staff can demonstrate active participation in the innovation(s).
 2. Innovations are not lead by one particular discipline or individual.
 3. There is shared responsibility in decision-making when advancing practice.
 4. There is evidence of patient or service user involvement in the care process.
 5. The user and carers or service user and carers are actively involved with the development/ evaluation of services.
 6. There is evidence of liaison with other groups both internal and external to the organisation.
 7. Working practices reflect innovative collaborative ways of working.
 8. Evidence of multidisciplinary documentation and patient or service user information.
 9. Collaborative practice underpins the quality of the service.
 10. Practice support is based on a multidisciplinary approach.
- (Kell et al 2005:8)

UNIVERSITY OF LEEDS

1. The unit has a clear and defined client group focus, which is reflected in the membership of the team; for example a ward, clinical, community or integrated team.
2. The team has chosen the accreditation approach itself.
3. The team has a shared vision for the PDU.
4. An approach to leadership is identified, which will facilitate the team in sustainable development, evaluation and dissemination of its work.
5. The unit has an explicit framework for organising and developing best practice, which incorporates devolved decision making, staff and patient empowerment and partnership working.
6. Each member of the team is proactively involved in self-development, which is clearly related to patient care need, and the plan for the development in the unit/team as a whole.
7. The unit's development plan identifies the resource requirements needed in order to achieve accreditation in terms of time, expertise and financial support.
8. The unit's development plan includes the process for disseminating evaluated practices both within the organisations and externally.
9. The unit. Team will have a reciprocal partnership with a centre for education, in order to support the development of clinical practice and theory.
10. The unit develops a rigorous, evidence-based approach to practice.
11. The unit/ team and the individuals within it are actively engaged in reflection and in learning from practice experience.
12. The unit/ team exhibits tangible evidence of creativity and innovation in relation to patient care issues and unit developments.
13. Developments within the unit are evaluated and reviewed in terms of their impact on the patient, organisation and staff, and advises the board. Senior management team.
14. The unit acts as an agent of change within the organisation, the region and nationally, publicizing its success to promote the value of best practice.
15. The unit re-wires a steering group which will focus and co-ordinate the strategic direction of the unit.

(Totterdell 2004:135)

EDGE HILL

1. Multi-disciplinary collaboration is evident in the current practices and developments of the PDU
2. Holistic care is underpinned by evidence based practice
3. Staff are involved in individual and collaborative research activity
4. There is evidence of dissemination of research findings within the local and national arena
5. Staff development for the PDU is planned, actioned and evaluated and meets the needs of the individual and the multi-disciplinary team
6. Users and carers are actively involved in the planning, delivery and evaluation of care and the co-ordination and development of patient services
7. Effective collaboration with academic institutions is evident within the PDU
8. The unit has developed a comprehensive communication strategy which addresses communication issues at both a local and national level

(Bates 2000:171)

NORTHUMBRIA UNIVERSITY

1. Identified patient focus of the practice development(s)
2. Identified ownership and responsibility for each development
3. A culture which encourages innovation, critical thinking and risk taking
4. Reciprocal link with a Higher Education Institution
5. Track record of innovation and practice development
6. Evidence based practice developments
7. Evaluation of the impact of developments on users, staff and whole organisations
8. Clinical effectiveness demonstrated through the use of audit and research
9. Dissemination of work to other practice areas and professional groups
10. Professional development profiling and ongoing professional development program for all staff

(Information gained from correspondence with leader of this scheme, 2007)

APPENDIX III **COMMONALTIES & DIFFERENCES OF** **ACCREDITATION CRITERIA**

Key:

BU – Bournemouth University

UL – University of Leeds

UT – University of Teesside

EU – Edge Hill University

NU – Northumbria University

	BU	UL	UT	EU	NU
A collaborative approach to change should be assumed	✓		✓	✓	
A steering group should be created	✓	✓			
Academic partnerships should be established	✓	✓		✓	✓
Action plans which link with organisational plans	✓				
Best practice should be utilised	✓	✓			
Change should be patient focused		✓			✓
Changes should be evaluated / audited	✓	✓		✓	✓
Communication strategies should be established	✓			✓	
Clinical effectiveness should be utilised					✓
Critical thinking should be adopted					✓
Decision making should be devolved		✓			
Development should be planned				✓	
Developments involve research	✓				✓
Disseminate results/ ideas	✓	✓		✓	✓
Information on future developments should be provided	✓				
Information on the unit should be provided	✓				
Information should be provided on resources required for personal development	✓	✓			
Innovations in practice		✓	✓		✓
Leadership should be established	✓	✓			

Liaison with other agencies and groups should occur	✓		✓		
Make practice evidence based	✓	✓		✓	✓
Multidisciplinary approach to development	✓		✓	✓	
Patient empowerment should occur		✓			
Personal/ professional development should be undertaken	✓	✓			✓
Reasons for accreditation and how it was undertaken should be provided	✓				
Reflection should occur		✓			
Risk taking should be undertaken					✓
Shared responsibility for developing practice should be assumed			✓		
Staff empowerments should occur		✓			
Staff should be involved in changes			✓	✓	
User evaluation of services should occur			✓		
User involvement/ partnerships should be established	✓		✓	✓	
Succession planning should be undertaken	✓				
Staff should assume ownership in developments					✓
Staff should assume responsibility for developments					✓
The culture should be conducive to change					✓
There should be a shared philosophy and vision created	✓	✓			
Units should undertake change agency		✓			

APPENDIX IV: CONSENT FORM

CONSENT FORM

Title of Project: What is Practice Development Accreditation? An exploration towards an understanding of the process and culture of practice development accreditation.

Name of Researcher: Corrina Dickson

Please tick box

1. I confirm that I have read and understood the information sheet dated May 2005 for the above study and have had the opportunity to ask any questions.

☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my employment or legal rights being affected in any way.

☐
3. I agree to be interviewed about my practice development experience. I understand that these interviews will be anonymized.

☐
4. I agree to have my interview recorded by a Dictaphone and I understand that all information will be anonymized.

☐
5. I voluntarily agree to take part in the above study.

☐

Name (please print)

Date

Signature

Name (researcher)

Date

Signature

APPENDIX V

PARTICIPANT INFORMATION SHEET

May 2005

What is Practice Development Accreditation? An exploration towards an understanding of the process and culture of practice development accreditation.

I am inviting participants to take part in a research study. Before you decide, it is important to understand why I am conducting the research and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish. Please contact me if there is anything that is not clear, or if you would like more information (my details are on the following page). Please take time to decide whether or not you wish to take part. Thank you.

What is the purpose of the study?

The part of the project in which I need participation is called an ethnography. This means that I will be present at practice development meetings and discussions and will make notes on what happens as you go through the accreditation scheme. I want to get a picture of how different people experience the process, so I also hope to be able to discuss this with some participants in an interview at various times throughout my project. I will be following the accreditation journey over the next 18 months to see how ideas develop and how practice changes. I will mainly be observing and making notes on the process - I am not part of the assessment of accreditation and so what is discussed with me will not affect the outcome of accreditation status.

Why have I been chosen?

You and your colleagues have been selected to take part as you are taking part in Bournemouth University's Practice Development Accreditation Scheme.

Do I have to take part?

No - it is entirely voluntary whether or not you wish to take part. Those who do wish to partake are asked to retain this information sheet for reference and sign a consent form. Despite signing this consent form, all participants are free to withdraw from this study at any time, without a reason being given. If participants do wish to withdraw from the study, they are requested to contact me (details are given on the following page). A decision to withdraw at any time or a decision not to take part will not affect the accreditation status of the group.

What will happen to me if I take part?

A Dictaphone will be used to help record the meetings throughout the accreditation scheme which will allow me to remember important points I may not be able to write down whilst present. However if any participant in a meeting does not want the Dictaphone to be used, it will not be. All details such as the organisation name and names

of the participants will be changed. Any personal details that could make someone identifiable to people outside of the organisation, will be changed. Quotes from participants will be used in the study, but they will bear a false name to protect anonymity. From time to time I will ask for volunteers to be interviewed about how they feel about the practice development process - these interviews will remain entirely anonymous and only the participant and I will be present.

What are the advantages of taking part?

I hope that this study will help gain a clearer understanding of the practice development process and culture. This will then hopefully provide important insights to all people who will become involved in practice development in the future. I am happy to provide feedback of my findings to participants which will provide insight into the process. Participants will be asked individually if they wish to have feedback.

What will happen to the results of the research study?

The information will be used alongside other data that I have collected to form my PhD dissertation. I will analyse it to assess the different processes people go through in practice development. The findings will be submitted for publication in peer-reviewed journals and will be given at conferences. I will also offer to provide all participants with a summary of findings.

Who is organising and funding the research?

This research is funded by the Institute of Health and Community Studies at Bournemouth University. It is being undertaken and organised entirely by Corrina Dickson, a full time PhD student at Bournemouth University.

Who has reviewed the study?

The study has been reviewed and approved by ***** Research Ethics Committee.

Contact for Further Information

Please do not hesitate to contact me on the following email address, postal address or telephone number at any time if you have any questions or queries about this project. All calls will be treated confidentially.

e-mail: cdickson@*****
post: Corrina Dickson
 *** *****

 *** **

telephone: 01*** *****

Thank you for taking the time to read this information sheet.

APPENDIX VI

RESEARCH SUMMARY FOR PARTICIPANTS

Research Summary of Project “I Bet You Wish You’d Picked a Different Group: An Ethnographic Study of Practice Development Unit Accreditation

Undertaken by Corrina Dickson, Bournemouth University between May 2005 and June 2006.

Purpose of Research

This research was undertaken because practice development literature has not documented what exactly occurs during the accreditation process. In addition, although it acknowledges that culture plays an important role in practice development, details of this role is absent from the literature. Finally, practice development is differentiated from other similar change strategies in health care because of its emphasis on multidisciplinary team working, yet the experiences of professionals other than nursing staff in practice development are almost non-existent in the literature. It is for these reasons the following research aims were developed.

Research Aims

- To investigate practice development accreditation by studying a unit undertaking this process
- To examine the culture of a unit during accreditation
- To portray a multidisciplinary account of practice development.

Method of Data Collecting

Data for this research was gathered between May 2005 and June 2006 using ethnographic research techniques. This involved observing interactions during meetings, making fieldnotes and holding interviews.

Research Findings

Information collected during this study was analysed by searching for key themes which would explain why accreditation was unable to be achieved. Two main issues were discovered to be at the root of this, which were leadership and culture.

Leadership

Within the core group of practitioners instigating practice development on the wards, I found a lack of full commitment from all members to the accreditation, the absence of shared beliefs and goals of the accreditation, an uneven distribution of work among them and a lack of practical management support for the core group hindered practice development from being successfully achieved. Additionally I found the core group could often hinder some staff from participating and pressurize others to be involved in the accreditation, which caused staff to be resistant to practice developments.

Culture

I found divisions based on hierarchical and professional identity of participants also proved to be a barrier to the accreditation from being successfully achieved. I identified fourteen subgroups among participants, which were based on which ward they were based on, what professional position they held on the wards, which shift pattern they worked and the length of time they had worked on the wards. These divides hindered participants from wanting to work together to instigate changes on the wards for the accreditation.

Implications for Practice

Based on the findings of this research, I have recommended four key strategies that I think should be instigated by leaders initiating empowering change strategies such as practice development, to avoid similar problems. These are as follows:

1. Leaders should develop a 'vision' of how they would like their organisation to look. This is an image which demonstrates the aim of implementing changes and is often best represented through a visual picture. This enables everyone to understand why changes are being implemented and how these will affect them.
2. Leaders should try to overcome boundaries based on hierarchy and profession; this can be achieved by not having hierarchically senior people leading changes. It can also be achieved by ensuring professional identities are not eroded, but rather the barriers between them are. This will allow people to work together to make changes.
3. Leaders should ensure they make succession plans in order to hand over changes to others and not control the change process for too long. This will prevent leaders from pressurizing or hindering the involvement of others.
4. Leaders should understand that conflict and resistance to changes is a natural reaction and can often be useful. Indeed, some forms of conflict can ensure that alternative plans of action have been contemplated and improve decision-making.

Note from Researcher

I would like to thank again all participants who took part in this research project. The many stories and experiences of practice development have enabled me to produce a PhD thesis and I hope that that this research will be used in practice to help others undertaking accreditation or implementing empowering change strategies. I welcome feedback on both the research process and on this report therefore please call me on 07***** or email me at cdickson@*****, to discuss any issues further.

APPENDIX VII
RESEARCH ETHICS COMMITTEE LETTER OF APPROVAL

04 May 2005

Bournemouth University
I.H.C.S.

Dear ,

Full title of study:

*What is Practice Development Accreditation? An exploration
towards an understanding of the process and culture of
practice development accreditation.*

REC reference number:

Protocol number:

The Research Ethics Committee has reviewed the above application in accordance with the standard operating procedures for RECs.

The Committee has issued a favourable ethical opinion of the application.

The Chief Investigator has been notified of the Committee's opinion in our letter of 04 May 2005. The letter gives full details of the documents reviewed.

The favourable opinion applies to the research sites listed on the attached sheet. [Confirmation of approval for other sites listed in the application will be issued as soon as local assessors have confirmed that they have no objection.]

Statement of compliance

The Committee is fully compliant with the Regulations as they relate to ethics committees and the conditions and principles of good clinical practice.

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Please quote this number on all correspondence
--

Yours sincerely,

Administrator
Committee Administrator

E-mail:

APPENDIX VIII

COMPLETE TRANSCRIPT WITH TOPICS IDENTIFIED

Transcript of Core Group Meeting (12.10.05)

Present: Anna, Christine, Jenny, Kate

CG meeting attendance
Jenny's leadership
Kate's leadership
Liaise with other agents
Understanding of
projects
Allocation of work

- o Discuss absence of Emily and Margaret from this meeting
- o Jenny says yesterday they started looking at the health plan
- o Protected meal times emails to others in the hospital have been sent
- o Need to get it verified by others before can issue it again
- o Response from estates manager says need to better explain what protected meal times is
- o They discuss what it means – i.e. not interrupting staff, no cleaners etc
- o Kate will write this and email it

CG disagreements about
projects

- o Christine not too pleased about closing ward off completely for this project
- o They discuss benefits of doing it
- o Discuss wording of email

- o Anna says a 'patronizing manager' called her 'darling' – short conversation ensues about this,
Kate drags it back to PDU

Kate leadership

- o Anna raises point that it's a wards discretion if they want protected meals time
- o Kate mentions that this conflict arises because of discharge/transfer needs

CG lack of project

consistency

Staff involvement in
projects

- o Discuss implementing protected meal times in evening (Anna and Christine thought it was happening already and have been doing this)
- o Want ward clerks to tell callers about protected meal times
- o Talk about putting poster up so visitors can see what it is
- o Discuss potential exceptions to closing ward off – such as transport/ emergencies
- o Discuss writing criteria's for submission document
- o Anna and Christine haven't written anything as been on holidays

Distribution of PDU work

Non-completion of work

Distribution of PDU work

CG attendance at meetings

PD events

CG attendance

Distribution of PDU work

Kate's leadership

Jenny's leadership

Distribution of PDU work
CG attendance

Kate's leadership

Jenny's leadership

Distribution of PD work

Jenny's leadership

Anna's status

Non-completion of work
PD work

Jenny's leadership

Projects not being done on ward

Anna's role in CG

- o They are going to tell Angela she has been nominated to write one
- o Aim to get criteria done by next steering group meeting
- o Discuss when meeting is and whether Anna and Christine are on holiday then
- o Want to discuss criteria's with Theresa before next steering group meeting
- o Discuss attending the PD Dissemination day
- o Discuss who will attend the day - Anna and Christine maybe on holiday. Emily might want to go
- o Want to show steering group the criteria's
- o Discuss when to meet up to write them
- o Discuss what criteria's they are each doing
- o Anna tells story of how she dyed her uniform green
- o Uniform dyed green story continues
- o Jenny and Kate discuss criteria's while Anna tells her story
- o Anna's story ends and they say they need to tell Angela which criteria she is writing
- o Discuss when Anna and Christine are going on holiday
- o Discuss who will be there to attend steering group
- o Kate says Anna and Christine are always on holiday
- o Kate says criteria's need to be written by 10th
- o Jenny runs through list of people who can't attend steering group meeting (most of the group)
- o Jenny asks Kate to arrange refreshments for it and quantities
- o Discuss where meeting is taking place
- o Jenny asks group if anything else has been happening since they last met
- o Anna needs someone to sort out things needed for sluice room project as she has had many blocks due to her HCA status
- o Anna is yet to write this project up
- o Jenny asks Anna if she has written the projects template form up yet – she hasn't
- o Kate is to arrange her info classes for HCAs
- o Jenny asks if the exercise classes are being done nearly/ almost every day
- o They're not so Jenny asks Anna if she will get involved

Jenny's leadership Funding	<ul style="list-style-type: none"> o Anna says yes o Anna and Christine reminisce on an occasion when Anna dressed up as old woman to encourage patients to join in exercise groups o Jenny asks if any news on funding for observation project equipment yet o Anna reveals no funding is available and they will have to fundraise themselves o This project is therefore still ongoing o Kate says need new date for information leaflet project meeting o Christine after Kate's instruction has liaised with someone from another hospital about the leaflets they are producing – they have similar problems (that they're unsure which info to leave out) o Jenny says just need simple 2 sided A4 o Kate says it can be changed as and when needed o Jenny wants it to contain routine of when to get up etc o Christine thinks can't fit it all into 1 leaflet o Jenny disagrees o Kate offers to take part in project and meet with Christine o Christine discusses which members of staff originally said they wanted to be involved with project from away days o Jenny asks Kate if she has looked at ways relatives can help, as this is written on last meeting minutes – she hasn't o Kate asks when next project meeting is o Kate asks Christine to amend meeting date on white boards o Discuss rotating staff project - Aiming for January o Protected meal times project – has been initiated on wards ('in theory' as Jenny says) o Anna says 'we just need tweaking, don't we' o Jenny will send email round regarding this o Kate wants to set date to evaluate it o Will meet in November o Need to get ward clerk involved in keeping time protected
Kate's leadership	
Liaising with other agents	
Jenny's leadership Kate's leadership	
CG disagreements over ideas	
Kate's leadership Staff involvement	
Non-completion of work Jenny's leadership	
Kate's leadership	
Projects progressing Jenny's leadership Distribution of work Kate's leadership	
Staff involvement	

Kate's leadership	<ul style="list-style-type: none"> o Arrange next meeting date for this project o Discuss handover projects next meeting date o Kate asks if everybody knows about the handovers next meeting o Discuss when going to begin role of rehab assistant project training o Jenny keeping list of people who have attended o OT training sessions aimed for November
Distribution of PDU work	
Jenny's leadership	<ul style="list-style-type: none"> o Jenny wants to get feedback on the sessions so meeting on 20th o Jenny asks about structure of the day project o Christine says Willow ward haven't done well with it o She asks how Oak ward have been getting on - OK o Christine says her late starting staff cause problems
Lack of project consistency	
Therapy understanding nursing routine	<ul style="list-style-type: none"> o Jenny asks reason why they start later o Christine has to let workforce be flexible for child care etc
Willow ward staffing	<ul style="list-style-type: none"> o Discuss how short staffed Christine is o Jenny wants to find a solution
Jenny's leadership Willow ward staffing	<ul style="list-style-type: none"> o Christine says she needs to replace staff that have left
Christine's leadership of Willow ward	<ul style="list-style-type: none"> o Anna knows someone's daughter who would like a job
Rehabilitation focus	<ul style="list-style-type: none"> o Jenny wants more independent patients to be encourages to walk down to breakfast and thinks this will make it easier for nurses working o Anna and Christine say have few independent patients o Jenny asks them to clarify
Night staff	<ul style="list-style-type: none"> o Anna wants night staff to bring some patients down to day room at 7
Debating merits of changes	<ul style="list-style-type: none"> o Jenny says might be a bit too early for the patients o Anna says its only 15 mins difference o Jenny asks if they can't move breakfast time til later on o Anna says it will change whole day structure schedule o Jenny doesn't see this as necessarily a problem o Lunch time is main reason for not having breakfast any earlier
Therapy understanding nursing routine	

Rehabilitation focused	<ul style="list-style-type: none"> o Jenny asks questions about how breakfast time works o Anna would like to have all patients up at table for breakfast but its not feasible on a daily basis o Jenny says she just means those who can
Willow ward staffing	<ul style="list-style-type: none"> o Anna says staffing is problem for doing this – particularly the staggered starting shifts o Kate clarifies what problems are: times staff come in
Rehabilitation focused Kate’s leadership	<ul style="list-style-type: none"> o Jenny asks if can’t identify at least some patients that are suitable – more independent and able
Rehabilitation focused Jenny’s leadership	<ul style="list-style-type: none"> o Kate says even if its only 2
Night staff involvement	<ul style="list-style-type: none"> o Christine says could try it
Kate’s leadership	<ul style="list-style-type: none"> o Anna wants night staff to interact with patients o Kate suggests liaising with night staff and seeing if anything can change o Christine thinks patients already get up early enough o Kate says it depends on patients – too many dependent ones would be impossible
Rehabilitation focused	<ul style="list-style-type: none"> o Jenny says on Oak ward not had any patients down for breakfast as they’re all very dependent o Jenny says 2 weeks ago had lots of independent patients so they could get themselves down o Christine says need to identify certain patients o Kate thinks patients should be consulted over whether they want to go for breakfast before they are washed and dressed
Therapy understanding nursing routine	<ul style="list-style-type: none"> o Anna says they’re unable to get them dressed and washed before breakfast o Kate questions this as she thinks they should have the opportunity to do what they would normally do at home
Therapy/ nursing tension	<ul style="list-style-type: none"> o Christine says that depends on whether they are independent o Kate says could do it of people just need to be given bowls of water and prompting o Anna suggests Kate comes and works with them cos she doesn’t think its feasible o Kate acknowledges it is dependent on patients o Anna thinks it’s impossible o Kate says that is OK if that is the case
Rehabilitation focus	<ul style="list-style-type: none"> o Kate says if patients will get dressed and washed anyway in the morning, why can’t it be done when patient wants it

Willow ward staffing	<ul style="list-style-type: none"> o Christine explains because not enough staff to do that and explains what happens on Willow ward o Kate can see her problem o Jenny acknowledges it would be good for patients though o Anna wants to encourage patients to come down for breakfast o Christine suggests putting it on the information leaflet o Jenny says not to give patients the option of staying in bed for breakfast when they are admitted – wants to get them in a routine o Anna reiterates they are on the ward for rehabilitation and that most of the patients they have at the minute should really come down o Christine says ‘part of the problem is our interpretation of rehab and what they are expecting – its completely different’ o Jenny hopes information leaflet will help solve this o Christine says patients expect to be down the gym o Jenny wants it emphasised to patients that staff want them to be as independent as possible and that nurses are trained to be hands off o Jenny reiterates that they are helping patients to help themselves o Jenny wants it incorporated activity sessions made into a timetable so that they are aware to expect it and want to participate o Jenny thinks this might free up nursing time o Anna doesn’t think it will free up any more time o Christine and Anna discuss which patients they think may be a category 1 o Jenny tells them that another PDU ward they visited identified patients able to go down to breakfast and helped them get the right tools to make this happen and that it was incorporated into their OT assessment o Patients then felt it was something they needed to work on as part of their rehabilitation o Jenny suggests a therapy staff member who could do the identifying of patients and then the onus is taken off the nursing staff
Rehabilitation focus	
PDU expectations	
Rehabilitation focus	
Jenny leadership	
Therapy/ nursing understanding	
Other PDUs	
Staff involvement Therapy aiding nursing	

- o Jenny would also highlight the level of dependence and any special tools patients might need
- o Jenny suggests the 4 wheel trolley, but Kate tells her they aren't allowed to use them any more
- o Jenny says it would be useful having a breakfast trolley
- o Kate and Jenny agree there is a whole load of stuff they could do at breakfast time
- o Anna suggests putting cereal, milk, bread and butter on the tables
- o Jenny agrees and says first step is to get patients down to the breakfast room
- o Jenny wants to keep patients encouraged to try
- o She suggests night staff could sow idea of getting up for breakfast into patients minds and that it could be discussed in morning handover
- o Kate says even if it's just one patient getting up
- o Jenny says getting up for breakfast is quite a big OT goal
- o Anna says she doesn't want Kate and Jenny to be her therapists if she is ever in hospital
- o Jenny says she would hate to be her own patient because she likes to get them up and moving and so she can understand how they feel
- o Christine looks to see if there are any suitable patients currently on Willow ward
- o Jenny says she can't think of anyone on Oak ward who can't get up for breakfast
- o Anna says a patient has been her entertainment
- o Jenny recognises that this is a hard project – like the protected meal times one because there are so many things that potentially could be done
- o Kate thinks that patients will see others going down for breakfast and will want to do it too when they are independent enough
- o Jenny says then will have lots of people who are ready for discharge being down there in the morning
- o Once they have gone, the more dependent ones will be admitted and the number of people going down for breakfast will always fluctuate
- o Jenny emphasises rehab importance of getting patients up – even if its in their nighties
- o Kate says she wants to protect patient's decision not to go down in nighties if they don't want to
- o Jenny agrees 'Oh yes of course'

Rehabilitation focus

Night staff

involvement

Rehabilitation focus

Therapy view

Willow ward patients

Oak ward patients

Rehabilitation focused

- o Jenny says Margaret’s first couple of days doing it was great and she didn’t know what her staff had been doing before they started it!
- o Jenny says loads of people are ready for therapy now because of it
- o Anna is doubtful that the patients were washed properly
- o Jenny says they might not wash properly at home, however unpleasant that may be
- o Anna says but they aren’t at home
- o Jenny says patients might sit at home all day
- o Anna says but she wouldn’t see it
- o Christine discusses what staff she has in at breakfast time tomorrow
- o Jenny wants those staff members to tell the patients that they are going to the day room for breakfast
- o Jenny and Kate suggests ways of doing it
- o Jenny says need to break the mentality of the staff into accepting these changes “it’s really about breaking their mentality which is the hardest bit”
- o Jenny suggests Margaret and Christine swapping wards one morning to get a different point of view
- o Anna says- ‘its hardly the same - I don’t think Margaret’s got many late staff’
- o Jenny and Kate acknowledge that this is the problem for Willow ward
- o Jenny says to try it and ‘never give up’
- o Jenny asks if there is anything else to discuss – asks the whole group
- o No one has anything, so meeting ends. Dictaphone off.

Projects working well

CG tensions

Willow ward staffing

Jenny’s leadership

View of staff

Jenny’s leadership
Willow ward/ Oak
ward conflict

Jenny’s leadership

APPENDIX IX

COLLAPSING OF THEMES

- Work for the PDU
- Not pulling weight in core group
- 'Donkey work'
- Documentation for PDU
- Organisation of work for PDU
- Shared leadership + work
- Need to finish projects
- Steering group work
- Time constraints
- Checking policy
- Jenny's leadership
- Kate's leadership
- Margaret's leadership
- Liaising with other departments/ agencies
- Visiting other PDUs
- Getting work 'back on track'
- Information gathering
- Need for a single leader
- Attendance at practice development events
- Conferences
- Extra work generated by PDU

collapsed into theme **DISTRIBUTION OF WORK**

- Core group restructures / resignations
- Core group ownership
- Core group conflicting views
- Core group attendance at meetings
- Core group relationships
- Core group camaraderie
- View of Elm ward
- 'Inappropriate' patients
- Identity of ward
- Mission statement
- Aims of PDU
- Core group conflict over projects
- Physical restructure of ward
- Profile raising
- Core group shared goals
- Core group expectations of PDU
- Core group positive views of PDU
- Core group negative views of PDU
- Rehab focus of wards
- Core group reasons for PDU
- Core group predicted PDU outcomes
- Core group reasons for individual projects

collapsed into theme
→

***CORE GROUP SHARED
BELIEFS & AIMS***

- Expelling Willow ward
- Cancelled meetings
- Enthusiasm for PDU from core group
- Core group morale
- Willow ward problems
- Christine's commitment
- Anna's commitment
- Megan's commitment
- Projects going well
- Projects stagnant
- Gaining commitment of new Willow ward leaders

collapsed into theme
→

***CORE GROUP
COMMITMENT***

- Management team placing 'restrictions'
- Management team support
- Trust secrets
- Trust bigger picture
- Funding/ Finances
- Information on Trust plans
- Resources
- Management team view of staff
- Management and Elm ward relationship
- Management team view of PDU

collapsed into theme
→

MANAGEMENT SUPPORT OF CORE GROUP

- Attempts to gain participation
- Core group withholding information
- Staff 'must' be involved
- Staff as 'vehicle' for PDU
- 'Relaunch' PDU
- Staff view of projects
- Staff ideas for projects
- Ignoring staff ideas
- Staff feeling forced
- Information to staff
- Staff involvement
- Core group projects
- Staff attendance at meetings
- Staff resistance to projects
- Staff lack of commitment
- New projects to implement
- Restricting staff suggestions
- Lack of communication
- Forcing staff to participate

collapsed into theme
→

RESTRICTING & FORCING STAFF INVOLVEMENT

- Staff view of PDU
- Kerry’s experience of PDU
- Staff view of core group
- Core group view of Helen’s leadership
- Staff reluctance to suggest projects
- Core group view of staff attitude
- Core group view of staff competency
- Staff feeling ‘angry’
- Core group view of Oak ward
- Core group view of Willow ward
- Staff view of hierarchy in core group
- Core group perceived power
- Staff powerlessness
- Staff rotation project

collapsed into theme **CORE GROUP**
→ **vs. STAFF**

- Willow ward reputation
- Willow ward view of Oak ward
- Oak ward physicality
- Oak ward view of Willow ward
- Willow ward physicality
- Willow ward reputation

collapsed into theme **WILLOW WARD**
→ **vs. OAK WARD**

- Status of core group members from wards
- Clinical leader power
- Empowerment of core group
- Core group hierarchical structure
- Emily’s view of projects
- Anna’s lack of influence
- Megan’s powerlessness
- Helen and Megan relationship

collapsed into theme **CLINICAL LEADERS**
→ **vs. CORE GROUP**

- HCAs view of nurses
- Nurses views of HCAs

collapsed into theme **NURSES**
→ **vs. HCAs**

- collapsed into theme* **NURSING STAFF**
 vs. THERAPISTS

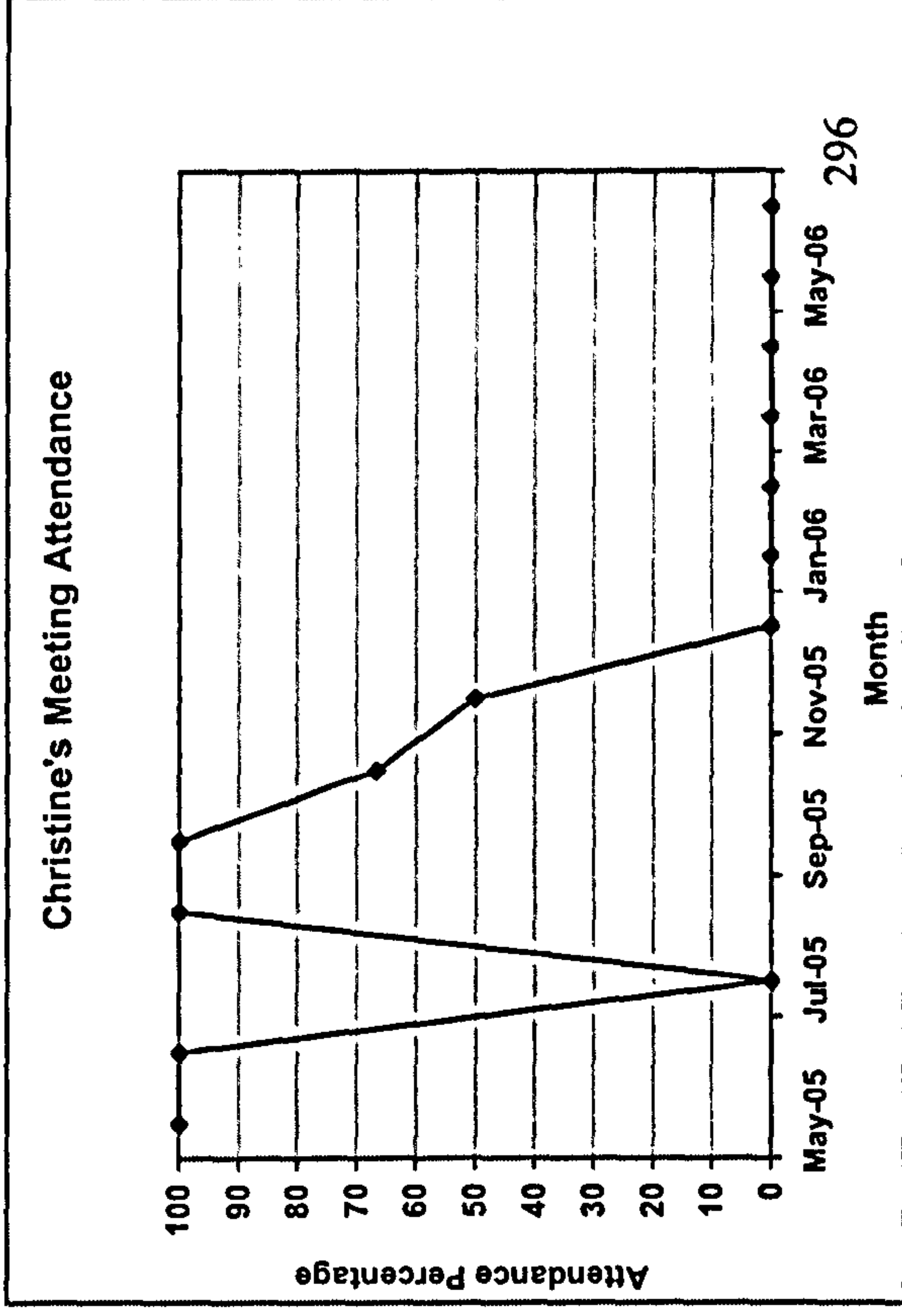
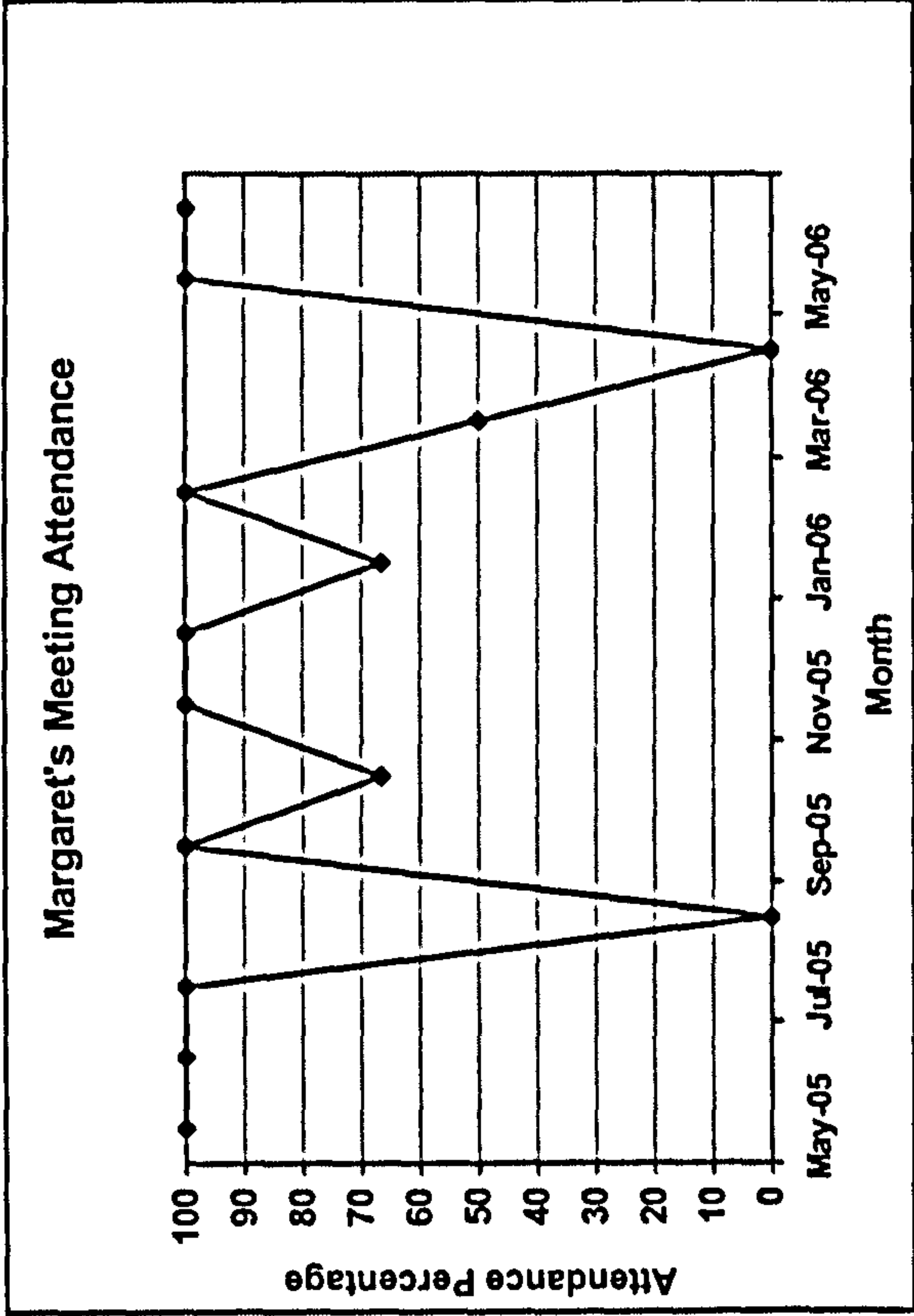
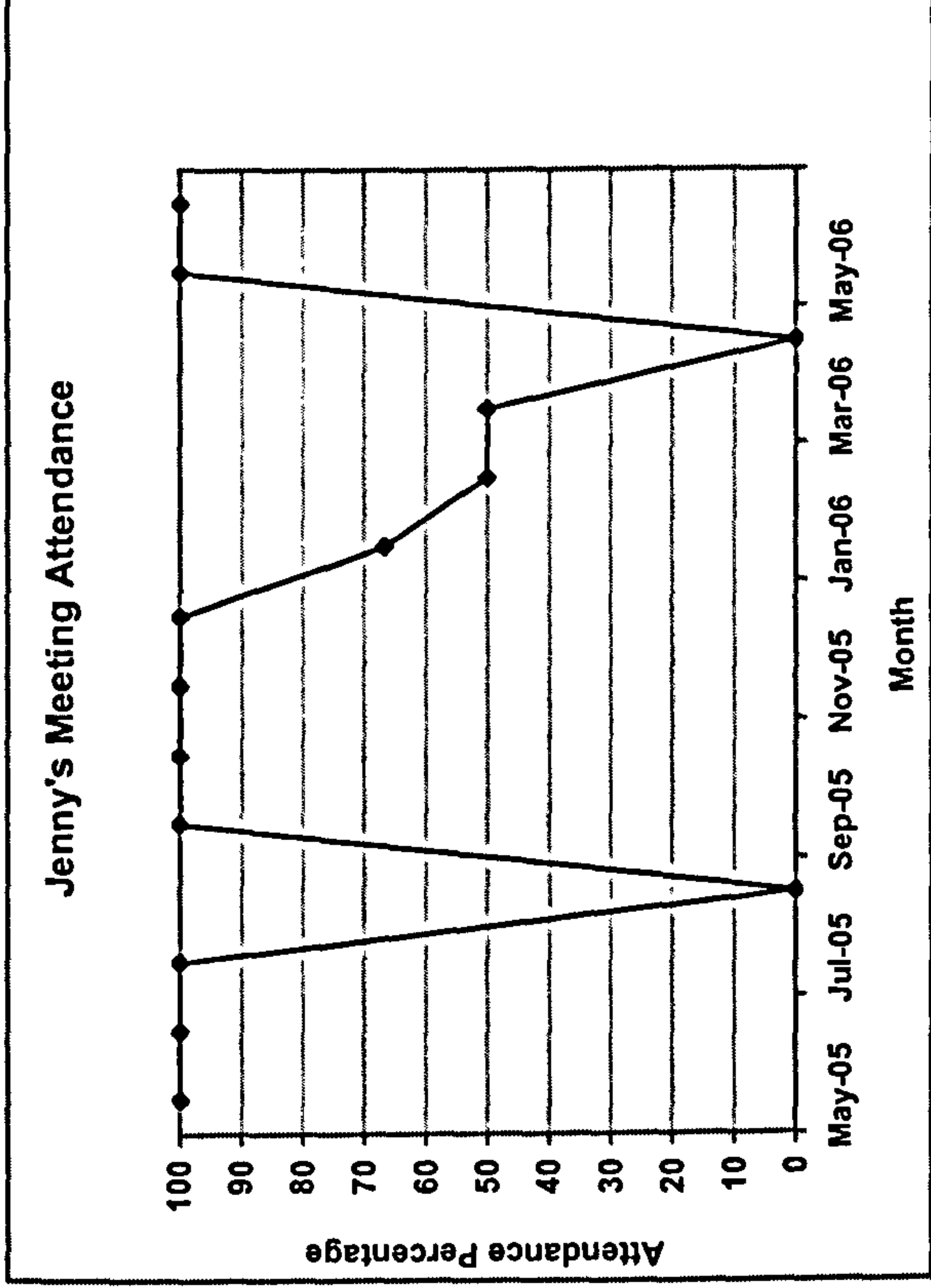
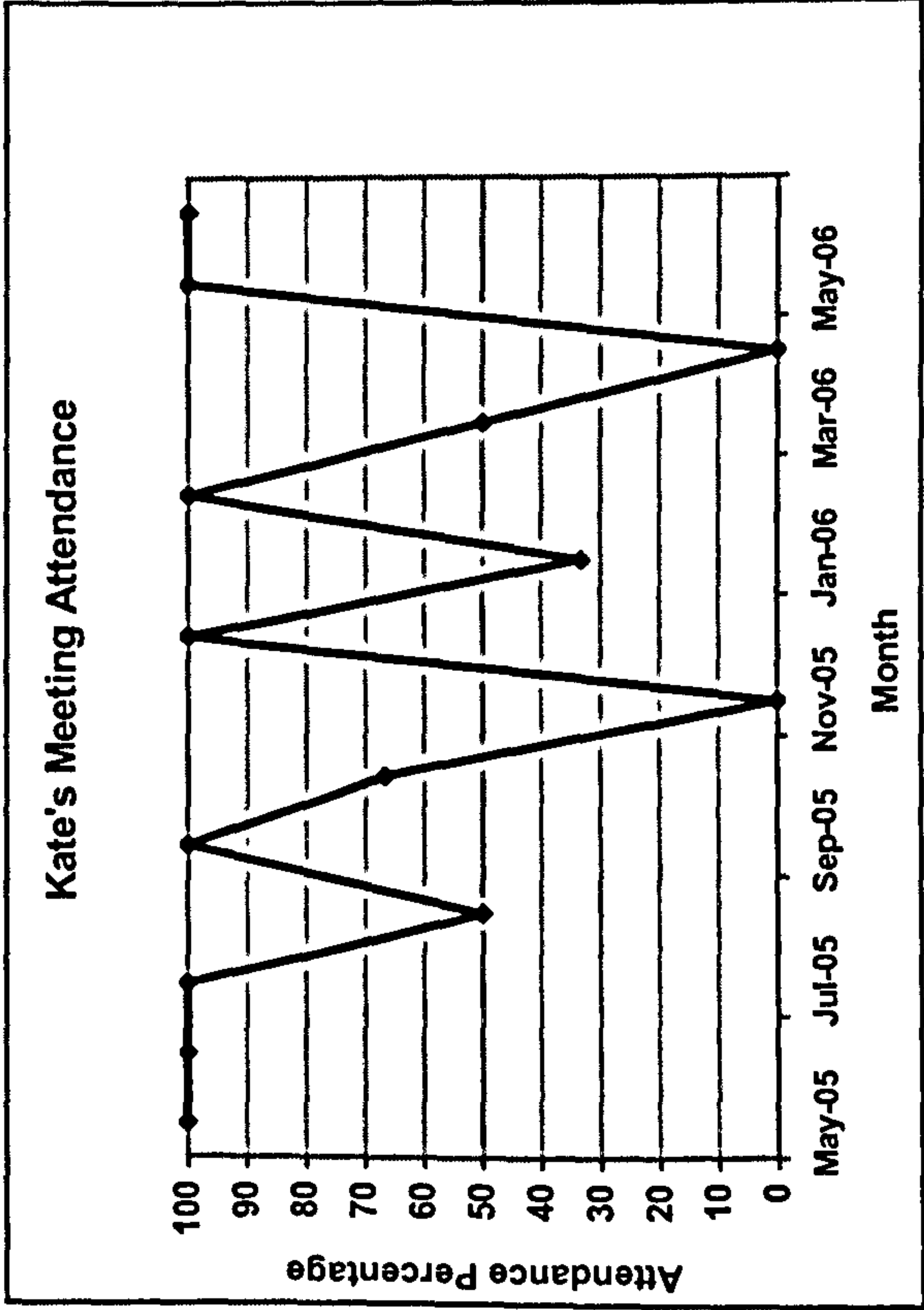
- collapsed into theme* **NEW STAFF**
 vs. OLD STAFF

- collapsed into theme* **DAY STAFF**
→ **vs. NIGHT STAFF**

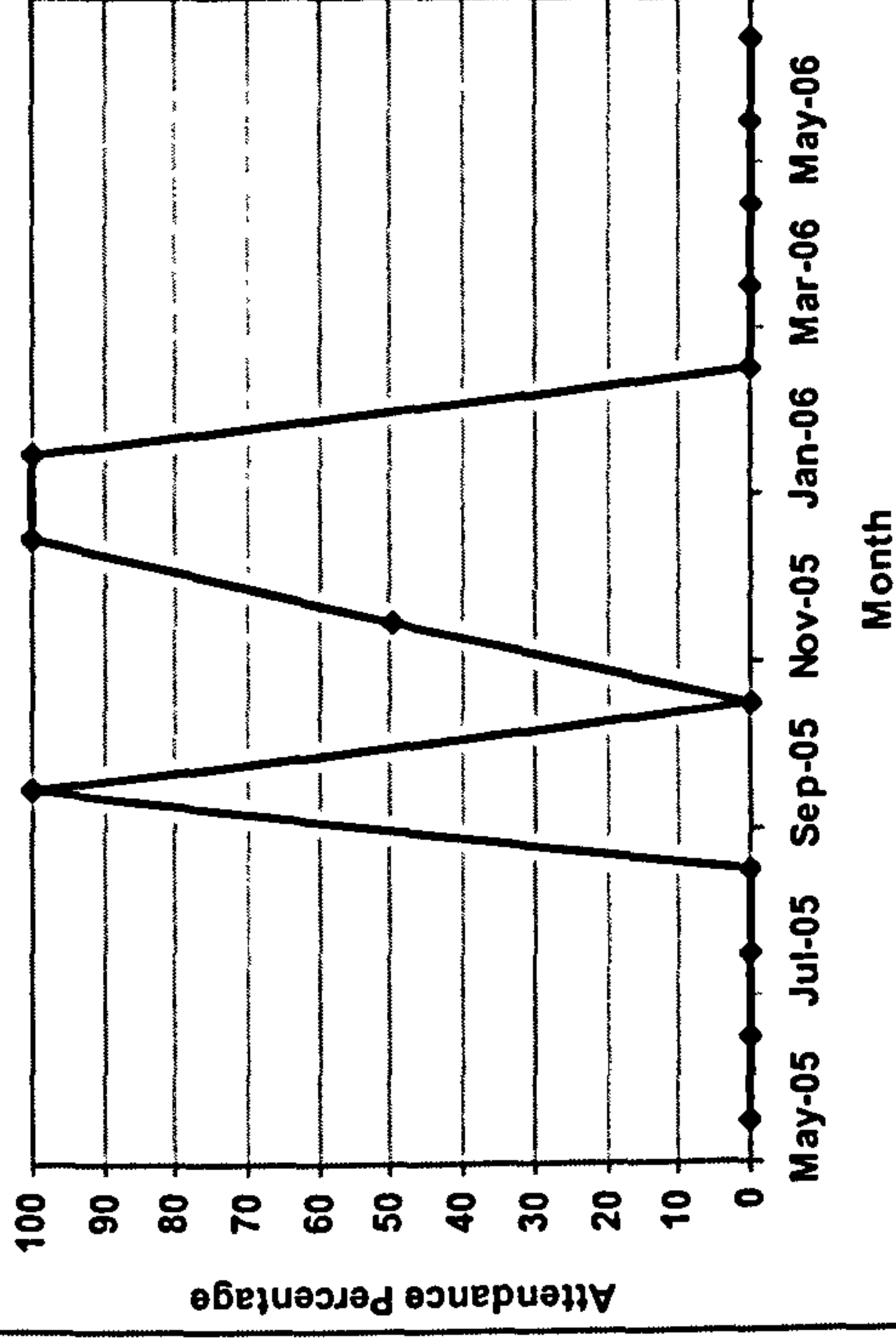
APPENDIX X DIFFERENCES BETWEEN MANAGEMENT & LEADERSHIP

	Management	Leadership
Creating an agenda	Planning and Budgeting – establishing detailed steps and timetables for achieving needed results, and then allocating the resources necessary to make that happen	Establishing Direction – developing a vision of the future, often the distant future, and strategies for producing the changes needed to achieve that vision
Developing a human network for achieving the agenda	Organizing and Staffing – establishing some structure for accomplishing plan requirements, staffing that structure with individuals, delegating responsibility and authority for carrying out the plan, providing policies and procedures to help guide people, and creating methods or systems to monitor implementation	Aligning People – communicating the direction of words and deeds to all those whose cooperation may be needed so as to influence the creation of teams and coalitions that understand the vision and strategies, and accept their validity
Execution	Controlling and Problem Solving – monitoring results vs. Plan in some detail, identifying deviations, and then Planning and organizing to solve these problems	Motivating and Inspiring – energizing people to overcome major political, bureaucratic, and resource barriers to change by satisfying very basic, but often unfulfilled human needs
Outcomes	Produces a degree of predictability and order, and has the Potential of consistently producing key results expected By various stakeholders (e.g. for customers, always being On time; for stockholders, being on budget)	Produces change, often to a dramatic degree, and has the potential of producing extremely useful change (e.g. new products that customers want, new approaches to labour relations that help make a firm more competitive)

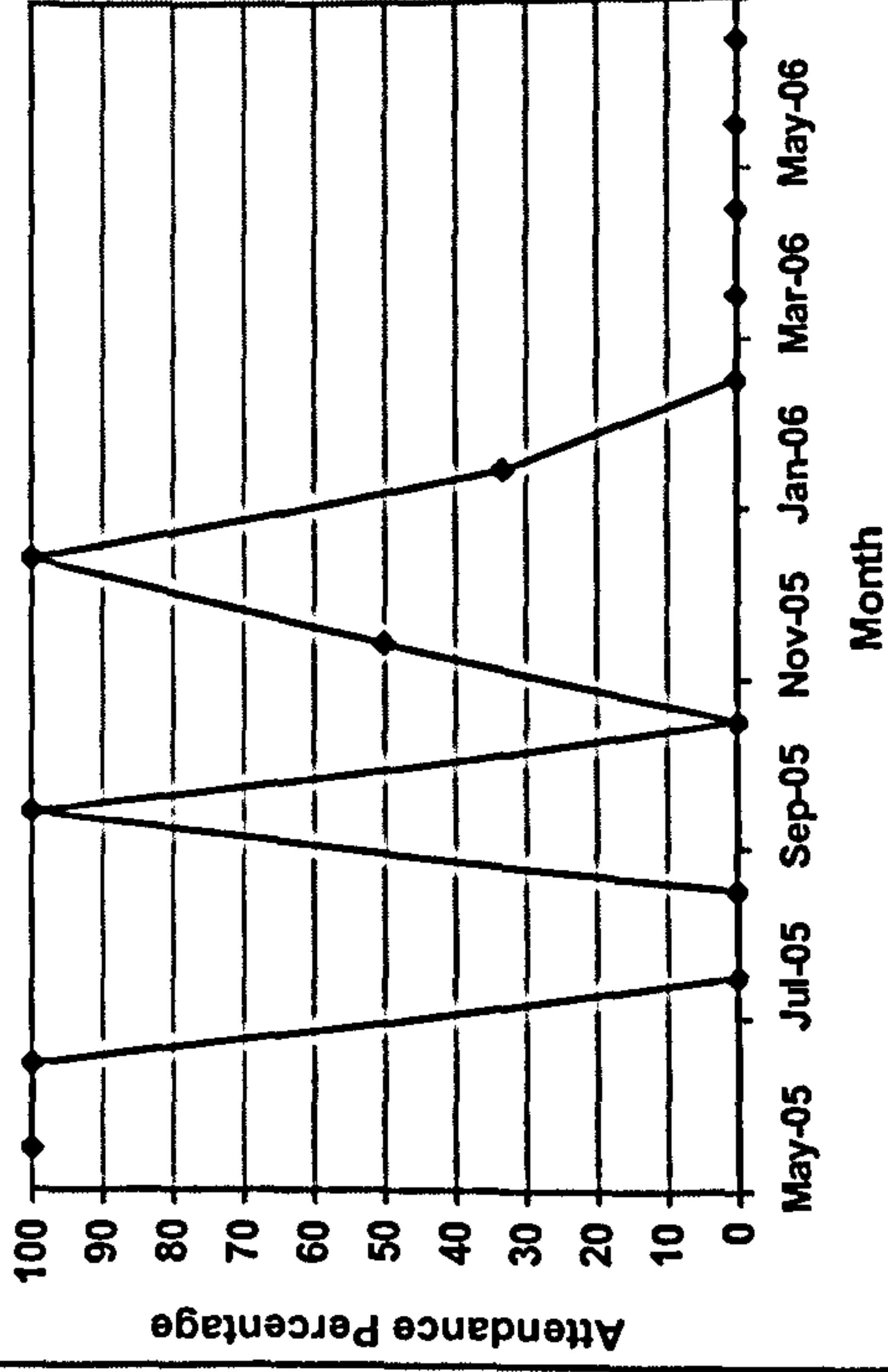
APPENDIX XI
CORE GROUP ATTENDANCE AT MEETINGS



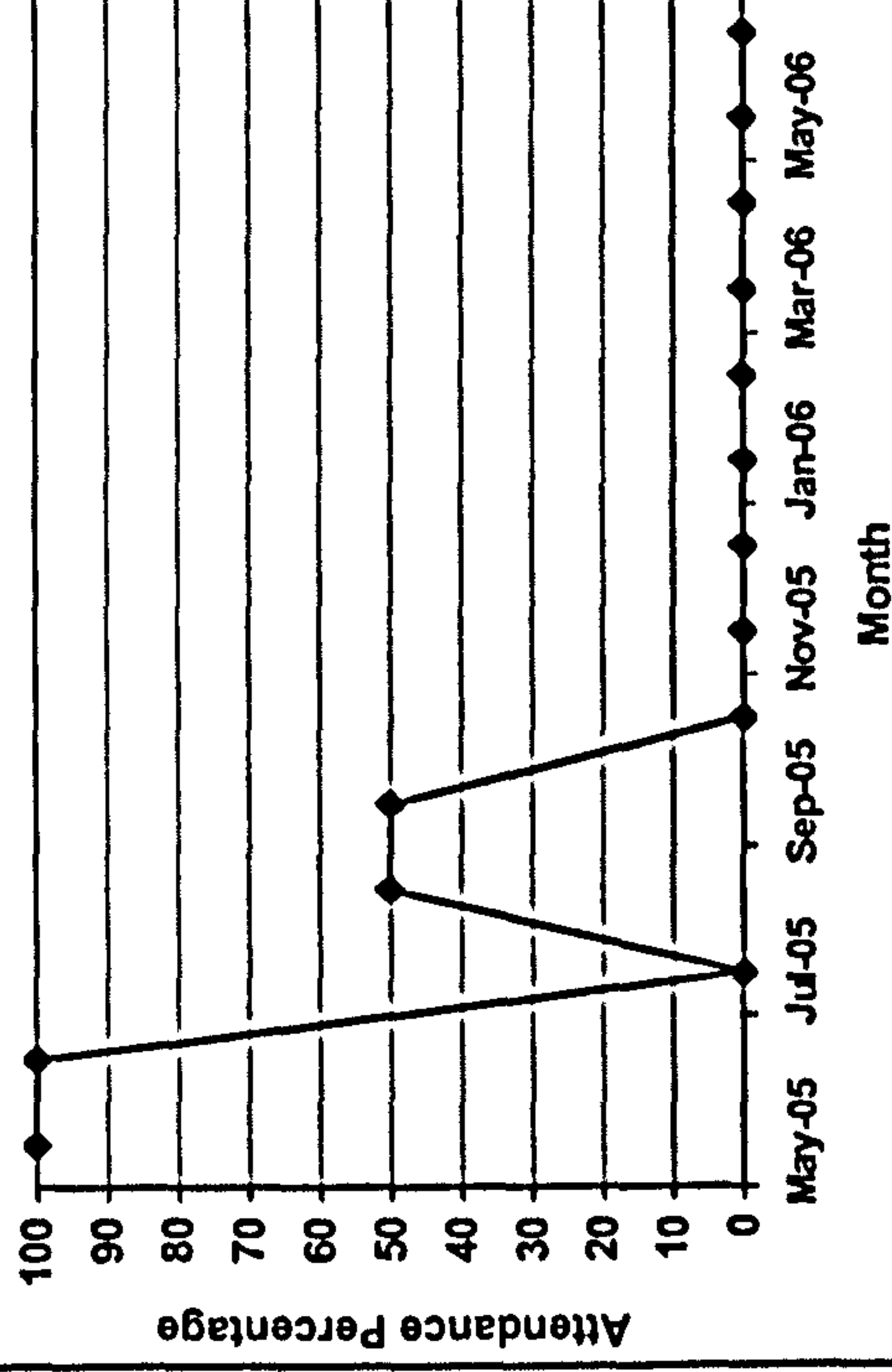
Emily's Meeting Attendance



Anna's Meeting Attendance



Angela's Meeting Attendance



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NUMBERING
AS ORIGINAL**

APPENDIX XII
VARIOUS LEADERSHIP STYLES

Scale of Empowerment

DELEGATION

- Individuals/ group is given authority and responsibility for making decision
 - Manager specifies limits within which final choice must fall
 - Prior approval may be required before the decision can be implemented
- Advantage: potentially more skill development

JOINT DECISION

- Manager meets with others to discuss the problem and decisions are made together
 - The manager has no more influence over the final decision than any other participant
- Advantage: potentially a high satisfaction rate

CONSULTATION

- Manager asks other people for suggestions then makes decision alone after *seriously* considering their suggestions and concerns
- Advantage: potentially a high decision acceptance

AUTOCRATIC DECISION

- Manager makes a decision alone without asking for opinions or suggestions of other people
 - The employees have no direct influence on the decisions (there is no participant)
- Advantage: potentially a high quality decision

APPENDIX XIII
POSTER ANNOUNCING THE 'STAFF ROTATION' PROJECT

STAFF ROTATION

It is planned that starting in January as part of our PDU project each member of staff will be rostered to work on their opposite ward for a period of 1 week.

The plan is that two members of staff from each ward will go at the same time, so that there is someone that you will know on the ward.

The reason for this is along with improving team-work across the two wards will be to gain a greater insight into how each ward works and so that we can share good practice and develop areas that are not so good.

We have designed a questionnaire which we will send out probably in December. The same questionnaire will be given to you again after you have worked in the other area so we can compare answers and see how successful the project has been. It is therefore important that when you fill in the questionnaire the first time you do it from your own knowledge at that time and that you do not seek out the answers.

If you have any queries regarding this process then please speak to your Clinical Leader.

APPENDIX XIV

LEADERSHIP THEMES GENERATED & COMPARATIVE LITERATURE

Key: (PD) denotes practice development literature

ANALYTICAL THEME	CORRESPONDING KEY LITERATURE
Leadership of the Core Group	Klein 2004, Northouse 2004, Ridgeway 2003, Schein 2004
Distribution of Work	Robbins and Judge 2007, White 2005 (PD)
Core Group Shared Beliefs & Aims	Baron and Byrne 2003, Chin and McNichol 2000 (PD), Frey and Sunwolf 2004, Hatch and Cunliffe 2006, Page 1998b (PD), Schein 2004, Sullivan and Decker 2000, Totterdell 2004 (PD), Yukl 2006
Core Group Commitment	Allsopp 1998 (PD), Burke et al 2003, Clark 2006, Halbestrom 2006, Marquis and Huston 2006, Rickards and McCormack et al 1999 (PD), Seibert et al 2003
Management support of Core Group	Gerrish 2001 (PD), Northouse 2004, Page 1995 (PD), Page 1998a (PD), Rickards and Clark 2006, Yukl 2006
Leadership of the Staff	Cooley 1902, Knights and Wimott 2000, Marquis and Huston 2006, McCalman 2000, McCormack and Garbett 2003 (PD), McIntyre 2006, Paton and Rickards and Clark 2006, Yukl 2006
Restricting & Forcing Staff Involvement	Allsopp et al 1998 (PD), Baron and Byrne 2003, Bates 2003, Bowles and Gallie 1998 (PD), Brewer 2003, Casley 1998 (PD), Chin and McNichol 2000 (PD), Dean et al 1998, Goffee and Jones 2006, Halbestrom 2006, Hatch and Cunliffe 2006, Kirby 2000 (PD), Klein 2004, Knights and Wilmott 2000, Knippenberg and Hogg 2003, Marquis and Huston 2006, Northouse 2004, Page et al 1998 (PD), Paton and McCalman 2000, Rickards and Clark 2006, Robbins and Judge 2007, Sandstrom et al 2003, Schein 2004,

	Seibert et al 2003, Senior 2002, Sheehan and Hayles 2006 (PD), Tebbitt 1993, Thornberry 2006, Tietze et al 2003, Totterdell 2004 (PD), Van Lashley 2001, White 2005 (PD)
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APPENDIX XV

CULTURE THEMES GENERATED & COMPARATIVE LITERATURE

Key: (PD) denotes practice development literature

ANALYTICAL THEME	CORRESPONDING KEY LITERATURE
Core Group vs. The Staff	Allsopp et al 1998 (PD), Casley 1998 (PD), Frey and Sunwolf 2004, Gerrish 2001 (PD), Halbestram 2006, Hatch and Cunliffe 2006, Johnson and Scholes 2006, Klein 2004, Klein and Lundin 1999, Lashley 2001, Martin 2001, Marquis and Huston 2006, Pearce and Conger 2003, Rickards and Clark 2006, Robbins and Judge 2000, Sandstrom et al 2003, Seibert et al 2003, Sheehan and Hayles 2006 (PD), Smith 2007, Tebbitt 1993, Tietze et al 2003, Walsh 1998 (PD), Walsh et al 2004 (PD), Williams et al 1993(PD), Yukl 2006
Willow Ward vs. Oak Ward	Frey and Sunwolf 2004, Hatch and Cunliffe 2006
Clinical Leaders vs. Core Group	Baron and Byrne 2003, Burke et al 2003, Klein 2004, Marquis and Huston 2006, Northouse 2004, Robbins and Judge 2007, Seibert et al 2003, Walsh 1998 (PD)
Nurses vs. HCAs	Spilsbury and Meyer 2005
Nursing Staff vs. Therapists	Baron and Byrne 2003, Brewer 2003, Mackay 1989, Parker 2003, Robbins and Judge 2007, Schein 2004, Walsh 1998(PD), White 2005 (PD)
New Staff vs. Old Staff	Brewer 2003, Hatch and Cunliffe 2006, Marquis and Huston 2006, Miers 1999, Page et al 1998 (PD), Robbins and Judge 2007, Senior 2002, Schein 2004, Schirato and Yell 2000
Day Staff vs. Night Staff	Goffee and Jones 2006

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