Developing Nursing Practice to Meet the Needs of Persons Admitted to Acute Care with Chronic Obstructive Pulmonary Disease (COPD): An Action Research Study

Submitted By

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Declaration of Authorship

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ABSTRACT

Acute care nurses represent a large component of the healthcare workforce and are in a prime position to effect better care provision to persons with chronic disease in an acute setting. Many authors highlight the role of nurses in the delivery of care to persons with Chronic Obstructive Pulmonary Disease (COPD) and subsequently urge them to take a proactive role in COPD disease management. In recent times there has been a rise in community or primary health care innovation in care for persons with COPD, and a subsequent improvement of understanding of nursing roles in that area. Nurses in acute care have attracted scant attention in the COPD literature and their role remains characterized by descriptions of task focused support for persons who experience acute exacerbations of the disease.

There is a paucity of research which articulates the current situation of nursing care provision for people admitted to hospitals with COPD and how improvements in such care might occur. Specifically, there is a lack of research which includes those acute care nurses in investigation and improvement of their own practice as it relates to care of persons with COPD.

This study addresses the concern of understanding and improving COPD care within hospitals from the perspective of acute care nurses. Nurses from an acute care setting came together to collaboratively work in an action research group, at first to enhance their understandings of the issues that impacted on care provision and then to work toward improving the care received by people with COPD nursed on their ward.

The findings suggest that utilizing and action research framework approach is effective in engaging acute care nurses in understanding and improving their practice. However they also highlight the difficulties of undertaking collaborative research in a complex, changing acute care environment and the need to ensure support for such activities from a management perspective. The study adds to what is known of COPD care provision by contributing to understandings of acute care experiences and provision from the perspective of nurses caring for this group of patients. In addition the study demonstrates that is it possible for acute care nurses to be empowered to change practice and to improve care to persons with COPD.

Acknowledgements

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1   Introduction

> Knowledge in the practice disciplines entails not just knowing that but also
> knowing how, when, why, whether and for whom... (Sandelowski, 2004, p. 1367)

The management of chronic disease within acute care settings is undertaken by a
multitude of players, whose actions are informed by a variety of purposes and aims.
Within these settings nurses interact with patients, carers, community and other health
care providers. As they do so, nurses consider, interpret and enact, as Sandelowski (2004)
suggests, the evidence of what is known, together with the how, when, why, whether and
for whom of the situation. This research engages acute care nurses as investigators of their
own practice in an acute care setting in order to examine possibilities for change, with a
focus on improving provision of care to persons admitted to hospital with chronic
obstructive pulmonary disease (COPD).

1.1   How I came to the research

I had worked within a medical ward specialising in respiratory care in varying capacities
for the four years prior to commencement of this research. When I commenced as a new
graduate, some of the nurses who later became participants in the research had been my
mentors. I continued to work on the ward for a total of three years, progressing to a more
senior position which included being in charge of the ward outside normal working hours.
I left the ward to take up a position as a clinical educator prior to undertaking project work
focused on discharge planning. It was within that role that I developed a heightened
awareness of the tensions which existed between management driven goals and ability of
nurses on the ward to effect change. I was involved with implementing hospital
management directives for change which included patient discharge, early referral to
allied health, predicting a discharge date on admission, and risk management assessment
for every patient in the hospital. As the project manager, with central responsibility for
embedding these practices into place, ward nurses often addressed their complaints to me.
The ongoing theme of their complaint was simply that *'they* [managers] *just don't
understand what it is like* [on the ward]*'*. Such comments revealed a fundamental

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communication breakdown between the hospital managers and the nurses in practice which the ward nurses felt resulted in their voices often not being heard.

It was these very conversations which resonated with my understandings as a ward nurse, and provoked my own reflection about the difficulties inherent in melding the needs and desires of management with the reality of the practice setting. During these reflections on my own experience I came to understand that the ward nurses wanted to make a difference for patients but struggled to do so in the context of their every day work. This research is the result of my desire to give voice to the acute care nurses and to provide an avenue through which they could examine and improve their own practice.

1.2 The research question

This study developed in an acute medical ward specialising in respiratory conditions where nurses held shared concerns about poor outcomes for patients admitted with COPD. COPD is progressive, with a trajectory of decline impacting on quality of life. Primarily affecting the lungs, it has wide ranging effects on individuals which permeate all parts of their life (Pauwels & Rabe, 2004, p. 615). People with the disease require escalating support from health care providers and their community as the disease progresses, and acute exacerbations often necessitate hospital admission for intensive management of the disease (McKenzie et al., 2003).

Nurses on the ward were aware that patients with COPD were frequently readmitted to the ward, in what they considered preventable circumstances. As a consequence, they were keen to explore how continuity of care provision for persons with COPD might be improved. Yet as the research unfolded, the key question became whether nurses could improve care to this group of patients in the context of their own ward environment. The core question underpinning the research contained within this thesis is:

How might a group of acute care nurse's work together to investigate and improve care provision to patients admitted with COPD?

In order to address this question an action research method was employed. Despite the existence of COPD care guidelines embedded within their practice setting as policy and

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procedure documents, the nurses held concerns that issues with care were unresolved and over a long period of time expressed frustration at their inability to effect change. Action research provided a framework by which to engage nurses in a process of further investigating and then addressing their issues of concern to improve care provision to people with COPD nursed on the ward.

1.3 Methodological Approach: Action Research

A group of nurses from the medical ward agreed to come together, forming an action research group (ARG) in March 2006. Central to the research was the desire to work together to investigate the current situation, to improve their understandings of the issues that impact on the care of people with COPD nursed on the ward, and to take action aimed at improving provision of care to these patients. This thesis documents the journey of the ARG as they sought to develop their nursing practice in order to improve the care of persons with COPD on the ward. In doing so group members also developed understandings of action research and the role of research in their practice.

As Kemmis & McTaggart note (2003, p. 337) the action research approach offers three distinct attributes which the acute care nurses identified as important:

- shared ownership of the research project,
- analysis of identified problem undertaken by the ARG, and
- an orientation toward action aimed at improving the situation

Multiple spirals of planning, action, analysis and reflection capture the process of action research as a complex activity where collaborative reflexive processes underpin much of what occurs (Kemmis & McTaggart, 1988a). A diagrammatic representation of the action research process follows:
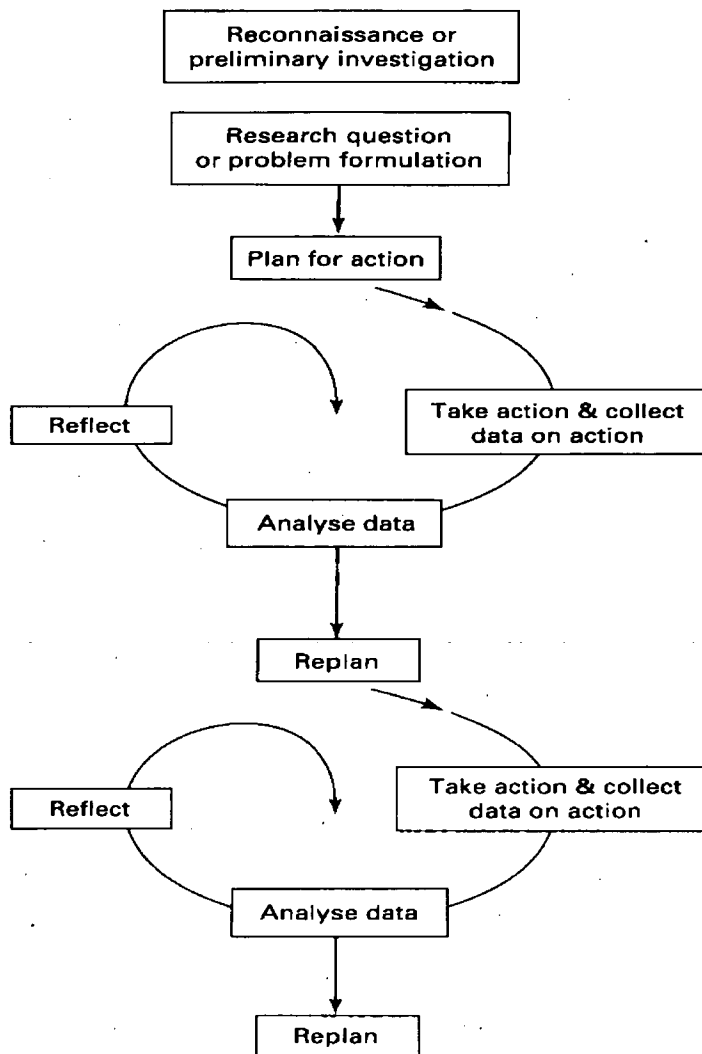
Figure 1: The Action Research Process (Street, 1995, p.xxv)

The detail of action research processes and other methodological issues are explored in greater depth during chapter three which addresses the history and theoretical construct of the action research approach taken.

1.4 Structure of the Thesis

The thesis is constructed in keeping with the methodological intent and is set out to assist the reader to follow the complex interplay of group activities. Although the information within the thesis is presented in a linear fashion it is inherent within action research that

the process is messy and at times several aspects are occurring simultaneously (Herr & Anderson, 2005).

Providing a background to the complexities of providing care to people with COPD in an acute care context Chapter Two contains an examination of the literature as it relates to multiple aspects of the research. In order to understand the role of nurses as they provide care to people with COPD it is necessary to review the broader concepts of chronic disease management, the structure of health care delivery and current recommendations for COPD management based on available evidence and publications. The literature reviewed within this chapter represents what was known at the time of research commencement, up until mid 2006, as it was this information which informed the approach. The need for further research to investigate the current construct of acute care nursing practice and delivery of COPD care is supported by the literature review. Specifically it is argued the use of critical action research methodology offers acute care nurses an opportunity to engage in an investigation of their practice with the potential to take action to initiate change in order to improve care to persons with COPD.

Action research is the method argued to be most appropriate for this research. In Chapter Three the theoretical underpinnings of action research and critical social theory as it relates to this method are explored. Particular attention is paid to the work of Jurgen Habermas, arguably one of the most significant contributors to critical theory in the 20th century (Fontana, 2004, p. 94; Lont, 1995, p. 40). Action research methodology encompasses a multitude of approaches, as such the key characteristics as they apply to this research are discussed together with some of the inherent tensions which occur in the application of the approach.

Chapter Four is presented in order to 'set the scene' for the remainder of the thesis. The practice setting, like action research approaches described within the preceding chapter, was inherently complex. Hospitals and hospital wards are alive with the activities of individuals and groups who inhabit the setting as providers of health care, together with individuals who seek the services of those providers. Hence a general description of

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staffing structure and profiles, as they relate to patient management and flow, are provided as a background to the study.

Chapter Five details the data and first level analysis which resulted from undertaking reconnaissance. Reconnaissance data collection was designed by group members' to further inform them of the issues impacting on the provision of care to people with COPD on the ward. They adopted four data collection strategies which were; ARG discussions during research meetings; seeking the views of the multidisciplinary team; seeking the views of community providers and patients and carers; and finally, an audit of documentation related to care provision on the ward. The work contained in this chapter represents the first action plan undertaken by the group, which was confined to collecting data only. Issues with capacity of the group to meet and to sustain group activities emerged during this stage, and subsequently limited the ARG members' ability to fully engage with the data.

Chapter Six documents in detail the ARG members' response to reconnaissance data, as they engaged with the findings. This chapter details how they come to terms with the findings and identified strategies to move the research forward.

Chapter Seven recounts the work of the group as they enter into the action stage. In this phase further possibilities for action are considered in light of factors which might constrain or impact on their ability to proceed with implementation. ARG activities are focused on change in this chapter as they initially formulated and then undertook an intervention that was targeted toward improving care to persons in the ward.

The last chapter draws together final reflections on the research. The impact of the research on bringing about change is examined in the context of the practice setting, the nurses who participated in the ARG, and my own experience as a researcher. Further clarification is sought from theoretical literature which informs understandings of events as they occurred. I argue that the outcomes of the research must also be considered in the broader context of tensions which exist between practitioners and the systems employed in

the everyday management of acute care facilities. The thesis concludes with recommendations and, as primarily qualitative research often does, posing of further questions to be addressed.

2 Literature Review: Framing of COPD Nursing Care

The preceding chapter has introduced the research and the need to explore the complexities of chronic disease care delivery within hospitals. This study has a central interest in exploring the possibilities for a group of acute care nurses to develop their practice to better serve the needs of people with COPD nursed on their ward. Literature was searched to explore the role of acute care nurses in chronic disease management, and the development of nursing practice in care provision to persons with COPD. In order to understand the issues that impact on attempts of nurses to develop their practice in the management of people with COPD it is also necessary to review the literature related to broader concepts of chronic disease management, the structure of health care delivery and current recommendations for COPD management. The literature reviewed within this chapter represents what was known at the time of research commencement, up until mid 2006, as it was this information which informed the research approach. Literature subsequent to this period will be considered in discussion sections outlined in later chapters.

2.1 Chronic Disease

Chronic disease is characterised by conditions which do not resolve spontaneously and are rarely cured resulting in high mortality either directly or through contribution to other causes of death (Australian Institute of Health & Welfare (AIHW), 2002, p. 3). The proportion of persons experiencing chronic disease in Australia, was estimated in 2001 at ten per cent of the population, with this figure predicted to rise (AIHW, 2002, p. 6). For example, in the case of diabetes incidence has doubled since the early 1980s and is predicted to pass one million by 2020 (National Public Health Partnership, 2001, p.4). Indeed, published figures may underestimate the prevalence of chronic disease because many individuals suffer from more than one condition (AIHW, 2002, p. 12). Furthermore the AIHW (2002, p.5) claims around 80% of the total burden of disease, including mental health problems and injury, measured in terms of disability adjusted life years (a summary

statistic combining years of healthy life lost due to disability and premature mortality by the AIHW) is attributable to chronic disease. Chronic diseases are largely linked to lifestyle factors such as tobacco smoking, alcohol intake, poor nutrition and low levels of physical activity (AIHW, 2002, p.5). A range of diseases have been identified to result in part from unmodified risk factors and include diabetes, heart disease, renal disease and lung disease such as COPD. The burden on the health care system is large and governments are moving toward tackling the burden of chronic disease, calling for 'comprehensive action' as a national health priority (National Public Health Partnership, 2001, p. 21). COPD is of particular interest because of its incidence, complexity, and the demands on health care resources.

2.2 COPD – the disease

COPD presents a range of challenges to health care delivery, which are typical of chronic disease states. A multifaceted disease, COPD has wide ranging effects on individuals, and is defined as:

> A disease state characterized by airflow limitation that is not fully reversible. The airflow limitation is usually both progressive and associated with an abnormal inflammatory response of the lungs to noxious particles or gases. (Pauwels et al., 2001, p. 321)

2.2.1 Cause and Incidence

COPD is attributable to tobacco smoking in approximately 85-90% of cases in Australia (McCrory et al., 2001, p. 1191). Other causes include exposure to industrial pollutants, genetic conditions and long term diseases affecting the lungs such as asthma. Over 665,000 Australians are estimated to be living with COPD, and it is ranked as a leading cause of death with over 5,378 deaths resulting from COPD in 2003 (AIHW, 2004, p. 80). The AIHW reports that COPD affects 3.5% of the Australian population (AIHW, 2004, p. 80), yet the incidence has been estimated in an Australian study to be as high as 5.4% (Wilson et al., 2005).

The forecast disease burden, which is largely based on tobacco smoking rates, is not predicted to drop significantly within the next decade. Whilst there has been a decline and change in demographics of smoking rates in the last twenty years, the rate of decline has

slowed in recent years (AIHW, 2004, p. 109). In 2004-2005, 23% of the population were current smokers, with an additional 30% identified as ex smokers. Both current smokers and ex smokers remain at increased risk of developing COPD. There is a long latency period, ranging from years to decades, between causation and COPD manifestation which varies according to individual susceptibility, pack years (measurement of level and duration of smoking behaviour) and interaction with other risk factors (e.g. pollutants, secondary smoke). Lundback et al. (2003) in a Swedish cohort study showed COPD developed in 50% of elderly smokers, whilst Wilson et al. (2005) showed in an Australian study using a population sample of 2500 that 1 in 7 or 15% of current or ex smokers were demonstrated to have COPD. The difference in findings may be attributable to the different age groups which were investigated, or the different criteria used to establish presence of disease; however both studies confirm the significance of the problem.

Diseases, including COPD, which result from smoking behaviour, will contribute to chronic disease burdens for many decades to come (Hill et al., 1998; Mannino, 2003). Hill et al (1998) have monitored tobacco smoking prevalence in the Australian population since 1974 and claim that smoking trends have reached a plateau. They highlight that the finding is of some concern to the long-term health of Australians and future chronic disease levels. If, as suggested by Wilson et al (2005), one in seven current and ex smokers are diagnosed with COPD, it is unlikely that the number of persons with the disease will diminish greatly. Although smoking rates and incidence of COPD varies between countries, analysis and modelling of COPD burden, based on an ageing population and smoking rates in the Netherlands suggest the incidence of COPD will rise (Feenstra et al., 2001). It is unclear what the situation will be in Australia, but tobacco smoking trends within the population suggest there will be a need to provide health care and support to persons with COPD, both within acute and community care settings well into the future. As tobacco smoking is implicated as a causal factor in other chronic diseases, people with COPD often experience more than one chronic disease (McKenzie et al., 2003). Hence the role of nurses, as key members of the health care work force present in areas of community and acute care, will be critical to care provision.

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2.2.2 Economic Cost of COPD

Costs associated with the disease are borne by health care providers, governments and communities. Given the numbers of persons with COPD, it is not surprising that expenditure related to provision of health care to people with COPD represents a large economic burden (Rea et al., 2004; Rutschmann et al., 2004; Vermeire, 2002). The calculated cost of COPD for the Australian community is between $818-$898 million annually (McKenzie et al., 2003, p. S7), with a significant proportion of that cost associated with hospital care. Hospital care is most often required when an exacerbation of the disease occurs, with worsening symptoms which require additional medical treatment and support (McKenzie et al., 2003). Hospital care alone during 2001, was estimated to cost $300 million (Australian Lung Foundation, 2001), with persons aged over 65 years accounting for 77% of hospital separations, with a principal diagnosis of COPD (AIHW, 2004, p. 81).

2.2.3 Difficulties with Diagnosis

COPD patients may initially experience symptoms which include chronic cough, shortness of breath, wheeze and sputum production. Early diagnosis of COPD can improve outcomes for patients, who are encouraged to cease smoking, engage in pulmonary rehabilitation, and learn to identify and treat acute exacerbations of the disease early (Morgan & Britton, 2003, p. 453; Wouters, 2004, p. 883). Yet, because of the insidious nature of the symptoms, often accepted as a normal part of ageing, people may present late to health care providers for diagnosis (McKenzie et al., 2003). Diagnosis frequently occurs when the patient is already experiencing significant impact on their quality of life and the opportunity to intervene and manage the disease at early stages is consequently missed or delayed.

2.2.4 Nihilistic Attitudes: COPD as Self Inflicted

Under diagnosis due to late presentation, is compounded by the attitude of members of the community and health care providers to the disease. Described as "nihilistic", this attitude reinforces understandings that little can be done to improve patient outcomes (Celli, 2006; Vermeire, 2002, p. 59). Nihilism is said to result from the disease being

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'considered incurable, self inflicted and relatively resistant to treatment' (McKenzie et al., 2003, p. S7). Given that COPD is attributable to tobacco smoking in most cases, and relates to lung damage which is not reversible, it is perhaps not surprising that such nihilism exists. Yet there are recent claims that nihilism can be replaced with optimism (Celli, 2006), as the development of new treatments and improved outcomes associated with early diagnosis and intervention emerge. Movement toward optimism also relies on healthcare providers engaging with current evidence for care to persons with COPD, as well as a change in attitude .

The perception that COPD is self inflicted contributes to the negative attitude of some health care providers towards those with the disease. A study by Barr et al. (2005) where American pulmonologists and primary health care physicians (n=1051) were surveyed, found that eighty eight percent agreed with the statement that COPD is a self inflicted disease. Persons with COPD may therefore be considered responsible for their disease and even deserving of the negative consequences which occur. Such an argument is put forward by Galvin (2002) who posits that chronic illness is increasingly being viewed as 'culpability in the face of known risks' (p. 107) in her examination of chronic disease policy documents published in Australia and overseas. Galvin (2002) utilises a 'genealogical' analysis (p. 108) informed also by the work of Michel Foucault and proposes that 'the infiltration of the notions of choice and responsibility' support the 'the perception that the chronically ill are blameworthy' (p. 127) which is evident in concepts of health and illness 'currently deployed as tools of government' (p. 107). The notion that people who suffer chronic diseases as being personally responsible is not new, however, as Galvin argues, such understandings require careful examination and 'unpicking' of how they came to be, so we might understand how such notions impact on care provision. While there has been some work which indicates that a sense of nihilism impacts on health care providers in that they might question the worth of diagnosis in COPD, there has been no rigorous study or investigation into how such attitudes impact on care structure and delivery more generally.

Considering people as personally responsible for a disease further adds to an understanding that little can be done about it, except by the person themselves (Germov, 1998, p. 8). Such framing also denies the social influences on disease occurrence which include, but are not limited to socio economic influences. In the case of COPD for example, higher levels of tobacco smoking and thus an increased likelihood of nicotine addiction in lower socio economic groups (Bobak et al., 2000) have been reported. Furthermore, situating responsibility for the disease with the individuals who smoke, may contribute to the negative consequences for the person with COPD. Whilst stigma in COPD has not been explored at length, it is suggested that feelings of guilt and shame are associated with COPD (Fraser, Kee, & Minick, 2006). Such effects, along with the physiological manifestations of the disease impact on quality of life.

2.2.5 Impact on Quality of Life

The effects of COPD include physiological, social and psychological manifestations, as McMahon (2000, p. 327) notes:

> ...people with chronic lung disease experience a succession of distressing physical, psychological, and spiritual responses that challenge personal resources for coping. Progressive dyspnoea and fatigue impair functioning in physical, emotional and social dimensions of daily living.

As a disease that has no cure, a key concern in COPD management is to maintain or improve quality of life and enable people with COPD to live more comfortably with the condition (Frith, McKenzie, & Pierce, 2002). As the disease progresses, impaired exercise tolerance, lowered functional capacity and decreased levels of energy, which result from decreasing lung function, ensure that even the lightest of tasks take on larger proportions (Boyle & Locke, 2004, p. 46; Katula et al., 2004; Pauwels & Rabe, 2004, p. 615). The decline in physical functioning affects activities of daily life and can lead to social isolation (Boyle & Locke, 2004, p. 46; Seamark, Blake & Seamark, 2004, p. 619) and affect emotional wellbeing (Heinzer, Bish & Detwiler, 2003, p. 98). Quality of life measurements are frequently used to assess the efficacy of COPD interventions ranging from pharmaceutical trials through to self management approaches (see for example (Bourbeau et al., 2003; Monninkhoff et al., 2002; Rea et al., 2004; Rowett, Simmons, Cafarella, & Frith, 2003).

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2.2.6 The Patient Experience

The experience of the disease and the impact on quality of life, are themes often explored by authors undertaking qualitative enquiry. The findings from such studies are a poignant reminder of the struggles people living with COPD face every day. Physical activity limitations and breathlessness dominate patient and carer experiences of COPD (Barnett, 2005; Booker, 2003). Sufferers must adapt to their changing world and feelings of loss that often result (Seamark et al., 2004). Living with COPD is conceptualised as 'hard work' and people with the disease contrast their life with the way things were previously, including loss of travelling, social life and interests they had previously held (Eloffson & Ohlen, 2004, p. 613). Shortness of breath (dyspnoea) impacts on almost every aspect of sufferers' lives, and is seen to threaten their lifestyles (Fraser et al., 2006). For example Barnett (2005) reports that breathlessness, identified as the most troublesome COPD symptom, can lead to anxiety, panic and fear, while the loss of ability to undertake activity is further described as having flow on effects which impact on identity and intimacy. People who struggle to adapt to limitations of the disease can reportedly enter into escalating spirals of 'acopia, depression and anxiety' (Seamark et al., 2004). However there are no studies identified that illustrate how nurses draw on patient experience in structuring care to support people with COPD during treatment or more particularly in the context of an acute exacerbation requiring hospital admission. Yet, such spirals can affect not only the person experiencing COPD but their carers also.

2.2.7 Carers

The experience of persons with COPD, together with their carers, as they struggle to adapt to effects of the disease, is eloquently captured by McDermott (2000) who describes life for the person with COPD in the title of her work as a *'Body Out of Balance: Surviving the Frustrations'*. Adjustment to loss and changed circumstances, which are described by McDermott in her study are presented as the central experience of the person with COPD and their carer. Studies by Seamark et al (2004) and McDermott (2000), identify carers as providing critical support to persons with COPD. But support does not come without cost, with the experience of being a carer identified as mirroring that of the people to whom they are providing care (Bergs, 2002; Seamark et al., 2004). In this sense the evidence

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indicates that carers of persons with COPD also suffer isolation, depression and anxiety (Bergs, 2002; Kara & Mirici, 2004). The recognition and articulation of findings on the experience from the carer and patient perspective aims to inform health care providers about 'what it is like' to experience the disease. Whilst we have an insight into this experience no literature was found which addresses how these insights have been used in the context of acute care nurses making decisions about care provision for people with COPD and their carers during a period of hospitalisation.

2.3   Managing the Impact of COPD on Individuals

Despite the multifaceted impacts of the disease on a patient and carer experience of living with COPD, not all persons with COPD experience negative cycles associated with chronic disease and disability. In an analysis of 270 COPD patients in the United States, Wu et al. (2001) found that negative effects can be offset in part by positive coping behaviours, which include maintaining meaningful activities in life, finding humour and having a sense of spirituality. Wu et al (2001, p. 318) further claim that health care professionals can assist people with COPD to increase capacity to cope with impacts of the disease through understanding and assisting patients to develop coping strategies and seek support mechanisms. The study highlighted the need to improve patient knowledge about their disease and improve integration of interventions delivered by healthcare workers. It also serves to illustrate the central role of the healthcare worker in providing support to persons with COPD to improve coping behaviours. However no studies were found on how such education might be undertaken during a hospital admission, or what the impact might be. Two further approaches, self management and pulmonary rehabilitation are particularly designed to facilitate patient education and support which are also highlighted as central tenets of care provision to persons with COPD.

2.3.1 Self Management and Patient Centred Care: A Necessary Collaboration

Patient or client centred care has become a core construct of chronic disease management and is more broadly claimed to be a 'key characteristic of quality health care in the 21st century' (Anthony & Hudson-Barr, 2004, p. 118). The patient centred care model has

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resulted in part from recognition that health interventions and care must take into account individual experience and skill (Bodenheimer et al., 2002). Such an approach shares commonality with self management, and is an area that highlights the need for health professionals to work in partnership with individuals experiencing chronic disease.

Self management approaches to chronic disease support the role of the individual as a health care partner (Bodenheimer, et al., 2002) and recognise that much of the day to day management of chronic illness rests with the person experiencing the disease and their family (Von Korff et al., 1997, p. 1097). Positioning the client or patient at the centre of care is fundamental to successful management of chronic disease if they are to become partners in care, managing the daily impact of chronic disease, adopting appropriate health behaviours, monitoring symptoms and responding to changes which might occur (Fuller, Harvey & Misan, 2004). Research examining the role of self management education for persons with COPD has shown that the approach reduces hospitalisation rates and provides economic benefits primarily through hospital avoidance (Bourbeau et al., 2003; Monninkhoff et al., 2002). More importantly self management specifically targeted toward persons with COPD has been shown to improve quality of life for these people, as well as their self efficacy, or confidence to manage the impact of the disease on their everyday life (Bourbeau, Nault & Dang-Tan, 2004).

A core construct of self management is 'either implicit or explicit concept of partnership between patients and health professionals' (Aroni & Swerissen, 2003, p. 7). Yet despite the rhetoric of patient centeredness, empowerment and partnership within the chronic disease literature, there is evidence that the strong influences of the traditional biomedical model as operationalised in contemporary health care setting, such as acute hospitals, acts to neutralise patient input and situate the health professional as the ultimate decision maker (Paterson, 2001, p. 580). Rogers et al. (2005, p. 224) argue that individual interpretation of the term 'patient centeredness', may be limited to mean compliance with medical instructions. Hence the traditional patient/ physician relationship may impact on possibilities for collaboration to support self management approaches. Yet, it is also arguable that caution is required lest self management be considered the panacea to

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management of all chronic disease issues and states. Results from a meta analysis of chronic disease self management which included a review of interventions delivered to older adults with a range of disease states indicate:

> ...although enthusiasm is growing for self-management programs for chronic conditions, there are conflicting data regarding their effectiveness and no agreement on their essential components. (Chodosh et al., 2005, p. 427)

This approach has not extended into the acute care setting with no research which indicates the degree to which chronic disease self management programs are supported by the actions of nurses in the context of hospital admission. At the same time there is recognition that the difficulties in comparing a broad range of approaches to implementing self management interventions, all of which have multiple outcome measures, impacts on the ability to undertake greater analysis of effect. Because of this, policy makers involved in health care reform agendas support further investigation of self management and its integration into health care approaches (World Health Organization (WHO), 2002b).

2.3.1.1 Support for Embedding Self Management

Funding programs such as the sharing health care initiative which allocated $36.2 million over eight years (1999-07) by the Australian Government to government and non government health care providers and agencies, demonstrate the increasing support for exploring interventions designed to facilitate chronic disease self management. The aim of this Australian Government initiative was to develop a range of self-management models that would be suitable for 'embedding' within the Australian health care system. As an example, a project which has successfully engaged COPD patients and health care providers in self management approaches is a demonstration project in South Australia. The project, 'Informed Partnerships for Effective Self Management of Chronic and Complex Lung Diseases' (Rowett et al., 2003) focused on COPD management in the community, and sought to increase availability of a system for self management. Participants attended a pulmonary rehabilitation program and then worked with their primary health care team to develop goals related to adopting healthy behaviours, such as exercise or nutrition. The project included greater integration of evidence based COPD practice, engaged a variety of health care providers across disciplines and service

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providers, and resulted in improved health outcomes for persons with chronic lung disease. Patient outcomes post program included increased exercise tolerance, decreased hospital use and decreased levels of anxiety and depression. The findings from the program are relevant to this study, as they illustrate the benefits of collaboration and partnership between health care providers in order to effect change in practice and to provide improved care to persons with COPD.

2.3.2 Pulmonary Rehabilitation as a Means to Assist Self Management in COPD

An individual's ability to share in health decisions and their self-management capacity may be enhanced by participation in pulmonary rehabilitation, a core component of treatment for people with COPD. Pulmonary rehabilitation 'increases patient/carer knowledge base, reduces carer strain and develops positive attitudes toward self-management and exercise' (McKenzie et al., 2003, p. S37). Pulmonary rehabilitation is delivered in varying formats and may include any or all of the following; smoking cessation, pharmacological education, health education, exercise training, dietary advice, inhaler techniques, and relaxation (Tiep, 1997, p. 1637). The literature is replete with research endeavouring to identify the best mode in which to deliver rehabilitation. Literature addresses exercise only rehabilitation (Rochester, 2003), a combination of exercise and education in rehabilitation with a focus on multidisciplinary input (Man, Polkey, Donaldson, Gray, & Moxham, 2004), and place of provision (Elliott, Watson, Wilkinson, Musk, & Lake, 2004). Yet, it is difficult to comparatively assess the outcomes of pulmonary rehabilitation because of differences in models, design and outcome measures. However, a Cochrane systematic review (Lacasse, et al., 2006), which included randomised controlled trials of rehabilitation in COPD patients, which used quality of life and functional or maximal exercise capacity as outcomes, identified improvement in patient outcomes following rehabilitation when compared to normal care without rehabilitation. Given the gains that can be made by persons with COPD by attendance at pulmonary rehabilitation it is somewhat worrying that deliveries of such programs are recognised as limited (Fahy, 2004; Gibbons, 2004).

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The publication of studies which articulate the role of self management and attendance at pulmonary rehabilitation to aid in developing coping strategies to minimise the impact of the disease are important in overall COPD care provision. Programs can impact positively on the experiences of persons with COPD, and decrease the impact of the disease on their lives. As negative impacts of the disease are shown to be significant, the need for any disease management strategies to incorporate aspects of social, emotional and physical health is highlighted.

2.3.3 Disease Management: the role of guidelines

Evidence of the incidence and wide ranging effects of chronic diseases such as COPD on individuals and society, including health care delivery, necessitates consideration of how such diseases may be managed. The first line of management is prevention, and approaches targeted at uptake of healthy behaviours to prevent chronic disease are evident within both government and health care literature (AIHW, 2006). For example, decreasing uptake of tobacco smoking and increasing smoking cessation rates are key to management of COPD burden in the longer term (McKenzie et al., 2003). When chronic disease does occur, diagnosis and integrated disease management becomes important. Guidelines provide a strong evidence base for interventions and integration of such guidelines is identified within the literature as facilitating improved chronic disease management and outcomes for individuals (Wagner, 1998). Within the context of the Australian health care setting a COPD management guideline has been developed (McKenzie et al., 2003). Similar guidelines exist for other chronic diseases such as Diabetes (http://diabetesfoundationofaustralia.com/en/) and Asthma (http://www.nationalasthma.org.au/index.php). The rationale behind development of disease guidelines, which are evidence based, is that the use of such guidelines will improve outcomes for patients, by standardising care and improving health care workers knowledge of, and access to the evidence to support best practice (Woolf et al., 1999).

2.3.4 COPD Guidelines

Guidelines for treatment and management of COPD have been developed globally over the last two decades. Worldwide, forty one clinical practice guidelines for COPD were

published between 1990-2000 (Iqbal et al., 2002). The Australian & New Zealand guidelines have been updated and re-released, most recently in late 2006 and are known as the COPDX plan. Collaboration at an international level has also led to the development of a guideline for chronic obstructive lung disease (Pauwels et al., 2001). Known by the acronym 'GOLD', the document is identified as a primary source of evidence within the COPDX (p. S7). The COPDX results from a partnership between The Thoracic Society of Australia and New Zealand and the Australian Lung Foundation in accordance with the National Health and Medical Research Council recommendations for guideline development. As this study is situated within Australia, discussion on the management of COPD is informed by the Australian and New Zealand Guidelines for the management for Chronic Obstructive Airways Disease plan (McKenzie et al., 2003) as the primary source. Listed aims of the COPDX document are:

> To effect changes in clinical practice based on sound evidence; and
> Shift the emphasis from a predominant reliance on pharmacological treatment for COPD to a range of interventions which include patient education, self management of exacerbations and pulmonary rehabilitation.' (McKenzie et al., 2003, p. S7)

Five core elements which form the acronym COPDX provide a structure to the guideline. The areas are **C**onfirm diagnosis, **O**ptimise function, **P**revent deterioration, **D**evelop a self-management plan and manage e**X**acerbations. The elements are supported by evidence which is ranked according to source. The elements and evidence levels are summarised in tables contained in appendix one.

2.3.5 Key Informants and Focus of the COPDX

Traditionally, disease guidelines are targeted to physicians as the primary health care provider. The writing group and editorial committee, steering committee, evaluation committee, and contributors named in the COPDX development are drawn from medical disciplines or specialty areas within respiratory care (McKenzie et al., 2003, p. S3). Given this history, despite the need to integrate and manage social impacts of the disease in any management approach, it is not surprising that the COPDX document is primarily informed by medical interests. This is reflected in the majority of the guideline being concerned with pharmacological treatment, medical diagnosis and intervention. For example, demonstrating the pre-eminence of medical management within the document,

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information related to pulmonary rehabilitation, already highlighted as an effective intervention in COPD (p. S25), is contained in less than one page of the 40 page document. Furthermore, nursing, allied health professionals and non-medical care agencies (p. S26) are noted as contributors to the care of people with COPD in short descriptions within the document while general practitioners and specialist physicians are highlighted as central to care provision. It would appear from a privileging of medical contributions that despite the claims of patient centred care and the importance of non pharmacological interventions stated in the COPDX aims (p. S7), medical constructions of disease management predominate.

The manner in which self management is described within the COPDX would appear to further confirm the medical focus. Despite the rhetoric contained within the COPDX document about patient engagement and support, self management is limited to symptom control and recognition of exacerbations (McKenzie et al., p. S26). Such a finding may support the notion discussed by Paterson (2001, p. 580) that strong influences of the traditional biomedical model often act to neutralise patient input and situate the professional as the key decision maker. In addition, it is suggested that although patients are encouraged to participate in healthcare decisions, they are often expected to be compliant in the context of a system which emphasizes the direction of health professionals (Koch, Jenkins, & Kralik, 2004, p. 485; Paterson, Russell, & Thorne, 2001, p. 3380). Because of the strong biomedical focus the guidelines fail to adequately address how the recommendations for supportive care might be achieved, except to situate the general practitioner as the co-ordinator of care, a point discussed further under 2.3.6.

2.3.6 Dissemination and Uptake of COPDX

Dissemination of the COPDX has occurred via publication in the Medical Journal of Australia (McKenzie et al., 2003) and via direct provision of a range of support materials and the guideline to physicians. It has been 'widely circulated to key stakeholder groups and professional organisations', and published on the internet (p. S7). Yet problems related to any disease guideline uptake and implementation are highlighted by Pearson (2000, p. 38S) who states the mere publication of support material for disease

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management does not guarantee it will be read or acted on. The increasing production of clinical practice guidelines was examined in a systematic review by Grimshaw et al. (2004), who sought to understand the effectiveness and efficiency of guideline dissemination and implementation strategies. They found that distribution of guidelines may have a modest effect on implementation yet such effect may be short lived (Grimshaw et al., p. 9).

Multiple factors impact on uptake of guideline recommendations in general practice by promoting or inhibiting use. They include complexity of the guideline, compatibility with practice structure and the need of individuals for new skills (Burgers et al., 2003; Grol et al., 1998). In addition, availability of individual and workplace resources, including time and commitment, knowledge and capacity can influence overall guideline uptake (Harvey et al., 2005). The end result of both individual and workplace factors may be poor uptake and implementation of guidelines (Bratzler et al., 2004; Harvey et al., 2005; MacNee & Calverley, 2003). Similar issues have been identified specific to uptake of COPDX recommendations by members of the medical profession (Smith et al., 2005).

Investigations of guideline uptake by physicians, arguably the primary targets of COPDX dissemination, provides an indication of how difficult adoption of such guidelines may be in reality (Smith et al., 2005; Smith et al., 2003). In the COPDX, GPs are identified as central providers of care across all areas including detection/diagnosis, smoking cessation and overall management (McKenzie et al, 2003, p. S25). Yet their ability to fulfil the role would appear to be questionable in the light of studies which indicate poor knowledge and engagement of GPs with guidelines (Smith et al., 2005). Whilst the important role of the GP is not denied, the literature suggests that situating them as central to COPD care is flawed. For example, a study which investigated guideline use in Australian general practice found that, knowledge of guidelines for COPD management was essentially nonexistent among GPs (Frith et al., 2002). The situation appears to mirror that from overseas where, as Rutschmann et al (2004, p. 936) note:

> '...despite widely disseminated evidence-based clinical practice guidelines, current knowledge of primary care physicians and outpatient medical management of patients with COPD remain suboptimal'.

Indeed levels of misdiagnosis and under diagnosis of COPD in the United Kingdom have led to the claim that 'GPs need help tackling COPD because of worrying levels of under diagnosis' (Ford, 2004). Findings such as these raise questions of how GPs might co-ordinate services provided by a range of healthcare professional and care agencies (otherwise known as the multidisciplinary team), described within the COPDX plan (p. S26). The struggle of GPs to uptake and implement guidelines as central health care providers to persons with COPD might also suggest the need to engage other health care professionals including nurses and allied health team members at higher levels in the implementation of COPD guidelines.

2.3.7 A Broader Chronic Disease Management Model

Guidelines such as the COPDX are recognised as part of a suite of tools for chronic disease management which are acknowledged as key components in care provision (Wagner, 1998). Yet, effective chronic disease care requires much more than adherence to disease guidelines and 'evidence about efficacious tests and treatments' (Wagner, 1998, p.3). Because care delivery to persons with COPD, falls under the broader rubric of chronic disease care it is necessary to consider not only guidelines but also care provision in relationship to the broader chronic disease model. The chronic care model produced by the McColl Institute, (Wagner, 1998; Wagner et al., 2001) illustrates the central tenets of management of chronic disease together with the relationships between those components. The research from the Institute is recognised as highly influential in the area of chronic disease management (WHO, 2002a).

Core components of the model described by Wagner et al (2001) include health care organisation which has a focus on chronic care provision; access to community resources both inside and outside an organisation; self management support for patients and carers; planned and coordinated actions between health care providers; decision support through guidelines (such as the COPDX), and improved clinical information systems. As such, central to the model are patient centredness, teamwork between health care providers,

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proactive planned care and greater integration of guidelines into the flow of decision making. Wagner et al (2001, p. 65) claim the model is derived from recognition that:

> Many chronically ill persons wrestle with the physical, psychological, and social demands of their illness without much help or support from medical care. More often, the help received, while well intentioned, fails to afford optimal clinical care or meet persons' needs to be effective self managers of their illness.

Yet, despite such critique it is recognised that providing greater alignment with the chronic care model by health care providers in health care delivery is difficult and faces many challenges, not the least of which is the organisation of health care delivery and management (Aroni & Swerissen, 2003; Beilby & Holton, 2005). The manner in which health care delivery is structured, together with the role of individuals within those systems are critical to deliver effective care.

2.4 Tensions between Acute and Chronic Care Models

Wagner et al (2001, p.64) call for continuing work in the area of chronic disease management and note:

> The growing number of persons suffering from major chronic illnesses face many obstacles in coping with their condition, not least of which is medical care that often does not meet their needs...The primary reason for this may be the mismatch between their needs and care delivery systems largely designed for acute illness.

Here, Wagner et al (2001) are referring to broader health care delivery systems which include both primary and acute care settings. While this study is specifically focussed on appropriate care delivery for those with chronic disease, it is set within the acute care setting, where a focus on managing episodic care is implicated in the struggle to provide appropriate chronic disease care.

2.4.1 Orientation of Acute Care Delivery

Historically acute care settings had a focus on the need to respond to acute medical illness or injury, and have primarily focused on treatment and containment of infectious diseases. A major epidemiological transition in the early part of the twentieth century occurred as infectious diseases were largely brought under control and replaced with rising numbers of patients with chronic disease (Aroni & Swerissen, 2003; Weeks et al., 2003; Yach et al., 2004). Yet as Wagner et al (2001, p. 65) highlight most health care practices remain

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oriented to acute care provision, where the patient role was passive and practitioners could reasonably expect the illness episode to be limited to days or weeks. Increasing stressors on such systems have arisen due to an ageing population and increasing prevalence of chronic disease. This change has led to efforts directed at trying to serve a different problem (i.e. management of chronic disease) within an existing system, rather than implementing a redesign (Wagner et al., 2001, p. 65). The problem reflects an inability of policy makers and health care providers to move toward adopting strategies aimed at improving management of chronic disease (Beilby & Holton, 2005; Chew & Van Der Weyden, 2003). It is notable that the World Health Organization (2002a, p. 29) has been critical of the structure of health care systems within developed countries, such as Australia, claiming they remain organised to provide acute illness care, and as such fail to engage consumers in the management of their disease, include only sporadic follow-up, and largely ignore issues associated with community based service provision.

2.4.2 Professional Silos

Chronic care provision is further impacted by the fragmented structures in which care is delivered often organised in terms of professional silos (Brooks, 2003; Mann, 2005; Owen, 2004). The term professional silos, refers to health care providers who work within their own domain with little or poor communication with other providers working with the same patient group. The financial, organisational and system approaches of each 'silo' are influential, and can act to limit collaboration between professional groups (Mann, 2005). Fragmentation of care occurs at high levels between acute and community service provision where 'information about patients may not be shared within, let alone outside of an institution' (Mann, 2005, p. 34). In addition, systems of care are noted as encouraging fragmentation and siloing (Brooks, 2003), with providers often utilising different systems (e.g. computer programs) and approaches to individual care. The implication for patients with chronic disease, such as people with COPD, who may be managed by a number of health providers, is that information related to their care and treatment, may not be shared between providers (Berg, 1999, p. 91). For example people with COPD who often have multiple co-morbidities, may need to consult a range of services including general practitioners, specialist physicians, psychologists, social care

agencies and allied health care providers. If each does not co- ordinate their actions with others the person is at risk of either 'falling between the gaps' or not being able to 'navigate their way through multiple systems' (Parker, 2006).

Within the Australian health care context, the situation is further complicated by intergovernmental relations where the structures of funding are shared by non government organisations, state and territory governments and the Commonwealth Government (Medicare Fact Sheet, 2001), further adding to communication difficulties between service providers. The result is a system which is difficult to navigate for both users and providers of health care services (Richardson, 2005, p. 12). Brooks (2003, p. 260) describes healthcare structures as 'often, by their nature, hierarchical "ego systems" [that] interfere with the ability to develop comprehensive healthcare delivery services'. If collaboration between sectors is complicated by poor system alignment and low levels of communication, the end result may be one of confusion and inaction. Poor inter sectoral or health care provider collaboration may also impact on self management support to patients, which has previously been discussed.

2.5 Summary of COPD Healthcare Provision

To this point the examination COPD care has been on the delivery of care from the perspective of the health care system in general. This highlights opportunities to improve provision of services through more effective health care delivery structures and collaboration. Better management of COPD may be achieved through improvement of health care delivery structures, early detection and effective management. Individuals who experience chronic disease have a key role in management of the day to day impacts of the disease; therefore improvements may be most effective if focussed on their interaction with a range of health care professionals who can support the development of partnerships and self management. As previously discussed, the COPDX guideline is an important document that can be utilised by health care providers to improve COPD care, yet it is recognised the uptake in practice is suboptimal. In addition, the medically dominated focus of the guideline is problematic as it fails to recognise the important role of the patient and family and does not engage or clearly articulate the roles of other health care

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providers in provision of care. Historical influences on care provision also limit possibilities for improving both guideline uptake and movement toward improved systems to assist in chronic disease management as the foundation and continuing focus of health care systems remains oriented to treatment of episodic or acute care. Little is known of how these issues impact on provision of care to persons with COPD when they are admitted to acute care for treatment, and importantly to what extent acute care nurses integrate the guidelines into their daily practice.

On the background of complex and interrelated components of both health care and individual disease management, the remainder of the chapter now focuses on nursing care for persons with COPD, and will situate acute care nurses within the broader milieu of care. This is undertaken to further examine the literature and identify the scope of nursing practice with respect to COPD management. In particular issues around the critical role of nurses in care delivery to persons with COPD within a complex care structure, medically dominated disease management strategies and poor co-ordination are explored.

2.6 COPD Care Provision by Nurses

Representing over half the health care workforce within Australia (Australian Bureau of Statistics, 2005), nurses numbered over 245,000 in 2004. They represent a large component of the health care workforce working broadly across two macro levels of community and acute care sectors (Eggert, 2005). Chronic disease models recommend the use of the nursing workforce to assist with management and to provide services directly to persons with chronic disease (Bodenheimer, MacGregor, & Stothart, 2005; Brooks et al., 2004; Cumbie, Conley & Burman, 2004). Some new models of care have also been proposed where nurses might play a more significant role in chronic disease management (Temmink et al., 2000). Yet the nursing role is not generic, and can be highly variable, multifaceted and at times quite specialised dependent upon the practice setting and context (Daly & Carnwell, 2003, p. 158). In terms of care provision to persons with COPD nurses have been identified as a group who hold a holistic view of the patient and patient care. It is little wonder that authors tackling the thorny issue of chronic disease management often

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refer to nurses as key to successful interventions (Bodenheimer et al., 2005) and filling a pivotal role in care provision (Temmink et al., 2000).

The literature reports the provision of care to persons with COPD by nurses in many different settings – acute, community and as part of multidisciplinary teams. As a consequence it is often difficult to dissect the specific role of nurses. Even the role of nurses in teams is varied, ranging from undertaking a single task (eg spirometry) through to case management (Egan et al., 2002). As a result there are many ways in which to examine nursing literature as it relates to care provision to persons with COPD.

Within this thesis the focus is on improving overall care provision and the review is presented through examination of three themes related to such a focus. Firstly there are publications which articulate précis or opinion – what nurses should be doing related to care provision. Secondly there are those which focus on specific areas of care, including technical or task oriented aspects of care. The final theme is research in areas which investigate specific or broader aspects of care.

2.6.1 What Should Nurses be Doing?

Discussion of disease management guidelines fall under the first category of the literature, where summaries of care, evidence or opinion are provided and relate to what nurses should or could be doing in COPD care. Guideline discussions do not constitute research or clinical studies, but rather, report summaries of the evidence and highlight the need for nurses to have sound knowledge of the principles of COPD management. Within the literature for example, Booker (2005), Boyle & Locke (2004), Chojnowski (2003), Gronkiewicz & Borkgren-Okonek (2004) and Smith (2004) all report on current best practice referring to the GOLD guidelines. The key thrust of journal articles written by these authors is to promote awareness of the guidelines; as such they present the evidence base to support recommendations for areas of care. Not surprisingly these summaries share common features with the COPDX, which includes awareness, prevention, diagnosis, pharmaceutical treatment, management of exacerbations, social support and education.

The guideline descriptions and discussions contained within literature are aimed at increasing nursing knowledge, and encouraging nurses to engage with evidence based practice related to COPD care. Some also provide continuing education articles where nurses complete learning assessment in order to gain education points (Fehrenbach, 2002; Simmons & Simmons, 2004). Yet it is as though simple awareness and knowledge of the guidelines will lead to the development of evidence based nursing practice. Although the 'vital' role of acute care nurses in managing patients with COPD is highlighted in this literature (Gronkiewicz & Borkgren-Okonek, 2004), such claims are based on the authors opinion, not a critical review of practice. Indeed none of the discussions of guidelines and evidence which support their formulation demonstrate a critical stance or examine the barriers to implementation which may exist. Nor are the roles of nurses in guideline implementation articulated, other than to urge adherence to evidence based practice.

Given the COPDX guidelines were produced by and for Australian health professionals, the absence a commentary about the guideline or their use in Australian nursing journals is notable. Nurses may read literature published outside their country and discipline (Spath & Buttlar, 1996), but the absence of COPDX promotion within Australian nursing journals at the very least demonstrates a gap in dissemination of the guideline in those journals to which Australian nurses have the most exposure. Whilst dissemination to specialist respiratory nurses may have been undertaken via their membership of the Australian Lung Foundation, the Thoracic Society of Australia and New Zealand, or by reading broader literature (such as respiratory journals), the general nursing population appears to remain untargeted. Even if specialist respiratory nurses have been exposed to guidelines there is little investigation into the application of evidence or barriers to implementation in the workplace. The context of Australian hospital care, where COPD patients are often admitted to general wards which may not include specialist respiratory nursing services, highlights the need to ensure dissemination of this information to all nurses. Furthermore, it raises questions about how the role of general nurses is conceptualised and promoted in the management of people with COPD. It is intended

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during this study to raise such questions, in order that acute care nurses can explore these issues.

Published discussion of a range of COPD disease guidelines fails to address two major issues in care of persons with COPD; strategies to facilitate uptake and the extent of uptake. Specifically Kara (2005, p. 127) claims that nurses need to be more prepared for the 'global pandemic of chronic obstructive pulmonary disease', and notes 'no wide scale studies about promotion of health and prevention of COPD in groups of people or the implications of the epidemic on nursing education were found in the literature'. In the context of investigating the possibilities for a group of acute care nurses to develop their practice to better meet the needs of persons with COPD admitted to their ward, this study will necessarily involve an investigation of the way that nurses engage and utilise guidelines in their nursing practice.

The publication of guideline summaries also includes opinion that nurses should be doing more within the area of COPD. For example, early identification of COPD is highlighted as an area for improvement and nurses are nominated as health professionals who should be playing a key role in facilitating this important facet of care within the community (Holt, 2004). As early identification of disease provides an opportunity to encourage smoking cessation and hence lessen the severity of disease long term, nurses are urged to become proactive in their efforts to identify those at risk and provide screening (Pountney, 2006; Seljeflot, 1998). Pountney (2006) provides a discussion piece which addresses the cost of COPD to communities and quotes expert opinion from others to highlight potential interventions. As an example, a leading physician is quoted as saying 'we are encouraging all practice and respiratory nurses to be proactive in identifying COPD cases in their communities' (Pountney, 2006, p. 13). The importance of knowing what care should be provided to people with COPD is further illustrated in literature which addresses technical aspects of care.

2.6.2 Technical or Task Oriented Aspects of Care

Much of the published literature focuses on technical or task oriented aspects of care provision to persons with COPD care which relates to the complexity of skills required in the area and reflects more detailed aspects of care that nurses might be required to deliver. Mirroring the complex and multifaceted nature of COPD care, such areas are numerous, and include spirometry (Booker, 2005a; Joyce, 2001; South, 2005), oxygen management (Edwards, 2005; Lynes & Riches, 2003; Smith, 2004), education (Carlson, Ivnik, Dierkhising, O'Byrne, & Vickers, 2006) , non invasive ventilation (Phillips, 2005), vaccination (Gosney, 2000; Pierrynowski-Gallant & Vollman, 2004) and medication administration (Horner, 2005; Small, 2004). Also considered in the literature are less easily defined tasks such as discharge planning and implementation (Armitage & Kavanagh, 1998). Not all of these areas are discussed in this literature review but rather serve to illustrate that on occasions the nursing care of people with COPD is broken down to tasks requiring technical skills.

Breaking down COPD care into tasks is perhaps necessary when considering the broad range of skill and knowledge nurses require in order to provide care to persons with COPD. Indeed nurses may seek such literature in order to improve knowledge in specific areas of care, and articles which address these areas are important (Spath & Buttlar, 1996). Yet it is equally important to recognise that information across a range of tasks needs to be drawn together in order to provide holistic COPD care. The last area of the literature to be examined is research publications which seek to provide information about how COPD care is delivered.

2.6.3 Investigation of Care Provision

In terms of answering the research question about possibilities of a group of acute care nurses to develop their practice, the investigation of nursing care provision to people with COPD is the final thematic area of the literature to be addressed. Once again publications which detail investigation of COPD care may address specific areas (for example spirometry use) or delivery of care in a broader context (such as hospital in the home). Much of the literature in this area is concerned with provision of care within the

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community, on a background of health care policy which supports an investigation into ways to decrease the burden of COPD, particularly around the use of acute care beds (Bourbeau et al., 2003; Casas et al., 2006; Ram et al., 2004). Further areas of investigation include detection of disease, management of stable disease and support to persons experiencing exacerbations of the COPD, a state which may precipitate admission to acute care.

2.6.3.1 Prevention and Detection of Disease

Smoking cessation is a primary component of disease prevention and important for those who are diagnosed with COPD, as cessation will slow the trajectory of decline. Research has also been undertaken in a number of settings in order to investigate the impact of smoking cessation provided by nurses in hospitals (Bolman, DeVries, & Vvan Breukelen, 2002), the community (Lenaghan, 2000) and specifically with people who have a diagnosis of COPD in the community (Tonnesen, Mikkelsen, & Bremann, 2006). A Cochrane review of nursing interventions for smoking cessation (Rice & Stead, 2004) illuminates the area further and provides a summary of randomised trials which had been undertaken. Criteria for inclusion in the review were nurse involvement; and established non smoking status six months post intervention. Twenty nine studies were reported to meet the review criteria. Rice and Stead (2004) conclude there are potential benefits of smoking cessation advice and counselling provided by nurses. However they also caution that evidence of an effect is weaker when interventions are brief and are provided by nurses whose main role is not health promotion or smoking cessation. Identification of smoking status and other risk factors is often used to facilitate referral of individuals for further screening and to aid in early identification of COPD.

The effectiveness of a respiratory specialist nurse led COPD screening and intervention program in America was examined by DeJong & Veltman (2004). 243 participants without COPD diagnosis, were recruited via letter, newspaper and physician referral. Participants undertook spirometry screening, were educated about the test results and COPD risk, and provided with smoking cessation counselling by a respiratory nurse. 209 participants were identified as at risk of COPD, 55 were found to have mild to moderate

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COPD. Follow up was poor (n=61) but of those, just under half indicated they had stopped smoking, or were considering quitting. Of note smoking cessation status was reliant on self reports, which may be a limitation of the study. Yet DeJong and Veltman (2004, p. 78) claim the findings demonstrate how clinical nurse specialists can lead and direct community initiatives contributing to diagnosis and smoking cessation within an at risk population. A similar study in the Netherlands investigated the role of nurse practitioners in screening and detection of COPD (Vrijhoef et al., 2003). A convenience sample of 231 participants who were current smokers was recruited as they visited one of eight participating GP practices for reasons unrelated to respiratory disease. Following recruitment they were asked to provide a medical history and undertook spirometry. Nineteen per cent of the participants were identified with airflow limitation which led to treatment guided by the general practitioner. Vrijhoef et al. (2003) claim the results demonstrate the value in development of the nurses' role in screening and management of COPD. Studies by DeJong & Veltman (2004) and Vrijhoef et al. (2003) support the claims or opinion of other writers (see 2.6.1) that nurses have a role in interventions focused on screening and early identification of the disease.

2.6.3.2 Management of Stable Disease

As COPD is detected and smoking cessation opportunities are offered the focus of care also includes other disease management strategies and the role of nurses as members of the health care teams that deliver care. It is in this area that researchers have sought to understand how the role of nurses is enacted in care provision. For example, Jones et al. (2001) used a survey instrument to investigate practice nurse roles in the United Kingdom and to seek respondent understandings of how future services to persons with COPD should be delivered. Interestingly the impact of resource constraints, including time, was reportedly high, and detracted from practice nurses' capacity to fulfil their co-ordination and support roles related to COPD care (Jones et al., 2001). The findings share commonality with some of the practice constraints identified in uptake of management guidelines by GPs. An area suggested by respondents to be of use was greater input in general practice from specialist respiratory nurses.

Case management or integrated care of stable COPD by specialist respiratory nurses has been explored in the research literature. In order to understand the effect of specialised nurses in COPD care Vrijhoef, Diederiks, & Spreeuwenberg (2000) reviewed the literature. The review included both clinical trials and randomised controlled trials published during 1966-1999 where nurses were the main caregiver in the intervention group (Vrijhoef et al, 2000, p. 244). Eight such publications were identified by the authors who also noted the small number of publications, which highlighted that specialised nurses represent a more recent development in care of persons with chronic disease. The authors note that robust research into the impact of new delivery methods in nursing is very limited (p. 248). The review concluded that specialised nurses with a central role in an intervention to manage chronic disease can have positive impacts on patient outcomes. Such outcomes include improved self care, quality of life and patient satisfaction (Vrijhoef et al, 2000p. 243).

In contrast to the findings of Vrijhoef et al (2000), a Cochrane systematic review reported 'there is little evidence to date to support the widespread implementation of nurse led management interventions for COPD' (Taylor et al., 2005, p. 1). The review included nine randomised controlled trials studies which evaluated clinical services provided or led by nurses. Two of the reviewed studies were also included in the review by Vrijhoef et al. (2000). Taylor et al. (2005) included review of case management by nurses in the community and specialist nurses either as part of normal care or following admission to hospital following an episode of acute exacerbation. The authors concluded that further research was required in the area, as they were unable to assess potentially important outcomes including patient satisfaction and self management skills.

It would appear that there are divergent findings within the area of nurse led COPD care. Much like pulmonary rehabilitation or self management approaches to care, discussed previously, it remains difficult to draw conclusions about exactly how and when care should be delivered with all studies reviewed demonstrating a range of approaches and outcome measures. Difficulties in assessing the impact of nurse led provision of COPD care also reflect the multifaceted role that nurses fulfil in care provision where it is not

only the actions of nurses, but those of other team members which impact on outcomes. The situation is similar to provision of care within acute care settings where nurses are engaged across a range of activities with other health care providers.

2.6.3.3 Nursing Management of People with COPD in Hospitals

The delineation of roles between acute and community care is not clear cut and there are service approaches which bridge the two. For example, after an acute care admission patients may be followed up with outreach services to support ongoing recovery (Egan et al., 2002). In addition greater integration of services has also been explored (Casas et al., 2006; McManus, Marley, & Kidney, 2005) across the two areas. Yet the more recent and growing body of work undertaken to understand how nurses contribute to delivery of COPD care services in the community, is not replicated in acute care settings. Indeed descriptions of acute care provision to persons with COPD appears limited to the rhetorical calls for evidence based care contained in guidelines or guideline discussion together with task related components of care discussed earlier rather than proactive approaches to investigate and improve care delivery to better meet the needs of persons with COPD admitted to hospital.

The emerging preference to manage people with COPD in their home setting is one area of considerable interest. Whilst the care for acute exacerbations, known as hospital in the home, is not delivered in the physical location of a hospital building, it is nevertheless considered equivalent to acute care (Ram et al., 2004). Hospital in the home services for COPD patients have emerged over the last decade or so and are gaining acceptance by policy makers and health care providers (Shepperd & Illiffe, 2005). Although there is still some contention about the benefits (Ram et al., 2004; Shepperd & Illiffe, 2005), on a background of increasing demand for acute care beds and understandings of practitioners and service providers that the intervention is safe and effective, the number of such services is growing. Nurses often hold a key role in the hospital in the home approaches to care. With appropriate back up from medical and allied health team support members, nurses fulfil their role through management of exacerbations which also incorporates

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broader aspects of disease management including smoking cessation, social support, and pulmonary rehabilitation (Schofield, Knussen & Tolson, 2006).

Published literature on the quality of care in hospitals to persons with COPD maintains a focus on examining to what degree guidelines for treatment are followed. Lindenauer et al. (2006) undertook a retrospective cohort study which included 160 American hospitals and almost 70,000 patients with the objective of evaluating quality of care for patients hospitalised with exacerbations of COPD, with a focus on hospital and patient characteristics. Comparing treatment with accepted American guidelines they found a variation in practice across hospitals which ranged from 10-60% with respect to adherence to recommendations (p. 895). Similar findings are published by Roberts et al. (2001 p. 343) from the UK in a smaller study of 38 hospitals and 1400 cases where large variations in the application of guideline recommendations were found between centres. Lindenauer et al. (2006) did not examine follow up care at all, whilst Roberts et al. (2001) limited assessment of follow up to medications and attendance rates at pulmonary rehabilitation, with neither study addressing social or continuing care of patients. The studies did not contain any reference to the specific role of nurses within application of guidelines.

An audit undertaken in the UK of care to hospitalised patients with COPD (Anstey et al., 2004, p. 5) examined two distinct areas, 1) organisation of care, and 2) process of care and clinical outcomes. Eight thousand admissions were reviewed, and data reported included mortality, length of stay, readmission rates and general demographics. Of interest in this study the authors also provide data on the levels of access to specialist respiratory physicians and specialist respiratory nurses, together with the patient referral to early discharge schemes and hospital in the home (p. 14). Whilst the report delivered a snapshot of services and care provision, in order to facilitate comparisons between hospitals and over time, it does not provide in depth detail of how care is delivered. However the findings do highlight that COPD care provision is highly variable between sites, and is affected by resource constraints at local government and hospital level. As a result the clinical outcomes of the patient cohorts were also variable.

Further, a journal article published for a nursing audience does not provide more than a superficial investigation into the nursing care provided to people with COPD in hospital. Using a retrospective approach, Trudeau & Solano-McGuire (1999) evaluate hospital care for COPD patients in the American state of Ohio. Using criteria for the study developed by the research team from best available evidence, they examined 492 patient histories. The study examined areas of history and physical examination on admission, appropriate pharmacologic treatment, and appropriate discharge planning and education (pp. 48-9), yet no specific nursing care criteria were investigated, other than those associated with established guidelines, which related to a range of care providers. Hence in the discussion of results there is no clear description of nursing care, or delineation of health care roles, except to note that nutrition screening is usually completed by nurses, and nursing interventions may alleviate 'irritable behaviours' and 'fear' exhibited by patients (p.50). Although they caution that the audit findings can only reflect care that was documented, Trudeau and Solano- McGuire (1999) claim the project reveals 'that COPD lungs seem to be well treated, while COPD patients are not' (p.50), a claim largely based on low assessment of nutritional status and high levels compliance with pharmaceutical recommendations for care.

Investigations of care provision to people with COPD in hospitals similarly maintain a focus on outcomes which relate to guideline recommendations, which inevitably reflect the medical interests which inform the guideline development. The primary intent of such investigations is to measure to what degree care provision is aligned with best practice recommendations and to provide motivation to health care providers to improve their care by comparison with others. When combined with other literature which demonstrates poor alignment with evidence based practice it would appear that total COPD care is rarely aligned with the evidence. Although the nursing role is not specifically identified in studies, the poor alignment between hospital care and evidence based guidelines, suggests that acute nursing care is also implicated in the deficits of care provision. There is ample evidence that care provision to people with COPD needs to be improved across a range of service providers, yet there is a paucity of studies which address the role of nurses in that improvement. It is a gap that this study aims to address.

2.7 Acute Care Delivery of COPD care

The need for further research to investigate the current construct of acute care nursing practice and delivery of COPD care is supported by the literature review, which has revealed gaps in understandings of care provision. Because it is also possible that nursing practice in hospitals is affected by historical and cultural factors, there is a need to explore how such influences might impact on provision of care to people with COPD. It may be as the broader literature suggests that health care professionals working in acute care hospital environments have an engagement which is primarily concerned with acute exacerbations of the disease. It may also be that the provision of COPD care to patients is dominated by medical interests with little focus on provision of holistic care which includes social or longer term care planning. Whilst it is not clear from the literature to what extent acute care nurses engage with these areas of COPD disease management, the potential of acute care nurses to engage in research aimed at developing their practice to further align with evidence based practice has been explored.

2.7.1 Potential for Nurses to Improve Practice

The potential of acute care nurses to improve their practice using participatory research methods has gained increasing support (Fitzgerald & Armitage, 2005; Nolan & Grant, 1993). Participatory approaches recognise the practice theory gap cannot simply be bridged by providing the evidence and hoping it will be translated into practice, but rather move toward understanding the barriers to uptake from the perspective of practitioners themselves. As Keleher & McInerney (1998, p. 1) advise us, nursing is

> ...closely linked to a network of social infrastructure including...the state, the social relations of production and the politics of health...nursing cannot be adequately theorised in isolation from these structures or influences...

Participatory research offers a way for nurses with shared interests and concerns to work collaboratively to examine and to improve practice.

Annette Street has been a firm advocate of the use of action research to improve nursing practice (Street, 1995, 2003). In action research it is not only the findings of the study which are of importance but also the empowerment of 'participants to examine their

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situation... in order to begin to formulate solutions' (Bennett-Jacobs et al., 2005, p. 12). Embedding empowerment within the research process is intended to enable sustainable change in practice environments (Grundy, 1988).

The literature provides examples of participatory research where change in practice has occurred. The circumstances are similar to acute care nurses engaged in providing care to people with COPD in this study, and such research demonstrates the possibilities of collaborative enquiry aimed at improving care provision to patients. The focus of research is varied, and includes a range of topics. At the broad level Bennett-Jacobs et al. (2005) engage nurses in an examination of practice to identify and address issues in contemporary nursing practice. Greater insight into issues identified which included disempowerment, fragmentation of care and loss of control over nursing practice allowed the nurses in the study to engage in strategies to nurture each other and to value nursing practice. Glasson et al. (2006) and Reed (2005) both utilise action research to investigate and improve care to older persons in acute care. In the study by Glasson et al. (2006, p. 589) nurses were able to adopt a greater evidence based practice approach to care of older persons, informed by their insights and 'driven by the clinical nursing staff at the grass roots level'. The success of such studies indicates that by working with practitioners in acute care greater alignment with evidence based practice may be achieved.

Gaps in care provision to people with COPD admitted to acute care identified in the literature review highlight the need to enact changes in practice and to improve alignment of practice with available evidence. Evidence which is presented in documents including the COPDX provides compelling reasons for change, in order to improve patient outcomes. Yet there is recognition that changes in nursing practice are influenced by a range of factors which must be taken into account in the process. The success of researchers who engage practitioners in the research process in order to facilitate exploration and change in nursing practice, which include an examination of such factors, illustrates the central role of participatory approaches to attaining greater alignment of nursing practice with evidence based practice.

2.8 The Research Question

Delivery of care to persons with chronic disease is difficult and impacted by a range of factors including the construct of care provision and tensions between acute and chronic disease management models. In the context of care provision to people with COPD, it is evident such problems have been investigated primarily from a medical or health care delivery perspective and that there has been little or no exploration of the role of acute care nurses in improving care for this group of patients. Unlike their counterparts in primary health care settings, the engagement of acute care nurses in the area remains a largely unexplored area of care provision. This study has been designed to take up this issue and address three key aims:

1) To explore the issues which impact on the provision of care to older persons admitted to hospital with COPD.
2) To establish an ARG made up of nurses from an acute care medical ward, encompassing the respiratory unit, in order to explore ways in which to develop nursing practice to better meet the needs of persons with COPD.
3) To develop nursing practice in order to improve the care of persons admitted to hospital with COPD.

This research has a focus on initially undertaking an investigation with acute care nurses to understand the current construct of care provision, critically examining that information in the light of historical, social and economic influences and then moving forward to undertake change in areas identified by those nurses. Such aims are encapsulated in the preliminary research question which as stated in Chapter One asks: *'How might a group of acute care nurse's work together to investigate and improve care provision to patients admitted to acute care?'*

The use of critical action research methodology offers acute care nurses a means to engage in investigation of their own practice together with the potential to change practice in order to improve care to persons with COPD.

3   Methodology

> The consistent divergence between theory and practice in all the social
> science fields is especially notable. How this develops in a group of
> disciplines explicitly founded to inform social practice should puzzle
> everyone (Greenwood & Levin, 2008, p. 62)

The quote by Greenwood and Levin (2008) above is apt, although not referring directly to health disciplines, it highlights the need to conduct research focused on gaps between the theory and practice. It is a gap clearly identified in the preceding chapter between COPDX evidence (theory) and the practice of health care practitioners. Management of COPD, a disease which is chronic in nature with no known cure, requires a focus on maintaining or improving quality of life through the provision of support including smoking cessation, attendance at pulmonary rehabilitation and early recognition of exacerbations. Such management heralds a requirement for a holistic approach to care and multidisciplinary collaboration which includes the involvement of nurses.

Yet, identified in the literature review and a central concern within this research is a lack of knowledge about the role of acute care nurses in the provision of care to people with COPD, and how it is enacted in practice. Similarly, there were no studies identified which investigated strategies to simultaneously improve acute care COPD nursing practice. This research aims to engage acute care nurses in a study which will explore the possibilities for them to develop their practice to better meet the needs of people with COPD admitted to the ward, and in doing so will identify gaps between theory and practice. Importantly they will also explore how those gaps have arisen and how they may be successfully bridged.

3.1   The research question

At inception of this project the continuity of care between acute and community care providers, following an acute care admission, was identified as the broad area of concern and provided a lens through which to explore acute care nurses' engagement with delivery of care to persons with COPD. To achieve this, the research approach endeavoured to assist acute care nurses to collaborate in a process of change.

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The research question was informed by an iterative process which as described in Chapter One was driven by my own personal reflections on practice and shared with fellow nurses working in acute care. The common ground provided impetus for the beginning of the research journey. A review of the literature further informed and affirmed my own understandings of COPD care provision in hospitals as problematic and worthy of greater investigation. Concurrently I held a view, shared with other acute care nurses from the ward, that the research needed to elevate nursing knowledge, and provide nurses with a means to both investigate nursing practice and move toward change to benefit patient care. Hence in undertaking the research there was a clear intent to investigate relationships between evidence based knowledge and practice, using the techniques of critical enquiry to explore the current situation, and move toward informed planned actions to improve care to persons admitted to acute care with COPD.

The methodology forms the theoretical framework to support the method chosen for the research. My own epistemological and ontological cogitations, together with findings of the literature review assisted me to make decisions about a suitable means of enquiry to answer the research question. It is important to note the method chosen was not the only means in which the research could be undertaken. I wanted to collaborate in this endeavour with acute care nurses who were engaged in providing care to persons with COPD, an approach supported by the literature as an appropriate mode of enquiry. It was also important that the research was undertaken with a view to improving care to persons with COPD. As Goodrich (cited in Diers 2004, p. 39) claims

> ...to effectively interpret the truly great role that has been assigned [to the nurse], neither a liberal education nor a high degree of technical skill will suffice. She must be the master of two tongues- the tongue of science and that of the people.

The quote by Goodrich highlights the need for research to address both the scientific foundation of COPD care and also the social context in which it is delivered. Action research methodologies provide a means by which to investigate the application of evidence based practice and the social context of where care is delivered (Kemmis, 2001). Furthermore, action research involves the formation of a group of practitioners who share

a common concern and a shared interest in improving care. As such it presents an appropriate mode of enquiry to answer the research question posed in this project.

3.2 The Choice of Action Research

Action research can be employed to bring about improvement in a problematic situation, but importantly is informed by the participation and critical insights of the ARG members (Grundy, 1988). A group of practitioners who share a common interest in the research, work together and collaborate to explore an agreed area with the intent to consider and take action to improve the situation (Heron & Reason, 2001, p. 180). The emphasis on taking actions differentiates the approach from ethnographic methods which aim to describe and critically analyse a complex situation and context (Tedlock, 2003). The activities of the ARG group may provide such description but move forward with an attempt to also effect change in the situation.

From the perspective of a change agenda, action research has features in common with practice development, which has been utilised increasingly within nursing research to bring about change (Fitzgerald & Armitage, 2005; Manley, McCormack, & Wilson, 2008). Person centredness is a central concern within practice development (McCormack, Manley, & Walsh, 2008, p. 17), and is also important within this research endeavour, as the nurses' interest was to take action to improve patient care. Practice development also assigns high importance to evidence based practice and the role of evidence in nursing care (Bucknall et al., 2008, p. 84). Evidence has a primary role in the practice development approach and often provides the central reference point on which to predicate change. However there is a recognition that the weight of evidence alone is not sufficient to bring about change in complex social and political spheres (Ritchens, Rycroft-Malone, & Morrell, 2004; Rycroft-Malone et al., 2004; Van Zelm, 2006), such as that represented by an acute care hospital environment. Rather the emphasis in the research which is the subject of this thesis is on interrogating and considering applicability of evidence to practice, and working through an action research process, to facilitate change in practice. The 'dynamic relationship between theory and practice' is examined during action research, with a view that 'theory may inform but not legitimate

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practice'(Grundy, 1988, p. 359). Within the context of this research practitioners had an opportunity to not only examine the gaps in application of evidence based practice but to consider how the broader social, historical and political environment might facilitate or constrain acute care nurses' engagement in delivery of evidence based practice. In this sense, while having a focus on implementing change, the choice of action research also provides clinicians with an opportunity to more fully understand current practice and how it came to be (Grundy, 1988, p. 358).

The aim of the research, to engage acute care nurses in a research endeavour exploring current delivery of care to people with COPD, to critique and reflect on their concerns and to take action to improve the situation made the choice of action research methods clear. Yet, action research is not prescriptive, nor defined by given rules. Rather, the methodology involves a range of approaches, each of which is informed by different traditions, which have developed over time (Reason & Bradbury, 2001, p. xxiv). In order to explore the methodology within this research project a history of action research, the types of action research and the influence of critical social theory including the theoretical contribution of Habemas (1971, 1974, 1990) are presented in the following pages.

3.3 Action Research

Grounded in a discipline of social psychology, the initial development of action research is attributed to Kurt Lewin in the 1940's. A seminal paper by Lewin, first published in 1946 and titled *Action research and minority problem*s (1946*)*, focused on action as a means of improving inter-group relationships (Kemmis & McTaggart, 1988, p. 2). Collier, Commissioner for Indian Affairs (1933-1945), was also an early advocate for a cyclical research process (Kemmis & McTaggart, 1988; Meyer, 1993), described as 'action-research, research-action' (Collier in Kemmis 1988, p31). Broadly the intended outcome of action research is one of effecting social change through a problem solving approach which purposely engages researchers and practitioners in collaborative study (Meyer, 1993, p. 1066).

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The methodology is applied where researchers and practitioners wish to collaborate in order to facilitate improvement across varied settings. Action research has been used across several disciplines, notably within Australia, it has been used extensively within education (Kemmis & McTaggart, 2003), nursing (Meyer, 1993; Robinson, 1995; Street, 2003) and organisational development (Dick, 1999; Wadsworth, 1991), but is not limited to these disciplines. The usefulness of action research across diverse settings and disciplines is supported by the flexibility of approach offered by different typologies.

3.3.1 Types of Action Research

Action research is a multifaceted methodological approach comprising several branches. The interplay of researcher and chosen field of research, together with the intent of the project, define which approach is most suited to the research endeavour (Grundy, 1988). All branches have in common an aim to provide solutions to identified problems. Kurt Lewin, as noted by Kemmis & McTaggart (1988, p. 6) 'had in mind a dialectical relationship between the improvement of understanding and the improvement of action'. The point which all authors agree is that the correct 'modus operandi' must be chosen for the research topic and situation. While classifications of action research are described by several authors (Grundy, 1988; Hart & Bond, 1995; O'Brien, 2001; Titchen & Binnie, 1993), Grundy (1988) provides a very useful typology which is strongly grounded in the tradition of action research and is used in this account of the method to further describe the methodological approach taken.

Grundy (1988, pp. 353-364) describes three categories of action research under the headings of technical, practical and emancipatory. Grundy's typology is theoretically informed by the work of Jurgen Habermas, as was much of the critical work emanating from the group she worked with at Deakin University in the 1970s and 1980s. The Deakin group included Stephen Kemmis, Wilfred Carr, Shirley Grundy and Robin McTaggart (Kemmis, 2001; Kemmis & McTaggart, 2003). They drew on Habermas' work to further develop conceptions of action research informed by a critical social theory perspective. Prior to an examination of the work of Habermas the theoretical underpinnings of critical theory and how it is realised in action research is explored.

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3.4 Critical Social Theory

The term 'critical theory' is a term recognised as encompassing a diverse body of work, by its very nature fluent in process and subject to the influences of historical and social contexts it seeks to reveal (Kincheloe & McLaren, 2008, p. 404). Situated in Germany, the Frankfurt Institute of Social Research is most commonly associated with the emergence of critical theory in the 1920's and 30's (Fontana, 2004; Lont, 1995; Wells, 1995). Adorno, Horkheimer and Marcuse were prominent early members of the Institute where a critique of positivism was central to their activities, and they argued for rejection of the dominant paradigm that valued objective reality above all else (Lont, 1995, p. 40). In contrast to positivist interpretations of the truth, critical theorists posited that 'no aspect of social phenomena can be understood unless it is related to the history and structure in which it is found' (Fulton, 1997, p. 530).

Knowledge is understood to have a social dimension which results from activities of human beings in the world (Crotty, 1998, p. 52; Fals Borda, 2001, p. 28). The work of critical theorists encapsulates a desire to reveal these influences that act to maintain behaviours and activities of social groups, and by extension impact on their ability to effect change in social circumstances. Kincheloe and McLaren (2008, p. 405), provide useful insights into the foci of the critical agenda. Key among these is a concern with power relations, such that those undertaking research informed by critical theory accept:

> ...basic assumptions that all thought is fundamentally mediated by power relations that are social and historically constituted; that facts can never be isolated from the domain of values or removed from some form of ideological inscription... (Kincheloe & McLaren, 2008, p. 405)

Hence, critical theorists advocate for an imperative to interrogate commonly held values and assumptions' and to challenge 'conventional social structures' (Crotty, 1998, p. 157) in order to reveal the operation of power relations which shape the values of groups and individuals. In doing so, one may move toward determining what interests are privileged in everyday interactions. Critical theorists claim the influences of power relations are embedded within the coercive nature of society, underpinned by ideological interests; perpetuated through taken for granted understandings related to cultural, social, economic

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and political practices (Crotty, 1998, p. 158). Here, ideology can be understood as 'the stories a culture tells itself about itself [which] people inhabit in very daily, material ways' (Lather, 1991, p. 2). Hence it follows that by examining dominant ideology, power structures and taken for granted ways of being, participants in critical research can come to new understandings of the situation under investigation.

Crotty (1998) suggests the way practitioners think about and engage in practice on a daily basis is informed by ideological constructions of health care. In this study such influences on practice are evident in the previously described ways that COPD care is heavily inscribed by interests that support medical and technical agendas, on the basis that this approach is most beneficial for patients. Yet in the process, social and cultural interests critical to the provision of care to people with COPD (e.g. self management and pulmonary rehabilitation), are potentially marginalised in care provision. Indeed it is not only within COPD care that the domination of medical and technical agendas prevails, but as some argue, the construct of health care generally (Brown & Seddon, 1996; Germov, 1998). Germov (1998, p. 231) further describes medical interests as exercising power not only over their own profession but also the work of other care providers together with decision making around resource allocation, health policy and the manner in which hospitals themselves are run. This is also apparent in the framing of relationships between nurses and doctors as a number of feminist critical theorists have identified medical interests are privileged within the web of power relations at work within the health care sector (Lovell, 1981; Roberts, 1983; Wicks, 1998). In this sense the critical theorist is concerned with the operation of power relations to entrench privilege and the ways that ideology functions to sustain dominant interests, or in the case of this study, a dominant biomedical focus driving care provision for people with COPD. Further, it is suggested the biomedical focus evident within acute hospital settings is closely bound to the managerial and economic ideologies which inform the provision of acute care service delivery (Weinberg, 2004). An examination of such interests is important because they may limit the capacity of nurses to engage in evidence based care provision, including a holistic approach to care which is demonstrated to be necessary in provision of care to people with COPD.

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Expanding the focus, critical theorists also hold a core interest in the critique of capitalist society in general (based on the work of Marx) and the ideological interests that support capitalism (Crotty, 1998). It is claimed that ideological interests of capitalism permeate systems within society including, for example media, politics, and other socio cultural productions (Kincheloe & McLaren, 2008, p. 412) such as the provision of care to people with COPD in hospitals. For example, Gordon (2005) and Weinberg (2004) critique the influence of health care cost cutting and economic agendas on the provision of nursing care within the American context arguing that such influences support economic rationalist ideological agendas. Ideological interests shape the ways that economic interests are communicated and sustained within the hospital system. Here the key interest is reactive, short term care, aimed at achieving cure and early discharge, an agenda which sits in contrast to the provision of evidence based chronic disease care (Wagner, 1998), which would privilege a much more holistic focus on patient management. In these circumstances it becomes evident how people with COPD, like many older people with chronic disease are characterised as problematic in the context of acute care encounters.

Further, Kincheloe and McLaren (2008, p. 405) articulate how a privileging of specific interests sets up hegemonic power relations. They argue:

> …that certain groups in society and particular societies are privileged over others and, although the reasons for this privileging many vary widely, the oppression that characterizes contemporary societies is most forcefully reproduced when subordinates accept their social status as natural, necessary, or inevitable…

In this sense hegemony can be understood as a form of control exercised through social structures informed by dominant ideologies (Gramsci, 1971, p. 11) whereby 'commonsense and habit work to shape both interests and practices in ways that promote conformity and adherence to dominant ideological constructions of the world' (Robinson, 2001). Hegemony is not easily disrupted as less powerful groups accept everyday understandings as commonsense, or the right way to do things, and in doing so support hegemonic understandings.

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Kincheloe and McLaren (2008, p. 405) argue that hegemonic understandings serve to both legitimate and support dominant interests. Hegemony is subtly ambiguous as it is operationalised through the 'cultural forms, the meanings, the rituals, and representations that produce consent to the status quo and individuals' place in it' (p. 412). Further, as Crotty (1998, p. 59) argues that critical theorists must 'be suspicious of the constructed meanings that culture bequeaths to us' as they are loaded with hegemonic and ideological inscriptions. Within the context of this research, for example, hegemonic understandings may be perpetuated when nurses' accept as right and proper that patient centred care is subordinated to medical, technical and economic rationalist interests (Manojlovich, 2007, p. 14). In turn it may be argued that the patients with COPD have their interests subordinated to all manner of acute care health professionals as they prescribe 'what is best for the patient' (Wagner, 1998). This is accepted as legitimate despite the growing ideological perspective associated with chronic disease self management which would privilege a more holistic approach.

The relevance of work advanced by critical social theorists to this study is further highlighted in the findings of the literature review which suggest that the constraints of the practice setting and organisation of health care lead to difficulties in developing nursing practice to meet the needs of people with COPD. Hence development of broader understandings of how nursing care is constructed and delivered to people with COPD must be undertaken. It is evident that research concerned with the social context of COPD care, which utilises the key foci of critical theory beckons with the prospect of developing improved understanding of appropriate ways to structure care provision, and to imagine possibilities for change which challenge the dominant medical/ technical focus. This represents a key interest of this thesis and is further informed by the work of Habermas.

3.4.1 The Contribution of Habermas

Habermas is recognised as one of the most significant contributors to critical theory in the 20th century (Fontana, 2004, p. 94; Lont, 1995, p. 40). He joined the Frankfurt Institute in 1956, initially as Adorno's assistant and over subsequent years produced his own work.

Habermas advocated an extensive critique of the 'coercive' nature of society, further utilising the critical focus of social research to expose domination and oppression (Fontana, 2004, p. 94). Habermas (1971, p. 301) claims that the:

> ...only knowledge that can truly orient action is knowledge that frees itself from mere human interests and is based on ideas – in other words, knowledge that has taken a theoretical attitude...

He put forward a 'threefold typology of human knowledge' (Habermas, 1971), which incorporates the knowledge gained from positivist paradigms (or reason) and tempers this with other ways of knowing. His central epistemological tenet was that human beings constitute their reality and organise their experience in terms of cognitive (or knowledge guiding) interests (Crotty, 1998, p. 142). Habermas (1971, p. 313) posits that:

> we apprehend reality ground in three categories of possible knowledge; information that expands our power of technical control [technical knowledge constitutive interest]; interpretations that make possible the orientation of action within common tradition [practical knowledge constitutive interest]; and analyses that free consciousness from its dependence on hypostatized powers [emancipatory knowledge constitutive interest].

The recognition that knowledge is not detached from individual concerns but shaped through social and historical influences and constituted through everyday interests and needs is central to Habermas' theories (Lont, 1995, p. 41). Furthermore, Habermas (1971) claims viewpoints from which reality is apprehended originate in the interest structure of humans, linked to social organization. He claims that knowledge constitutive interests take form in the mediums of work, language and power. The relationship and application of Habermas' theories to action research typologies described by Grundy (1988, pp. 353-364) is further used to extrapolate meaning.

3.4.2 Technical Knowledge/ Action Research/ Work

Technical knowledge interests are evident in the empirical sciences where there is a central concern with predicting or controlling objectified processes (Crotty, 1998, p. 142). A close alignment between technical interests and a positivist paradigm is evident as information gained from such approaches is often used to expand technical control or predictions about a process or event. Yet, according to Habermas (1971, pp. 74-75) the certainty of knowledge is not guaranteed 'exclusively by its empirical basis' (p74) and

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must also include a 'grounding in a systematic procedure of the investigator'. As such Habermas explains that it is not only empirical evidence, but also the method undertaken by the investigator that informs the 'unity of knowledge'(p 75). Hence as Habermas (1974, p. 3) notes:

> ...technical questions are posed with a view to the rationally goal directed organization of means and the rational selection of instrumental alternatives, once the goals (values and maxims) are given.

Grundy outlines technical action research, which is informed by Habermas' technical knowledge interests as where a person or group of persons who are regarded as experts due to their experience or qualifications, shape and guide the project from its inception (Grundy, 1988, p. 354). The experts are responsible for the success of an action research project that aims to create more effective or efficient practice, where the measures of the project are defined by the expert, often in empirical terms. O'Brien (2001) summarises the structure of technical action research commenting it 'tends toward the conservative, generally maintaining the status quo with regards to organizational power structures'. The project is considered successful when the defined goal of the project, and hence the organisational goals are attained (Kemmis, 2001, 92). Grundy (1988, p. 355) describes an industrial setting as an example of technical action research, where workers team with management to meet production goals. Employees then actively work in monitoring and achievement of the goals stated by management. The workers are participants in the process, however as Grundy (1988, p. 356) cautions 'there is a chance of manipulation where the participants are regarded as the instrument, rather than the agents of change'. Grundy also notes (1988, p. 356) the likelihood of achieved changes being sustained when the focus is no longer on the project or when the researcher (or leader) is no longer involved, is low. Technical action research is pragmatic in approach and does not include the questioning of identified goals, nor a consideration of how the environment where the research is conducted is discursively, socially or historically constructed (Kemmis, 2001, p. 92).

3.4.3 Practical Knowledge/ Action Research/ language

Habermas' conception of practical knowledge constitutive interests is informed by interpretation and understandings of the social world. Hence Crotty (1998, p. 143) states that practical knowledge interests are closely related to cultural or human sciences, where there is an 'importance to human beings securing and developing mutual understanding in the everyday conduct of life'. Habermas (1971) argues that to understand others requires an understanding of social meanings which constitute reality. Such meanings can only be understood in the context of knowledge which arises from practical activity in the world (Habermas, 1971, p. 313). Language provides the means through which persons can examine practical activity, by investing 'a part of his [sic] subjectivity' (Habermas, 1974, p. 11), to investigate the construction of understandings, beliefs and tradition that inform such activity. The approach described by critical theorists is realised with practical action research (Grundy, 1988) through what Kemmis (2001, p. 92) suggests is 'wise and prudent decision-making in practical situations'.

Practical action research 'seeks to improve practice through the application of personal wisdom of the participants' (Grundy, 1988, p. 357), with critical reflection being instrumental in the process. In common with technical action research, activities are initiated by a person or persons who wish to change an aspect of practice they have identified and activities are focused on the practice setting within the local context (Grundy, 1988). The input of practitioners is sought at an increased level, as they are encouraged to utilize reflection as a tool to further define the identified problem and subsequently investigate possibilities for action. An expert external facilitator is often engaged to assist in the process of reflection and reasoning (Grundy 1988, p. 358), where language is a central concern. Street (2003, p. 221) posits that this mode (considered by her under the heading of professionalizing action research) has a:

> ...reflective practice perspective and is practitioner focused. Professional problems arise from practice or experience and the group is professionally led with a dynamic style aimed at improvement in practice and on behalf of others affected by the changes.

The engagement of the practitioners in the process of change ensures greater ownership by the group. The intent to improve practice in functional terms is realised as practitioners

evaluate their work by seeing and understanding how it may be informed by social influences (Kemmis, 2001, p. 92). There is an opening up of communication channels as all participants collaborate to solve problems and improve the situation. Unlike communication in technical action research which occurs mostly as the leader directs activities, practical action research is characterised by communication between the leader and practitioners, but also between practitioners as they act to examine the issues in greater depth (Grundy, 1988). Yet ownership of the project is likely to remain with those who have brought the group together, and although there may be improved sustainability of outcomes, it will remain difficult following dissolution of the group or removal of the leader. Practical action research remains focused on change in the local environment, and practitioners do not direct their actions toward external forces.

3.4.4 Emancipatory Knowledge/ Action Research/ Power

Habermas' emancipatory knowledge constitutive interests represent knowledge which is informed by deliberate attempts to address injustice and the inhibitions often associated with tradition. When taken in the context of critical theory Kincheloe & McClaren (2008, p. 282) state that 'those who seek emancipation attempt to gain the power to control their own lives in solidarity with a justice oriented community.' Research with an emancipatory intent therefore aims to encourage practitioners to question, and to examine the experiences of their everyday lives, related to the conditions in society (Wittmann-Price, 2004, p. 439). It follows that within the emancipatory action research framework (Grundy, 1988) there is a central interest in revealing, examining and disrupting the influences and perpetuation of hegemonic power relations.

Reflection remains a central tool and importantly is expanded and underpinned by a critical intent, with a strong focus on overcoming power imbalances. Emancipatory action research is aimed at improving outcomes, improving understandings of practitioners and critiquing work *and* work settings (Kemmis, 2001, p.92). Significantly, as well as focusing on individual practice, emancipatory action research is also outwardly directed toward the social systems (Grundy, 1988, p. 358). The use of such a method allows for 'a consciousness raising, bottom-up approach designed to allow the problem

definition to develop and be addressed as awareness grows' (Street, 2003, p. 321). A range of strategies are utilised in critical action research to realise an emancipatory intent.

3.4.5 Dialogue, Critical Reflection and Collaboration

Implementing an agenda that facilitates critical reflection, collaboration and dialogue is essential to enact an emancipatory research approach. For the most part involvement in action research requires participants to engage in collaborative encounters. Whilst individual practitioners may also engage in dialogue and critical reflection which is external to group activities, collaboration of the group members is instrumental in realising the intent of the critical agenda.

3.4.5.1 Collaboration

In undertaking a participatory action research there is a central intent to enter into a collaborative process. Key to the approach is the desire to undertake inquiry where knowledge is generated through collaborative communicative processes (Greenwood & Levin, 2008, p. 72). Yet collaboration is hard to define and rests with the individuals and the group involved. Perhaps as Gray & Wood (1991, p. 4) suggest collaboration is a process whereby those who come together can explore differences and come to an understanding as a group, which goes beyond individual versions of what is, and what is not possible. Gelling & Chatfield (2001, p. 6) claim research collaboration can be understood as inclusive of concepts such as contribution, communication, commitment, consensus, compatibility and credit. Within the framework of this research endeavour collaboration occurs as practitioners engage in a process of what Kemmis & McTaggart (2003, p.385) describe as working together in reconstructing their world.

The coming together of practitioners to form an ARG with a focus on examining and changing practice to improve care to persons with COPD, may also be understood under the rubric of Habermas' theory of communicative action (1990). In coming together to critically appraise practice, in the first instance, participants who form the ARG enter into processes 'of reflective argumentation' in the context of an encounter where their 'needs and interests are themselves open to discussion and transformation' (McCarthy, 1990, p.

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xi). At the outset of this research project the participants came together, as McCarthy suggests, with a shared willingness to examine as a group how their practice and actions on the hospital ward had been shaped through socialisation within a medical and organisation milieu. McCarthy (1990) further notes in his discussion of communicative action, that whether a norm or taken for granted way of making sense of a situation is justifiable cannot be determined monologically. Rather is must be discursively tested to establish the truth of any claims to fairness (McCarthey, 1990, p.xii). Here McCarthy highlights that through collaboration, in the context of this project through the discursive encounter of an ARG, it is possible to make the movement from 'individual consciousness', as knowing, toward 'a reasoned agreement...done publicly'. However caution is required to ensure that such activities do not only involve one individual convincing another of their correctness. As Habermas (1990, p. 134) argues:

> Agreement cannot be imposed or brought about by manipulating one's partner in interaction, for something that patiently owes its existence to external pressure cannot even be considered an agreement.

Agreement which is secured though collaboration, is the means by which practitioners can arrive as a 'shared interpretation of the situation' (Habermas, 1990, p. 134). According to Carr and Kemmis (1986, p. 147) shared interpretation is bounded by the criterion:

> ...that insights achieved must be authentic for the individuals involved and communicable within the group (that is, that they are mutually comprehensible).

The role of dialogue in collaborative efforts of the group is a means to reach such understanding.

3.4.5.2 Dialogue

The work of Paulo Freire (2005) is derivative of critical social sciences and has been drawn on extensively in the action research literature because of his focus on addressing oppression in the third world. Freire offers useful insights into examination of dialogue and the role of dialogue in the social world. He describes 'dialogue is the encounter between men [sic], mediated by the world, in order to name the world' (2005, p. 88). The power of the word in both its written and spoken form is a primary determinant in how we experience ourselves and others within the world, and how we interpret those experiences (Crowe, 1998, p. 339). Hence there is a need to enter into dialogue in order to understand

the current construct of acute care nursing as it related to care provision to persons admitted to the ward with COPD.

Nursing practice is recognised as having an inherently oral nature and as such the importance of dialogue in exploring nursing has been highlighted (Street, 1991, p. 5). Aranda & Street (2001, p.797) argue that within participatory research, dialogue brings multiple voices to the encounter which facilitates a greater understanding and enhancement of nursing knowledge in the particular area of enquiry. As such there is a recognition that nurses benefit from engaging in a dialogue of their experiences of practice. Walker (1995, p. 156) suggests through engaging in dialogue or what he calls sharing stories, nurses can develop 'an incredible chronicle of experience that comes to expression in the everyday stories we share'. Similarly Koch (1998, p. 1183) argues that 'stories can make nursing practice visible', and the often personal, emotional stories of everyday life as a nurse, can expose nursing work where core activities are often taken for granted and undervalued. In this sense sharing stories of practice or engaging in a dialogue around practice issues can open up opportunities to expose taken for granted understandings. In the context of this research, the dialogic encounters of the research group members that took place in the environment of the research meetings opened up opportunities to develop narrative accounts of their practice in providing care to people with COPD nursed on the ward. Such dialogic encounters worked to, as Aranda & Street (2001, p. 797) suggest, challenge 'simple interpretations of the practice experience of nurses' and give voice 'to the complexity surrounding their everyday interactions with patients'.

Similarly the importance of engaging in dialogue in order to interrogate a situation prior to undertaking action is further highlighted by Tucker, Edmondson, & Spear (2002). They argue that as frontline workers in health care delivery, nurses are used to being reactive and act quickly to fix problems which hinder effectiveness in care delivery, yet in doing so nurses may fail to recognise broader need for change at the systemic or organisational level (Tucker et al., 2002, p. 123). Involvement in this study gave the research participants the chance to disrupt a reactive approach to problem solving and take

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carefully planned action on the background of improved understanding of the issues they faced.

Returning to Freire's theory is useful here as he explains dialogue is made up of words, and within the word we find two dimensions; reflection and action. The dangers of engaging in only reflection or action are highlighted (Freire, 2005) as he cautions against engaging in dialogue for the sake of it. Dialogue without action, he argues, 'can become idle chatter... [which is] an alienated and alienating blah' (Freire, 2005, p. 87). Yet at the same time Freire also argues if practitioners emphasise action depriving dialogue of reflection they are in danger of activism or 'action for action sake'(p88), such as that described by Tucker et al (2002) which involves assuming a reactive position. In the context of this research nurses participating in the project were engaged in a dialogue about their practice, and the context of their practice, with the aim of initiating change aimed at improving the care received by people with COPD nurses on the ward. Integral to this process was engaging in a dialogue about their practice and critically reflecting on the issues raised.

Freire argues that if dialogue contains elements of action and reflection, then a true word exists, and there is no true word that is not at the same time a praxis' (p. 87). Kemmis & Smith (2007, p. 4) note praxis is a particular kind of action, when they state:

> It is action that is morally-committed, and oriented and informed by traditions, in a field. It is the kind of action people are engaged in when they think about what their action will mean in the world. Praxis is what people do when they take into account all the circumstances and exigencies that confront them at a particular moment and then taking the broadest view they can of what it is best to do, they act.

During this study practitioners had an opportunity to meet, to stop and take time out of a busy world of practice to 'interrupt what they were doing' to explore and interrogate their world through dialogic encounter. Having the opportunity to share stories from practice, has the potential to open up a space where nurses can explore nursing work in ways that might challenge taken for granted assumptions and in the process inform any action they might take to improve the care received by their patients with COPD. Habermas (1990, p.158) terms this as 'argumentation', which is realised when practitioners come together

and use dialogue together with critical reflection to develop new understandings of 'the rights of norms of action'.

3.4.6 Critical Reflection

As outlined previously, a key process in the development of praxis is critical reflection. Street (1991, p. 5) claims that within nursing reflection on practice aids in personal and professional growth which in turn aids the development of the discipline of nursing. It is argued that through critical reflection individuals can examine the ordinary, taken for granted aspects of their professional activities and interrogate what has become accepted and routine (Stringer, 1999, p. 203). Such examination requires practitioners to consider their personal beliefs, assumptions and knowledge, 'pitting narratives against the scientific knowledge and claims, ethical and value standards...' (Kim, 1999, p. 1208). In this project acute care nurses had the opportunity to critically reflect on their practice of providing care to people with COPD nursed on the ward and to draw on these reflections to inform the development of action plans aimed at improvement. Critical reflection also opened up a potential for the participants in the research to bring to the surface 'contradiction between what they intend to achieve within any situation and the way they actually practice' (Johns, 1999, p. 242). Within an action research context, such reflections facilitate the participant's deeper engagement in the process of developing meaningful and sustained interventions.

The central place of critical reflection within the action research process can be understood by examining what may be accomplished. Edwards-Grove & Gray (2008, p. 86) document how reflective practice may provide capacity to construct knowledge of a profession, assisting in the movement toward praxis. Of importance to this research critical reflection as a strategy to support praxis can:

> ...create a space that assembles the individual and collective thinking required to reframe and progress action in a sound and morally right manner (Edwards-Grove & Gray 2008, p. 87)

Such is the impact of the approach that as critical reflection is used to peel away the layers of a problem, practitioners uncover new understandings which in turn may lead to further

problem redefinement. Freire (2005, p. 88) relates such a step to the ability of humans to name the world, which 'in turn reappears to the namers as a problem and requires of them a new naming'.

In the context of action research, activities which relate to critical reflection are visible across all stages of the process. In this project the participants had the opportunity in the context of their work within an ARG to critically reflect on their knowledge, the interests which inform their knowledge on action undertaken, the effects of action and how their activities were situated within the broader construct of their work and the social world, that is the hospital ward (Grundy, 1988, p. 360). Quite simply they started by asking what they knew and how they knew it (Street, 2003). In opening up such a space for dialogue and critical reflection within the broader collaborative rubric of a critical social sciences framework, opportunities for enlightenment, empowerment and emancipation emerge.

3.4.7 Enlightenment, Empowerment & Emancipation

The work of Carr and Kemmis (1986, p. 146) is useful to consider the processes of critical research agendas and the relationship to enlightenment, empowerment and emancipation, which are considered key concepts in action research. Enlightenment is defined by the Macquarie dictionary (2005) as 'instructed; well informed; not bound by prejudice and superstition'. Within the context of this study new understandings which are well informed (though critical enquiry) and reached though consensus of the group (collaboration) are the key factors in enlightenment. Indeed 'the processes for the organisation of enlightenment' are described by Habermas (1974, p. 32) to include unimpeded group communication and the application of critical intent aimed at achieving 'authentic insights'. Kemmis (1988, p. 36), claims that such processes are embedded in ARG activities as practitioners enter into dialogue and critical reflection as a 'community of enquirers'. Nevertheless enlightenment is not fixed, but subject to the ongoing interrogation of group members and tested through further dialogue (Carr & Kemmis, 1986, p. 146). Within the context of this study participants had a focus on a critical

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exploration of the practice setting, and sought to examine the 'ideological' interests which informed their practice.

As participants explore and identify ideological interests which underpin and influence their everyday social setting, they are able to expose taken for granted or hegemonic ways of being and operating as acute care nurses. Understanding how practice is 'culturally inscribed and historically situated' (Kincheloe & McLaren, 2008, p. 406) is aimed at not only exposing hegemonic power interests but moving toward liberating 'communities of enquirers from the dictates of tradition, habit and bureaucratic systemisation of individual experiences' (Kemmis, 1988, p. 36), and in doing so realising the emancipatory intent of the research.

Those who search for emancipation 'attempt to gain the power to control their lives in solidarity with a justice oriented community' with a focus on exposing those forces that compromise the ability of people to make decisions that will have a crucial impact on their lives (Kincheloe & McLaren, 2008, p. 409). Caution is required however as Kincheloe and McLaren (2008) highlight one can never be fully emancipated from the socio-political context. The search for emancipation in this study is appropriate as it allowed the involved acute care nurses to develop a critique of organisational structures that shaped the ways in which they worked. Greater understandings of ideological power structures and the ways in which they are operationalised to maintain the status quo assists practitioners to move to achieving feelings of empowerment to undertake change to address injustice (Habermas, 1974).

Yet empowerment is difficult to define and in some ways it is easier to define the absence of empowerment (Fulton, 1997, p. 533). Manojlovich (2007, p. 14) suggests empowerment 'enables one to act, whereas power connotes having control, influence or domination'. But empowerment cannot simply be provided to participants through their involvement in the action research process, nor is it something which can be done for or to someone (Lather, 1991, p. 5). Lather (1991, p. 4) argues empowerment can be understood as a process which sees individuals engage in a process of:

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>...analysing ideas about the causes of powerlessness, recognizing systemic oppressive forces , and acting both individually and collectively to change the conditions of our lives.

In the context of this action research project empowerment is not only viewed as the changes which are enacted by the group members as they move forward with a change agenda, but also the research process itself (Glasson et al., 2006; Sturt, 1999). It was intended at the outset of the research that the involved acute care nurses in the group would participate in the ARG eventually taking control of the direction and ongoing cycles within the research. The processes which underpin emancipatory action research endeavours are intended to ensure that power resides 'wholly with the group, not with the facilitator and not with the individuals within the group' (Grundy, 1988, p. 363). Yet as Grundy further advises the research approach may include shifts between types of action research reflecting changes in power relationships within the group (p. 363).

3.5   Stages of Action Research

The process which practitioners entered into at the outset of this research is diagrammatically represented in Chapter One of this thesis and commences with A reconnaissance followed by cyclical actions of collecting analysing and reflecting on data prior to replanning (Street, 1995).

3.5.1 Reconnaissance

Reconnaissance describes a phase within participatory action research where group members participate in activities to fully understand the situation, and in many cases findings from such activities can assist refinement of the research question (Street, 1995, p. 224). During reconnaissance researchers seek to 'enact an approach to inquiry that includes all relevant stakeholders in the process of investigation' (Stringer, 1999, p. 38), and in doing so will cast the net wide, exploring the current situation. Group members frame the activities which will inform action by utilizing their own 'experiential understandings' (Wadsworth, 1991, p. 3) as a starting point. In this project the reconnaissance is reflected in the ARG members meeting to explore their issues and concerns with provision of care to people with COPD on the ward. Even at this embryonic stage, where it is conceivable that the initial problem identified may not be the

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problem the group will address (Street, 1995), the value of critical social science approaches are evident. The group members must critically explore what they know on the subject, how they came to know it, and the knowing of others (Stringer, 1999). They may also start to explore the impacts of systems on the problem under consideration (Kemmis, 2001). In doing so it is possible to identify what they do not know, or whose perspective they have not considered.

3.5.2 Action Cycles

Completion of reconnaissance marks a point where the group will embark on planning action to address identified concerns. Action cycles are not necessarily discrete or separate entities, but may be occurring simultaneously and contain sub cycles (Street, 2003, p. 226). Although the processes are not linear it is useful to understand action research through the action research cycle diagram. The cycle includes planning, action, analysis, and reflection before re-planning and entering another cycle (Kemmis & R. McTaggart, 1988; Street, 1995). Each step may be interrelated and often overlaps with others (DePoy, Hartman, & Haslett, 1999, p. 562; Kelly, 2005, p. 71). Kemmis & McTaggart, (2003, p. 563) also note the group who are engaged and directing the action plans will need to use overall monitoring to maintain a clear vision of their plans. As Stringer (1999, p. 19) notes:

> ...although there may be many routes to a destination and although destinations may change, participants in the journey will be able to maintain a clear idea of their location and the direction in which they are heading.

The steps comprising an action cycle are described below, but specific methodological issues within each cycle are addressed later in Chapter Four.

3.5.2.1 Planning & Taking Action

An orientation toward action within this stage is based on group members' analysis of the reconnaissance where the group begin by asking 'what is to be done?' (Kemmis & McTaggart, 1988, p. 65). On the background of the initial critical exploration and information seeking, group members have an increased collective understanding of the issues and also of what is possible within the constraints of the situation (Kemmis

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&McTaggart, 1988). Action plans are formulated to address these issues taking into account the objective and subjective considerations, and constraints (Street, 2003, p. 225). The planning component requires the putting in place of the plans that have been developed, however as Stringer (1999) cautions this is not a simple process and requires complex interplay of personal commitment and collective action. The action plan is 'future oriented' (Street, 2003:225) and includes what will be done, what the expected outcomes are and the means by which these outcomes will be assessed.

3.5.2.2 Observing/ Data Collection

During the observation stage, evidence and data is collected related to the action under consideration. The nature of action research requires the process to remain flexible in order to ascertain positive and negative effects of each cycle (Street, 2003). A mix of techniques may be utilised including qualitative and quantitative approaches in order to ascertain outcomes, including institutional data, questionnaires, interviews and focus groups (Street, 2003; Stringer, 1999, p. 57). However the data gathered must be always be considered in light of relationship to action and context in which it occurs (Kemmis & McTaggart, 1988), and must be carefully planned by the group in order to accurately inform their analysis of action plan outcomes.

3.5.2.3 Reflection/Analysis

As Kemmis & McTaggart (1988, p. 86) highlight during collection of data to measure outcomes of action it is difficult not to undertake some analysis, yet they urge the researchers to 'keep a firm rein on ...tendencies to speculation' and to produce a 'reliable account...to use as a basis for reflection'. The role of critical reflection has been discussed earlier in the chapter, and in the action research cycle encapsulates a step where the group analyse, synthesise, interpret, explain and draw conclusions' (Kemmis & McTaggart, 1988, p.86) from the data prior to replanning action in the light of further informed understandings.

3.6   Ethical Considerations

Undertaking and designing action research projects raises ethical issues which are more complex than those within more traditional research (Nolen & Vander Putten, 2007, p. 402). In particular issues of choice, anonymity, respect for co-researchers confidentiality, and detail about the permission gained to access the research site are considered.

Prior to undertaking research in practice areas permission from direct and indirect managers responsible for that area is required. Such permission is sought on the grounds that activities undertaken by the ARG may have ramifications for the organisation and will potentially affect care provided on the ward, for which the managers are held accountable. However in seeking permission and support from managers it must be recognised that potential participants approached to be members of an ARG may find it difficult to decline when the research has been approved and encouraged by senior staff (Lofman, Pelkonen & Pietila, 2004, p. 334). The consent processes described further in Chapter four take into account such influences and how the choice to participate or otherwise was offered to practitioners. The information and consent processes also included discussion of anonymity of participants.

Lofman et al (2004, p. 335) note the degree to which anonymity can be assured within action research is complex and multifaceted. There is a recognition that within the ward environment, and for those who read the research who come from that environment, the identification of individual members is possible despite the provision of pseudonyms. Indeed as Zeni (1998, p. 15) notes, anonymity is problematic in action research and at times the publication of research requires changes of participant description in order to protect the identity of individual members, but with minimal impact on the reporting process. This may be necessary when a role could have only been carried out by one individual (Lofman et al, 2004, p. 335), such as a nurse manager. In this project members of the ARG accepted that their participation in the research was known by their colleagues on the ward, and so within this thesis some characteristics of individual participants have been omitted to protect their anonymity.

Confidentiality also requires ethical consideration in the conduct of action research. A breach of confidentiality can be understood as Nolen & Putten (2007, 403) describe as 'failure to maintain the security of data that may identify individual participants' and can occur at any stage of the research. Steps were taken in the conduct of this research project to ensure confidentiality, which included the secure storage of identifiable data and briefing ARG members on the importance of maintaining confidentiality regarding the discussions that took place within the group. In this manner it was both researcher and ARG members who held joint responsibility for maintaining confidentiality. While, ethical considerations when undertaking action research are the primarily the responsibility of researcher, in order to facilitate ethical conduct in keeping with recognised standards, it was important that the ARG members were fully informed and cognisant of ethical requirements.

3.7 The Research Encounter

In action research, the researcher working with the research participants works as a member of the group rather than leader or expert. However as Kemmis & McTaggart, (2005:569) note the role of the researcher is sometimes problematic. They note that often the researcher, also referred to as the facilitator, lapses 'into the role of "process consultant" with pretensions or aspirations to expertise about a "method" of action research' (p. 569). Titchen & Binnie (1993, p. 859) caution that if the researcher remains 'outside' the group seeking to effect change, the likelihood of sustained success is negatively affected. The researcher must therefore make known their interest and investment in the group together with the knowledge of what they hope to achieve (Avison, Lau, Myers, & Nielsen, 1999, p. 96; Wadsworth, 1991, p. 10, 2001). Yet the process of disclosing or making known the researcher's personal interests should not dominate the direction of the group. In the same way that other participants' in the group may share their background, reasons for involvement and their aspirations for the research, so should the researcher. Further, as Coghlan & Casey (2001, p. 680) note, the researcher who has prior knowledge of and involvement in the research setting, needs to remain cognisant of the strengths and limitations that accompany this experience and be

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able to draw on their experiential knowledge to consider their understandings of the situation under investigation. Wadsworth (1998, p. 11) states:

> The participating researcher, having identified the interests they wish to pursue, can see (and be seen in) their relationship to the critical reference group [action research group], and pursue more consciously and sceptically, alternative formulations of the situation.

In this sense as the project unfolds the researcher will be learning throughout the process and is in many respects on a shared journey with the other members of the research group.

3.7.1 Group Members

Wadsworth (1998, p. 7) claims that it is not possible to do social research without the participation of other human beings. Enacting a critical action research framework requires 'dissolution of the distinction between researcher/s and 'researched for'' (Wadsworth, 1998, p. 10). Within the action research paradigm it is critical to involve the researcher and the members of the research group in a manner that all have input to processes along the journey. The elements of dialogue, critical reflection and collaboration discussed earlier indicate the need for participation. The practitioners as a group drive and shape the research, and are involved in problem definition, creation of action plans, assessment of those actions and critical reflection. The distance between researcher and practitioners is purposefully minimised (Nolan & Grant, 1993, p. 306), the participants becoming co-researchers on the project.

3.7.2 Measuring Change

The means in which change or improvement in the practice of acute care nurses who entered into this action research project might be measured is further based on the work of Kemmis and McTaggart (1988, p. 25) who argue action research allows us to build records of improvement. Careful attention to recording the process of the research as described and the use of a research journal to assist in further identifying change, will provide evidence of what has been done and how that has helped created a 'developed, tested and critically examined rationale' (p.25) for action undertaken. The records of

improvement described by Kemmis and McTaggart (1988, p. 25) as the research evolves include monitoring of changes in:

> ...*activities and practices*...changes in the *language and discourse* in which we describe, explain and justify our practices...changes in the *social relationships and forms of organisation* which characterise and constrain our practices, and...development in our mastery of action research [their emphasis].

As such the work of Kemmis and McTaggart provides a conceptual framework for measuring change in this study. Over the course of the research attention has been paid to monitoring:

- Changes in nursing practice as they relate to provision of care to persons with COPD;
- Changes in the language used to describe, identify and analyse issues faced in care provision to persons with COPD which lead to development of new understandings and insights into practice;
- Changes in social relationships at a group and organisational level;
- The degree to which the members of the research team develop their 'mastery' of action research.

Monitoring of changes described above whilst group members engaged in the process of action research, commencing with reconnaissance and moving through to action cycles to improve care is intended to allow analysis of improvement to be undertaken at the conclusion of the research.

3.8 Summary

The methodological approach of action research described in this chapter is identified as an appropriate conduit through with to engage acute care nurses in a collaborative investigation of their practice aimed at improvement in care provision to persons with COPD. Despite the complexity of action research when applied in practical situations the work of Kemmis & McTaggart (1988) and Street (1995) provide a flexible structure for engagement and include a conceptual framework for measuring change. Prior to moving to the reconnaissance undertaken by the research team, a description of the research setting is provided with the research design in the following chapter. The research design articulates a three stage structure which is intended to further facilitate engagement and empowerment of acute care nurses in the research process.

4   Setting & Research Design

The practice setting where this study takes place was, like action research projects described within the preceding chapter, inherently complex. Acute care settings are constantly churning with the activities of individuals and groups who occupy the setting as providers of health care, together with individuals who seek the services of those providers. In order to assist understandings of the research contained within this thesis an overview of the ward and hospital setting is provided. A general description of staffing structure and profiles, as they relate to patient management and flow, are provided as a background to the ARG structure and study design in order to 'set the scene' for the remainder of the thesis.

4.1   The Research Setting

The location of the research was a ward which was part of an acute care hospital. Consisting of approximately 400 beds, the facility fulfilled the role of tertiary referral centre for the state. Specialist services including cardiothoracic surgery, neurosurgery, high risk obstetric care, neonatal intensive care, and burns management were all provided in the hospital, together with more general services including medical and surgical wards. Divided into multiple wards and areas, the hospital served multiple health care needs of the community, broadly under the areas of medical, surgical, and women's and children's health. Further, as the tertiary referral centre, the hospital was also a site which provided opportunities for clinical placement to undergraduate and postgraduate students across a range of healthcare disciplines, including nursing, medicine and allied health.

The research was situated in one of the four medical wards located within the facility which provided in-patient care to general medical patients, including those under the care of respiratory physicians. The ward consisted of twenty beds and the layout included six single rooms, one two bed room and three four bed rooms, a nurses' station and a reception area, together with further areas for storage and cleaning.

4.1.1 Patient Group

Patients admitted to the ward were intended to be admitted under the care of either general medical team 'F' or respiratory team consultants. As such the ward was considered the 'home ward' of these units. However patients within the ward were often admitted under other teams, especially in times of high demand. In common with other hospitals, the facility experiences times of demand, when such issues as 'bed block' and bed shortages occur (Proudlove, Boaden, & Jorgensen, 2007). As a result, patients who would normally be admitted to an identified 'home' ward were admitted to other wards according to bed availability. They were then known as 'outliers' and whilst hospital managers attempted to transfer patients to their 'home' ward as beds became available it was well recognised that at any given time there are outliers present within the system.

During the period of time whilst the research was conducted the closure of one ward in the hospital resulted in an increased number of outliers within the research ward. Conversely as the number of outliers present on the ward increased so did the need for the ward's patients to become outliers on other wards. The end result was all wards had a mix of both home and outlier patients with multiple patient moves occurring daily between wards in an effort to alleviate the problem. It was a multifaceted problem which was compounded by a variable daily demand for inpatient beds.

4.1.2 Medical Team

There were thirteen general and specialist medical teams who admitted patients to the wards within the hospital. Patients with COPD were ideally admitted under the respiratory team, but such a step was not supported by hospital policy, so at times they would be under the care of general medical teams. Within the COPDX guideline (McKenzie et al., 2003, p. S13) a number of circumstances are listed which highlight the need to refer to respiratory physicians, including recurrent exacerbations, but the document contains no recommendation for which group of physicians should provide hospital care.

The team of physicians providing inpatient care included layers of consultant, resident, registrar and interns. Consultant physicians were associated with a team for extended periods of time with little movement between teams. Registrars, resident and intern physicians rotated across teams at intervals which ranged from three to six months. After hours coverage when patient review was required was primarily undertaken by interns (patients under general medical team) or by the medical senior (respiratory patient review). Further after hours support could be requested by interns and medical seniors through communication with consultants or more senior physicians. Whilst a 'home' team of physicians held primary responsibility for an individual patients' care, a range of other physicians may also review their condition during the admission. The number of physicians involved in the patients care increased significantly if the patient condition was such that it required review outside normal working hours.

4.1.3 Nursing Team

The nursing team was led by the Clinical Nurse Manager (CNM) supported by up to five full time, level two registered nurses. Level two nurses are registered nurses who, as the more senior nurses on the ward, are able to demonstrate and advanced practice within the area which they work. The scope of practice for level two nurses included supporting and filling in for the CNM when she was on leave, taking on additional roles (for example acting as manual handling or resuscitation resource nurse for the ward), and providing support and guidance to other nurses on the ward through preceptorship. A further 24 nurses also worked on the ward and were a combination of level one registered nurses and enrolled nurses (with and without medication endorsement). At the time of the research there was 30 staff in total, working a range of part time and full time positions. The number of staff together with the age and gender of staff fluctuated with the churning nature of the ward which was often in a state of flux.

At the time research commenced on the ward, reflective of the wider nursing shortage, two level two positions remained unfilled and there were other nursing positions also vacant. One member of the nursing team worked permanent full time nights, all others worked a combination of full and part time rotating shift work including night shift.

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Nursing staff on the ward held varied levels of experience ranging from graduate nurse level to many years of post graduate experience. Student nurses, both Bachelor of Nursing and enrolled nurses were also accommodated within the unit several times over the year.

Shift times included nights (from 10pm-8am) morning (7.30am-4pm) and afternoon (2pm-10.30pm). Management of morning shift was co-ordinated by the CNM, who had a limited clinical role. She was supported by a shift leader, who was to oversee clinical care, whilst other nurses were allocated patients according to acuity. The shift leader had primary responsibility for overseeing patient care, troubleshooting any care issues, and collaborating with the bed management unit and roster office. Normal staffing consisted of six nurses working on a morning shift, five during the afternoon and two overnight, with the possibility of a third night shift nurse member if patient acuity was high. The CNM and nursing staff on the ward were provided further support through a structure which included the central roster office, (responsible for allocation of staff required in addition to ward staff), co directors of nursing (aligned to the medical wards) and after hours nurse managers (also aligned to medical wards).

4.1.4 Other Team Members

During day to day activities of the ward specialist nurses were also available to assist with patient care and advice. They acted in a consultant role across the hospital site and were available to assist and to offer advice pertinent to their area of expertise. Specific specialist nurse positions were allocated in the areas of urinary continence, respiratory, psychiatric liaison, wound care, phlebotomy, stoma, enteral feeding, aged care and vascular access.

In addition to specialist nursing roles the allied health team members also provided support and consultancy to patients with COPD on the ward. Allied health team members providing services to the patient group with COPD can be considered as two groups, those with frequent interaction and those who may have intermittent interactions as follows:

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Frequent	Infrequent
Physiotherapist	Podiatrist
Occupational therapist	Pharmacy
Dietician	Grief and Loss Counsellor
Social Worker	

Table 1: Allied Health Professionals available for consult to patients and carers admitted to acute care with COPD.

Allied health members were assigned patient groups according to either a specific ward location or associated with medical units. In common with members of the medical team, allied health staff also changed their assigned patient group at time periods which varied from three to six monthly. Minimal after hour availability of allied health team members was provided, physiotherapy being the exception. Physiotherapists were primarily available outside normal working hours to provide consultations to patients at high risk of respiratory disease (e.g. those ventilated within the intensive care unit). Like other health professionals in the hospital, allied health teams were experiencing staff shortages with unfilled positions, adding a further layer of complexity as individuals were asked to cover specific areas over periods of time. Demonstrating the impact on practice, it was not unusual for allied health team members to be carrying two or more pagers, representative of the requirement on them to provide consultations and responses to multiple areas.

In effect, the manner in which allied health team members were allocated patient workload, together with staff shortages led to scattered service provision. For example, although a patient would essentially be seen by a single occupational therapist, the patient group on the same ward may be serviced by multiple other occupational therapists according to their allocated medical unit. As such multiple allied health team members may be present on any one day on the ward. Allied team members would see any patient who had been referred by medical or nursing staff on the ward. Regardless of who was actioning the referral process, there was a requirement to identify the allied health team member who was assigned to the medical unit the patient was under, complete a paper referral, and phone or page the allied health team member to highlight that a referral was made.

4.1.5 Multidisciplinary Structure

Multidisciplinary care on the ward was intended to occur through a number of avenues in addition to assessment and care provision by individual disciplines, and included communication between individuals and more formally, multidisciplinary meetings. Multidisciplinary meetings were held on the ward for identified 'home' medical teams, with 'outliers' to the ward, also discussed at the meetings. It was normal practice for attendees to include the different layers of the medical team, clinical nurse manager, physiotherapist, occupational therapist, dietician, pharmacist, and social worker with the possible addition of specialist or ward nurses. For example, the specialist respiratory nurse attended the multidisciplinary meeting led by respiratory physicians, but not the Med F meeting. Most patients were discussed at multidisciplinary meetings, however those who were admitted, for example on the day of, or day after meetings, were less likely to have their case discussed as they may have been discharged between meetings. Hence their multidisciplinary care relied on personal or written communication between individuals.

4.2 The Research Group

The research participants consisted of the ARG members. At the inception of the research eight nurses from within the unit expressed a desire to participate in the ARG. The rotation of allied health team members through the ward on a 3-6 monthly basis meant they were unable to join the group as they would be rotated out of the area and so could not commit to what was envisaged as an eighteen month project. There was an understanding at this time that nurses within the group would co-opt other health professionals within the unit as necessary to facilitate the project. Yet despite such planning, disruptions to membership of the ARG occurred, mainly as a result of unforeseen changes to nursing staffing on the ward. Over the period the research was undertaken eleven individuals participated in the ARG to varying degrees.

Group members left the research group for varied reasons including work dissatisfaction, personal circumstances and life changes. While most left the workplace altogether; there were also individuals who undertook extended leave, but unfortunately did not rejoin the

ARG when they returned. The momentum of the research was interrupted by the variable group membership and group stability became a major issue over the course of the research. Following reconnaissance the ARG members even considered abandoning activities, because of the difficulties with attendance by all members. Yet they were able to continue by expanding membership in the final stages of the research to include a specialist nurse and a physiotherapist. Inclusion of a physiotherapist was made possible by a management decision (not related to ARG) to appoint a respiratory physiotherapist for a period of twelve months.

ARG membership, including the changes which occurred over time, is presented in table two, with meeting schedule and cancellation data. Group members are referred to by pseudonyms. As demonstrated, two participants (Carla & India) remained engaged throughout the entire period of the research endeavour, although one experienced significant sick leave during the time the group was active (Carla). Engagement was varied and included members who initially volunteered and never attended (Barry), those who volunteered but did not engage in group activities until much later (Dave), those who joined late (Jess, Fred, Henry & Greta), and those who joined but subsequently left the ward or went on leave (Anna, Barry, Emma, Greta & Kate).

It was planned at the outset of activities to undertake meeting fortnightly or twice a month and the numbers of planned meeting indicate this intent (table two). Table two also provides information of meetings actually held and cancellations. Approximately forty meetings were planned at the outset, although specific dates and times were not identified. Twenty one meetings took place over the course of the research and over twenty six cancellations also occurred, illustrating the difficulties presented by the acute care setting on the capacity of a group like this to meet regularly. At times when the group could not meet as planned alternate days were identified, yet may also have been subsequently cancelled. Hence the number of cancelled meeting as times exceeds the number of planned meetings.

Participant	Years on ward	Time since qualification	Total No of meetings attended	STAGE		
				Setting Up and Researcher Facilitated Process February 2006- January 07 **Meetings:** Planned: 26 Held: 9 Cancelled: 23	**Emerging Empowerment** February 2007- May 2007 **Meetings:** Planned:10 Held:6 Cancelled: 3	**Empowerment to Action** June 2007- September 2007 **Meetings:** Planned:8 Held:4 Cancelled: 4
				Number of meetings attended by participant in stage one.	Number of meetings attended by participant in stage two	Number of meetings attended by participant in stage three.
Anna	5	7	5	5	0	0
Barry	12	18	0	0	0	0
Carla	5	5	11	5	4	2
Dave	8	8	9	1	5	3
Emma	5	5	5	5	0	0
Fred	1	12	6	2	3	1
Greta	3	1	3	3	0	0
Henry	n/a	8	5	0	3	2
India	2	3	13	6	4	3
Jess	n/a	22	7	0	5	2
Kate	4	4	6	6	0	0

Table 2: Membership & Meetings of ARG by Stage

4.2.1 Ability to Meet

The research meetings were initially held within the ward, following clinical handover, for approximately sixty minutes, when both morning and afternoon staff were present. Traditionally this staff changeover time had been utilised for clinical handover of patient information, ward meetings and in-service education. For these reasons at the beginning of the research, this time was considered ideal. Lack of space within the ward, necessitated the meetings being held in an area approximately four metres square, utilised as a store room and handover area, known by nurses on the ward as 'the cupboard', an appropriate name for the small unventilated store area. Some months into the project this location was changed to facilitate greater focus on research activities (see chapter six for decision making process which underpinned the change). Nurses would (initially) attend meetings if they were rostered to work, and only if they had completed their clinical work for the day. Many meetings were cancelled due to the pressure of clinical workloads, staffing issues and other workplace impacts (for example ward staff meeting taking precedence over research meeting). The group did not formally agree on a quorum for meetings to go ahead, typically if there were three or more members the meeting was audio- taped and transcribed, but if only two members attended it was cancelled. At times when there were only two members attending there would often be an informal discussion, primarily focused on bringing participants up to date or answering questions from the group members who did attend.

ARG members' participation during stage one was highly variable (see table two). The group experienced significant disruption to activities, unpredictable attendance at meetings and activities of the ward setting which always took priority over the activities of the group. In addition to meetings planned and cancelled, attempts to identify additional meeting dates were unsuccessful due to staffing or availability of the members. As an example of difficulties encountered from November 2006 to February 2007 it was impossible to arrange meetings despite a summative paper containing all reconnaissance data being ready to present to the group. Toward the end of stage one I was attending the ward on almost every day of the week, attempting to elicit response to the need for a

meeting. It was clear the viability of the research endeavour was threatened. For these reasons, group members agreed on a different approach to undertaking group activities and decided to engage with data from this stage as a workshop activity, and to concurrently consider the future of the ARG.

4.2.2 Steering Committee

In order to engage other key stakeholders in the research, a project steering committee was established. The key aim of the steering committee, as described within the terms of reference was to support, guide and assist with management of the research process (appendix two). Steering committee members' role was considered as one of support in achieving the broader aims of the ARG, which may have required managerial or medical support. As the patient journey was a central theme and concept within the research, health care professionals from across the hospital care continuum were invited to participate in the committee. The committee was formed in late 2005 and individuals from the following areas were invited to participate.

Primary PhD Supervisor

Respiratory consultant

Student researcher

Clinical Nurse Manager

Senior Physiotherapist

Pharmacist

Discharge Planning Nurse

General Medical Consultant

Members of the steering committee were initially informed that meetings of the group would occur approximately every three months, but that they may be rescheduled depending on the research process and development. During the course of the research the steering committee met a total of six times, for approximately one hour duration. Meetings were at times held more frequently than three monthly, and were triggered, as highlighted earlier, by key issues which emerged such as the impact of the ward events on attendance at ARG meetings.

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The committee steering meetings were also impacted by low attendance rates. Although all invited individuals indicated a desire to be a part of the group, in reality they did not all attend. The steering committee then became a small group consisting of the first five listed invitees who regularly attended and contributed to the steering committee. The research design was progressed once membership of both the ARG and steering committee were established.

4.3 Research Design & Structure

It is important to recognise as articulated in Chapter Three, that action research is not a linear process, as a result the stages articulated in this thesis did not always fit discreetly into a 'box'. Indeed action research has been described as an inherently messy process (Herr & Anderson, 2005) understood as cycles on cycles (Street, 2005). But in order to assist with overall understandings of the research presented within this thesis, three stages are described, with the intent of providing an overview. Data collection strategies which were utilised in the life of the study were varied, and discussed following the overview of stages. Ethics approval was sought and obtained from the Human Research Ethics Committee Network prior to the commencement of the research (ref no: H8418).

4.3.1 Setting up the research [February 2006-May 2006)

As discussed earlier, as a researcher I had a key interest in improving care to persons with COPD admitted to the ward. My interest was further informed by a desire to engage other nurses who were delivering care to persons with COPD to collaborate in investigating their own practice. I believed that the nurses would bring with them 'intimate knowledge of local context' without which Stringer (1999, p. vii) suggests 'one cannot hope to devise solutions to local problems'. The importance of engaging the nurses who were delivering care, in the investigation of their own practice (Street, 2003), was clear to me. This stage involved establishing a group, calling for volunteers, setting up the project, and identifying key issues and concerns.

4.3.1.1 Recruitment

Nursing staff on the unit were initially invited to an information session about the research, and afterwards were asked to indicate their interest in participation. The response was positive and an ARG was formed, consisting of eight persons who had volunteered, although not all whom volunteered actually participated. The group members commenced as research novices, while at the same time being experienced clinicians. Essentially group members first came together with a shared interest, in improving the care provided to people with COPD who were admitted to the ward, which precipitated their involvement with the group. It was, at the beginning of the journey, a research concern which started quite broadly and was to be followed by actions to clarify the key concerns within the group (Street, 2003). The group commenced meeting in February 2006.

4.3.1.2 Consent Process

Each participant was provided with an information sheet and consent form (see appendix three) at the first meeting of the ARG. At this meeting it was also highlighted to the group members that at the beginning of an action research process it is difficult to predict how the research will unfold. This had implications for consent because, as a number of ARG scholars note, without knowing the exact direction the research will take, or which actions will follow, it is difficult to gain informed consent for participation in action research projects at the outset (Meyer, 1993, p. 1069; Sturt, 1999, p. 1062). Gaining informed consent therefore focused on the individual participants' willingness to share in the ARG process as a group journey.

4.3.2 Stage One: Researcher Facilitated Process [February 2006-January 2007]

The initial stages of the projects involved my taking a primary role in engaging the group members in the research process. This involved a number of activities which are outlined below.

4.3.2.1 Group Rules

Initial meetings of the ARG focused on building the group members understandings of action research which included discussions of what participation in the group entailed. Confidentiality was addressed as an important component of the group discussions, as was respect between members, and recognition that all members had a right to speak and be listened to. At the first two or three meetings these ground rules were revisited and highlighted to ensure mutual understanding. It was intended that recognition and application of the ground rules would provide opportunities for the group to participate in open and frank discussion of the issues.

4.3.2.2 Collecting Preliminary Data

During the setting up phase of the research, members were engaged in initial discussions of their concerns in practice, which assisted with formalising the approach they would take in order to build their understandings of care provision to people with COPD. Such a step is known in action research as reconnaissance. As group members considered their own understandings and experiences of COPD care provision they also recognised the need to draw on understandings of other key stakeholders, to undertake a reconnaissance. Hence stage one, consisted of multiple data collection strategies aimed at enhancing group members' understandings of the current situation. The end result was a collection of data informed by views of acute care providers, and community health providers, patients and carers, which were further contextualised by an examination of documentation on the ward. During stage one the primary activities of group members were to continue attendance at meetings and to enter into dialogue with other ARG members about practice. The areas of discussion were framed broadly around their data collection strategies and included patients and carers, multidisciplinary care, community care and an examination of their own nursing practice. Their participation in other data collection strategies was varied, yet predominantly undertaken by myself, as directed by the group. This was necessary because, as clinical nurses, the group had very limited time available, compared to my primary role of support and facilitation of the research. For the same reason, it was I who undertook a first level analysis of all data sources in preparation for stage two. In this sense, drawing on the work and structure of action research discussed by Robinson

(2001), I facilitated the research process and the ARG engagement in the research process during stage one.

4.3.3 Stage Two: Emerging empowerment [February 2007-May 2007]

Stage two encapsulates a time period where the group considered and made sense of the data collected during reconnaissance, further defined the issues and commenced planning for action. To enable engagement and critical reflection on the issues, ARG members were provided with a summary document which contained the analysed reconnaissance data. A mechanism to engage the group within this stage, in the context of the ongoing struggles experienced in maintaining attendance at meetings, was to hold two three hour workshops. It was also during this stage that two new members joined the group. The purpose of situating the meetings outside the work environment was to enable group members to 'step back' from the business of everyday life on the ward and focus on the issues identified as impacting on care provision to persons with COPD. This provided the group with a significant impetus to develop an understanding of the issues, renew enthusiasm for the research, and subsequently develop action plans intended to address key problems identified.

During this stage the group considered the findings of the reconnaissance and took a proactive stance in securing the appropriate time and place in which to do this. During consideration of the findings they began a process of exploring options for action to address the identified problems. In this sense they began to assume a more active relation to the research which was reflective of their emerging sense of empowerment.

4.3.4 Stage Three: Empowerment to Action [June 2007-September 2007]

Such was the impetus provided for action in stage two that during stage three the ARG members assumed responsibility for the direction of the research which followed on from their critical interrogation of issues. They were in effect empowered to build capacity on the ward to deliver a more evidence based approach to care of persons with COPD admitted to the ward. Group members moved forward with implementation of several inter related strategies to support education for less experienced nurses on the ward.

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Central to taking action, five competencies related to key areas of COPD care provision were used as support for an in-service education program. All members of the group had a role in the implementation, and essentially became responsible for group activities. In keeping with the intent of action research, a range of data was collected pre and post action to assess the impact.

4.4   Data Collection Strategies

Data collection strategies varied across stages of the research, with some utilised across all stages and others used as a single strategy. For example I kept a personal/professional journal throughout the entire research process, yet the audit of patient histories occurred only in stages one and three. The following table provides a representation of different strategies used.

Stage	One: Researcher Facilitated	Two: Emerging Empowerment	Three: Empowerment: to Action
Personal/Professional Journal	●	●	●
Audio Taping Meeting & development of case notes	●	●	
PREPARED Questionnaire to community providers	●		
Questionnaire to GPs	●		
Questionnaire to COPD patients	●		
Questionnaire to Acute care nurses			●
Focus Group	●		
Semi Structure Interviews	●		●
Audit of patient notes	●		●
Ward Statistics	●		●

Table 3: Data Collection Strategies Utilised Across all Stages of the Research

4.4.1 Audio Taped ARG Meetings & Edited case notes

A key source of data throughout the research process was edited case notes which were developed from the audio taping, transcription and analysis of the ARG meetings and workshops. As Kemmis and McTaggart (1988, p. 22) suggest the ARG meetings encouraged group members to be 'inquisitive about circumstances, action and consequences and come to understand the relationships between circumstance, actions and

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consequences in their own lives' as clinical nurses. Hence the meetings provided data related to the group's understandings of care provision to people with COPD on the ward. As the research progressed the meeting data also reflected members' deliberations on the identification of key issues and concerns, the development of plans for action; and insights and reflections on actions undertaken. A key intent of the meetings and subsequent case notes was to facilitate critical reflection and as Stringer (1999, p. 90) notes to 'make better sense of their experiences'. As they were returned to ARG members, notes continued to provoke further critical reflection and subsequent analysis of issues by members. There were nineteen meetings held throughout the research process, twelve were audio taped, transcribed and edited case notes returned to the ARG members. When only one or two members of the ARG attended the meeting audio taping was not undertaken and the meeting was conducted in a more informal manner. Information related to these meetings was primarily recorded in my researcher's journal, discussed in the following section.

4.4.2 Researchers Journal

Throughout the study I kept a personal professional journal with the intent of facilitating critical reflection and to assist in the mapping of the research process. The journal functioned as a repository for field notes containing both critical and descriptive accounts of engagement and encounters with the research process. The use of a personal professional journal is recognised as appropriate within action research where an exploration of facets of the researcher's involvement is considered a normal component of the process (Robinson, 2001, p. 100). Furthermore there was intent to lay bare some of the deeper cultural and personal perspectives of my own research engagement and 'to make sense of' what I experienced.

Information contained within my journal was primarily related to events and interactions with others who were also engaged with the research in some form, such as participants, managers, steering committee members and supervisors. I also documented information related to the mapping of the research process. As Holly (1991, p. 4) describes, the personal professional journal is a place to record both objective facts or events and also subjective interpretations. Importantly the reasons why decisions were made, with a focus

on obstacles and adjustment to the research process and reflections on these decisions were also contained within my journal. As Watson (2006, p. 866) notes:

> Starting out as a means to focus on the subjective experience of doing research... the journal became a resource for thinking and paradoxically perhaps, a realization of the processes of doing, writing, and performing research rather than just a reflection on it.

The journal was as Tripp (1987, p. 10) notes 'a valued research strategy', which was used as an adjunct to other means of data collection and analysis. In some circumstances the journal enabled what appeared to be unrelated or insignificant events to be considered as part of the whole research structure. As a consequence critical insights that were developed by me were then taken to the ARG for clarification or discussion.

4.4.3 Semi Structured Interviews

Semi structured interviews were conducted during reconnaissance as part of a larger data set intended to identify key issues impacting on provision of care to persons with COPD. They were also conducted at the conclusion of the research to elicit ARG members' experiences of participating in the research. Semi structured interviews allow all participants to be asked similar questions within a flexible framework (Dearnley, 2005, p. 22). Such an approach was taken in stage one as acute care nurses and other members of the multidisciplinary team were asked to share their experiences and understandings of care provision, using the same questions framework. Underpinning the use of semi structured interviews in this research is a desire to uncover many of the 'assumptions and purposes, feelings and knowledge' (Wengraf, 2001, p. 115) that participants held related to COPD care. Furthermore, as Hansen (2006, p. 99) argues researchers are not bound to ask identical questions of each participant and are able to ask additional questions, as well as respond to any queries from the interviewee. The semi structured interviews used in this study were conducted in a relaxed but focused mode, utilising questioning which encouraged participants to relate any information they felt to be important or relevant to the overall topic in a conversational manner.

4.4.3.1 Stage One Interviews

In stage one, semi structured interviews were held with a number of stakeholders from disciplines engaged in the care of people with COPD on the ward. They included two medical staff, five nurses and four allied health team members. An invitation to potential nurse and allied health interviewees, who were engaged in delivering care to persons with COPD at the time, was extended at existing ward or team meetings. In the case of medical staff, a request was made to members of the team that were directly involved in the provision of care. A consultant and a senior medical officer who had been part of the respiratory medical team responded and took part in the interviews. The overarching intent of these interviews was to collect data which would elicit perspectives of the care provided to people with COPD on the ward. As such the initial question asked of participants was as follows: "What is your experience of care provision to COPD patients within the acute care setting? Further questions are articulated in the table below. These were intended to draw out or build on specific issues.

Topics covered during semi structured interviews stage one.
• What are your concerns regarding the provision of continuity of care for patients with chronic lung disease?
• How could continuity of care for patients with chronic lung disease be improved?
• What issues do you think patients with chronic lung disease face immediately after discharge from hospital?
• What actions do you think you could take to assist in preventing re admission to hospital for patients with chronic lung disease?
• What do you think is the key information required by community nurses to provide continuing care to patients with chronic lung disease?
• What do you consider the positive aspects of providing care to patients with chronic lung disease?
• What do you consider the negative aspects of providing care to patients with chronic lung disease?

Table 4: Framework for Semi Structured Interviews: Stage One

4.4.3.2 Stage Three Interviews

Stage three interviews included three members of the ARG. These interviews were undertaken to interrogate specific issues that impacted on the research in order to add to evaluation of their experiences in the project. The importance of undertaking the

evaluation was highlighted by the fact that this was the first time many of the nurses had the opportunity to participate in research, including the opportunity to discuss and critically reflect on their practice. Areas which were considered are contained within table five below. Participants were encouraged to share their thoughts of what it was like to be involved and discuss what impact they perceived the ARG and actions of the ARG had on the practice setting in both a personal and group context.

Topics covered in semi structured interviews stage three
• What was your experience of being involved in this participatory research project?
• What were the positive aspects of participation in the research project?
• What were the negative aspects of participation in the research project?
• What impact do you perceive the ARG activities had on the practice setting?
• What impact do you perceive the ARG activities had on your personal development?
• What is your understanding of the action research process?

Table 5: Framework for Semi Structured Interviews: Stage Three

4.4.3.3 Consent & Analysis

Prior to participation in interviews, individuals were provided with an information sheet and signed a consent form (see appendix four). The importance of confidentiality and ability to speak openly were highlighted and participants were assigned pseudonyms. Interviews were undertaken at a time and place negotiated with the participants; all took place within the facility, in a space which ensured privacy. Interview times varied between 20-65 minutes and were deemed complete when both the interviewer and interviewee mutually agreed that all discussions had been concluded. The interviews in stage one were coded and are indicated in the text of findings as RN1- RN5, M 1-2, and AH 1-4. Participants interviewed during stage three are referred to by the same pseudonym utilised in the ARG activities.

Interviews were audio taped and transcribed by me, prior to content analysis undertaken with the assistance of NVIVO© software. Content analysis is described as a 'flexible method for analysing text data'(Hsieh & Shannon, 2005, p. 1277), which also encapsulates interpretation of the text content through a process of coding and identifying themes and/or patterns resulting from systematic classification (p. 1278). The

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transcribed interviews were coded initially by nominating single words or phrases which captured an aspect of the experience as a code. Related free codes were later collapsed into larger nodes if a relationship was identified. For example narratives related to allied health were contained under a larger code however may range from such diverse issues as referral rates through to participation within multidisciplinary respect. Analysis also included notes taken during or immediately after the interview process, and notes written during the transcribing which aided in analysis.

4.4.4 Questionnaires

Action research projects often use a range of tools to inform the group of the current situation. Questionnaires were used in this study during stage one and three. During stage one a validated questionnaire was used in order to elicit views of stakeholders in COPD care. During stage three a questionnaire was developed by ARG members to elicit views of nurses working on the ward toward education and support provided to them within the workplace.

4.4.4.1 Stage One Questionnaires

In order to ascertain information related to the patient and carer experience of preparation and discharge from acute care, the PREPARED © questionnaire tool developed by Grimmer and Moss (2001) from the University of South Australia was utilised, with the authors permission, to inform understandings of continuity of care provision. The use and administration of this questionnaire with both health providers and the patient group reflected the initial focus of the ARG members, to improve quality of continuity of care. The authors of the tool claim it 'offers a comprehensive way of closing the quality improvement loop, by providing information from the community perspective on the quality of planning for discharge from the acute hospital setting.' Importantly during its development, the questionnaire underwent testing for validity and application with older patients, the group to which most patients admitted to acute care with COPD belong (AIHW, 2002). Continuing on from their work related to assessing patient and carer readiness for discharge with the PREPARED© tool, Grimmer and Moss (2001) developed further questionnaires related to community provider perceptions of discharge

planning which were also utilised within the reconnaissance component of the research. The questionnaires, in relevant formats were distributed to community providers, patients and carers (see appendix five for example). The process of recruitment, distribution and administration are articulated in table six below.

Group	Recruitment/ Consent	Administration	No. distributed/ Return
General Practitioners 2 large general practices	Via practice nurse at staff meeting. Information sheet provided with questionnaire. Consent implied by return	Completion by individuals and posted back in return envelope provided.	8/0
Community Nurses at 3 sites including: rural & urban government & non government	Information & distribution of questionnaire provided at team meetings Invited by research student to participate Consent implied by return	As above	24/19
Patients	Identified by third party, according to criteria, provided with information sheet. Verbal consent obtained to forward name to research student. Research student met with individuals, provided questionnaire and gained signed consent and telephone number	Completed by individuals on day 7 post discharge and returned in envelope provided Follow up phone call if not returned by day 10 post discharge	38/16
Carers	Carer status identified by research student at initial meeting & invited to participate	Completed by individuals on day 7 post discharge	8/2

Table 6: Questionnaire Distribution Processes & Return Rates

The numbers of surveys distributed and subsequently returned by different groups requires some further examination. Community nurses provided the highest response rate at eighty percent. Response rates by patients (42%), carers (25%), and general practitioners (0%) were much lower. Whilst the reasons for non response may only be known by those invited there is recognition that GPs generally exhibit low response rates to questionnaires and remain a difficult group to engage (Barclay et al., 2002; Templeton et al., 1997). Response rates of lower than 50% are generally considered poor, and results are

understood to effected by bias related to those who are more or less likely to respond (Streiner & Norman, 2008, p. 102). However in this study, where the surveys formed one component of data collection, results were considered critically by ARG members in light of response rates and other data. Hence it was important to take into account the low numbers of respondents when considering findings.

4.4.4.2 Stage Three Questionnaires

As part of action cycle four undertaken in stage three, ARG members developed a questionnaire to be administered to acute care nurses who participated in the in-service education program, an intervention designed and implemented by ARG members. The evaluation questionnaire developed by the group focused on three ward areas, provision of education and professional development; support for education and professional development, and self ratings of knowledge, skills and confidence in areas of COPD care (see appendix six). Following development by the ARG members, the questionnaire was reviewed by the steering committee, and members of the Quality Improvement Unit at the hospital who had expertise in questionnaire development. Small changes were made to ensure clarity of questions prior to submission and approval for use by the Human Research and Ethics Committee. The intention was to distribute the questionnaire prior to commencement of the in-service program and after completion. In doing so the group would be provided with baseline data related to the respondent's understandings of support provision and knowledge levels with respect to COPD care, which could then be compared to post intervention findings in order to determine impact of the intervention.

4.4.4.3 Questionnaire Analysis

Data provided by respondents to questionnaires was entered into excel spreadsheets and analysed using descriptive statistics. Descriptive statistics provide simple summaries about the sample and the measures and are used to describe the basic features of the data in a study (Streiner & Norman, 2008). Descriptive statistics are typically distinguished from inferential statistics in that they are used simply to describe what the data shows. In contrast, inferential statistics are used when trying to reach conclusions that extend beyond the immediate data alone and to infer findings to more general conditions

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(Rowntree, 1981). As the intent of using questionnaire data was primarily to inform and broaden the scope of reconnaissance findings, and the small sample sizes inferential statistical analysis was not undertaken.

Descriptive statistics can be used to present population descriptions as a means of summarising the vast amounts of data collected to a more manageable form (Haslam & McGarty, 2003). Within this research descriptive statistics are used to describe responses of various groups. They are used in stage one in order to summarise responses of both community care providers and also patients and carers. In stage three the questionnaire and analysis were intended to assist in understanding the levels of support and provision of opportunities for education and professional development on the ward, pre and post delivery of the in-service education program.

4.4.5 Focus Group

Reflective of the initial focus of ARG members on continuity of care provision, information was sought from community providers about aspects of care delivery to people with COPD. A group of eight community nurses who were working and engaged with care provision to patients with COPD in the community participated in a single focus group, undertaken as a component of reconnaissance in stage one. Focus groups are used to collect data on a specific subject using a group discussion (Hansen, 2006), a collective activity that aims to explore the participants views and experiences around a particular topic (Kitzinger, 1994, p. 103). Kitzinger (1994) further highlights the interaction between participants in the group as a key characteristic of focus groups which needs to be recognised. However as Dick (1999, p68) argues it is not important to have agreement between all focus group participants on a particular issue, but to recognise how much agreement or disagreement exists related to the issue. The focus group discussion may also provoke members to consider issues in a different context or manner and is through these interactions facets of the topic being investigated may be raised which have not been previously considered by any of the group members or indeed the researchers (Hansen, 2006, p. 123). As the facilitator of the group I was cognisant of the need to examine the issues raised from the view of community providers engaged in direct care provision to

persons with COPD. The questions which shaped the focus group interaction were the same as those used within the semi structured interview schedule.

All focus group participants worked within the same geographical area and provided services to a similar group of clients. The purposeful targeting of these community nurses to recruit focus group participants was undertaken to broaden the scope of data collected, in line with the ARG intent to 'cast the net wide' using multiple sources to inform their analysis of the issues that impacted on continuity of care. Participants in the focus group were also invited to complete the questionnaire and return it to the research group prior to participation in the focus group. Other questionnaire respondents worked with a similar group of clients but were within government agencies and had previous contact with a research project focused on care provision to patients with COPD. Therefore the aim of collecting data from the group was to enhance and broaden information from community providers in responses to questionnaires. Analysis of the questionnaire and focus group data was utilised to inform the ARG of the key issues related by community providers of care to persons with COPD.

4.4.5.1 Focus Group Recruitment & Analysis

Participants in the focus group were recruited through a single approach to the clinical educator who supported community health nurses in practice who in turn provided the broader group with information sheets, prior to the invitation to attend the focus group. At the focus group participants were provided a further opportunity to ask questions, and the voluntary nature of participation was highlighted before individual signing of a consent form and subsequent participation in the discussion (see appendix seven). The single session was of eighty minutes duration and was audio taped and transcribed, prior to content analysis similar to that undertaken with the semi structured interview data described previously. I attended and facilitated the group with a member of the ARG who also took notes which were used in the analysis.

4.4.6 Documentation Audit

In order to ascertain the degree to which documentation contained within the medical record reflected best practice guidelines, an audit of medical histories of patients with COPD who had been on the ward was undertaken, in both stage one and three of the research. Development of the audit tool was undertaken in collaboration with the ARG and informed by relevant national and international guidelines such as the COPDX and GOLD documents (McKenzie et al., 2007; Scrivener et al., 2002), together with local guidelines and policies related to care of persons with COPD and discharge planning. The focus of the audit (see appendix eight) was to identify the documentation of nursing care and for that reason did not address information specifically related to medical care. A concern raised by ARG members about the fragmented nature of documentation across disciplines, led to attention also being paid to which health discipline had documented the audit items. The audit tool was structured under five key areas:

- admission assessment,
- multidisciplinary care,
- treatment,
- education (patient and carer), and
- discharge/follow up.

The audit tool was reviewed by an expert panel, which included a respiratory specialist nurse, respiratory physician, general physician, clinical nurse manager and a member of the quality improvement unit located in the facility that had experience in audit development. They were asked to consider the audit for clarity, language and content. Suggested changes were incorporated, including documentation of the medical unit under which the patient was admitted and noting whether utilization of the ward's COPD specific care plan had occurred. Prior to the first audit being undertaken three histories were examined to identify any undetected issues, none of which were evident.

The audit data was collected utilising interval sampling, over a three month period, from July – October 2006 (n=20) and over a five week period during August/ September 2007 (n=16). Audits were undertaken by one researcher, to ensure consistency. The audit included medical records of patients who had been admitted to the ward with a diagnosis

of COPD. Documentation was examined from presentation at the Emergency Department to discharge, including bedside charts. The collection of information from the history occurred post discharge.

Analysis was undertaken as audit data was entered into excel spreadsheets and analysed using descriptive statistics described under questionnaire data. Comparison between the two audit data sets was made.

4.5 Validity

Whilst this study employs the use of quantitative methods of data collection (for example questionnaire and audit) the overarching approach is qualitative. All sources of data were considered by the ARG members who critically appraised the findings and applicability to the research question. As such validity in this research project is considered under the rubric of qualitative research where it has been both widely debated and widely contested by scholars (Guba & Lincoln, 2008, p. 259). It is important to consider how interpretations and trustworthiness of data, together with the processes which informed strategies undertaken by the ARG to improve care to persons with COPD, can be established.

In the positivist sciences, the quality criteria for research includes 'benchmarks of rigor, internal and external validity, reliability and objectivity (Guba & Lincoln, 2008, p. 258). Such an approach is rejected in many qualitative research methods, including action research, where processes embrace subjective and objective knowledge which are considered 'interwoven and mutually informing' (Lather, 1991). Several authors suggest ways in which to examine validity in qualitative endeavours, whilst cautioning none are absolute (Bradbury & Reason, 2001; Guba & Lincoln, 2008; Lather, 1991). Lather (1991, p. 66) contends 'our best tactic at present is to construct research designs that demand a vigorous self-reflexivity'. In keeping with Lather there are several strategies within this research which were intended to ensure validity as she has described it.

4.5.1 Triangulation

Triangulation involves the use of several data sources focused on a search for consistency in findings, which assists an assertion that there is a accurate portrayal of an issue under investigation (Cresswell, 2007, p. 208). Importantly as Lather (1991, p. 67) highlights using data sources which seek 'counter patterns as well as convergence' adds to credibility of the research. Including data from a range of sources and stakeholders within this research has allowed triangulation and strengthened the validity of some findings. For example, during reconnaissance multiple data sources were utilised to inform understandings of current provision of care to people with COPD, and in the area of inpatient care, the audit findings supported the assertions by interview participants that gaps in inpatient care to persons with COPD were frequent.

4.5.2 Construct Validity

Construct validity, in participatory research , as described by Lather (1991. p. 67) requires 'a self critical attitude toward how one's own preconceptions affect the research' in order to guard against the threat of theoretical imposition. Construct validity is closely linked to ensuring congruence between the participants' understandings and experience and the analysis developed in the research, and 'determining that constructs are actually occurring rather than mere inventions of the researcher's perspective' (Lather, 1991, p. 67). Such a step is in keeping with what Heron & Reason (2001, p. 184) describe as 'being present and open' to meanings ascribed by participants in the research, and ensuring they are represented.

My own role in assuring construct validity was to remain cognisant of the researcher role, the aim of entering into action research activities with practitioners, and to develop an awareness of my own understandings and investment in the research. Such a process enabled me to examine how my own thoughts, understandings and experience impacted on the ARG activities and allowed me to further examine ARG members' dialogue to ensure I was representing events and critical insights as they happened. My personal journal, which served not only to provide a record of the research as it evolved, but enabled adoption of a self critical stance, and an ongoing analysis of any theoretical

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stance I bought to the research was central to the step. It was through this journal I was able to provoke investigation of my own understandings and relationship to the group and group decisions, whilst maintaining a focus on commitment to the underlying tenets of action research. At times this meant I shared my critical reflections with group members, which enabled other members to confirm or challenge my understandings.

4.5.3 Face Validity

Closely tied to the notion of construct validity, face validity is 'operationalised by recycling description, emerging analysis, and conclusion' back to participants (Lather, 1991, p. 67). It is a further way in which to ensure alignment of research analysis with the understandings and experiences of the group. Within this research, dialogue from the ARG members during meetings was recycled via circulation of case notes. When group members were provided with case notes they had an opportunity to come to a 'reasoned agreement' of meaning - agreeing, rejecting or modifying representations of their critical dialogue. Such a step provided the group members with opportunities to engage in ongoing analysis or to further challenge or elucidate intended meanings. Lather (1991, p. 67) discusses the work of Kidder (1982) and supports the notion that 'face validity provides a 'click of recognition' and a 'yes, of course' response from participants. Such responses from ARG members are most visible when they reached agreement or discussed similar experiences within the context of group meeting, or when first level analysis of reconnaissance data from sources other than ARG meetings provided the group with data which they debated, yet at completion resonated with their experience and understandings.

4.5.4 Catalytic Validity

Finally, given the emancipatory intent of this research the notion of catalytic validity must be considered. The argument for catalytic validity is described by Lather (1991) as 'unorthodox' and one which 'flies directly in the face of positivist demand for researcher neutrality'. Catalytic validity:

> ...lies not only within recognition of the reality-altering impact of the research process, but also in the desire to consciously channel this impact so that respondents gain self-understanding and, ultimately, self determination through research participation (Lather, 1991, p.68)

As demonstrated in Chapter Three, catalytic validity is a central measurement of success in action research, and as such the journey of ARG members where they at first sought to reach new understanding and then moved forward to take action represent clear achievements under this area.

4.6 Summary

This chapter has provided an overview of both the ward setting and the structure of the research undertaken within the broader rubric of action research. Acute care, and in particular the ward setting is demonstrated, like the research approach to be inherently complex and impacted by many variables associated with delivery of care to people admitted to the hospital. At the beginning of the research it was not known to what extent the setting would impact on the research endeavour.

In the context of this research the three stages of the research structure were intended to foster empowerment of participants. Providing higher levels of researcher support during set up and reconnaissance, it was intended as the participants gained familiarity with the action research process and the critical intent of the approach that they would emerge to take the lead in the research (Robinson, 2001). The reconnaissance which follows in Chapter Five was the first in such steps and was intended to provide participants with greater understanding of care provision to persons with COPD, and an opportunity to interrogate their own practice.

5   Researcher Facilitated Process Reconnaissance

The intent of the reconnaissance phase (action plan one) was to enhance and explore understandings of nursing care provision to people with COPD from the viewpoint of those within the ARG and other key stakeholders. In order to provide a comprehensive understanding of the current situation for patients with COPD admitted to the ward from multiple perspectives data was drawn from a range of available sources as discussed in the previous chapter. Such a step is in keeping with what Kemmis & McTaggart (2003, p. 372) highlight as a need to seek both insider and outsider information which is essential within action research endeavours to enable participants to consider 'the possible as well as the actual in their social world'. Action plan one is presented below:

Concern:	ARG understandings of situation for COPD patients admitted to acute Care
Action Plan:	Collect data to inform ARG understandings
Monitoring:	Feedback to meetings Researcher Journal Discussion Paper
Data Sources:	ARG research meetings Audit Semi structured interviews Questionnaires Focus Group
Analysis	First level thematic analysis Descriptive statistical analysis

Figure 2: Action Cycle One: Research Activity

Early discussions undertaken by the ARG in setting up the research, identified a range of other stakeholders that group members felt would inform understandings of care provision, with a focus on continuity of care to persons with COPD. Identified stakeholders were ward personnel, including medical, nursing, and the broader multidisciplinary team members; patients admitted with COPD and their carers; and

community care providers. The engagement of stakeholders was proposed by group members under different strategies to be undertaken during reconnaissance.

In collaboration with ARG members I undertook a primary role in the collection of data from other sources. It was also agreed that I would also undertake a first level analysis of the data, and present a summative paper to the ARG at the completion of reconnaissance. During reconnaissance, the key contribution of group members was to discuss and reflect on a broad range of issues related to care provision, using a framework which mirrored other data collection strategies as a guide (see figure three). The group planned to meet fortnightly from the beginning of the research, yet experienced some difficulty in maintaining their activities. Data are drawn from nine meetings undertaken by the group, their discussions, and reflections on discussions, comprise action cycle 1A, the first of four collection strategies reported in this chapter.
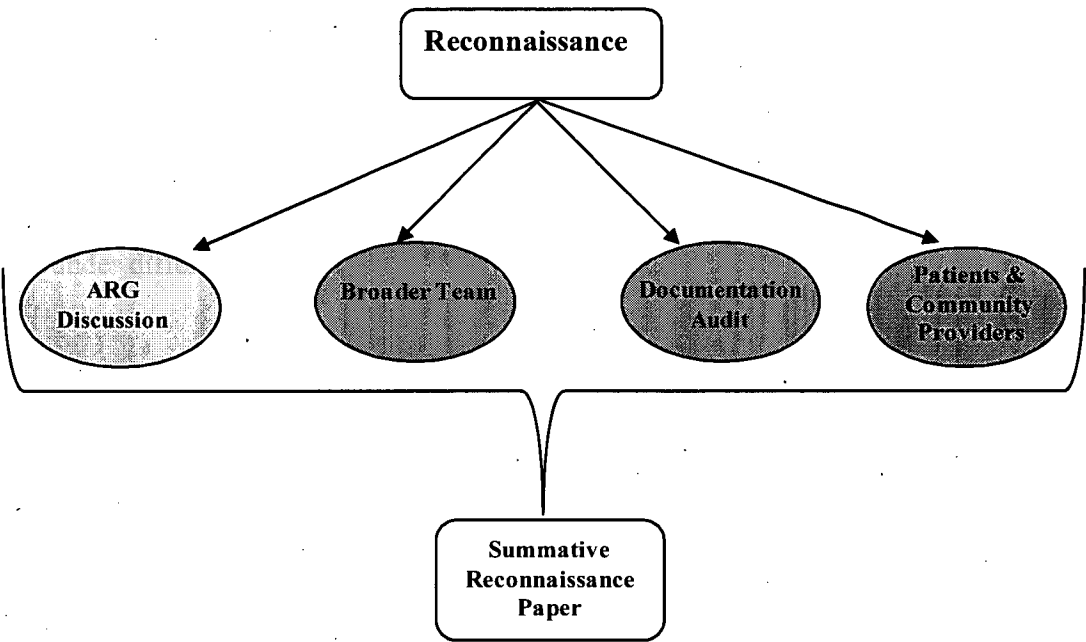
Figure 3: Overview of Action Plan One Strategy

5.1   Action Cycle 1A: ARG Discussions

In keeping with the critical approach of the research endeavour described in Chapter Three, members of the ARG attended research meetings during the reconnaissance with

the aim of examining their individual and collective experiences and understandings of COPD care provision. Edited case notes returned to the ARG members following research meetings were a key tool used to facilitate critical reflection on the issues identified during this stage. The ARG members commenced their discussions by considering care provision on the ward.

5.1.1 Care Plan for Patients Admitted to the Ward with Diagnosis of COPD

As the group were most familiar with their own area of acute care, they began discussions by interrogating care provision on the ward, including the role and use of the COPD care plan. The COPD care plan had been developed over several years by the nurses on the unit in collaboration with the specialist respiratory nurse, allied health and medical teams. The care plan was first developed in 2002 and based on best practice guidelines (COPDX), and had been reviewed and updated just prior to the commencement of the research. Nurses on the ward had been involved in the review. The COPD care plan was described by the ARG members as a significant tool utilised in the delivery of care to persons with COPD nursed on the ward. When considering the plan, nurses within the ARG indicated that they felt the existence of the care plan exemplified the excellent care their patients were receiving. As ARG member, Emma, commented *'our COPD pathway is really good...it gets a lot of things going and is quite organized and structured'.* Benefits of utilising the plan were seen as *'not missing anything'* and *'providing a sort of checklist'.*

My experience of the ward suggested that, despite the recognised usefulness, the care plan was often underutilised and rarely completed. In order to explore this further, I challenged the group to consider their use of the plan in greater depth. Two key issues arose: (i) a lack of time available to undertake interventions and (ii) variable nursing knowledge of the care plan and care plan contents. The group argued that either issue could impact negatively on interventions described within the care plan. Members of the group expanded on this theme, stating that less experienced nurses, such as casual pool or beginning level nurses, had lower levels of knowledge related to the use and

implementation of the plan. They felt that these nurses did not possess a sound understanding of each area addressed within the care plan. As Kate argued:

'most of them [inexperienced staff] *wouldn't even know where it* [COPD care plan] *was, let alone get it out and initiate it. It is much more than just ticking the boxes, you need to know what you are talking about and what the plan is getting at'*

Further highlighting their concerns, ARG members claimed inexperienced nurses demonstrated a lack of appreciation for the importance of the care plan as *'a lot* [of nurses] *don't initiate it* [the care plan] *or think about it'*. Working with patients to deliver education was one component of the care plan highlighted by group members as a key concern. This issue was the subject of further discussion

5.1.2 Education of Patients

Education to assist persons with COPD to better manage their disease encompasses areas such as medication use and technique, importance of exercise, self monitoring for disease exacerbation and management of breathlessness. Within the ward, COPD education included teaching sessions with patients, provision of education material or a combination of the two. Information was also reinforced when opportunities arose such as during medication rounds. When discussing patient education, the ARG claimed it was a critical nursing role they *'should be'* undertaking. They also argued this important aspect of care could only be *'fitted in'* amongst other demands and was not given the same priority as other nursing activities such as medication administration or provision of activities of daily living care. The group agreed that education of patients was often ranked low in their list of clinical priorities. Members of the group also argued that constant interruptions in the clinical setting impacted on their ability to maintain a patient education focus within day to day activities. Emma described being in charge of the ward and sitting by the bedside with a patient as *'impossible'* due to competing demands. As Emma related:

'...here I am sitting down, being quiet and trying to educate the patient and I can't tell you how many times I was interrupted. Like "Emma, have you got the keys? Emma, bed management on the phone for you... Emma, do you know when Mr X is going? Emma, Emma, Emma, I mean it is not anyone's fault, it is just busy and there are a lot of demands... a lot of the time we can't even get to tea...'.

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Hence, although the group described themselves as possessing necessary skills to deliver education to patients, they felt constrained from doing so by circumstances.

Group members agreed that all nursing staff on the ward should be making attempts to deliver education to patients but this process was often impeded by limited knowledge and capacity of some nurses. Inexperience was cited as a primary reason. Conversely group members felt inexperienced nurses had more time to spend with patients, as they were free of burdens such as overall ward management which *'weighed down more senior nurses'*. The theme is explored in greater depth during later discussions related to the practice setting. Group members argued that poor provision of COPD related education to patients led to patients being discharged with a poor understanding of disease management and potential impacts of the disease. This is illustrated in Greta's comment:

'...sometimes they [persons with COPD] *might go home and be none the wiser about the fact they have a chronic disease or need to watch for it happening again. They just think yes they were sick, had pneumonia or asthma or something and now they are better...'*.

5.1.3 Carers

The ARG members felt that the impact of poor education was not only limited to patients but affected their carers also. In instances described by group members, carers were not provided with information or education about the disease, in a timely fashion and as a consequence experienced anxiety. The impact is illustrated by the example provided by India:

...she [the carer] *just needed to know what was going on...she thought we were being unreasonable by expecting* [the patient] *to get up and do things for himself, no one had explained that it was important for him to do that and it was part of* [his treatment]*...it turned out that at home she would do everything for him because she didn't want him to be getting short of breath...and it was just that she didn't understand that he needed to do exercise and that she was actually, well didn't mean to but was making him sicker...*

Interactions with carers were described as a *'two way street'* where information sharing included nurses providing information to carers, but also seeking information to *'fill the gaps'* related to individual patient circumstances and concerns. ARG members related how information sharing in practice was undertaken in practice and Dave explained:

'I try to catch them [carers] *in the corridor or on their way out* [of the ward],...*Their*

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problems might be different than the patients and they might not say what it is unless they are away from the patient...but they can also tell you what is going on for the patient, and they might not say it in front of them ...'

Although members of the group recognised the carer role as important, they reported carers were often neglected in the everyday functioning of the unit. Group members described that a focus on acute management of the disease and the need to respond to pressing issues on the ward, led to poor engagement with carers and their needs. Carers reportedly could *'go into meltdown'* before their needs were identified as India argued:

'we are meant to talk to them [carers], *well the doctors are, it was on the care plan...to talk to them* [carers], *early in the admission, but it gets missed sometimes, and they get angry and you think whoops there might be an issue here, I mean you see them in the hall, or they come to the nurse's station and they are angry about something, but really they are having a problem or they just can't cope anymore...'*

5.1.4 Longer term planning

Lack of carer support and involvement in care, together with poor education provision to carers and patients by ward nurses, were identified during group meetings as having a negative impact on continuity of care provision. ARG members identified an emerging relationship between poor patient and carer knowledge (due to poor education) and lack of longer term care provision. Members of the group questioned how patients and carers could consider longer term planning if they did not know and understand they had a chronic illness. The issue of palliative care was raised during meetings and was explored in greater depth to further articulate group members' views that long term planning with COPD patients was not undertaken at high levels.

Palliative care was viewed by the ARG members as an important component of overall management, which should not be restricted to the days preceding death. Group members described patient and families experiencing COPD as often unprepared for death, generally not considering or speaking about the inevitable outcome of living with the disease. As one member noted *'they have been in and out* [of hospital] *so often and been so sick before, they just expect to go home'*. The implications of lack of planning were further explained by ARG member Emma:

'most of them [COPD patients] *die horribly and I think given a choice, most of them would like to die at home...No services are offered or explained to them to make an informed choice, until it's too late. It's like well this is it, you are going to die, well here you are and it will be too late, to let them know that they are actually dying, they are so anxious, it is all so horrible'*

Adding to Emma's comment, Fred also indicated that the focus on medical management of disease contributed to a lack of planning in this area. A belief that palliative care provision needed to be addressed across disciplines was evident as Fred stated:

'I think a lot of consultants [medical staff] *refuse to acknowledge that this* [death] *will be an eventual outcome* [of the disease]*...I mean if they don't acknowledge it how can the patients'*

The group reportedly felt impotent in their ability to change approaches to longer term planning or to incorporate a palliative approach to care. A recent initiative within the hospital was described as having given them some hope for change. The 'Respecting Patient Choices' program (RPC) (http://www.respectingpatientchoices.org.au/ref) was designed to encourage patients to consider advanced care planning whilst promoting respect for patient values and goals. Group members described their initial response to the program as positive. At the introduction of the program, they believed it would provide a mechanism to implement the concept of palliative care alongside the medical management of the disease. However during group discussions, the impact of resource constraints on adoption of the RPC program became increasingly apparent.

The RPC programme required that nurses were trained as consultants prior to undertaking sessions with individual patients. This meant they had to get time out of the ward to undertake the training, which in the context of staff shortages was not easy. Furthermore group members argued that interactions with patients, as set out within the program structure demanded a considerable time commitment. Between thirty and sixty minutes was required for the first consultation where the general concepts of the program were discussed. Formalising and documenting plans with the patient and family during subsequent follow up could take a similar amount of time. ARG members argued that, in practice, they did not have enough time to undertake the consultations. Indeed they

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reported that consultations were subject to the same interruptions and time constraints as the education delivery described previously. Adoption of the RPC program was also undermined by the need to factor consultations over several days which required nurses to take into account availability of program consultants, patients and families. Further problems arose when the nurse initiating the first consultation was unable to undertake the second because of the vagaries associated with rotating rosters. In the view of the ARG members work patterns, availability of RPC consultants to provide continuity of the program, and work pressures on the ward reportedly lead to low levels of completion.

Members also reported that implementation of the RPC program was subject to what they described as surveillance. They described audits undertaken by the program project officer to identify potential RPC consultations that could have been undertaken, which were then compared with actual consultations completed on the ward. This approach was viewed by the ARG as punitive in nature. They explained that low numbers of completed consultations inferred that nurses within the ward were not *'doing their bit'* towards adoption of the initiative. As group members critically reflected on these concerns it became evident they felt there was little they could do to change low levels of engagement with the program. They became aware that perceived issues such as time and resource constraints, which limited their ability to engage fully with the program, were outside their control. Indeed there was growing recognition from the group that the practice setting constrained their capacity to realise the potential of the ward COPD care plan or RPC program.

5.1.5 Practice Setting

The identification of gaps between the evidence and practice, such as those related to care plan and RPC implementation led the ARG to further explore the circumstances which impacted on their ability to deliver quality COPD care. During discussions to this point, nursing inexperience and the ward environment had been identified by members of the group as affecting their capacity to deliver care. They acknowledged the key focus of nursing care within the ward was on acute management of the disease. At subsequent meetings the members of the ARG now sought to explore the issues in greater depth.

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During these discussions the ARG articulated the complexity of their responsibilities on the ward and began a process of interrogating how their responsibilities as senior staff might impact on ability to deliver care. Responsibilities included; delivering direct patient care, overseeing or guiding other nurses' practice, undertaking ward activities related to organising staffing, patient co -ordination and bed management. In the group discussions they shared examples of how competing requirements in their role compromised their capacity to provide appropriate care. For example as Carla argued:

'...you have to juggle and you do have to prioritise...it is really quite tricky... I mean I have [the medical staff] saying to some patient... 'oh the girls[sic]will show you how to use your puffers' etc - like we can just slot it in and have nothing else to do...when it might take five minutes or it might take lots of time...who knows..'.

Frustration was evident as members identified the tensions that arose as a consequence of the need to complete activities related to COPD patient care, which were also impacted by circumstances outside their control. ARG members reported they were frequently unable to complete COPD activities due to circumstances being 'outside our control'. For example Anna recounted:

When I am in charge I try..., I really try... to check all those things about the care plan and what's been happening but you have all these things to do and there is never enough time, so I have to let some things just go...

Fred added a view that:

'...You can't do everything. So at the end of the day you have to be happy that no one died and you have done the most important things...like you can handover to the next shift, what needs to be done but you probably know they won't do it or can't do it cause they are going to be just as crazy...'

ARG members described feeling compelled to prioritise their responses in order to manage a myriad of demands. The level of demand was reportedly exacerbated by a lack of time and mounting work pressures, to the point where it became overwhelming. Members of the group indicated that at times many activities were left uncompleted, and their comments highlighted how practice gaps would inevitably occur, as Anna reported:

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'some things [care provision], *just fall through the net, I mean we are expected to do more and more things'.*

It was the contention of ARG members that nurses were stressed, busy and constantly prioritising and reprioritising, in order to meet the ever changing demands of the environment, in the knowledge that gaps in care provision would result. They argued that their practice was primarily focused on *'here and now'* and directed to immediate and most pressing patient or ward need. As Carla stated *'you know you can cope with the minute but you don't have enough time to do all the things you need to do '.*

Critically reflecting on the situation, the group recognised the focus of care was situated in the moment and was reactive in nature. Group members asserted that they did the best they could, and there was little they could do to change the circumstances under which they delivered patient care. As Greta explained, they were *'just getting through the shift'.* During their discussions, the ARG highlighted the role of other members of the multidisciplinary team as having a potential to fill some of the identified practice gaps, including education and continuity of care facilitation. The ARG discussions then shifted to an exploration of their interactions with the multidisciplinary team.

5.1.6 Engagement with Multidisciplinary Team Members

Nurses within the ARG recognised the care of persons with COPD on the ward included a range of other health care professionals, broadly known as the multidisciplinary team. Hence they chose to examine the referral to the multidisciplinary team, the structure of multidisciplinary work and the relationship of nurses and multidisciplinary team members.

5.1.6.1 Referral to the Multidisciplinary Team

Referrals to the specialist respiratory nurse, physiotherapist, occupational therapist, dietician and social worker are a key requirement for all patients with COPD admitted to the ward, as stipulated in the COPD care plan. The specialist respiratory nurse provides patient assessment, education, support and guidance in the acute care setting with capacity to provide outpatient care in the form of follow up in the community. However, during

their discussions the ARG members identified a reluctance to refer to the specialist respiratory nurse. The situation purportedly arose following the CNM's directive that nurses on the ward were specialist respiratory nurses and able to deliver interventions without the aid of that specialist. From their comments it appeared that the ARG members held a similar view, as Carla commented:

*'well there is that thing really, we **are** specialist respiratory nurses, lots of us have taken on that role when she* [specialist nurse] *is away, we can do all that stuff with puffers and education and things...'*

The ARG members' claim that ward nurses were able to deliver specialist respiratory interventions was in direct contrast to prior discussions where they asserted a lack of time led to an inability to provide key aspects of care. For example, their earlier discussions indicated they felt unable to provide education and support to patients in many circumstances. As these discussions unfolded they became increasingly aware of the contradictions in their argument. Further consideration of the issue led to a recognition that the CNM's directive and nurses' subsequent non referral to the specialist respiratory nurse had compounded problems around their apparent lack of capacity to provide appropriate education and support to patients. That is through non referral to the specialist respiratory nurse they had inadvertently increased their workload. The ARG members agreed that low levels of patient counselling and education could be in part ameliorated if they utilised the respiratory nurse to assist. Group members agreed that if they used the respiratory nurse their role could focus more on reinforcing information provided by the specialist and building on patient knowledge during their more general care provision activities.

However, low levels of referral to the specialist nurse did not infer similar low rates of referral to other specialists within the multidisciplinary team. ARG members described referral decisions as based on individual patient assessment, including knowledge of past admissions. No referral would be completed if the patient was characterised as unlikely to benefit from the intervention or if previous multi disciplinary team interventions had little impact. Although nursing assessment reportedly guided referral decisions, group

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members were also aware of utilising multidisciplinary team members appropriately and not wasting their time on fruitless assessments. Reflective of this view, India commented:

'well some of them [patients] *are just not interested, and if they have been in and out* [of the ward] *and they* [patients] *just don't care* [make no effort] *then it is a waste of time to get anyone else involved'*...

India's views were supported by other members. For example, Kim added:

'...we [nurses] *can tell when it is not necessary* [to refer]. *If we refer and the patient refuses input from them* [allied health] *or they* [allied health professional] *decide* [during assessment] *that no other intervention is required then it is a waste of time all the way round...'*

Overall the ARG members considered they undertook an appropriate level of referrals to allied health professionals, which they argued took into account an assessment of patient need, together with the likelihood of patient benefit. Furthermore, when referrals were actioned, the ARG members considered one of the clear patient benefits was the time allied health team members were able to spend on assessment and intervention.

5.1.6.2 Structure of Work

Multidisciplinary team members were viewed by the ARG as having the luxury of designated time to spend with patients, which was not subject to the interruptions and time pressures experienced by nurses on the ward. A key difference in the framework of care delivery, argued by ARG members was the transient but focused nature of multidisciplinary team member's engagement with patients. The ARG reasoned this was apparent in multidisciplinary health team members' completion of discipline specific assessments and interventions, conducted during normal working hours. In contrast the ARG argued that nurses were present for the 24 hour period and *'doing a little bit of everyone's job as well as our own'* As Fred highlighted:

'we do their job but they don't do ours, let the person they are with have wet pants or need to go to the toilet and they come running for us to fix it, yet they could do it'...but we pick up bits of their job all the time, like exercise, breathings stuff and all that...

Members of the group accepted the need to progress interventions requested from the allied health team such as exercise, social assessment, energy conservation and

management of diet. Given pressures of the workplace discussed within the group, members agreed the area warranted further examination to elicit greater understandings of how those responsibilities were absorbed into daily care.

5.1.6.3 Multidisciplinary Roles in Nursing

Although group members described integration of multidisciplinary interventions into their daily work load, nurses were not always aware of intervention details. As an example, the group discussed the manner in which education and techniques for breathing control were taught to patients by physiotherapy. It was claimed that, in the absence of the physiotherapist, nurses were expected to encourage patients to continue to practice breathing techniques. Of some concern, group members claimed they had never been formally taught these techniques, and could not identify the basis for their understandings of such techniques. Greta provided further explanation as she recounted an episode of patient care:

'So [the patient] *is* [saying] *I can't breathe, I can't breathe, and really getting panicky. So you try and work with them,*[saying] *can you remember what* [the physiotherapist] *told you, and you breathe with them...But the physio isn't on the ward when things like this* [panic attack/ anxiety] *happen, so we might take half an hour to calm the patient down and get on top of things. Even then you don't really know if you have done what they* [patient] *have been told* [by the physiotherapist] *or what. Like you have to be able to do everyone's job'*

When asked to explain exactly what it was that nurses were meant to be doing with patients, and if nurses knew the detail of physio interventions, Greta stated:

'*...well no, not exactly, but you know when you have looked after so many of these patients before* [you know what to do]...*the main thing is to just get them to calm down... I don't exactly know what the physio does... I have never sat down and listened to them with the patient but...'*

Members of the group reinforced previous claims that they were doing the best they could under difficult circumstances. To support their claim of delivering 'good' multidisciplinary care they drew on comparisons to other areas within the hospital. Patients with COPD admitted to a surgical ward were described as receiving poor overall management. Illustrating this view ARG members' detailed instances where patients were

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left in bed, not challenged to ambulate, had oxygen for longer than required and had low levels of referral to allied health, simply because *'staff on those units didn't know anything about COPD care'*. The comments showed a similarity to the problems the group identified within their own ward. However members of the ARG remained adamant that they provided care aligned with best practice care at higher levels than other wards within the hospital. Concluding their discussion of this area the ARG members were firm in their belief that, despite everyday struggles to provide care, they were doing the best they could and patients would not get better care anywhere else within the hospital. The ARG members now turned to consideration of community providers and care provision to persons with COPD.

5.1.7 Care External to the Ward

ARG discussions during these early meetings were also focussed on issues that impacted on care co-ordination or continuity of care. In particular, they were interested in links with the community based providers of care and the impacts on their capacity to provide care to people with COPD which arose from co-ordination between acute and community care. Patients with a diagnosis of COPD were commonly admitted to the ward, via the emergency department, with acute exacerbation of the disease. The majority of patients admitted to the ward were community dwelling. The ARG reported that they usually needed to *'pick up the pieces'* following a patient's admission to the ward. Further explaining the claim, members described patients as misinformed or misunderstanding the disease. At the very worst patients were characterised as having no knowledge of their diagnosis at all. This comment echoed the groups' frustration with the level of misdiagnosis and poor understanding of the disease. This was evident when Anna commented:

'...if the doctor[GP] *says they have asthma and they have puffers and stuff to take, then that's it they have asthma and you can't change how they think of it and it is totally wrong* [diagnosis]*'.*

ARG members' recounted episodes where patients admitted to the ward believed that they had pneumonia, asthma or bronchitis and such misunderstandings were perceived as resulting from misinformation provided by GPs. The ARG agreed it was difficult under

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these circumstances to change patient's understanding of their disease following admission. Group members also argued that misunderstanding added to difficulties they experienced in delivering education to both patients and carers. As Kate recounted:

'I have had the patient say "what no I haven't got that [COPD] dear, I have asthma". And they just won't listen to anything you have to say about COPD. Why would they? They don't have it do they? Then I might say 'oh well' and call the issue breathing problems. But they think of course they have asthma and can take puffers and it will all be okay. You try and explain in a roundabout way but sometimes you just can't get through, and in that case there is no use talking about managing or education or anything else, cause [in their mind] they will be okay...'

Although patient misunderstanding about COPD was a frustration for group members they described a *'drip effect'* which often occurred and which resulted in patients showing incremental improvement of their knowledge. As Anna noted:

'I would say the ones that come in...the frequent flyers know and understand COPD but they started out like the others...over the time they have come in, they see other patients, and they get to understand, yes I have smoked, yes I am like these other people and yes I have COPD. They might not call it that but they understand and call it emphysema, or smokers disease, or even if they still call it asthma, they know it is not...and it comes from smoking and it is going to get worse'

Complaints levelled by ARG members toward GPs involvement in the care to people with COPD were not extensive and related only to diagnosis. Of note, they reported having minimal interactions with GPs. As Kate stated:

'Once in a blue moon, their GP might ring in to see how they are...we don't have anything to do with them really. .and it is probably only from what patients say that you might get a feel for their GP and what they are doing...you sort of know which are better than others...'

To further explore issues in care coordination to people with COPD, ARG members considered the role nurses within the community setting. In their discussions ARG members demonstrated a poor knowledge of community nursing practice. For example, they expressed a view that the key service provided by community nursing was to support activities of daily living to clients. However critically reflecting on this issue, group members came to the realisation that their understanding of community nursing practice was founded in a range of personal assumptions and experiences. For example Fred, who was from overseas, based his understandings on experience in his country of origin and

recognised he had no knowledge of local service provision structure or practice. Student nurse experience from several years prior provided the foundation for Anna and Kate's understandings. Yet, although they recognised that their knowledge of community health service provision was poor, group members felt sufficiently informed to comment on what they considered community nursing services *should* provide.

Members of the ARG felt it was obvious that the focus of ongoing care and longer term planning for people with COPD should be located in the community. As Emma stated:

'...yeah I mean that is what I would say I think that when they [COPD patients] *are in hospital we are responsible for their acute care, their quality of life could be much better addressed in the community.... I mean we don't get to know them within their homes, within their home environment...'*

The assertion by ARG members that longer term planning (including RPC) was ideally addressed within the community setting was predicated on a belief that persons with COPD could as one group member commented be *'known and understood better in their real surroundings'*. Members supported this belief by claiming that whilst patients are in hospital *'life is not normal'*. Further they argued that acute care nurses were not in a position to fully address ongoing needs of patients because they did not *'know'* patients well enough. In order to provoke further consideration of this issue, I reminded group members that during our earlier discussions they provided very detailed information related to patients, which suggested that in fact they did have a good knowledge of them as people. Illustrating the point, I recalled an occasion when Kate knew the name of the patients' dog. Further critical exploration related to 'knowing' the patient provided a source of revelation to group members. They recognised that collectively they had high levels of knowledge of individual patients especially those who had multiple admissions, which included their needs and ongoing care, which countered their earlier view. Yet they maintained the view that in the context of a busy ward environment they would struggle to have a strong focus on long term care provision. As Carla highlighted:

Even if this is so, we do not have the time to consider their ongoing planning...we are struggling just to do the things we have to do every day...the community is the place to do it...'

5.1.8 Summary

During their discussions at meetings the ARG explored a range of issues that in their view impacted on their capacity to provide evidence based COPD care. Concurrently they engaged in critical reflection surrounding the issues raised, and demonstrated some changed understandings related to their role within COPD care. Constraints of everyday practice, the structure of that practice, of multidisciplinary care and relationships with other providers of care had also been discussed. Throughout their discussions and engagement with the research process, members of the group became increasingly aware of care deficits and issues which acted to maintain the circumstances described. A clear theme across the data indicated that group members considered they were doing the best they could under the circumstances. To this point, their engagement with data had been limited to their own understandings and investigations. Concurrent with the meetings further sources of data were collected. A consideration of these data follows.

5.2 Action Cycle 1B: Seek Views of Broader Acute Care Team
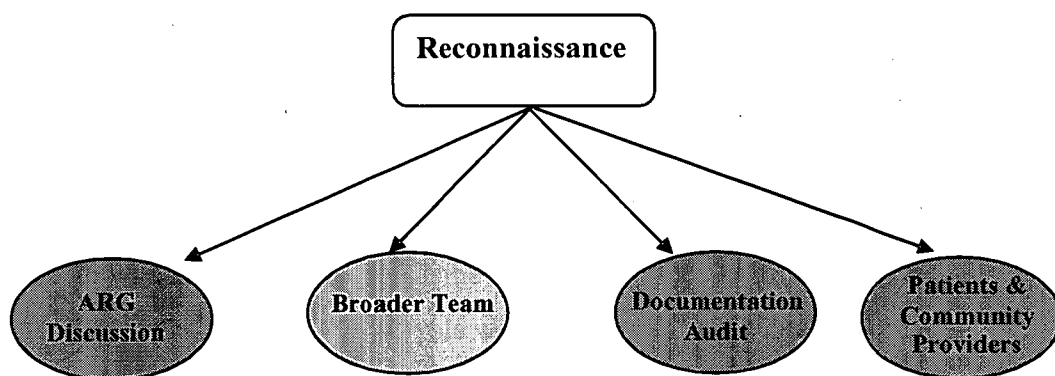
Figure 4: Action Cycle 1B

Semi structured interviews with a number of disciplines who were engaged with COPD care on the ward were undertaken. Descriptions of interview participants, process and analysis are contained within Chapter Four (page xx). Participants in the interviews were asked to share their experience of care provision to COPD patients within the acute setting, including continuity of care provision. Interviewees included two medical staff,

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five nurses and four allied health team members.

5.2.1 Care Plan

The COPD care plan was discussed by all nurse interviewees. Without exception they felt the care plan made a significant contribution to directing care. Comments were supported by claims care had improved since the plan had been utilised on the ward. There was a strong sense of nursing ownership of the plan as one interviewee commented:

'...*we* [the unit nurses] *actually sat down with* [the respiratory nurse] *and revamped it* [the care plan]. *There were a couple of nurses, we actually changed the format a bit and there were a couple of things... that we felt were quite important...* ' (RN 3)

Appropriate use of the plan was affected by the experience of the nurses within the unit, as interviewees indicated that less experienced members of nursing staff did not recognise the importance of some interventions, for example *'getting patients moving'*, as the following quote demonstrates :

'...*those* [nurses] *that have not had much to do with them* [COPD patients] *will tend to give them a sponge, not push them and be nice. Just wash them in bed, not make them get up and do stuff for themselves...* ' (RN 1)

Checking of patient inhaler technique was a further example of poor COPD care plan use, provided by two nurses. One recalled patients who had poor technique, or were left with empty puffers and even possessed the wrong inhaler medication, yet the care plan indicated that these areas of care had been checked. Another respondent stated:

'*I have seen nurses tick off the patients inhaler technique as good but the patient has not got a clue what they are doing...In that case neither has the nurse. In fact I think if I asked them to show me they couldn't... The patient only has to wave the puffer near their face and they will get ticked off*' (RN 4)

Further examples of poor adherence to the COPD care plan were revealed in the interviews. For example oxygen therapy was cited as poorly managed. Oxygen administration on the ward was intended to be titrated according to the patient's oxygen saturation readings and guided by medical orders written on the medication chart. Again nurses with lower levels of experience were identified during the interviews as struggling with this area of care. As one interviewee reported:

'...*you can just see them* [some nurses] *freak out sometimes. Sats are like 89-90% and they want to turn up the oxygen, but that person might be fine on that. But they* [less

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experienced nurses] *are used to other areas, like surg or something where you would be freaking out and doing something...They need to look at the patient and say right what's going on here- is it okay for this person?... But that only comes with experience. It is the same if the person is like short of breath, but most of the time it is anxiety...doing sats* [observations], *turning up oxygen, that will do nothing, probably make them worse...You need to deal with the anxiety and its okay, but it is very scary if you have a person doing that* [being short of breath and anxious]...' (RN2)

Despite comments which highlighted the negative impact of inexperienced nurses, all interviewees described overall COPD care provision on the ward as good. Comparison with other wards and across disciplines supported this position, as the following comments highlight.

'[recognition of the care level] *comes from doctors who have done rotations* [through the unit], *and they* [doctors] *know where they* [patients] *are going to be looked after well and we* [nurses] *know about puffer techniques and medications and nebulizers, and people needing oxygen. They* [patients] *are going to get better care on our unit because we know what we are dealing with...'* (RN1)

'*I think it is much more widely accepted in the hospital now that* [the unit] *is the respiratory ward and I think that is much more likely to benefit things* [patient care] *because the team there are more aware of the issues related to lung disease and therefore better positioned to service those needs...'* (M2)

'*I think one of the best things* [about care on the unit], *is the blanket referral to allied health* [which does not occur on other wards], *I mean it is done well, and quite quickly really...so things aren't just left til the patient needs to go home to have our input...it is done routinely...'* (AH3)

Opening remarks contained observations such as these in nine of the eleven interviews and prefaced further exploration of the issues. Despite this consensus, conflict was apparent in nursing comments related to medical management of patients. They claimed in some cases the medical staff valued nursing insights, yet in others demonstrated a complete disregard. The following comments highlight these views:

'*...some of the doctors ask so what do you want, and because we know what normal care is they listen to us...But some, even though you know you are right, ignore you and treat you like you know nothing. I would say that's not the norm anymore and most of them* [doctors] *know we are used to looking after these people, but when it happens you get quite pissed off...'* (RN3)

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'..anxiety [in COPD patients] *is a big issue and some of them* [doctors] *will listen to you about medications but it is not consistent...I mean the other day, one looked at me like I was wanting to like sedate the patient so I didn't have to deal with their demands... and it is not consistent, one day it is fine and the next it is like no way...'* (RN2)

Interview data also elicited information of how health care professionals worked together to achieve common patient care objectives.

5.2.2 Multidisciplinary Care

Early referral to allied health team members was identified as a facilitator of multidisciplinary care by interview respondents. Referral to social work and occupational therapy was described as occurring late in the admission whereas the physiotherapist reportedly received referrals earlier on. Interviewees suggested referral timing reflected the patient journey where physiotherapy is involved in patient care soon after admission, whereas the other disciplines had a greater role when patients were clinically stable (day three or four post admission). Early referral regardless of discipline was identified as important to allow planning. An allied health respondent noted:

'...certainly if we get the referral early we can plan, and touch base, like keep an eye on them [patients] *on the ward, and see when it is appropriate to assess them...it is more difficult if you are suddenly expected to see* [a patient], *and they* [medical team] *are waiting for your assessment to send them home...'* (AH2)

Medical and nursing staff recognised the centrality of allied health team referral to good patient outcomes with one physician commenting:

'...consultants have limited input into what happens to patients in hospital despite what they think...Perhaps more importantly [than medical input] *is things like other health professionals getting involved in care earlier on in the patient stay...'* (M1)

The importance of early referral to allied health professionals was raised repeatedly during interviews. Highlighting deterrents to early referral, two nurses commented about the unwieldy referral process. One nurse reported:

We are meant to refer [COPD patients] *to them*[all allied health team members], *but you know it means filling in about five pieces of paper... if you do them all, and it is just repeating the same thing, so often it doesn't get done...you mean to but then leave it to the*

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end of the shift of for someone else and it just doesn't get done.... (RN 3)

The use of informal referrals between health professionals, most often constructed as conversations in the corridor by respondents, was noted by allied health team members who suggested it was a mechanism that, in part, compensated for incomplete paperwork. Indeed familiarity between allied health team members was identified as a facilitator of this kind of informal networking. Members of allied health claimed that through this mechanism they could *'look after'* others, and *'pick up'* referrals that had been *'missed'.* As one respondent stated:

'...you get to know the others, and we help one another, and actually talk quite a bit about the approach we might take, especially OT and social work' (AH3).

Yet because of rotations through the ward the group dynamic of the allied health care team was subject to change which on occasions *'unsettled'* opportunities for collaboration. According to allied health interviewees rotations were problematic and interrupted the ease with which team members worked with one another. One interviewee noted:

'... if you don't know the other person, or how they work, then yes it can be more difficult...it takes time to know who to talk to and how they operate...' (AH4)

Understanding how *'things work'* within the ward was also an important component of workflow for allied health team members. As the following excerpt shows, one interviewee felt it was important to know what was expected when new to an area:

'... when I first came, it would have been helpful to have someone show me the ropes, what was expected... I mean I have been involved with these types of [COPD] *patients before but everywhere is different...I really struggled to know exactly what was expected, where things were, even when meetings were...* (AH2)

In response to the question of how a new member of the group may learn what is required about COPD care she responded:

'...well sometimes it is by making a mistake...finding yourself unable to answer a question related to what we are doing...but most of the time you can ask whoever is there. The nurses are good, and other allied health staff, if they have been there for a while can give you some pointers. It is often silly little things that you are not aware of [that cause problems]...' (AH2)

Several interviewees described how they sought out experienced nurses on the ward to seek specific information. They also indicated during interview that if they 'wanted something done' it was experienced familiar nurses they spoke to and made requests of. Further clarification of the role of nurses within the multidisciplinary team was sought during interviews across disciplines.

The response from medical and allied health team members, to the question of whether ward nurses formed part of the multidisciplinary team, was an emphatic yes. A request to provide examples of how ward nurses were part of the team, resulted in responses such as: 'well, they deliver the care' (AH1), and 'if they weren't there to provide information and to look after the patients then the place wouldn't run' (M2).

In contrast, nurses interviewed were ambivalent about their own role within the multidisciplinary team. On the one hand they felt that the multidisciplinary team worked well and patients were seen appropriately by allied health disciplines, which some nurse respondents described as partners in care:

'yeah I would say the patients get seen, sometimes we [nurses] don't do the referrals very well, or they get missed, but overall I would say it works well. They [allied health] talk to us when they need to and sometimes they know things we don't, or we can fill them in on things... '(RN2)

Alternatively one nurse shared a view that they were not truly a part of the multidisciplinary team, and were subordinate to allied health team members:

'It [allied health] is just another group who can tell us what to do. We actually do the work, everyone else just tells us what to do, and no they are not really interested in what we might think. I am sure they just see us as someone who does the wash etc, I mean we have a degree, but it is like everyone else is more important. The docs tell us what to do, the physio tells us what to do and then of course so does everyone else, I mean I had the social worker telling me to refer to community health. That is what I do, why do they think they need to tell me, like if they didn't tell me I would never do it cause I can't think for myself...trouble is we are here all the time and we are just taken for granted, like I said we just look after the patients and that doesn't require a brain... '(RN5)

Such varied responses suggest interactions between multidisciplinary team members and nurses were complex and multifaceted.

5.2.3 Collaboration with Community

Interviews elicited mixed information about continuity of care provision. The interviewees from the allied health area worked under a clear structure where they engaged with community care providers. For example occupational therapists were described as responsible for the patients care for up to three weeks post discharge and often undertook home visits to assess patient need. The other areas of physiotherapy and social work referred to their community counterparts if there was a requirement for continuing care. Allied health interviewees felt that continuity of care was characterised by good relationships between sectors, and they often collaborated with the community providers to seek information on admission and discharge. Poor staffing of the services was recognised as impacting on care provision across the continuum. Allied health interviewees claimed that *'there just aren't enough of us to go round'* and as a result *'wait times for clients can be high'* (AH 2).

During interview, nurses discussed their understandings of continuity of care and claimed: *'we only see patients when they are sick, we can't do much more than get them better and get them out'* (RN5).

Interviewees argued that referral to community nursing or ongoing care was *'done in a rush as they* [patients] *go out the door'* (RN5). Requests for support for daily living formed the basis for most referrals and the nurses interviewed identified minimal knowledge of how community nursing practice was carried out on a day to day basis. As one respondent noted:

'I think they [community nurses] *just do a lot of personal care and dressings and stuff, I don't think they do COPD care as such...we only refer for ADL support and it is usually when patients are end stage, when they need lots of help like that...'* (RN 1)

None of the nurses interviewed recalled speaking to community providers when patients were admitted, other than to notify them of the need to cancel appointments whilst the patient was in hospital. Contacting community providers on discharge was attempted but reportedly difficult. Frustration was evident when nurse interviewees from the ward reported *'attempting to do the right thing'* by phoning community health providers to

discuss a referral, but felt '*blocked*' by procedures. They reported difficulty in speaking directly to the community nurse who was to provide continuing care. This resulted from the limited availability of community nurses and what were described as '*overzealous reception staff*' who wanted to take a message, rather than facilitate discussions.

Information provided by medical interviews confirmed that they too knew little about community care provision for COPD patients. Indeed they declined to comment on community nursing, instead stating '*medical staff know little about that service*' (M1). One doctor claimed it was not in his remit to know anything about any community provision, and could not recall communication with the community sector other than the discharge summary to patients' GP. The second doctor interviewed felt that community and acute care provision was far too fragmented and both existed in '*vacuums*'. He highlighted the need to break down these barriers:

5.2.4 Summary

Interview data provided further information pertaining to provision of patient care within the ward, the multidisciplinary team and collaboration with community providers. Although interviewees may have varied in their understandings of care provision and views expressed, the information provided valuable insights into the issues that impacted on the provision of care to people with COPD nursed on the ward. Data from an audit examining documentation of care follows and builds on the data sources so far.

5.3 Action Cycle 1C: Examine Documentation within Ward
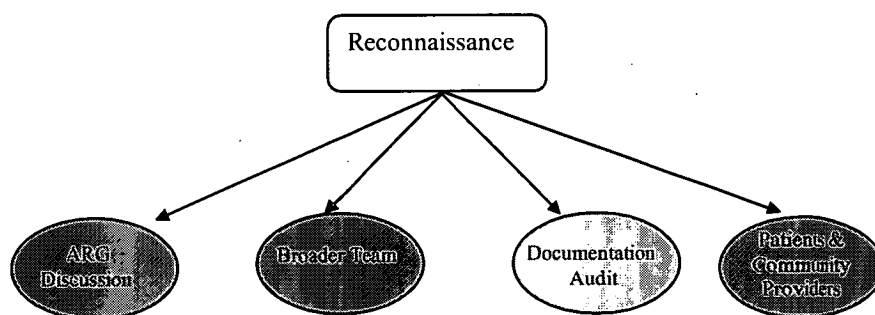
Figure 5: Action Cycle 1C

The audit was undertaken to assist with examination of care of people with COPD as documented on the ward. The process of audit development is described in detail within Chapter Four. Although group members had previously criticised the use of audits as a mechanism of surveillance they felt in this case it was the most appropriate way in which to examine the documentation of care. Members of the group had been central to the construction of the audit foci, and claimed the results would be meaningful to them. However in contrast to their prior experience of audits, interpretation of findings was a role situated within the ARG.

The audit examined patient histories (n=20) within 48 hours of discharge from the ward, including bedside charts and progress notes. The average length of stay (ALOS) for this sample was 7.1 days (4-18). The figure is similar to 12 month data provided by the hospital (ALOS 7.3 days) and Australian Institute of Health and Welfare (7.5 days) (2005). Consistent with other research findings, a high level of disease co morbidity which ranged from one to five was evident.

5.3.1 Patient Assessment

During hospitalisation patients' undergo a variety of assessments. The audit focus was admission assessment and specific COPD assessment. Admission assessment and subsequent planning for discharge are intended to commence within 24 hours of admission (Atwal, 2002). Admission assessment rates of pre morbid status undertaken during the first 24 hours of admission by each discipline are shown in table seven:

	Identified by nursing staff	Identified by medical staff	Identified by other*	Total Identified
Carer status	15	17	4	20
Previous use of community services	9	1	4	11
Normal ADL status	17	14	6	18

Table 7: Assessment of pre Admission Status in First 24 Hours by Discipline (n=20)

*includes allied health team situated within Emergency Department, unit based allied health

High levels of assessment duplication by a range of staff including medical, nursing and allied health within the emergency department and ward area are demonstrated in the sample. It cannot be clarified if patient assessment occurred multiple times or if information is noted from previous documentation and re written. Carer status was identified in all cases examined, and the identification of normal activities of daily living status is well assessed. The identification of previous community providers appeared to be at suboptimal levels.

COPD literature identifies other areas of assessment critical to overall management of the disease. These include smoking status, low or excess weight, vaccination status and identification of depression and anxiety (McKenzie et al., 2003). The identification of COPD specific risk by discipline from the audit is shown in Table eight:

Item	Nurses	Medical	Total
Smoking status identified	13	17	19
Vaccination status identified	1	2	3
Weight recorded	11	0	11
Depression screening	9	0	9

Table 8: Assessment of COPD Specific Risk by Nurses & Medical Team Members (n=20)

Identification of smoking status was assessed at high frequency. Assessment of vaccination status, weight recording, and depression screening occurred at low levels within the examined histories. Associated interventions linked with assessment of risk factors were also minimal. For example six cases were identified as current tobacco smokers, of these, one had a recorded intervention. Additionally there were no records of interventions aimed at increasing vaccination, managing weight or depression within the audited cases.

5.3.2 Multidisciplinary Team

The multidisciplinary team, early referral to allied health professionals and their role in overall patient care were identified as key to acute care management of COPD patients (McKenzie et al, 2003). The ARG understood that referral would be followed by assessment and intervention, in a standard manner. Therefore they chose to examine referral and subsequent consultation rates and discarded the need to examine details of the interventions which took place. The data is contained within table nine.

	Physio-therapy	Occupational Therapy	Dietician	Social work	Respiratory Nurse
Referral completed	18	12	8	9	6
Patient not reviewed	0	2	1	1	1
Reviewed without completed referral	2	2	1	1	4
Total patients reviewed	20	12	8	9	9

Table 9: Completion of Formal Multidisciplinary Referral by Nurses & Subsequent Review by discipline (n=20)

The figures demonstrated high referral rates to physiotherapy, as the audited sample had referral and consultations completed. Other disciplines had variable referral rates; of note the number to the specialist respiratory nurse was low. The patients identified as seen by allied health team members without written referral suggests that informal referral may

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occur in keeping with information provided during interview. The mode of referral was not identified within the audit. Consultations with disciplines occurred across the cases' length of stay, for example sessions with social work and occupational therapy were more likely to occur after the initial acute phase of the admission on day three or four.

The audit also sought to identify documentation of discussions or planning from multidisciplinary meetings. Despite these meetings taking place for each medical unit once per week, none of the audited histories contained notes related to the meetings and decisions undertaken during those meetings. Furthermore there was no documentation by nursing or medical staff about patient understandings of COPD, or their involvement in plans of care. Information related to COPD management is intended to enhance patient and carer understanding of the disease and is contained within the COPD patient pack which according to normal practice should be provided to every COPD patient admitted to the ward. The pack contains information about the aetiology of the disease, medication use, relaxation, available support and pulmonary rehabilitation. Six patients in the audit sample were documented as receiving the pack.

5.3.3 Continuing Care

Evidence of continuing care and assistance to patients to manage ongoing impacts of the disease post discharge were sought during audit. Pulmonary rehabilitation is a critical component of COPD management and was provided with the hospital where the research took place. Referral was facilitated by physiotherapists or medical personnel. At the time of audit nurses could not directly refer to the program. Referral to this program occurred at low levels within the audit sample, with only three patients being referred. All were referred by the physiotherapist with one in the group also referred by the medical team.

Low levels of referral to community health for continuing support were also evident from audit data. Two patients out of the twenty cases audited were referred to community health from the acute care sector. Both patients were referred for assistance with activities of daily living, one included the filling of a medication box. Despite one of these patients having demonstrated difficulty using an inhaler, this was not identified on referral.

There was no evidence that general practitioners were involved with discharge planning within the audit data. There was no documentation that GPs were contacted for information related to patients at any time during admission or discharge process. Information transfer to general practitioners from the acute care sector occurred in the form of a written discharge summary completed by the medical team around discharge time. The audit showed 90% of these summaries were complete and posted within 48 hours of discharge. The content of the summaries was not included within the audit data.

5.3.4 Summary

Audit outcomes added valuable data related to documented patient care within the ward. Information related to admission and assessment, multidisciplinary referral and consultation rates, provision of continuing care and the involvement of patients and carers in care delivery continue to build a picture of a complex and multifaceted care provision structure. The views of patients and community providers further illuminate information sought by the ARG in the process of the identification of key issues as s focus for action.

5.4 Action Cycle 1D: Views of Patients & Community Providers
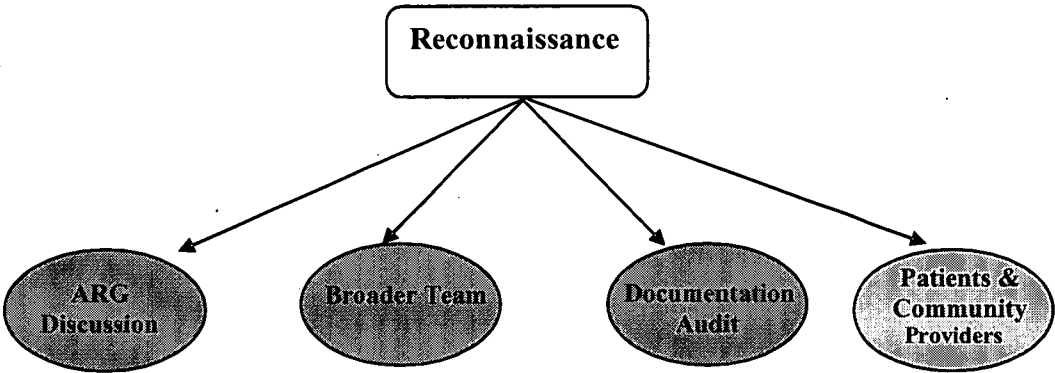
Figure 6: Action Plan 1D

5.4.1 Community Providers Views on Provision of Care to Persons with COPD

Data related to community nurses' role and understandings of COPD management and continuity of care was derived from a single focus group in one community health centre together with responses to a questionnaire distributed to community health nurses from several practice centres. Nine community nurses attended the focus group, and a total of nineteen community nurses, including some from the focus group completed the questionnaire. Further information related to the structure and collection of the data is documented in Chapter Four. Under this heading the responses of patients to the prepared questionnaire are also included. Thirty eight questionnaires were distributed, and sixteen were returned. Due to the low response from carers (eight questionnaires distributed/ two returned) their responses are not considered as the ARG members considered the return rate to low to provide meaningful data which could be generalised to the broader carer group.

Although suggesting COPD may be a 'taken for granted' co morbidity within their general client group, community nurses at the focus group viewed themselves as well situated to discuss and examine issues around care provision for these clients. They claimed that the disease occurred at high rates within their normal cohort of clients, as one focus group participant commented:

'...I would think the majority of our patients have got it [COPD] *anyway - so it's not something you think 'oh gosh I've really got to be totally aware of this'. It's always something in the background and maybe we do take it for granted a bit and maybe we don't give it the care we should be because most of our patients would have an element of COPD'.*

On this background two key topics are considered: (i) referral to community health, including patient readiness to return home, and, (ii) the broader topic of their normal practice as it related to providing care to persons with COPD. Data from the focus group is further informed by questionnaire respondent data which was provided from members of the focus group and two other community health centres.

5.4.2 Referral Process

Referrals received by community nursing generated from the acute care sector regarding the discharge of people with COPD were reported to be mostly related to support for the activities of daily living or assessment. Focus group members criticised unclear, ambiguous referral requests which in their experience occurred frequently. They cited situations where they were expected to *'read between the lines'*. The following comments of focus group participants reflect these concerns:

'... we get a referral saying 'assess'...Well assess what? There are very few clues...Are we assessing respiratory function?... there is no indication of what their previous peak flow is, we don't have sats monitors and I would say our assessment [respiratory] is not that great...but they could mean social or for services...we just don't know...'

'We want to know the tests they had, and the outcome of the tests... the overall picture of why they went in, and the events that led them to be admitted into the hospital. What treatment have they received, what assessment were made, and what is the [longer term] goal [for the patient]...What do we want to achieve and what was the level of function [for the patient] before [admission to hospital]. Do we want to maintain [general level of health], or are they going to deteriorate slowly? What are the goals for this person...We just don't get that...'

Comments made during the focus group suggested that referrals were plagued by poor communication of both prior client function and the intent of referral to community services. Questionnaire responses supported such claims and indicated referrals contained sufficient information in only 65% of cases, with only half of the clients referred perceived by community nurse respondents as understanding the reason for referral. In contrast to this finding 65% of patient respondents to the questionnaire indicated in they were satisfied with the level of information received about community services.

Focus group participants reported they often sought clarification of the information contained within referrals from acute care providers and claimed the process to be both complex and time consuming. A clear point of contact was reported to be frequently missing on the referral. Community nurses argued they could spend significant time attempting to elicit further information. Their attempts were not always successful and were a source of frustration. Group participants reported that, based on previous experiences, many would not even attempt to contact acute care providers.

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Questionnaire data indicated that most (90%) community health referrals were received on the day of discharge or later, a perception which was also discussed by focus group participants who described referrals received on the day of discharge as maintaining a focus on reactive care. That is, late notification limited planning time available for community nurses, forcing them to review of patients 'in a rush'. The referrals received when the day of discharge was Friday were a specific concern because in such cases three days could elapse before the patient was visited by a community health nurse.

5.4.3 Readiness for Discharge

Participants in the focus group also nominated deficits related to discharge planning and the education of patients. The community health nurse accounts indicated that their interactions with clients informed these perceptions. One nurse reported:

'The client often has no idea what has happened in hospital, they have no idea why they were there, their discharge is often a surprise to them...they find out on the day they are going home and worse than that they don't really know about what is going to happen with the disease, what the plan is...how to prevent getting sick again...'

The focus group participants claimed many of their clients were ill prepared for discharge and under educated about their disease process. This was supported by community health provider questionnaire responses which indicated they felt that over half the clients were not sufficiently prepared for discharge.

Yet overall patient respondents to the PREPARED questionnaire indicated they felt moderately or well prepared for returning home when they looked back at the time they left hospital (see table ten), with only two indicating they were not prepared.

	Very prepared	Adequately prepared	Unprepared
Patient ratings of preparedness to return home	9	5	2

Table 10: Ratings by Patient Questionnaire Respondents on Preparedness to Return Home at Discharge (n=16)

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5.4.4 Communication at Discharge

Patient respondents who completed the PREPARED questionnaire indicated waiting for medications as a key reason for delay in discharge, they reported that they received verbal and written instructions about their medications in the majority of cases. Of concern all patient respondents indicated they did not receive any information designed to give to their general practitioner at the next appointment.

Community nurses at the focus group confirmed these reports and in contrast to the findings of the audit data, which demonstrated that summaries of the patient admission, were posted to general practitioners promptly, noted that general practitioners often waited for significant time periods before they received a discharge summary leaving the patient in what they called 'limbo'. As one community nurse commented:

'...the doctors, they don't know what has happened. They have the patient turn up at the practice being told they need to see the GP in a week from discharge, and they [the GP] don't even know the patient has been in hospital...Then they have to guess about medications and what the plan is, just like us [community nurses]...'

Free text fields in the questionnaire provided a space for respondents to make comments related to aspects of care. Of the four responses two specifically commented that they were not ready for discharge but had to leave because the bed was needed. The two respondents comments stated:

'I felt the same as I was when I went in but you can't complain because they need the bed...they reckoned they knew my body better that me...' (patient respondent 8)

'I was told on Monday at 8.30 I was going, I thought I was going Tuesday, but then I was kicked out pretty promptly' (patient respondent 3)

Community nurse respondents in the focus group also added to such perceptions and recalled how patients often told them that they were sicker than when they went into the hospital, or that they needed to leave because of the need for beds to be freed up.

5.4.5 Normal Practice and Understandings of COPD care

Focus group data indicated that the community health nurses held a perception of COPD management in acute care as focused on technical tasks, providing examples of

intravenous therapy, oxygen management, and saturation monitoring and blood gas analysis, all of which was directed by medical respiratory specialists. In the context of the focus group the community health nurses were not able to demonstrate knowledge of the COPDX management guideline, and their comments indicated that had poor knowledge of pulmonary rehabilitation programs or self management programs for chronic disease and expressed the view that their current COPD care and management strategies could be improved. In response to the question of how good their current delivery of COPD care was, one nurse commented:

'Not very good, I mean we know to use reliever medication etc prior to activity and all that, but really we don't have to manage acute episodes, we couldn't manage acute episodes and I certainly don't advise people about the disease, just to be aware of symptoms and see their GP for any concerns'.

When asked to consider if community nurses' had the ability to be involved in other areas of care provision to people with COPD, for example smoking cessation or medication education, the group felt that this was possible but rarely undertaken. Focus group members suggested such interventions would be hampered by lack of ongoing contact with those clients after they had been assessed and subsequently referred to other agencies. The focus group participants agreed that in the majority of cases they could recall people with COPD who were initially referred to community nursing for support of daily living activities would be referred on to agencies which provided personal carers and home help. No community nurses could recall *'keeping COPD clients on the books'* for more general chronic disease support and management.

5.4.6 Summary

Overall information provided by community providers and people with COPD was predominantly related to concerns with discharge from hospital and the co-ordination of ongoing care. Continuity of care was impacted by poor communication between health care providers, and to patients themselves. Although patients in the majority of cases who responded to the questionnaire felt prepared for discharge the understandings of community nurses also highlight ongoing concerns in the area.

5.4.7 Reconnaissance Postscript

During reconnaissance the ARG members' capacity to engage with the research agenda was impacted by general activities on the ward and the reactive nature of ward structure. Impacts of the practice setting, which were clearly articulated by the ARG during meetings, were also affecting the ability of the group to maintain their activities. Over the duration of reconnaissance data collection the attendance at meetings had been sporadic, and meeting frequency had waned. A decreased number of meetings occurred despite my attempts to reschedule or to provide flexibility in time of meetings. Our meetings were disrupted for a range of reasons which were related to the busy ward environment and were also affected by the scheduling of other ward based activities (e.g. general ward meeting of staff). Despite such activities only being scheduled on that day, they inevitably took precedence over attendance at the research meetings. This situation was seemingly accepted by ARG members as the directive came from the CNM or other hospital management personnel. As a consequence of all factors, during the reconnaissance most ARG meetings were only attended by two or three members. With two members on long term leave the group experienced on ongoing change of membership at each meeting. Cancellations and rescheduling of meetings, together with low attendance and subsequent changing membership of the group added to the complexity of maintaining the research focus.

5.5 Discussion

The reconnaissance was intended to provide information in order to facilitate ARG members understanding of the key issues and concerns in the current situation for patients with COPD admitted to their ward. Whilst the ARG focus up to this point was their own experiences, they were now poised to consider interpretations from others, who whilst occupying a related space, were essentially outsiders (with the exception of nurses interviewed), to the ward. Overall, the reconnaissance findings appear to verify the concerns expressed by members of the ARG during their meetings. Despite nurses from the ward articulating substantive knowledge of evidence based COPD care provision, problems were identified across all areas of patient care, from admission to discharge, including poor integration with community care provision. The findings also emphasize

the impact of the practice setting and overall organisational structures of the hospital on the capacity of acute care nurses to engage with delivery of evidence based care to persons with COPD. Worryingly, as the group moved through the reconnaissance stage it had become increasingly evident that such influences were also impacting on the ability of the group to meet and to progress the action research agenda.

5.5.1 Difficulties Experienced by the ARG

The ongoing difficulties experienced by the group in meeting together reflect issues reported in the literature by others who have undertaken collaborative research in hospital settings. They argue that whilst collaboration is a central tenet of action research the very nature of acute care impacts on the possibility of realising a collaborative agenda (Kelly & Simpson, 2001; Mongeau, Champagne, & Liben, 2007; Reed, 2005; Shaha & Rabenschlag, 2007b). Shift work together with the lack of capacity for nurses to organise their own work time is cited as negatively affecting group activities, cohesion and collaboration (Reed, 2005, p. 596; Titchen & Binnie, 1993). In addition shift work impacts on meeting attendance rates further compromising the potential for and collaboration between team members. Similarly Mongeau et al (2007, p. 12) highlight the impact of personnel turnover in the practice setting which interrupts the action research process as new members of the research group must be supported to both understand events to date as well as the action research approach. In the context of this research the problems with managing meetings and subsequent ongoing collaboration between group members became an emerging challenge for the ARG. The challenges of maintaining an action research agenda within an acute care environment shared commonality with the day to day struggles faced by nurses in their attempts to deliver evidence based care to people with COPD.

5.5.2 Knowledge of Acute Care Nurses

From the discussions of ARG members and the nurses who participated in the semi structured interviews, it was evident that acute care nurses believed they had a good knowledge of the evidence related to COPD. They claimed to understand what it was like from a patient and carer perspective and expressed insight into the experience of being a

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person with COPD. In addition they were able to articulate what constituted high standards of care delivery to persons admitted with COPD to the ward. The data suggests that the ARG members did not lack awareness of, or the desire to, include a strong evidence base in provision of care to patients with COPD.

5.5.2.1 Capacity to Apply Knowledge

Within the ward setting, not only were there multiple barriers which impeded the realisation of a research agenda, but also in the provision of care designed to meet the needs of persons with COPD. At the heart of acute care provision is the ability to respond to acute disease states by providing treatment and cure (World Health Organisation, 2002). As highlighted in the literature cited previously numerous studies reveal that those who are most poorly served by acute care services are people with chronic disease (Wagner et al., 2001; Swerissen 2002) and older persons (Hickman et al., 2007). Consequently it was little wonder that within the reconnaissance data issues such as chronic disease management, education and continuity of care were relegated down the list of priorities. The data also illustrates that attempts to improve chronic disease management at an organisational level, such as those addressing implementation of the Respecting Patients' Choice program, appear to ignore or be unaware of the additional resource demands associated with implementation.

Feelings of frustration and a sense of stress amongst the ARG members was unmistakeable as the group explored their struggle with attempts to juggle the competing demands of being a nurse on the ward. These problems were underpinned by the reactive nature of the acute care environment evident in the ARG member's perceived need to prioritise bed management and staffing management over direct patient care delivery. The group members realised that adopting a reactive approach to addressing practice issues opened up significant gaps in care, but felt impotent in their ability to change the circumstances of practice. The findings provide an insight into competing interests within the acute care sector, and the problems faced by nurses as they attempt to deliver care to persons with COPD.

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Such problems demonstrate the struggle by nurses to deliver care in the *'real world'*, where change was constant and the environment chaotic. Medical nursing has been described as 'about messiness, complexity, filth, [and] chaos...'(Parker, 2004, p. 211) as well as burdensome and stressful (Shaha & Rabenschlag, 2007). The ARG dialogues identified recurring situations of work overload or poor resourcing which Shaha & Rabenschlag (2007) link firmly with loss of motivation and repeated stress for the nurses involved. Members' descriptions of how care deficits occurred are similar to that articulated in the literature. Indeed as Allen (2007, p. 43) suggests, nurses find themselves 'at the intersection of multiple requirements' within the practice setting. It is at this intersection that the nurses within the ARG became the 'conduits' through which complex and conflicting demands of the health care environment were enacted (Latimer 2007). The data would suggest that it is at that point of juggling and prioritising demands that nurses may feel there is no other option but to modify care delivered in ways that move away from adherence to best practice guidelines for delivery of care to persons with COPD. In doing so they were influenced by hegemonic understandings of the hierarchy of needs within the ward, which in effect saw nurses prioritise proactive planned care, such as the provision of education and support to patients with COPD, as something they could do if and when there were no other more immediate demands to be met.

5.5.2.2 Application of Evidence Based Guidelines

The COPD care plan used on the ward was discussed during ARG meetings and by interview respondents, as well as being the subject of examination through the audit of documentation. The care plan in part reflected recommendations contained within the COPDX guideline. For example key nursing interventions were represented including education, assessment of puffer technique and titration of oxygen (McKenzie et al., 2003, p. S16, S31). However the reconnaissance data derived from all sources indicated that use of, and adherence to, the care plan on the ward was a significant problem. The findings of reconnaissance suggest that barriers to full implementation of the care plan may be similar to those which impact on overall uptake of COPDX recommendations in general practice (Ford, 2004; Rutschmann et al., 2004). Indeed one such study (Smith et al., 2005, p. 124) echoes the discussions of ARG members, identifying heavy workloads, poor time

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resource, organisational behaviours and organisation systems as barriers to uptake. The findings indicated there were significant issues with practice inside the ward setting related to care provision of nurses in the ward which also reflected concerns with the broader focus on continuity of care.

5.5.3 Multidisciplinary Care & Discharge Planning

Continuity of care is a difficult concept to define, however is described as '*a series of connected patient care events both within a health care institution and among multiple settings*' (Sparbel & Anderson, 2000, p. 17). Achieving continuity of care is frequently dependent on both individual and community resources (Armitage & Kavanagh, 1998). The reconnaissance findings would suggest that provision of continuity of care may also be influenced by the understandings and expectations held by individual practitioners, as to what this constitutes. Nurses and medical practitioners from within acute and nurses from community care demonstrated a paucity of knowledge about the others' activities, except for general assumptions which were underpinned by various past experiences. Criticism was forthcoming between sectors and related to patient preparedness for discharge, understanding and management of disease and gaps in planning. In addition the reconnaissance data demonstrated acute care providers did not seek information about the patients' status prior to admission from any sources other than patient and carer, further negating any consideration of care provided by primary healthcare professionals. Similar disconnections were evident in the provision of multidisciplinary care provision, which also has a role in continuity of care between professionals and sectors.

Multidisciplinary team care is highlighted as central to care provision for persons with chronic disease and has a key role in delivery of care to persons with COPD (McKenzie et al, 2003). The data from reconnaissance indicates nurses' role within the multidisciplinary group was limited to referral, provision of information and undertaking interventions suggested by other health team members. Highlighting further tensions apparent between roles, many nurses were not aware of the detail of interventions undertaken. Practical constraints such as nurses not attending the multidisciplinary meeting, or lack of recognition of nurses' contribution to the team appear to consolidate

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the perception that they were not active multidisciplinary team members (Miller et al., 2008; Reeves & Lewin, 2004). The delivery of multidisciplinary care was therefore identified as inconsistent in approach, and not collaborative in delivery.

5.5.4 Summary

Based on the events which occurred during the reconnaissance stage of research, I would argue that the missing element for group members was the power to, and knowledge of how, to effect change within the practice setting. It was hoped that engagement with participatory action research would provide them with opportunities to build such knowledge and skill. The first steps which had tentatively been taken to ensure members of the group could gain a broader understanding of the issues, through collection of the reconnaissance data, implicated the setting of acute care as impacting on capacity to apply evidence based practice. However the group were at an important intersection of the research. Group members had been able to, albeit in a limited capacity, consider the broader issues which impacted on the provision of care to people with COPD, yet had not fully engaged with reconnaissance findings. Activities of the group to this point had elicited data which could further enhance the understandings of members in relation to such care provision. However they were at a point where deeper exploration of the issues was hampered by the ability to maintain consistent activity within the group. Despite the successes of the ARG as they interrogated the issues related to care provision, the future of the group became uncertain. The group members and I had invested significant resources in obtaining the reconnaissance data and members felt that actions of the group now needed to focus on viewing the first level analysis of reconnaissance data I had completed, together with considering the future of the group and whether it was viable. Both of these actions are addressed in the following chapter.

6 Emerging Empowerment

As illustrated in the previous chapters, group members were faced with multiple barriers as they attempted to remain engaged with the research endeavour. During this next stage of the project the intent was to ensure time for group members to consider the reconnaissance data prior to developing plans for action. As outlined previously thus far, their engagement in the research process had been constrained by an inability of all group members to regularly meet. At this point group members had been unable to maintain such activities and recognised the need to consider their future. Although not openly discussed there was an unspoken sentiment emerging within the group which questioned the viability of the research. At this point the ARG members needed to decide whether they could continue in the face of multiple barriers.

In order to achieve their aim of considering the reconnaissance data and to address identified problems with meeting together it was agreed to hold a workshop where group members would have the opportunity to respond to the reconnaissance data and then consider the future of the group as an entity.

6.1 Planning a Workshop Approach

During the reconnaissance ARG members had been able to meet a sufficient number of times to consider their issues and concerns. Yet over the period they struggled to maintain meeting schedules and as a result their attendance rates at meetings diminished. Meetings were characterised by delayed starts, frequent interruptions, cancellations and competition with other events, such as general ward meetings. Because of inconsistency in attendance, the levels of engagement with and understanding of the discussions and reflections undertaken during stage one was inconsistent across the group membership. As outlined previously, membership had also diminished during the time reconnaissance was undertaken with two members being on extended leave, a further three resigning their positions on the ward and another taking intermittent sick leave with a complex health issue. The group was in a state of crisis, which was reflected in the inability to arrange a time for the next meeting.

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During this period my efforts to re-engage ARG members in the context of conversations I had with individual members was intense and resulted in us reaching an agreement to allocate dedicated time and a space away from the acute care environment to undertake review of the reconnaissance data. During such conversations, members of the group, who were equally frustrated with the problems we faced, highlighted the importance of ensuring maximum attendance in order to reach consensus about both the reconnaissance data and the future of the group. In consultation with members, it was agreed that two workshops would be held offsite to counter the current impediments to group activity (e.g. interruptions) and provide an appropriate strategy to maximise attendance and engagement. Undertaking the second workshop was contingent on decisions undertaken by group members about the future of the group. In the previous three months I had developed a document which synthesised all the reconnaissance data, ready to hand to the group once the workshop was organised.

6.1.1 Advice from Steering Committee

Concurrently, the steering committee (Dec 2006) were provided with data from the reconnaissance stages of the research. They were also informed of the decreasing membership and attendance at meetings of the ARG. The steering committee was able to provide some support for the workshop and suggested members of the group consider other persons who might be invited to join and strengthen the ARG. Such a step, they argued may reinvigorate the ARG, and provide encouragement for continuation. The CNM was supportive and released three group members from the workplace for part of their scheduled shift. Through informal discussions and negotiation on the ward, members of the group invited a further respiratory nurse (Jess) and an allied health team member (Henry) to participate in the project. Jess and Henry were identified by the group as they had shown interest in the activities of the group so far, and were keen to contribute. Dave, a nurse who had initially volunteered to be part of the ARG, but only attended one meeting thus far, was also approached and asked to participate at a higher level. Subsequently six staff members attended the workshop, of three hours duration.

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Three members participated in their own time. Workshop one was held on the 28th February 2007, approximately twelve months since the project had commenced.

Three members participated in their own time. Workshop one was held on the 28th February 2007, approximately twelve months since the project had commenced.

6.2 Considering the Reconnaissance Data: Action Plan Two

Concern:	Engagement of ARG with reconnaissance data
Action Plan:	Hold workshop to consider data and future of group
Data Sources:	Summative reconnaissance paper Record of ARG meetings
Analysis	Group reflections and dialogue
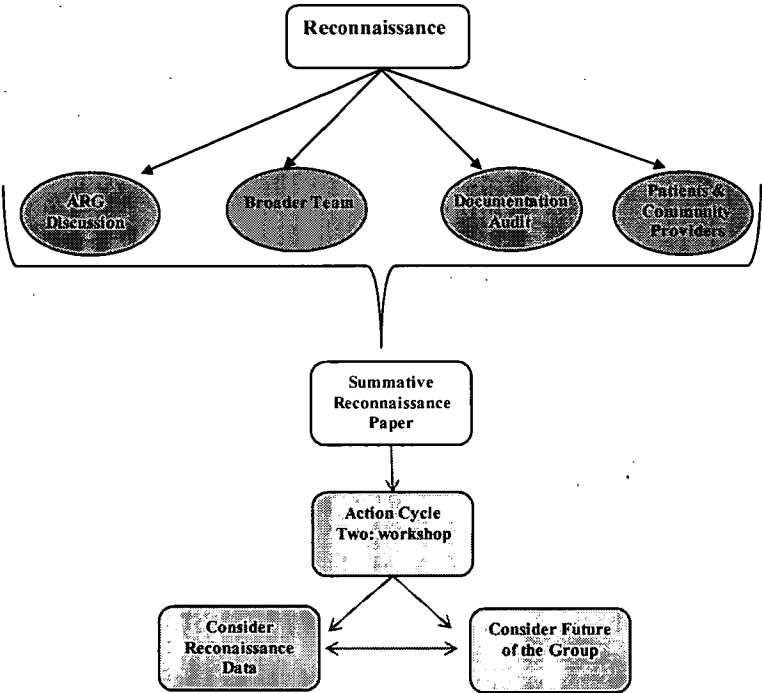
Figure 7: Overview of Past and Present ARG Activities

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6.3 Take Action & Collect Data

The first workshop was designed for group members to consider all of the data generated to this point. This was presented to them prior to the workshop, in a document which summarised reconnaissance data following a first level analysis which I had undertaken. Group members were asked to read the document, to attend the workshop to contribute their interpretations and critique of the findings, as a precursor to developing possible action plans to address the problems identified. However prior to the workshop group members also expressed the need to reconnect with the action research process and new group members needed to be provided with information to facilitate their engagement within the action research methodology. As such the workshop provided a forum where members of the group were reminded of the intent of the research, the need for respect and confidentially between members and the key strategies of dialogue and reflection as they fitted with the critical intent of the research.

The need to refresh understanding of the action research process and activities so far, as well as to provide an opportunity for members to discuss any issues related to their participation in the research, was based on both comments from the ongoing group members and my own perceptions of the difficulties they were experiencing. I too shared the concerns of group members regarding the changing membership, poor attendance and ongoing viability of the group. My journal entries at the time were replete with comments indicating my concerns that members of the ARG had become disconnected from the research. For example I noted:

'Fred says he has lost the plot really, at least he is honest about it. He indicated that he is not really sure about what the group has said or not said, and welcomed the idea of getting together to sort things out...'

As well as limited understanding of group activities, articulated by Fred, other members also expressed a sense of futility related to the progress of the group, and whether the activities themselves were fruitless. I further noted in my journal:

India is unsure if she will continue as [she feels] *the group is not getting anywhere...and*

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she doesn't really understand what is going on ...I guess when we are not achieving anything it is hard to assign value of the research...

At the beginning of the first workshop members of the group welcomed the opportunity provided by participation to refresh and refocus instead of, as one member commented *'wandering along not knowing* [what was going on]'. It was also evident that they had spent time reading and considering the content of the reconnaissance document prior to attendance. They had not yet discussed the findings as a group and the workshop provided an opportunity for frank and open discussion of findings between group members which was intended to provoke further critical reflection on the issues at hand.

Group members' initial response to the data was one of shock. One group member revealed he was so disturbed by the information contained within the reconnaissance document that he drove for thirty minutes to the CNM's house to present the paper to her in disgust. His response was reportedly based on a perception that the reconnaissance paper presented nursing practice on the ward in a bad light, and was not representative of reality, as he saw it. Overall responses by the group members to the data were negative, in the sense that some members of the group did not agree with the first level analysis and others felt that the analysis provided evidence of issues in practice which reflected badly on the ward. In an apparent attempt to dismiss the data gathered during group discussions, members questioned the context in which comments were made during reconnaissance. Highlighting the struggle of members to come to terms with ARG accounts contained within the summative reconnaissance document Carla argued:

'I think what has happened is that the [ARG] meetings were always at the end of a shift ...we were debriefing...it is natural at the end of the shift, I mean it's horrible and you haven't been able to do anything...and then we sit down and [at a meeting] *it just all comes out...'*

Others within the group expressed similar feelings and added that complaints about problems with care provision had been made simply because ARG research meetings provided an opportunity to air grievances. Quite simply, the group members claimed, the findings arising from the research meetings were tainted with their own dissatisfaction with the workplace. In order to explore the issue further I highlighted that group comments

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about concerns with care were made over the course of several meetings and represented a strong theme. I asked them to consider if nurses should accept feelings of stress and discontent as part of normal life on the ward after every shift. They reconsidered the issue and their responses confirmed their sense of daily dissatisfaction and that this was considered normal. As Carla claimed *'well that is the way it is...'* Others in the group agreed articulating a concern that nursing care provided on the ward was subject to multiple demands from others which in effect devalued overall care by nurses. As Fred claimed:

'oh I mean it might not be like that all the time...but we are medical nurses, and that is it we always get the shit...we cop it from everyone during the day, patients, bed managers, you name it we cop it...you can't always do anything about it and here there's not enough nurses or anything to go round...you know what it is like...'

One of the new members further elaborated concerns about dissatisfaction on the ward and the impact on morale. Jess argued:

'...there is a sense of dissatisfaction on the ward, people are leaving and always complaining...when there are problems with care, nurses claim there is not enough time or that no one else cares about it...'

In these discussions the group members expressed the view that more often that not they finished a shift feeling they *'had achieved nothing'* during their working day and were operating in an environment which made *'constant demands without any recognition'* for their achievements. They went on to claim that this was a common feeling amongst other staff members also. ARG members pointed to the fact that three ARG members had resigned from the ward, and cited workplace dissatisfaction as a key factor in their decision to leave. Changes in staffing on the ward were felt by the group members to further exacerbate workplace pressures. As the discussion continued ARG members reiterated many of the sentiments contained in the reconnaissance data, agreeing that increasing demands were made on more experienced nurses whilst, as Carla commented, they *'watched patient care go down the gurgler'*. Whilst group members spent some time during the workshop sharing further exemplars from practice to explain and justify situations where patient care was poor, upon critical reflection on the findings, they increasingly came to recognition that the reconnaissance document did indeed contain some truth.

Analysis of this workshop discussion revealed that the ARG members' initial negative

reaction was tempered with increasing engagement with the information contained within the reconnaissance document. For example, members of the group made comments such as *'it's pretty bad* [the overall picture from data]' and *'when you put it together* [all data sources], *we are not doing as well as we thought'*.

6.4 Analysis and Reflection

The realisation that the reconnaissance data did contain information which was valuable and valid, provoked members to reconsider their response and discuss the data under categories used in reporting the reconnaissance data. It was a pragmatic decision undertaken by group members as they saw the necessity for a framework to expedite their understanding and discussion of the reconnaissance data in greater depth.

6.4.1 General Care Provision

It was clear to group members that the reconnaissance data revealed significant problems with care provision. Furthermore members of the group acknowledged that most of the problems identified in the reconnaissance remained unaddressed at the time of the workshop. They were not surprised that care deficits identified during reconnaissance included areas of inhaler technique checking, ongoing management of the disease, referrals to pulmonary rehabilitation and strategies to assist patients in avoiding further admissions. Although, as Fred stated *'it is a bit of a shock to see it there in black and white'*, as the discussion continued group members accepted there were problems. Further agreeing with reconnaissance findings, the impact of the busy ward environment was confirmed as a key influence on undermining their capacity to provide an evidence based approach to care provision. Closely related to the busy environment, group members also argued that many of the negative findings were directly associated with the inexperience of many nurses who worked on the ward. This issue was explored in order to further elaborate on the perceived impact of inexperience on patient outcomes.

6.4.1.1 Impact of Inexperienced Nurses on Care Provision

During discussions, less experienced nurses working on the ward were described as poorly equipped to provide the complex holistic care to patients admitted to the ward with COPD.

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That being the case, I asked ARG members to consider how these nurses were supported to improve their knowledge and the breadth of their practice. The members of the group agreed that little time was spent attempting to improve others' knowledge of COPD care. A number of group members drew on their personal experience to further expand on this point. Attempts to assist with education on the ward were described as *'a waste of time'*, or *'unappreciated'*, because so often nurses moved on to other wards and were replaced by other transient staff. High turnover of staff was cited as a possible reason for poor completion rates of education packages, where attempts to engage new staff in completion were classed as futile. As Carla explained:

'They all leave anyway, we haven't had grads stay here really, they move on...not like before where they would stay, so they are only here for a year and can't wait to get out...'

Several ARG members described feelings of hopelessness and a sense of futility related to provision of education to nurses on the ward. For example members described how compulsory education packages were not utilised on the ward and that new and inexperienced staff received little assistance to build their knowledge and skills. As an example Dave argued:

'...so many of them [inexperienced nurses from pool or graduates] *come through here, the grads are meant to do things [education packages] but no one really helps them do that anymore...We are meant to have an educator, but that didn't happen, we are all too busy, they just don't do it and no one makes sure they do...When we were new you had to do a whole package, and do an in-service presentation, and it got done, but now it is just hit and miss...Those things have got worse...Often they don't care though and leave things like VPAP to us...then they are here and might have a patient who needs it and no one knows how to set it up...*

Further expanding on the discussion, some ARG members went as far as claiming inexperienced or graduate nurses were very different to nurses of the ARG's generation. Articulating a sense of hopelessness for change Carla stated:

'...they don't care anyway, it is a different kind of nursing now, they come from uni and think they know everything, you try and teach them stuff, but they are not really interested in the patients...They don't know how to talk to patients and they are not encouraged to anymore...'

In these workshop discussions it was apparent that ARG members had what seemed like a never ending litany of complaints about less experienced nurses who worked on the ward.

6.4.1.2 The Position of Experienced Nurses

As I listened to ARG members' characterisation of inexperienced staff, I was left feeling that they considered their own practice to be far superior. In my role as critical friend and in order to bring about greater exploration of the issues, I shared this interpretation and challenged them to reconsider their views and assessment of the current situation. Group members initially responded by making further claims that they *were* more experienced and *did* provide better care than many other nurses on the ward. As Dave commented:

'...yes we are providing better care...We have been on the ward and even [prior location of respiratory ward], *I mean look at the experience we have, years of this* [caring for respiratory patients] *you can't just get that it takes time...We used to have staff that belonged there and we all knew what to do, but we had* [permanent] *staff and it was easier...more people knew the stuff...These guys* [inexperienced staff] *just don't know and it is a different era, some of them just don't care... they don't stay here so they can learn...'*

During their explanation of what it meant to be more senior and experienced, group members spoke about the respect they had from hospital managers and members of the multidisciplinary team which, they argued, was linked with their experience on the ward. They also related how they thought others saw them as nurses who *'knew what was going on',* who delivered *'superior care'.* Highlighting the benefits of such recognition when Fred said:

'Well it is nice. The consultants always talk to me, they know that I know what is going on, we are the ones in charge and so know...We can get things done, and we know the patients better, and how to get things done...'(Fred)

Critically reflecting on the issue of their experience and capacity to provide better care, group members articulated the importance of inherent rewards provided by managers and other health care professionals, in the form of recognition and status. Subsequently, I challenged group members to ask themselves if their own actions, evidenced by not supporting the education and development of less experienced nurses' skills, were informed by their own desire to maintain a position of privilege. As the group struggled with this issue, the discussion was somewhat difficult. Group members felt their status on the ward was earned by way of long experience on the ward and having *'done the hard yards'.* Yet critically reflecting on this issue, group members started to interrogate the relationship between their complaints, their observation of poor engagement with education among less

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experienced nurses, and the maintenance of their own position of privilege on the ward. A tension emerged between group members' expectations of the limited capacity of less experienced nurses to provide high quality care on the ward, and lack of support experienced ward staff provided them. This tension was evident in the areas of patient care, where less experienced nurses struggled to deliver high quality care because of the scope of their responsibilities and the general business of the ward. As the discussion continued, the ARG members agreed there was a potential to both educate and encourage inexperienced staff to develop their knowledge and skills in the care of respiratory patients. They agreed the subject warranted further discussion during a second workshop if the group continued. The decision to consider the issue further was a significant step for group members, as they began to see emerging opportunities for change.

6.4.2 Communication of Patient Care

Having resolved to critically reflect on the issue of supporting inexperienced nurses prior to workshop two, the group now moved on to the considering the role of communication in care provision to people with COPD. The audit revealed specific concerns with communication related to patient care including:

- Poor referral rates to allied health
- Poor communication between health care providers
- Low referral to cardiopulmonary rehabilitation

The group members challenged validity of some data contained within audit findings, and in some cases rejected audit findings outright as they sought to 'make sense' of the reconnaissance report. With reference to the audit data, as the discussion progressed, group members assumed a defensive position and argued that not every nursing activity relating to care of patients with COPD required documentation. This argument essentially challenged the validity of some audit findings with group members suggesting it was not representative of the reality of practice. The group identified distribution of the COPD education pack as an example. While the audit findings indicated patients did not routinely receive the pack, members claimed that most patients received the pack, but the action was not routinely documented. Hence they claimed that the audit, which examined

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documentation of pack distribution, was not representative of actual practice. India
stated:

'You can see if they [patients] *have it* [pack] *or not, it is often lying around on the bed table,
and if they have been in before they have got it then...I would say most people get one...'*

Further, the audit findings that indicated discussions with carers and patients were
undertaken at suboptimal levels was also rejected by the ARG. Members claimed that such
interactions were undertaken *'all the time'*, asserting there was no reason to document
'something which is a given'. Carla went on to argue:

*'if we wrote down every discussion we had with a patient there wouldn't be time for
anything else'...we talk to them in the shower, doing the meds, like everything we do we are
talking to them...*

In support of their position, group members asserted that their interactions with patients
(including carers) were communicated to other nurses mostly in a verbal manner, rather
than in written form. They stated that verbal information transfer occurred at handover, or
during the shift via informal conversations. Yet critically reflecting on this issue the group
recognised that their reliance on the verbal transfer of information was problematic, being
'hit and miss, India highlighted:

*'...but that is how problems can happen, you can forget to tell other people what is
happening...or they might think it is not important so don't pass it on at their
handover...you come back from days off and think "I told them that I thought such and such
was happening and no one has a clue that has been said, it has disappeared somehow, not
important...'*

Discussions surrounding information transfer highlighted that group members considered it
important to ensure key information was transferred somehow, yet they did not reach
consensus on the best mode. The group remained divided about the best approach to
address such a complex issue, but agreed that sharing the information with other nurses in
verbal form did not always ensure information was provided to all care providers.

The recognition amongst group members that verbal transfer of information was not always
the appropriate manner in which to communicate components of COPD care represented a
significant shift in position. Like the issues with education of inexperienced staff, the
difficulty with communication, including the transfer of core patient information, was

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considered by group members to warrant further exploration and consideration.

6.4.2.1 Multidisciplinary Care

The discussion of communication led group members to consider engagement with multidisciplinary care provision, where communication within the team was also highlighted as an issue within audit data. To explore this issue ARG members' considered the interaction of nursing staff with multidisciplinary team members through the referral process. The audit data identified the referral process as resource intensive, which at times led to delays in patients being reviewed by allied health team staff. Previous discussions by the ARG during reconnaissance identified the reliance on formal channels of communication to be a key impediment to a timely referral. In these discussions, ARG members concurred with the reconnaissance findings, discussing the resource requirements associated with writing separate referrals for each allied health team member who needed to see a patient. The use of a rigid referral process, with the requirement for a written referral, and subsequent notification to each allied health team member by post or telephone was claimed to result in decreased referral rates and represented a barrier to an effective and timely referral. Follow up of referrals was also time consuming, and members described the need to 'wade through notes' to determine referral status. Hence, during the workshop, ARG members confirmed that referrals were a source of frustration and they articulated a desire to streamline the referral process.

The manner in which referral rates were prescribed (i.e. all patients referred to all allied health providers) and the rate of referral, identified in audit data caused the group to critically reflect on this issue. Members argued that non referral to individual allied health members were valid if nurses' assessment indicated it was not necessary. They argued that nurses held expertise in assessment of the need for a referral, yet this expertise was negated in the dictum that *all* COPD patients *must be* referred to *all* allied health disciplines on *all* admissions. In effect ARG members saw their role in this process as 'robotic', simply completing and actioning referral, and felt their knowledge and assessment of patient need was undervalued by others. As they continued to critically explore the validity of audit findings related to referral rates, group members argued that

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an audit which simply identified if a referral had occurred did not take into account the more complex issues surrounding the overall referral process and, in essence, contributed to the undermining and negating of nurses' role in the referral process. It was a strong claim by members and led them to reconsider their broader role in the multidisciplinary team which had been previously raised in the reconnaissance discussion.

6.4.2.2 Role of Nurses in Multidisciplinary Team

Findings contained in the reconnaissance data from nurses and allied health team members who participated in interviews indicated issues with multidisciplinary collaboration. Group members confirmed a perception of their role as outsiders to multidisciplinary processes and described interpretation of their role within multidisciplinary teams as one of *'working alongside'* the various allied health team members. The ARG members critically reflected on the information in the reconnaissance data and argued that during the previous two to three years nurses had become marginalised by some multidisciplinary practices. Members of the group considered the delineation of different roles within the hospital discouraged actions which had previously been within the realm of nursing practice. Dave drew on an example from practice to illustrate the point further. In relationship to physiotherapy and patient mobility, Dave described how nurses confined patients to bed, based on the directive that nurses should not mobilise patients if they had not had a physiotherapy assessment. He explained that if the patient was admitted on a Friday evening this meant patients could remain at 'rest in bed' for at least two days because the nurse on duty did not feel they had the authority to make a decision to mobilise the patient. Dave stated:

'Some nurses won't make the call about getting patients up because if you get them up and they fall, and they don't have an assessment or guide from the physio related to mobility then we are in trouble...But we used to make that judgement...I still do that but it might only be for my shift when I do it, because others won't get them up without the okay of the physio...but these people have been getting around at home, might not be very well, but if we leave them in bed for days then we are making it worse...'

Other group members agreed with this assessment and argued that in the recent past there had been an increase in the application of discipline specific boundaries. In considering this issue, group members agreed greater understanding, communication and collaboration with

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allied health team members may provide possibilities for action where they might be able to improve the care people with COPD received on the ward. Henry, a physiotherapist who was a new member of the team, and somewhat tentative in his contribution, nevertheless indicated clearly that his concern was also with patient care. He agreed that the situation described by Dave was not beneficial to anyone. Henry indicated a willingness to work with group members to address such issues but also cautioned that those in his discipline were also constrained by the situation. Henry reported:

'It is a problem, and some patients should not be mobilised before we see them, but others should be...We are in difficult situation because we see some [patients] that just shouldn't be moved and their safety, and ours is compromised if they are got up with the wrong equipment or worse with no equipment...So we have taken a hard line...It probably needs to change but how can you do that when there are so many people involved...'

Henry's comment further highlighted concerns with the differential expertise of nurses on the ward, which, in his view, sees patient safety 'compromised'. Hence he felt that the application of a standard procedural approach which limited the nurses' scope of practice decision making in these circumstances was at times warranted. However this discussion also highlighted that working relationships and interactions within the health care teams warranted further consideration. What was notable in these discussions was a change in focus to a consideration of the broader issues of multidisciplinary care. Rather than questioning the validity of the data, the group shifted to a position where they were now were examining the data in depth, and drawing on their experience to further interrogate and critically reflect on the issues raised. This was an important step forward in these discussions as group members now recognised an imperative to find better ways to work with members of the multidisciplinary team. Indeed they felt action in this area may lead to improved multidisciplinary care which might have the added benefit of facilitating the integration of nurses as part of the broader team.

6.4.2.3 Precipitating Action

Out of these discussions it was apparent that the group were being galvanised to take action. This was evident when one group member reported that reading the reconnaissance document had spurred him into action independent of the group. During the time between circulation of the document and workshop one, Fred had elected to improve tracking of

referrals and consultations completed. He had reformatted the nursing handover sheet, a document which is used by nurses on every shift to communicate core patient information, such as name, diagnosis and current treatment. He included tick boxes in the new format which documented completed referrals and whether there had been an assessment by the allied health group. The tick boxes included core disciplines of physiotherapy, occupational therapy, respiratory nursing and social work. Fred related to the group how this had come about:

'It was easy really. I wasn't busy on nights so fiddled with the [handover] *sheet...the last column has tick boxes to show whether referrals have been sent, and then others* [tick boxes] *to show whether they have been seen* [by allied health]...*it is already been used but we need to make sure people tick the boxes, not ignore them...'*

The group welcomed and supported the initiative, considering it of assistance in tracking referral and response rates. Such an initiative held the potential to enhance more timely review by allied health team members and hence improved preparation for discharge.

6.4.3 Ongoing Care Provision

The reconnaissance data which presented views of community providers, patients and carers added further perspectives for consideration by ARG members. These data provided insights into how well patients were prepared for discharge and how acute care nurses worked with their community counterparts in facilitating continuity of care, a key focus at the inception of the research. Overall, the findings from the audit together with questionnaires and focus groups responses from community health care professionals indicated that patients were rarely referred to community providers and, if they were, relevant patient details contained within the referrals were limited. In addition, while the data provided from respondents to the patient survey indicated they felt well prepared for discharge, the feedback from community providers presented a contradictory picture. For example, community providers felt patients were often not aware of reasons for referral to community services and felt ill prepared to provide appropriate care following a discharge. During consideration of this issue group members confirmed that as acute care nurses they had little interaction with community providers when patients were admitted or discharged. They further related this apparent lack of focus on liaison with community

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service providers to having a primary focus on managing the patients' acute care episode, which in turn left little time for other considerations. Group members questioned how they could consider discharge or ongoing care if they were constantly struggling to meet the immediate needs of the patient in the acute care setting. As India noted:

'This is why all of that other stuff (outside direct care acute care needs) *needs to be done in the community...So when they come here* [to the ward]...*well we can't do it, we just don't have time...It* [longer term planning] **should be** *done in the community, they have more time, the patient isn't sick, they* **know** *the family...it isn't our job, we just can't do it...'* [emphasis in bold]

Such comments indicated that, when challenged, the ARG members continued to deflect responsibility for key aspects of care provision to people with COPD, which they argued would be more appropriately undertaken in the community. Similarly, with regard to discharge readiness of their patients, group members again claimed, in the context of workload pressures that they did the best they could. Carla reported that despite the best intentions to facilitate planning for discharge, nurses were often *'blindsided'* when a decision to discharge was made. She stated:

'...we know roughly how long they [patients] *will be in here. You know* [from past experience]... *know they are well enough to go home... And then sometimes they* [patients] *say I am not ready to go home and the doctors just say, 'oh ok stay another day'. Other times you can see they are really struggling and need to stay a couple more days but the doctors insist on sending them home...There doesn't seem to be rhyme nor reason sometimes...Other times we are just too busy and the patient is gone, or knows they are going before you have a chance* [to catch up]...'

Carla's claim further illustrates the chaotic nature of the ward and how nurses are often forced to adopt a reactive stance to patient care provision. Whilst the ARG members considered the area of ongoing care provision required further discussion but at this stage could see no clear way in which to proceed in order to improve the current situation.

As ARG members concluded their discussions of the reconnaissance findings, they had decided on areas that required ongoing attention which would be the focus of future discussions. These included; general care provision on the ward and the influence of inexperienced nurses, a focus on the care plan, improving relationships with the multidisciplinary team, and continuity of care. They were not able to fully discuss all issues or exhaust all discussion because of the need to also discuss the future of the group

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within the timeframe of the workshop. It was this issue which dominated the final period of the workshop discussions.

6.4.4 Viability of the ARG

Members clearly recognised similarities between the difficulties of adopting evidence based practice in care delivery to people with COPD in the context of a busy and unpredictable ward environment, and the difficulties of engaging in the action research process. During workshop one it was evident they blamed the busy and unpredictable nature of the ward setting for poor attendance at ARG meetings and in the process indicated that they felt they could do nothing about this. They argued, as they had previously, that events within the ward, including patient care should take precedence over their participation in research. But in considering the issue, they recognised that disruption to research meetings, particularly related to the inconsistent attendance resulted in great difficulties in advancing the research agenda. As Carla argued intermittent attendees were constantly required to be *'kept up to speed with events'*. During a discussion around the problems they experienced in sustaining and advancing the project, group members aired their frustrations at always seeming to *'rehash things'* and going *'over and over the same ground'* as a result of aforementioned problems with consistent participation. In addition, members expressed exasperation at constant interruptions to meetings, evident when other ward staff entered the room where meetings were held, to access equipment or when ARG members were summoned from the meeting to attend to practice issues.

Critically reflecting on the research journey so far, the group considered the efficacy of the workshop approach. Uninterrupted time and space for the research had not been a feature of the prior group's activities, yet having participated in the workshop, members now recognised benefits of *'being able to focus'* and *'being here for the research'*. It was also apparent that holding the workshop away from the ward had fostered a renewed focus on the research activity. In effect being away from the ward meant the meeting was not subject to interruptions and members were not pre occupied with meeting immediate

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needs of the ward, as they had been when meetings had been held there. As such India commented:

'I can see that you have done a lot, and even though it seemed we were going in circles, there is a lot here for us to think about..."

Further benefits associated with extended, uninterrupted engagement in the research process included having an opportunity to consider the data as a whole which facilitated the conceptualisation of whole of practice issues which impacted on the quality of care received by people with COPD nursed on the ward. As Dave argued:

'...when you are working [on the ward] you can only see that you haven't done this or that, but now I can see the overall [situation]...Lots of things which go together and mean...and they aren't small things when you put them together... Well we are not doing as much as we thought... there are things we could fix'

6.4.4.1 Reinvigoration of the Research Agenda

Such comments signalled a shift in the groups understanding of the problems they faced. Indeed as group members explored the issues over the course of workshop one, they began to see possibilities for action emerge. Issues such as working with inexperienced members of staff to develop their knowledge and skills, and developing greater levels of collaboration with members of the multidisciplinary team were considered. While the ARG at this point had not formulated action plans to address issues, importantly they had begun the process of identifying possible areas for action, which could be explored in future activities of the group. As possibilities emerged so did the commitment of group members. They were excited by the realisation that things did not need to be as they were, and that as a group, they could make changes. In this sense they shared a desire to continue with the project to improve care provision on the ward, but were unclear how to facilitate ongoing activity. Members of the ARG were reinvigorated by the workshop, which they claimed allowed them time to consider *'what they really wanted'*. Such were the group members' impressions from participation in the workshop that they now considered that dedicated time for the research was necessary to *'really get somewhere'*.

Given the success of the first workshop members agreed to plan future meetings at a location external to the ward. A second workshop was to be held which would include

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further dialogue and formulation of the meeting schedule which was dependent on further actions they might decide to take. They agreed that ARG activities would be best facilitated by undertaking meetings at a location external to the ward. Positive decisions about the future of the group meant that the tentatively planned second workshop would go ahead and members would consider planning for further action. The ARG members had initially expressed a mixed response to the data, and through group dialogue and critical reflection they accepted and expanded on many of the problems in care provision to persons with COPD that the data highlighted. Case notes were provided four days after conclusion of workshop one, in order to provide a summary of discussions to date and to assist further critical reflection on topics discussed.

6.5 Discussion

Data provided from the reconnaissance was critical in that it provided the ARG members with multiple issues on which to critically reflect, and in doing so assisted members to clarify the nature of their concerns. Importantly the information provided in the reconnaissance document was informed by the broader views of stakeholders, together with data generated by the ARG members during prior meetings. The continuing aim of this phase was to actively involve members of the group in what Lather (1991, p. 63) terms the 'construction and validation of meaning' from the findings. In order to meet such an aim, group members entered into dialogue, resulting in a reasoned agreement reached through the use of critical reflection and argumentation (Habermas, 1984, 1987). Such a step is evidenced in the manner in which ARG members debated the issues, and considered points of view which may have challenged their existing understandings of the situation. Further illuminating the data, members of the group drew on their own experience to explore and make sense of the issues at hand. Evidence of new understandings of the key issues impacting on care provision to persons with COPD on the ward, was provided by the movement of ARG members from denying and abdicating responsibility for addressing care deficits to realising their central role in determining a way forward.

6.5.1 Defending and Rationalising Findings: Abdicating Responsibility

The shock expressed by group members on reviewing the reconnaissance data could in part be explained by their expressed perception that the data was not representative of what they understood to be the situation. On commencement of workshop discussions, their initial defensive position was perhaps a familiar, taken for granted response to defending practice, in the face of critique and challenge. For example, their response to the management audits which assessed levels of support for initiatives like Respecting Patients Choice were perceived by group members as representing an attack on their practice, and by implication, their competence. In a context where nurses are continuously judged across a range of criteria framed by institutional imperatives and economically derived outcome measurements (Latimer, 2000, p. 14), it is not surprising that the group members assumed a defensive position.

In terms of rationalising the situation the ARG members indicated that they were not responsible for areas of care deficit because of an expectation that they keep up with the demands of a busy ward setting. Indeed a lack of control over the busy practice environment was cited by group members as a rationale for what the data indicated was problems with nursing care. Lack of control over the ward environment and an associated dissatisfaction with the workplace, is supported by other research which highlights such issues have a negative impact on nurses' ability to deliver care (Chan et al., 1990; Jackson, Mannix, & Daly, 2001). Members saw themselves as *doing the best* they could in the circumstances. Such rationalisations are supported by literature which highlights that nurses feel caring for patients is being eroded from nursing (Vere-Jones, 2008, p. 16), and that decreasing amounts of nursing time is spent on direct patient care (Hurst, 2009, p. 14; Krichbaum et al., 2007, p. 86). Indeed it is argued that nursing practice itself has become increasingly dominated by the need to meet demands exerted through structural components of health care delivery systems (Krichbaum et al., 2007). Further, it is suggested by Spilsbury and Meyer, (2001) that a move toward measuring nursing outcomes in quantifiable terms works to negate the role of nursing time spent on

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education, relationships and interaction with patients simply because they are not easily measured and therefore remain largely invisible.

The implications of this situation are evident in accounts of ARG members that nurses who left the ward had done so primarily because of work dissatisfaction and an inability to deliver care as they saw it should be. The impact on nurses, who remained on the ward, was reportedly one of increasing stress. McVicar (2003) and Cavanagh & Coffin (1992) note that a loss of staff has a negative influence on staff morale, while there is an body of research which highlights that when nurses cannot deliver a standard of care they deem necessary, they are more likely to experience stress, and an increasing sense of work dissatisfaction often resulting in leaving the workplace (Jackson et al., 2001). Whilst some abrogation of responsibility for apparent care deficits is reasonable within this context it can also be interpreted as a consequence of nurses' sense of disempowerment within the setting reflected in their comments that they feel unable to effect change in their practice.

6.5.2 Disempowerment of Nurses

At the commencement of workshop one, the nurses in the ARG articulated a feeling that they were not in a position to make any changes in their practice. Their dialogues suggested they felt disempowered and unable to challenge organisational or medical constructs of care. Such constructs exerted a pervasive influence on the way aspects of care to people with COPD was understood and prioritised, that had until this point remained unquestioned. The group members accepted, as they so often argued *'this is the way things are'*. More worryingly they felt that as medical nurses their role in care provision was destined to be assigned little status in the overall context of acute care provision. Within the context of acute care delivery there is a growing body of evidence which suggests nurses continue to be disempowered by the hierarchy of hospital management systems which have a focus on disease (Fletcher, 2006, p. 50), and are in turn heavily influenced by economic rationalist agendas to do more with less (Weinberg, 2004). Describing the impact of economic agendas in an American hospital where she undertook an ethnographic study, Weinberg's (2004) description of practice demonstrates

similarity with the ward setting of this study, as described by the ARG members. She states:

> Nurses said they were doing the best they could, but they felt powerless to change either the daily breakdowns and problems [in the ward itself] or the hospital policies that contributed to them. (Weinberg, 2004, p. 110)

Similarly Latimer (2000, p. 6) argues that the bedside has been reconfigured as a 'commodity' and a space of production, where activities related to patient care need to be visible in order to justify expenditure. It is argued that strong forces are exerted on nursing practice to align actions or individuals with organisational goals of patient throughput, cost containment and process (Ballou, 2001). When nurses align their goals with those of management, the ideology of the health care system pervades their activities and ways of thinking. This ideology can be seen as being perpetuated through hegemonic understandings which the ARG nurses expressed as *'the way things are'*, where they accepted getting *'no recognition for what they did achieve'*.

The operation of hierarchical power relations on the ward are evident in the ARG members descriptions, also discussed by Attree (2005, p. 393) as trends in the delegation of managerial functions in health care organisations (consider bed management and staffing) which are not matched by autonomy or discretion in decision making. Attree (2005) goes on to claim that nurses are increasingly expected to accept individual responsibility and accountability for clinical decisions, yet concurrently have less control and influence over the major factors which govern their daily practice. In effect this works to further disempowering them, whilst increasing job dissatisfaction. The effects are evident in the ARG members' defensive initial response to the reconnaissance data and their perception that they could do little to change the situation.

6.5.3 Engagement and Benefits of Critical Reflection

While the reconnaissance data exposed problems in care provision it also highlighted tensions inherent within the everyday work of nurses on the ward. Whilst the initial group response to the reconnaissance data was not positive, members also recognised that the *'time out'* from practice provided by a workshop had conferred significant benefits. The necessity of a free space for reflection in action research is highlighted by Eikeland (2001,

p. 151) who argues that it is essential for practitioners to facilitate discussion of 'local knowledge' which is then made amenable to be considered critically for further meaning. During the workshop the ARG members made important advances in understanding the relationship to, and benefits of, their involvement in an action research approach. In turn this provided them with a growing level of enthusiasm and impetus to continue with the project. Such benefits may not have been possible had the group continued to meet on the ward where engagement with the research process was hampered by continued interruption and an inadequate commitment of time.

As the group members sought meaning within the findings, they also developed relations of reciprocity within the group (Lather, 1991, p. 61). As Lather (1991, p. 61) further describes, such activity involved the ARG members in a process of recycling of descriptions, emerging analysis and conclusions. It was through their involvement in this process that a willingness on the part of group members to consider the issues in greater detail emerged, which in turn conferred benefits to the research activities. By critically reflecting on the issues, members of the group were able to move forward from their initial defensive position, to further interrogate findings and importantly, their own stance. Key to the ability to move forward was what Carr & Kemmis (1986, p. 122) describe as a 'willingness to make views and preconceptions available for critical inspection and to engage in discussion and argument that is open and impartial'. Within the context of the workshop, ARG members spoke freely, and in the process their taken for granted understandings of their world as practitioners on the ward were challenged, as they drew on individual and collective experiences to arrive at new understandings of the situation.

Yet the new understandings were not easily realised. As stated previously my own role as facilitator was at times integral to the process. Such a role was undertaken with the intent of identifying 'contradictions and conflicts' in the reflections shared by group members (Pawan, 2003, p. 31). The group responded positively to my provocation and this facilitated a process where they critically reflected on the issues to come to an increasing 'awareness' in what Johannisson (2004) terms an 'awakening'.

New understandings became evident as ARG members entered into dialogue about their specific concerns. Awareness of their taken for granted understandings developed which in turn underpinned their adopting a new positioning on various aspects of care provision. For example, members of the ARG perceived inexperienced nurses as disinterested in learning more about care provision to people with COPD. Yet through critically reflecting on the issues they came to recognise their complicity in being disinterested and non supportive of the education and professional development of these staff and how it was implicated in the problems identified. At this stage of the research ARG members agreed to continue their interrogation of the issues by agreeing to return to a second workshop to explore the key areas of concern identified. The processes they had undertaken to this point are further illustrated in diagram below
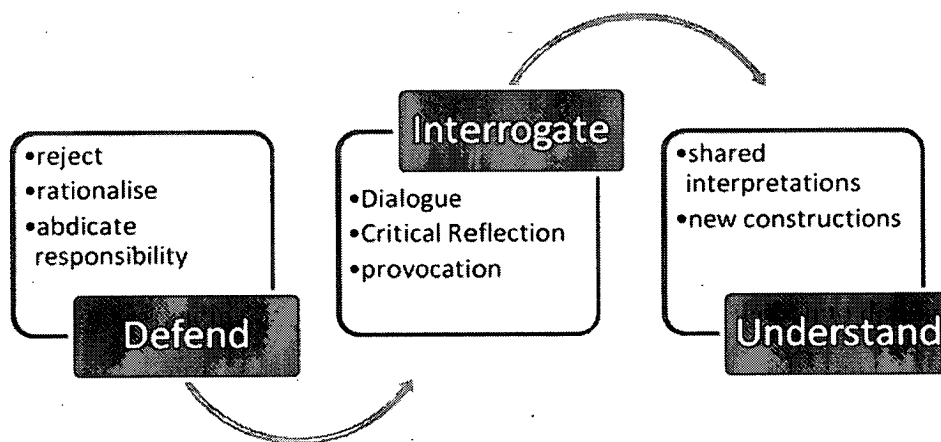
Figure 8: Summary of Process Undertaken in Consideration of Reconnaissance data

The group members were ready to continue advancing the action research project, and exhibited some hope that they would be able to undertake action to improve the current situation. Agreement had been reached on the core issues of concern to group members. Hence it is argued that members of the group had moved toward realising a glimmer of enlightenment which emerged through their engagement with the reconnaissance data and a process where they had an opportunity to critically reflect on the findings.

6.6 Summary

This stage of the research had been tortuous one for the ARG and in the events leading up to the workshop the viability of the ARG was at risk. However, against the odds, members were able to manoeuvre into a position which ensured the immediate survival of the group. The workshop represented an epiphany where they came to agreement about the desire to continue the ARG endeavour and had identified key areas for further critical reflection and consideration of action plans. They now had greater insight into potential areas for action if they were to improve the situation for persons admitted to their ward with COPD. Not only did members of the group have improved understandings, but they now also saw a hope that things could be different. It was with this hope firmly entrenched in their conversations they moved forward to a second workshop where they would consider possibilities for action. The following chapter details the continued response of ARG members to the data and their critical reflections on key issues discussed in workshop one as they return to a second workshop and subsequent meetings with ideas for change, and then continue to take action. How would members of the group take new knowledge and insights and transfer them to action in order to impact on practice in positive ways?

7   Empowerment to Action

In the time leading up to this stage of the research the ARG had undertaken reconnaissance which included collection of data, and utilised critical reflection as a key strategy to increase members' understandings of the current situation for patients admitted to the ward with COPD. Of immense importance members of the group had also spent time considering viability of the research endeavour. They entered this stage with increased commitment, a clearer vision for the future, and renewed understandings of the action research process. In effect the group were entering a stage of the project where they felt empowered to take action to improve the situation. As such the ARG initiated two further action research cycles which aimed at firstly identifying and refining possible interventions to address the problems identified (action cycle three), and then proceeding to take action (action cycle four) to implement the targeted interventions. However, in keeping with the experience of group members up until this point, their commitment and enthusiasm for implementing change was disrupted by external influences which eventually overrode their momentum and resulted in the abandonment of activities. The initial component of the ARG work during this period occurred as they further ruminated on the reconnaissance findings and sought to identify areas of possible action during workshop two.

Action Cycle Three: Developing Understandings of Possible Action

Concern:	Identify possible areas for improvement of care provision to persons with COPD
Action Plan:	Brainstorm possibilities for action based on reflections from workshop one
Monitoring:	Feedback to meetings (case notes) Researcher Journal
Data Sources:	ARG Workshop two and subsequent two meetings
Analysis	Group analysis

7.1   Plan

Building on workshop one outcomes, members of the group aimed to utilise further critical exploration to brainstorm possible ways to improve care delivery during a second workshop, and to further develop these ideas in subsequent meetings. On this background the ARG planned to meet for the second workshop with a clear intent to follow up with an ongoing schedule of group meetings. The aim of group members during workshop two was to continue to move forward. From activities during this workshop, members of the group intended to develop a list of possible actions in order to provide a platform to select and implement an intervention.

7.2   Take Action& Collect Data

A need to maintain a focus on undertaking action which was achievable was identified by ARG members as they used collective experience and insights to identify and review potential actions. The plan for workshop two was to undertake a central activity where group members brainstormed ideas for action to improve COPD care. There were no constraints to imagining possible actions at this point, as priority was given to eliciting *any* ideas which resulted from group members' engagement with, and consideration of, the reconnaissance data during workshop one and in the intervening two weeks prior to the conduct of workshop two. A focus on action within the acute care environment was identified by members to be a central interest from the beginning of this workshop and followed ongoing reflection by the group members subsequent to workshop one.

At the second workshop members of the group argued that the original intent of the research, to improve continuity of care for persons with COPD, could not be tackled before they *'set their own house in order'*. As Fred further argued:

'...we can't very well go to community nurses and say well this isn't happening or we want to improve home care when what we do is not up to scratch...Its like um hypocritical...we think we are doing the best we can, there might be some stuff we can to

[to improve things], *which isn't that hard, some of it* [action] *we should be doing anyway, we just need to do it....'*

In effect this led to recognition by ARG members that they needed to take action to improve care provision on the ward. The alternative was to do nothing and accept that provision of care to people with COPD in the ward, was suboptimal and would remain this way. Such a notion members argued was unacceptable in the light of their new knowledge. Engagement with reconnaissance data had raised tensions for group members, which resulted from the mismatch between what they considered they *should* be doing and what they now understood to be the reality of care delivered to patients. In identifying a shifting focus to the ward as a site for action, group members also acknowledged the inter relationship between the ward and other stakeholders and suggested action taken within the acute care area could also impact on community or ongoing care provision. For example, they claimed that if they were able to better educate and improve patient and carer understandings of COPD then surely they would be better prepared to cope post discharge. As Carla said:

'...even if we can just make sure we give them [patients] *a bit of education, I mean they're not getting much now, then that has to help, it has to...then they might get to the doctor earlier or they might know more about what to do* [if they have an exacerbation]...'

During the workshop discussion members of the group also considered that in the future there was potential to build on change, perhaps by working with community nurses to examine follow up care. As the workshop progressed a level of excitement emerged within the group as they moved to focus their activities on the identification of action to improve patient care within the ward environment.

As ideas were raised detailed notes were taken which documented these and provided further opportunity for discussion about potential actions. Ideas were listed on a whiteboard during the workshop to allow members of the group to further understand and theme actions under the headings of the patient journey in acute care such as admission and assessment, inpatient care and discharge. Such theming provided a structure to guide the workshop activities. Documentation from notes and the whiteboard provided a basis

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for a written summary which detailed all ideas contributed. The summary, as the intended key output of workshop two, was circulated to ARG members via email two days after the workshop (table eleven)

Overall Area of Practice	Suggestion	Rationale
Admission & Assessment	Sticker in notes identifying vaccination status, inhaler technique, commencement of care plan, smoking status.	Highlight important interventions within medical history for other disciplines
	Liaise with safety and quality re admission & assessment form	Decrease duplication of assessment and ensure applicability of form to the ward activities
	Blanket referral to psych liaison nurse	Address issues of anxiety within COPD population
	Investigate possibility of on line referrals to allied health	Streamline referral process
	Enter alerts into patient histories when they are identified as CO2 retainers	Lessen events where patients are administered high flow oxygen resulting in decreased conscious levels
	Education Provision in Emergency Department	Lessen events where patients are administered high flow oxygen resulting in decreased conscious levels
	Complete incident reports when inappropriate care provided by other areas in hospital	Highlight occurrences of inappropriate care
Inpatient care	Signage around ward to encourage exercise and patients to sit out of bed for meals Explain expectation to patients, nurses and visitors	Closer adherence to COPD care plan
	Create mobility flow chart to be used by nurses	Encourage early mobility of patients Decrease need to wait for allied health assessment to mobilise patients
	Focus on a particular area of care each week. EG: physical mobility, sitting out of bed, dressing in day clothes, inhaler technique. Focus includes posters and messages to staff at handover	Increase awareness of care plan components Audit and feedback related to foci will add incentive to achieve
Discharge	Refer all patients to community health on discharge	Ensure patients are assessed within community re need for ongoing services and support
	Educate community health nurses	Enable community nurses to better fill needs of COPD patients by increasing knowledge.
	Further investigate role of community nurses and how best to utilise. Invite Community nurses to provide in-service within ward	Enhance understandings between acute and community care providers

Table 11: Summary of Possible Action Areas Identified by ARG during Workshop 2

Members of the group were asked to critically reflect on the ideas presented in table eleven and return to the next meeting ready to explore possibilities for interventions to be undertaken on the ward. In considering the possibilities, ARG members were encouraged to think about resource constraints, likelihood of success, ability to implement, and risk factors associated with implementation. A meeting was scheduled for one week after workshop two. Although at completion of the workshop there was no clear intent for members of the group to discuss ideas outside the meetings, conversations undertaken during the follow up meeting indicated the document had provided the basis for informal and ongoing discussions between members. At completion of workshop two, ARG members expressed a desire to continue meeting at a location external to the ward, as they felt it would facilitate their continued engagement, and provide a time and space to work solely on the research. Subsequently two meetings were held whilst they analysed the outcomes of workshop two and made decisions related to action. Discussion was lively and animated with a sense of moving forward to explore what action might be possible in the context of the ward setting

7.2.1 Analysis and Reflection

The activity of the group in the first meeting following workshop two was centred on identifying actions for further development. It became evident at this meeting that difficulties perceived with implementation of some suggestions impacted on which ideas the ARG members chose to move forward with. The meeting opened with a general discussion and response to suggestions where members of the group entered into dialogue about actions considered most likely to succeed, resulting in some suggestions being discarded almost immediately. For example referral of all COPD patients to the psychiatric liaison nurse was identified as a high priority. However, at the same time, members of the ARG recognised the action as complex, requiring support from the medical staff (thought to be unlikely by ARG members) and viewed as unachievable given liaison nurse resource constraints. Ideas such as this, discarded after consideration of likely success and feasibility of implementation, are not discussed in depth in this thesis. Actions which the group identified as priorities and subsequently undertook remain the central focus of this chapter.

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Affirming the central role of the COPD care plan in delivery of nursing care on the ward, members of the group identified that many suggested actions were closely linked to the care plan. As such, questions were raised by group members, about how to enhance usage and alignment of practice with the principles underpinning the care plan. Knowledge of the care plan components and use of the document by less experienced nurses (e.g. casual pool or graduate nurses), whom the group identified as struggling to deliver the required standards of care, were identified as recurring concerns of the ARG members. Clear linkages between ensuring timely and appropriate use of the care plan, and increasing nursing knowledge of care plan components were identified in group discussions.

Concurrently, members of the ARG reiterated their concerns regarding diminishing levels of skilled nurses on the ward, and increasing workplace pressures, claiming ward nurses were close to exceeding their capacity to cope in current circumstances. They also expressed an increased understanding of their own responsibility to support less experienced nurses on the ward. In contrast to how they had previously viewed less experienced nurses, as disinterested and with low skill level, ARG members now considered that the behaviour of experienced nurses may have contributed to an unsupportive and stressful environment for all nurses. As Dave suggested:

'...we might have a focus on different things but when it is busy you just don't have time to do everything, and neither do they [inexperienced nurses]*...we need to stop criticising, look at why or help understand why it is important to get things done..'.*

Consensus was reached by members of the group that improving education to inexperienced nurses on the ward held the potential to improve workplace relationships, nursing knowledge and skills and patient care on the ward. Group members expressed a desire to link the education closely with the COPD care plan. Given previous discussions of education and professional development provision within the ward I was somewhat hesitant about the action. As I noted in my journal:

'...this is unlikely to succeed, as a group we have had so many problems with meeting, how do they think they will be able to manage in-service without interruption and cancellation...' (30/03/2007)

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However despite my apprehension I was aware of the sense that the group were now empowered to take action. In contrast to my thoughts, group members agreed and were confident about the potential for such a program to impact positively on staff morale and knowledge, as well as patient outcomes. They felt a commitment to such a program, informed by their critical insights and improved knowledge of the issues was high. Recent experiences during workshops had resulted in renewed enthusiasm for the research and members of the group saw real possibilities to make a difference. At completion of the first meeting after workshop two, group members flagged an intention to develop an action plan to deliver an education program to nurses within the ward context to address known deficits with respect to the evidence base care provision to people with COPD. Hence they entered into a replanning stage, focused on the fleshing out of the structure and delivery options for an education program on the ward.

7.3 Action Cycle Four: Education on the Ward

Concern:	Improving care to persons with COPD
Action Plan:	Develop Education Program
Monitoring:	Feedback to meetings
	Researcher Journal
Data Sources:	Ward Documentation
	Questionnaire to ward nurses
	Case notes
Analysis	Group analysis
	Researcher analysis

Figure 9: Overview of Action Cycle Four

7.4 Plan

The decision by group members to deliver a supported in-service education program meant that at the five subsequent meetings they explored and documented the approach to be taken. Based on ARG members' knowledge of the ward setting, they focused on

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factors they considered essential for success, identifying the following as important components:

- Providing short frequent in-service education sessions
- Providing incentive to staff to attend
- Targeting known areas of knowledge deficit
- Engaging others to assist in implementation
- Evaluation of the education and support program

7.4.1 Providing In-service Education

The group agreed that the structure of an in-service education program should include mechanisms to facilitate maximum attendance. Historically, problems had been experienced with completion and attendance at in-service education sessions. Information kept on the ward about in-service education confirmed ARG members' understandings. According to these records, in the three months preceding the ARG education program, ten sessions of varying topics had been planned, five had taken place and attendance was recorded as between 2-6 nursing personnel at each session. Hence the group members recognised a need to develop strategies to facilitate attendance.

Members of the group argued that low attendance not only impacted on capacity to build knowledge and skills for ward staff but also affected *'how the ward looked'* to others, including external presenters of in-service education topics. Their discussions indicated that they considered poor attendance at in-service education to reflect badly on the ward, with presenters left thinking that no one on the ward was interested or engaged with ongoing education and development. Members of the group also argued that they felt that low attendance at in-service education reflected negatively on them as having poor management of the staff due to not being able to facilitate attendance. As Dave noted:

'We have had them [in-service] *before, and arranged for someone to come to the ward and it is embarrassing when you can't get anyone there to attend...you have to apologise...and they think there is no one interested, or we are disorganised...'*

Reasons identified by ARG members for current poor attendance at in-service education included the impact of shift work patterns and the demands of the ward environment, which had been clearly articulated during previous discussions. Two nursing staff members were required to remain on the ward during sessions to respond to patient needs,

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potentially enabling nine members of staff to attend each time. ARG members recounted that there was rarely a full complement of staff (or that ward staff were supplemented with casual pool staff), and work was not completed to a level that nursing staff felt they could leave the ward to attend in-service education, hence attendance rates were low. The ARG members reiterated that patient care was the priority in day to day work on the ward, and would take priority over in-service education attendance. Fred articulated this clearly when he described a typical situation on the ward:

'...you get to the end of the shift and haven't really had time for writing notes, following up doctors and doing the paperwork, the afternoon staff are there and can take over the patient stuff, you are just like thank goodness, they can do that and you have time to catch up on all the other stuff...and then of course there is stuff you need to do with patients which requires both of you [morning and afternoon staff] *there is never enough time and you just want to get out of there, so the end of shift is always frantic...'*

On this background the group argued short (15 minute) in service sessions, would encourage attendance by individuals as Jess noted:

'...to come for 15 minutes is doable, but if it is half an hour then that is different...If we make the teaching bit 10-15 minutes then they can be in and out, the person [delivering in-service] *can be there longer if people still want to talk about it...that way it is up to individuals and if they want more they can stay longer...*

By introducing a measure of flexibility, allowing time outside the specified delivery period for questions and further interaction, members of the ARG argued that the sessions were more likely to be attended and meet the needs of the staff. They planned that the in-service education sessions were to be open to any nurse who wanted to attend, including casual pool nurses. However, members of the ARG had in mind to primarily target a specific group of attendees, those being nurses who had been on the ward less than twelve months. This was in keeping with prior discussions where they identified nurses who were less experienced as having poorer levels of COPD knowledge.

Prior to the ARG focus on education, the handover period between morning and afternoon shifts had been used for in-service education provision on the ward. The group members argued that, in previous attempts to provide in-service education, the time during shift handover was considered ideal to capture both morning and afternoon shift nursing staff,

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for a half hour session. Education sessions had previously been scheduled somewhere between 2.15 and 4pm. Yet, ARG members pointed out that under this structure attendance was poor. Confirmation of difficulties associated with provision of education during the handover period was evident in the groups own struggle to meet during this time. To ameliorate this problem, group members suggested focusing their in-service education activities during the morning tea break and during the final 30 minutes of handover. By allowing staff to use the first 45 minutes of the handover period to complete important activities related to the end or beginning of the shift, the group members reasoned that both attendance and participant concentration would be enhanced.

With the aim of further enhancing attendance, group members planned for provision of in-service education on set days at set times, which they argued had the potential to set a pattern of education provision. Over the course of several weeks during which they planned to run the program the ARG suggested that such arrangements would well become accepted practice or indeed become habit forming for nurses on the ward. Hence the decision was made by ARG members to provide 15 minute in-service education sessions at the morning tea break (10am) and at 3.30pm on Tuesdays and Thursdays. Further ARG members assigned days for in-service education when they were working on the ward so they could facilitate attendance. They proposed bringing the sessions to the attention of their ward colleagues at the beginning of the shift and supported that strategy by what members described as *'rounding up nurses'* immediately prior to the start of sessions.

7.4.2 Support and Incentive to Attend

While finding a suitable time to deliver in-service education was critical, the ARG considered that providing incentive for nurses to attend was also important. Group members argued that rewards should be both immediate and cumulative. While agreeing that the immediate reward would be provision of morning or afternoon tea, ARG members identified the additional benefits of an enforced break. They claimed that nurses often forfeited their break in order to get work done, so that by attending the sessions, they

would receive a much needed break as well as provision of sustenance. As India noted *'we need to value ourselves first, and have that break...'.*

As a further incentive, members argued for the inclusion of a mentoring model for nurses attending, in order to provide opportunities to develop collaborative relationships between the two broad categories of experienced and less experienced nurses. ARG members argued that developing their role as mentors had the potential to assist in closer working relationships between nurses on the ward. As noted, the current situation was one where nurses were allocated patients on the ward and delivered care to this group with little support from others, unless it was requested. Carla commented:

'...we have been very critical of those nurses, and what they don't do, but I suppose we don't really work with them to improve care...If we know there are problems then we have to start working with them instead of just expecting them to know...It will be better if there is someone they can go to and ask, or someone who is looking out for them and knows where they need help...'

The ARG members proposed that each nurse, identified as being on the ward less than twelve months, would be provided a folder which contained additional information related to each area, and a competency checklist aligned with each in-service education topic. The intent was for the novice to complete the checklist with their assigned mentor. It was intended that each nurse undertaking the in-service education program would be assigned two mentors to provide ongoing support and sign off competencies after satisfactory discussion. The notion of support was tempered with understandings of the ARG members that less experienced nurses also needed to take responsibility for learning and completion of competencies. Those who were responsible for the mentoring aspects, were adamant that nurses undertaking the in-service education program had primary responsibility for completion, including organising appropriate times to meet with their identified mentor to discuss completion. Members of the ARG agreed as Dave noted:

'...they also have to take this on and make sure they meet to sign off the competencies...It is not like we will do everything for them, dish up the in-service and then chase them to complete...They need to recognise the importance and what has been provided for them...We are already busy and it will be impossible for us to keep track of them and chase them down to do stuff...'

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7.4.3 In-Service Education Content

The ARG completed their discussions related to the in-service education program content and approach with a general understanding of the content to be developed for education sessions. The prior activities of the ARG provided an excellent basis for the discussion of the program structure which was felt by members to target known areas of knowledge deficit. As such, findings from reconnaissance and the subsequent discussions of these by group members were considered alongside other documents which identified best practice care of persons with COPD. These documents included COPDX recommendations and other publications which addressed areas of nursing care provision to COPD patients. On this background ARG members identified the following areas to be included in the in-service program:

- Inhalers and Nebulisers
- Oxygen Management
- Pulse Oximetry
- Non invasive ventilation (VPAP)
- Overall COPD care

7.4.4 Outcome Measurement

Prior to delivering the in-service education program, ARG members considered how they would measure learning outcomes. Critically reflecting on the issues and exploration during and after implementation of the education program was to remain central to the groups' activities. In order to ensure they had sufficient information to assist reflection and analysis, members of the group highlighted the need to consider how they might evaluate the program. To examine whether the intervention improved provision and attendance at the proposed in-service education the ARG members agreed to collect data related to prior program provision to compare with the program planned. Further data would be sought from the participant's folders to determine levels of competency completion.

As group members also sought to provide support and mentoring to less experienced nurses through the delivery of the in-service education program, they explored avenues to

measure outcomes related specifically to the area. The need to do so was predicated on group members' insights that support to inexperienced nurses *together with* an education program was required. Group members suggested the development and use of a questionnaire to be administered pre and post in-service provision as the best way to evaluate impact. The questionnaire was designed by the ARG members, and in line with their previous discussions, it was intended to target nurses who had been staff on the ward for less than 12 months

7.4.4.1 Questionnaire Development

The evaluation questionnaire developed by the group focused on three ward areas; provision of education and professional development, support for education and professional development, and self ratings of knowledge, skills and confidence in specific areas of care provision to people with COPD (see appendix six). Following development by the ARG members, the questionnaire was reviewed by the steering committee, and members of the Quality Improvement Unit at the hospital who had expertise in questionnaire development. Small changes were made to ensure clarity of questions prior to submission and approval from the Human Research and Ethics Committee. The intention was to distribute the questionnaire prior to commencement of the in-service education program and after completion. In doing so the group would be provided with baseline data related to understandings of support provision and knowledge levels which could be compared to post intervention understandings. ARG members now felt sufficiently prepared to enter the next phase of the action cycle which was focused on delivery of the in-service program.

7.5   Take Action & Collect Data

Data from the reconnaissance provided the ARG members with key areas of concern, which they used as a basis to provide in-service education topics in order to tackle areas of knowledge deficit. The topics were related to the patient journey through acute care, with each session designed to build on the previous one. All aspects of the education and support program, as agreed by ARG members, were drawn together to form the in-service calendar as per table twelve on the following page.

Theme	Date	Time	topic
Inhalers & Nebulisers	19th June	1000	Types of Inhalers
		1530	Types of Inhalers
	21st June	1000	Nebs versus spacers
		1530	Nebs versus spacers
	26th June	1000	Educating patients re inhalers
		1530	Educating patients re inhalers
	28th June	1000	Review of competency
		1530	Review of competency
Oxygen Management	3rd July	1000	O2 Delivery devices (incl prescription)
		1530	O2 Delivery devices (incl prescription)
	5th July	1000	CO2 retention (incl symptoms)
		1530	CO2 retention (incl symptoms)
	10th July	1000	Humidifier set up
		1530	Blender set up
	12th July	1000	Home O2
		1530	Home O2
Pulse Oximetry	17th July	1000	Getting an accurate reading
		1530	Getting an accurate reading
	19th July	1000	What the reading means (compare gases)
		1530	What the reading means (compare gases)
VPAP (non invasive ventilation)	24th July	1000	What is VPAP/ indications for use
		1530	What is VPAP/indications for use
	26th July	1000	How to set up VPAP
		1530	How to set up VPAP
	31st July	1000	Troubleshooting VPAP
		1530	Troubleshooting VPAP
	2nd August	1000	Q & A VPAP
		1530	Q & A VPAP
Overall COPD care	7th August	1000	Allied Health Referrals
		1530	Allied Health Referrals
	9th August	1000	Huff & Puff
		1530	Huff & Puff
	14th August	1000	Dietician Interventions
		1530	Dietician Interventions
	16th August	1000	Community Support
		1530	Community Support

Table 12: In-service program schedule

With regard to providing support and mentoring to other nurses, ARG members sought the assistance of other staff on the ward. Five staff members, who were in addition to ARG members, were approached to assist with aspects of the education program. Those approached were informed of the in-service education program and the aims of the ARG in maximising attendance, and were supportive of the initiative. Experienced nurses who assisted with the assessment of competencies attended short sessions with the ARG members to ensure they understood both the competency document (for e.g see appendix nine) and their role within the endeavour. As planned, each nurse participating during in-service education was assigned two mentors who would provide ongoing support and facilitate competency completion. It was also proposed that nurses participating in the program were provided with a degree of flexibility related to completion. Part of the mentor role was to remind staff to attend or to gather and direct them to attend at the scheduled times. ARG members felt it was important to request day to day support for the in-service education program directly from the CNM, and subsequently asked her to facilitate attendance. Members of the ARG felt the support of senior leaders lent importance to the initiative.

In order to increase educational content of the proposed in-service education program, supporting documentation was provided to participants. Folders were developed by group members to include literature for further self directed learning about in service topics and competencies related to each topic. The competencies were closely aligned with available evidence and the group drew on a range of resources to support development. Sources included those available from the Australian Asthma and Respiratory educators' organisation, COPDX, the Australian Lung Foundation, and journal articles which documented best practice. One member agreed to develop the specific competencies, and provide them to the group for review, ensuring relevance and application to the ward setting.

7.5.1 Delivery

The program was delivered during the period from 19th June to 31st July 2008. Sixteen out a possible thirty six sessions were delivered by the group. The table below shows attendance and also documents the number of planned and completed sessions.

Theme	Planned	Held	Attendance
Inhalers & Nebs	8	5	4-5
Oxygen management	8	5	5-8
Pulse Oximetry	4	3	5-6
VPAP	8	3*	4-6
Overall COPD care	8*	0*	0*

Table 13: Delivery of Planned In- service Education Sessions with Attendance

*activities were suspended at this point

Seven cancellations occurred because of the busy state of the ward. Yet by far the biggest impact on delivery of the program resulted from hospital management decisions to close the ward and transfer staff and patients to a larger 30 bed ward. Nurses in the ARG had heard rumours about such a move, however did not consider such events would occur until they were provided by the information directly from the assistant director of nursing. The news of the move was delivered as a fait accompli, without consultation with the nurses or others who were working on the ward. The move was met with disquiet by ward staff and because not all details of the move were provided to the nursing group further rumours circulated about staffing models, bed numbers, dates of the move and the practicalities of the move itself. The time which elapsed between official notification to staff and the move was approximately six weeks. This caused the immediate abandonment of the action research intervention as members prepared for closure and transfer of the ward. Consequently the final twelve sessions were cancelled, and there was limited time for reflection on action. In the interim however members sustained an interest in what was achieved so far and wanted to evaluate the data. Subsequently I collected and collated the data sets for consideration of the group, who managed to meet once after notification of ward closure.

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7.6 *Analysis and Reflection*

As planned by the ARG members' data informing this part of the action research cycle is drawn from existing ward documentation, together with documentation of the current in-service education program initiative maintained by the ARG. In-service program participants completed the questionnaire outlined previously.

7.6.1 Participants

Questionnaire completion was undertaken by ten of the fourteen nurses approached to participate in the in-service education program, resulting in a response rate of 70%. Of these, eight were registered nurses and two were enrolled nurses. Seven nurses were female and three male. The time since qualification as a registered or enrolled nurse ranged from less than twelve months (n=3) through to more than four years (n=5) but all had been on the research ward for 12 months or less. Age of respondents also varied from 20 years through to 39 years or older.

Further data contained in the pre intervention questionnaire is included and compared with data sources related to implementation of the education program in the following sections. Unfortunately as a direct impact of the ward closure group members were unable to distribute and collect the post intervention questionnaire. Hence information from the questionnaires was only provided at one time point immediately prior to commencement of the in-service education program.

7.6.2 Availability of In-Service

In order to seek data for analysis of in-service education attendance ARG members examined prior records on the ward, including a master document where each person recorded their attendance. However ARG members reported not all in-service education sessions were recorded there, and the document appeared to contain inaccuracies. Data was therefore also sought from the daily work book, which contained information about scheduled in-service education sessions. In order to examine if their intervention had improved in-service education provision and participation ARG members compared this data with attendance at the current initiative.

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Responses contained in the pre intervention questionnaire confirmed information from ward documentation that attendance by nurses who had been on the ward less than twelve months at in-service prior to the implementation of the ARG program, was at low levels. Most respondents had attended two or less in-service sessions in the previous three months (table 14). Respondents who attended more than two sessions had availed themselves of education opportunities on other wards or those provided by the graduate nurse unit.
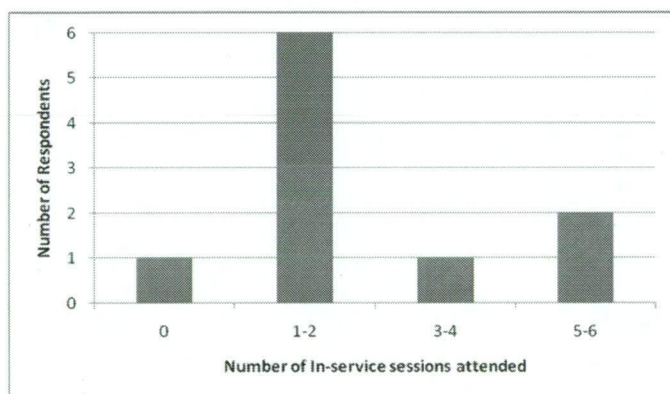
Table 14: Attendance at Education Sessions by Questionnaire Respondents in 3 Months Prior to ARG Initiative (n=10)

In keeping with the above findings, which indicate low levels of provision and participation at in-service education sessions on the ward, respondents to the questionnaire rated the provision of professional development and education using a five point likert scale ranging from very adequate to very inadequate (see Table 15). Comments added within the free text area of the questionnaire elicited further information. Three persons noted the need for increased in service and planning of education and a fourth made a note that the appointment of a clinical educator who *'has good knowledge and skills related to respiratory nursing'* would be of benefit to the ward.

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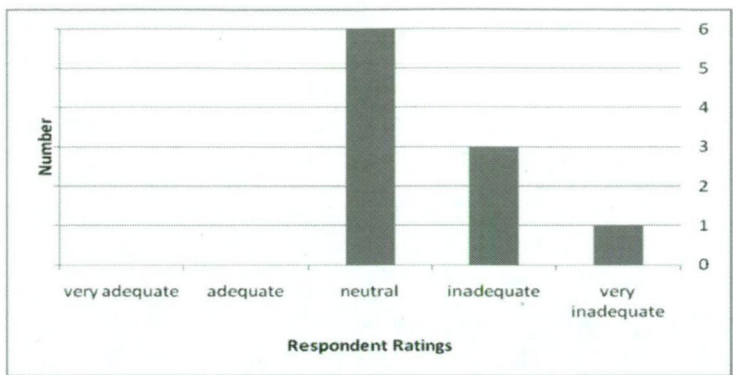
Table 15: Respondent Ratings of Continuing Education & Professional Development on the Ward (n=10)

The questionnaire tool also sought information related to respondent's perceptions of the provision of support materials for education on the ward and the ease of access to such resources. The question elicited a more positive response, the majority identified provision of materials and the ease of access as adequate or above suggesting individuals could find material to support self education.

7.6.3 Self Rating of Knowledge Skills & Confidence

In contrast to the lack of in-service education and inadequate provision of staff development and education prior to the ARG initiative represented in questionnaire responses, the area pertaining knowledge, skill and confidence to deliver specific areas of care delivery to people with COPD, demonstrated mixed results. The majority of respondents self rated at satisfactory levels across all areas. A limited number of respondents gave themselves high ratings. The responses from those surveyed contained in table sixteen relate to areas of inhalers, oxygen use, pulse oximetry, non invasive ventilation (VPAP), and overall COPD care would appear to indicate overall that respondents understood themselves to have a satisfactory level of knowledge confidence and skill to deliver evidence based care.

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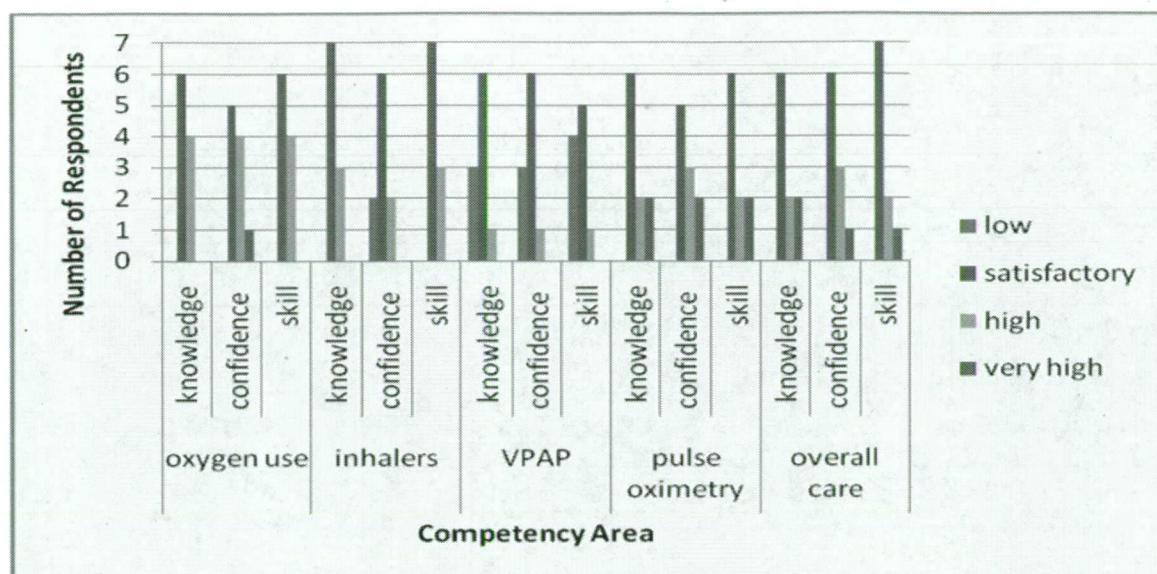
Table 16: Respondent Self Ratings of Knowledge, Confidence & Skill in COPD Care Areas (n=10)

(refer to questionnaire, appendix six).

Non invasive ventilation (VPAP) was a key area that respondent self ratings indicated lower levels of knowledge, confidence and skill. Yet responses to the area of inhalers also highlight low confidence by two respondents to educate patients in inhaler use. As ARG members considered this data Dave commented:

'on a respiratory ward you would want to see all the nurses ratings be high or very high, if it is your specialty...'.

Other ARG members agreed with his comment and felt that although the responses indicated staff members felt they were delivering these areas of care to a satisfactory level, there was room for improvement from satisfactory to high or very high.

7.6.4 Support as a Key Component of the In-service Program

All nurses who completed surveys were supplied with individual folders containing information about in-service topics, which included space in which they could record completion of the competency package. In addition, as awareness of the in-service education program developed in the ward, three additional nurses approached members of the ARG in order to obtain an individual folder. The nurses who requested access to the folder resource claimed that use would provide them with an avenue to complete the

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competencies, in a manner which was consistent with the Nurses Registration Board requirement for evidence of engagement in continuing education. The additional nurses were not allocated mentors, nor provided questionnaires but were asked to identify nurses on the ward who could work with them to sign off competencies. The number of folders provided totalled 13. The level to which the ten key attendees of the education program completed the competencies was not high. Out of a possible thirty that could have been completed, twelve were signed off by mentors. The reasons for low completion were cited as busyness and difficulty with finding time to meet mentors. Despite low completion the attendees commented to ARG members that the information in the folder provided a useful resource.

Part of the intent of ARG members in providing folders to in-service education participants was to provide a mechanism of support with additional information and the competencies contained therein. This step was predicated on new understandings of the ARG members that they may not provide enough support to newer staff members to assist knowledge and skill development. Therefore it was not only the provision of material that was considered important, but also the provision of a mentor for competency completion. As a further measure of the status of perceived support for nurses who were less experienced, prior to the provision of the in-service program, questionnaire respondents were asked to rate levels of supportiveness, helpfulness and interest of permanent staff with regard to ongoing professional development end education on the ward, using a five point likert scale from very unsatisfactory to very satisfactory (see table 17).
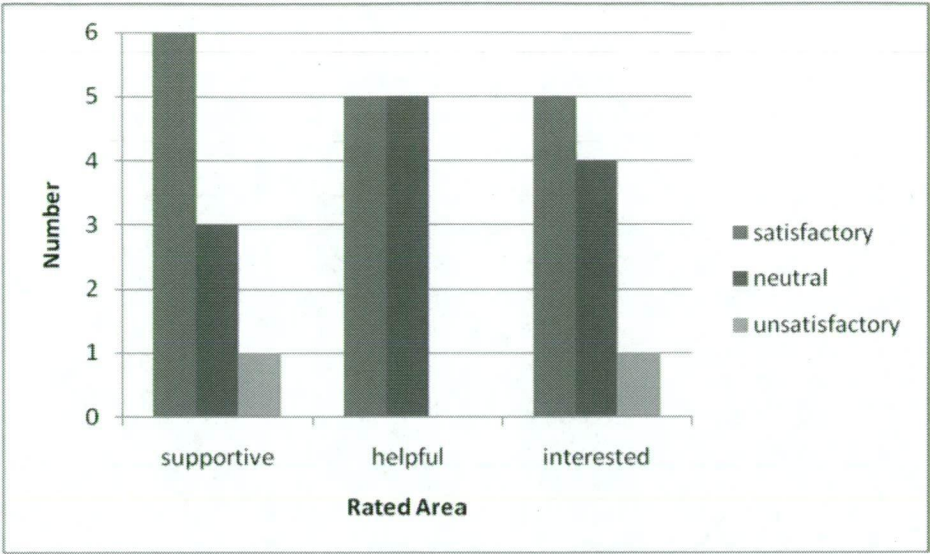
Table 17: Respondent Ratings of Levels of Support, Help & Interest from Permanent Ward Staff in Regard to Ongoing Professional Development on the Ward (n=10)

The findings were mixed with just over half ranking the areas as satisfactory. The levels of neutral or unsatisfactory response may indicate respondents were unhappy with the levels of support, help and interest from others on the ward prior to in-service education program implementation. Although a small number of persons were surveyed, the responses would appear to support the understandings of members of the ARG, who identified a lack of support to less experienced nurses as a key focus of action.

7.6.5 Engagement with Reflection

The ARG had been pragmatic in their delivery of the in-service education and the four meetings which were held over the time when in-service delivery was taking place were focused on the practical aspects of maintaining and delivering the program. The manner in which members of the group had set up in-service education required them to maintain a schedule, prepare competencies ahead of each theme, and ensure they kept the broader support team informed and engaged between sessions. Follow up between in-service education sessions occurred as ARG members consulted and reminded other ward members, especially those undertaking a support role, of upcoming sessions, competencies and attendance. On the days of in-service education at least one member of

the ARG took responsibility for motivating nurses on the ward to attend by raising awareness at the beginning of the shift, and completing the action by gathering nurses at the appropriate time to attend. The ARG members facilitated the in-service education sessions and often delivered the sessions. Because the focus of group members was on the practical aspects of delivery, there was little critical reflection undertaken by group members during this time.

The activities of the ARG became impossible to sustain in light of importance assigned to preparation for the ward move. The key concern of group members, and indeed other ward staff shifted to the area of the ward move and what it might mean for them both individually and collectively. Hence the ARG were unable to engage in critical reflection on the group action. It was at this point, I sought permission from the group to undertake the final component of data collection, through the planned post intervention audit proposed in the original research approach.

Whilst the action cycles undertaken by the ARG were not specifically targeted directly at patient care outcomes and the group acknowledged that any change detected in the re audit.could not be directly attributed to group actions, they were confident that the very existence of the research group and the activities they had undertaken, including a high level buy in from other nurses on the ward, would result in changes to patient care. As Russell, Boynton & Rigby, (2004, p. 1175) note, the presence of evidence based activities in a health setting can effect change in practice, even for nurses not directly involved in group activities, calling this 'passive participation'. It was thought by group members that the activities of the group would highlight the importance of improving care delivery to patients with COPD more generally, and impact as individual clinicians considered how they currently delivered care and how they might contribute. The audit of documentation was undertaken in some haste in order to facilitate completion prior to the ward move and was necessary to ensure that comparisons between both sets of audit data were drawn from a similar circumstance. Audit results demonstrate some changes in care provision between data collected prior to ARG activities, and data collected immediately prior to the ward move. A period of approximately 12 months had elapsed.

7.6.6 Audit Data Pre & Post ARG Activities

The audit of medical histories of patients nursed on the ward which compared documentation to best practice guidelines was undertaken at two time points, during July/ October 2006 and August/ September 2007. The sample number in the first audit was 20, but due to constraints which occurred as a result of the ward move, the second audit sample was limited to 16. The average length of stay for both samples was 7.1 (4-18 days) and 7.2 days (4-12) respectively. Co-morbid disease medians for the samples were 3 (±2) in the reconnaissance audit and 5 (±3) in the audit undertaken at completion of stage three. The first area examined is frequency of patient assessment undertaken on admission to the ward. Comparison of pre and post audit data is shown in Figure below:
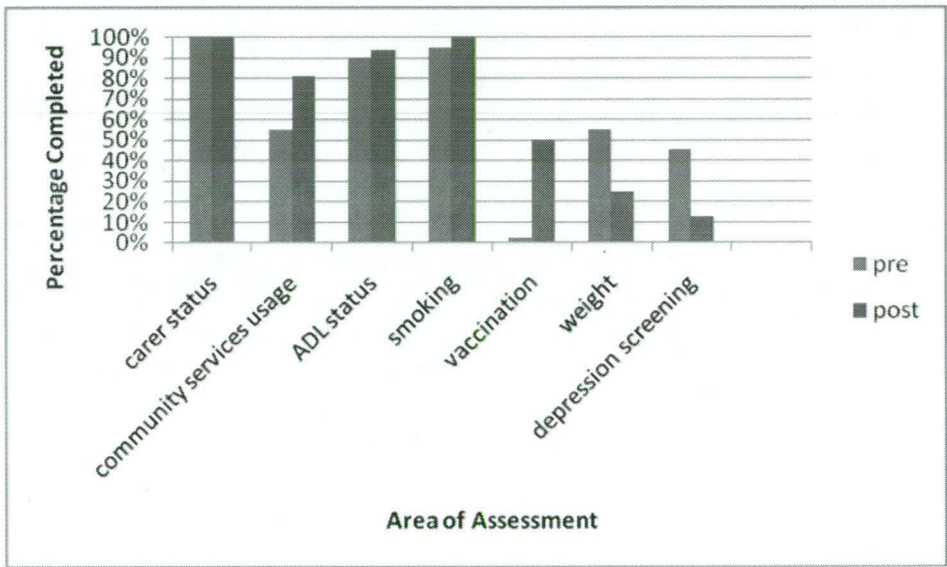
Table 18: Comparison of Completed Patient Admission Screening Pre & Post Audit

The audit data demonstrates some improvement in the areas of assessment related to community services usage pre admission and vaccination levels, whilst carer status, ADL and smoking assessment remained static, with little change. Decreases in weight recording and depression screening are evident. Admission assessment is intended to be followed by referral to the multidisciplinary team member which is the next area of audit data to be considered. Referral rates to all multidisciplinary team members are contained in the table below:

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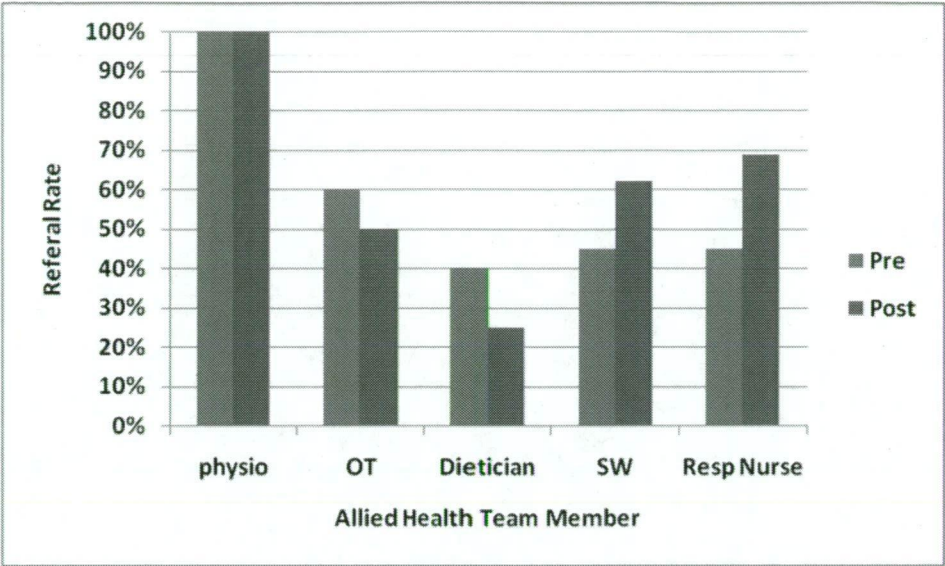
Table 19: Comparison of Referral Levels to Allied Health Team Members Pre & Post Audit

(OT = Occupational Therapist; SW= Social Worker)

Rates of referral remained similar in most cases, with all patients being seen by the physiotherapist, in both audits. Referral to occupational therapy and dieticians fell a small amount from 60% to 50% and 40% to 25% respectively. In the case of referrals to social work and the respiratory nurse referrals increased. Other areas which are considered in the audit relate to overall care management and provide further information about the differences pre and post ARG activities. Rates of completion of elements of care management are shown pre and post ARG activities below:
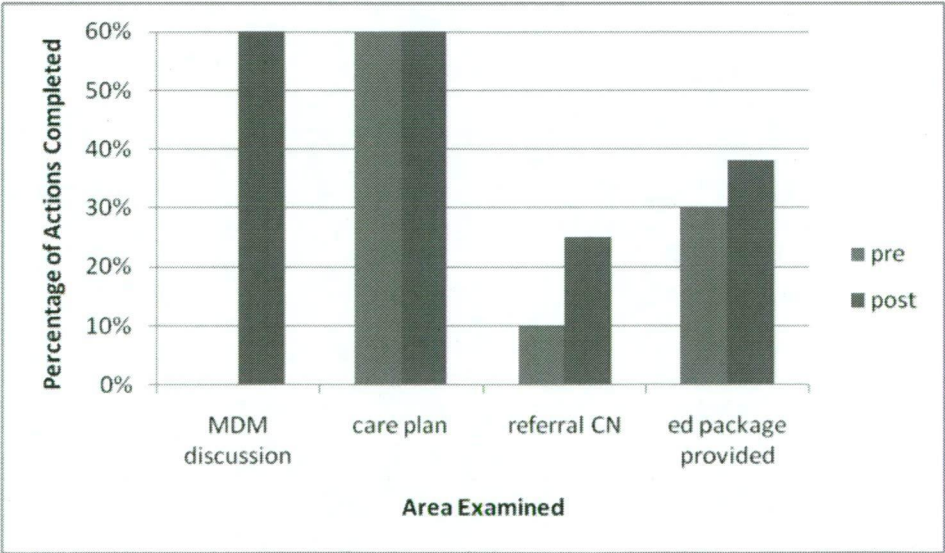
Table 20: Comparison of Multidisciplinary Care Areas, Pre & Post Audit

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By far the biggest difference in care provision identified in the pre and post audit data was the level of documentation from the multidisciplinary meetings. At the pre audit, no patient histories contained documentation of multidisciplinary meeting discussions, and in comparison at the post audit, ten of the sixteen audited histories contained such documentation. Improvements occurred in levels of referral to community health services, which may simply have related to the patient cohort, and documentation of distribution of the COPD education package, whilst the use of the care plan remained static.

As indicated the ARG members did not have the opportunity to consider this data as a group due to cessation of the meetings, although some individuals did seek information about the outcomes. Members of the group also took the opportunity to attend presentations by myself at completion of the research, and three members of the group also agreed to participate in semi structured interviews in the two months following completion of the research in the ward. The feedback and reflections of these ARG members is contained in the final chapter of this thesis, as part of the research closure. So what did the group achieve during this phase and how do their actions relate to the central concerns of action research?

7.7 Discussion

The activities of ARG members during this stage of the research marked their increasing engagement with the research process where they continued to critically reflect and build new understandings which in turn provided the impetus for change. Reflective of their new found sense of empowerment to take action, they were strategic as they planned and implemented action informed by their new understandings. The emancipatory intent of the action research process was facilitated when ARG members became increasingly active in decision making processes (Roberts & Dick, 2003, p. 486). The approach adopted by the group to this point, encapsulated three distinct attributes of action research outlined by Kemmis & McTaggart (2003, p. 337) ; shared ownership of the research project, analysis of identified problem, and action aimed at improving the situation. The activities of ARG members as they implemented the in-service education program impacted on overall practice and the changes to patient care represented in the pre and post audit of

documentation on the ward are suggestive of some improvement in care delivery to persons with COPD as a consequence of their work.

7.7.1 Changes in Care Provision & Practice

The audit data was analysed using descriptive statistics, and the audit sample was relatively small making it difficult to draw conclusions. Yet there are subtle indications of improvement in care provision. Screening and assessment of patients on admission to the ward was likely to have been affected by a change in screening tool. During the pre audit, screening of patients admitted to the ward was often duplicated as the ward was transitioning between the use of different assessment tools. Audit two was undertaken when this transition was complete. Hence the degree to which weight and depression screening decreased in the post audit is most probably related to use of an assessment tool which no longer included these two categories.

The expectation within the ward setting that all patients admitted with COPD would be referred to physiotherapy, occupational therapy, dietetics, social work and the specialist respiratory nurse remained the same across time. Given that members of the ARG identified increased referral to the specialist nurse as an area to be considered for action post reconnaissance the finding of increased referral in this area is important. The data supports a suggestion that ARG members had undertaken this step without a formal plan to do so. Alternatively the inclusion of this nurse in the ARG activities as they took other actions may explain the increased referrals.

The most significant changes indicated in the pre and post audit data related to documentation of multidisciplinary care planning where rates went from zero to just over 60%. The area had not been targeted by ARG activities and cannot be claimed as a direct result of the action cycle undertaken by ARG members, yet I would argue resulted more broadly from their research activities. Such documentation was not the remit of ARG members, it was however related to the practice of two steering committee members who were made aware of the care deficit during reporting of reconnaissance data, and as the data suggests, subsequently took action to remedy the situation.

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Significantly the biggest changes as the ARG undertook action were in providing opportunities for all nurses on the ward to increase their knowledge and application of evidence based practice through the provision of the COPD in-service education program. The aim of ARG members when they implemented the in-service education program was to increase knowledge and capacity of less experienced members of the nursing team to · deliver evidence based practice. ARG members were not able to administer the post education questionnaire to participants in the in-service education program, yet the findings from before the program confirmed understandings of ARG members that there a need to assist nurses on the ward to improve their knowledge, confidence and skills in the areas targeted during in-service education. Additionally provision of the program increased the level of engagement nurses on the ward had with COPD education topics more generally. In a twelve week period ARG members were able to facilitate sixteen sessions that amounted to 81 individual attendances at in-service, a significant improvement when compared to the three months preceding ARG activities where five sessions had been provided and approximately twenty individual attendances recorded.

7.7.2 Active Stance of Members: Ownership of the Research

In taking on the role of facilitating the in-service education program, members of the ARG embraced ownership of the research. Initially the ownership and intimate knowledge of the practice setting held by members was represented by their determination to develop an in-service education program in what was historically a difficult space. Even I was somewhat hesitant about the approach, given the knowledge of how difficult it had been to hold meetings of the research group during these times. Yet the very detailed and meticulous planning which members afforded the implementation phase was rewarded with success. Such ownership is further illustrated by the choice of members to hold in-service education sessions during morning tea and in the last half hour of the rostered shift, again not previously considered as the best mode in which to deliver education. The group's ownership and support of the in-service education program was rewarded by the broader support of the nursing team members in attendance at such sessions.

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7.7.3 Summary

In discussions leading up to action cycle four ARG members had recognised a lack of control within their own practice environment. Lack of control may also be considered to result from the operation of power imbalances inherent within nursing practice (Fletcher, 2006, p.50). Such imbalance can be traced to economic and management imperatives which result from the need to maintain efficiencies of acute care institutions. Nowhere is this more apparent than the directive to move the ward, and staff working on the ward to a new location which took little account of the impact on those individuals, or indeed the patient group to which they were providing care. The changes in practice and care delivery to persons with COPD which are suggested by the pre and post audit data and examination of action plan four outcomes were subtle, however, the changes in the ARG members themselves, and the relationship of that change to overall practice are also a central concern, and it is to an overall examination of the effect of engaging acute nurses in an action research endeavour that I now focus in the next and final chapter.

8 Final Thoughts and Conclusion

From the very beginning of this research endeavour it was my contention that the engagement of acute care nurses in an action research study had a.potential to improve care provision to persons with COPD. Further, their activities within the ARG were underpinned by a critical social sciences philosophical approach through which it was intended to engage them in an empowering action research process. Within chapters Six and Seven, evidence of improved understandings and the empowering potential of the research emerged. In the context of an engagement in a collaborative action research project participants were able to explore and implement action to improve the situation. The thesis documents the journey of the ARG nurses and their colleagues' participation in action research which moved through stages of facilitated engagement (Chapter Five), emerging empowerment (Chapter Six) and empowerment to action (Chapter Seven).

During stages two and three nurses from the ward were joined in their endeavour by a physiotherapist and specialist nurse, and the group assumed a more interdisciplinary focus, which was further realised by the engagement of other discipline members in the in-service education program delivery. Yet within the context of this research there was little opportunity to explore the dimensions of that engagement, as the research came to an abrupt end associated with closure of the ward. Hence the focus of discussions in this final chapter is on changes within the context of nursing practice on the ward.

8.1 Demonstrating Change as a Result of the Engagement of Nurses in Action Research

As discussed in Chapter Three, the framework for monitoring change and improvement in practice in this action research project was aligned with the aims of the research. The framework consisted of monitoring to provide evidence of:

- Changes in nursing practice as they relate to provision of care to persons with COPD;
- Changes in the language used to describe, identify and analyse issues faced in care provision to persons with COPD which lead to development of new understandings and insights into practice;
- Changes in social relationships at a group and organisational level;

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• The degree to which the members of the research team develop their 'mastery' of action research.

In this discussion I will examine each of these areas, with data from interviews undertaken with ARG members, Dave, Carla and Jess at completion of stage three also informing the discussion. I conclude that the engagement of acute care nurses in action research is a worthwhile endeavour, which has resulted in demonstrated change across all areas of the monitoring framework. Initially I examine the changes in practice.

8.1.1 Changes Evident in Practice

Evidence of change in practice generated through activities of the ARG was demonstrated through comparisons of pre and post group audit of documentation, the increase in provision of education and support on the ward, and some further changes which resulted indirectly from the ARG activities. The results of the pre and post audit of documentation on the ward, discussed in greater detail in Chapter Seven, are suggestive of positive changes in practice. Secondly, provision of in-service education on the ward was significantly improved with more sessions provided and more than three times the participant numbers attending compared to the time preceding ARG activities. Such change provides evidence of increased delivery of education related to COPD on the ward as a direct result of ARG activities. Finally, changes which can be attributed indirectly to ARG activities also occurred. For example, post intervention audit data identified that the content of multidisciplinary meetings was documented and that this was a significant change in practice which occurred in the context of the project. The change reflected the engagement of key players in the steering committee who initiated change in response to the reconnaissance findings. These findings highlight the importance of reference groups and how they can have a transformative function in addition to the support provided to ARG members.

Whilst the improvement in provision of in-service education was increased directly by the activities of the ARG, the links to how the education program impacted on the quality of care that people with COPD received on the ward was not clear. However the evidence in the literature indicates that better educated nurses provide improved nursing care (Aiken et

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al., 2003; Blegen, Vaughn, & Goode, 2001; Levett-Jones, 2005) and that continuing education, such as that provided by ARG members supports the development of clinical competency (Harper, 2000; Penz et al., 2007), and the uptake of evidence based practice (Melnyk & Fineout-Overholt, 2005). Whilst education is not the only strategy which might be used to improve alignment of practice with the evidence, it remains a key component. Support amongst co-workers is further highlighted in the literature as assisting with uptake of evidence based care (Maben, 1999, p. 137; Griffiths & Clark, 2004, p. 78), and was central to activities of the ARG during stage three when they linked delivery of the in-service education program, with a mentor support model. Hence whilst the outcome data collected by the ARG at completion of the study does not indicate strong changes in patient care, it is reasonable to suggest changes will have occurred.

The changes in practice are also illustrated in comments by ARG members following completion of the project. Carla had been absent due to ill health during much of the delivery of the education program but offered insights into the effect of the programme when she commented:

'When I came back [from sick leave], *I could see things were different...it wasn't big, was subtle really ...it was just there were things on the* [shift planner] *list which were different...people were including getting the care plan done* [on the planner]*...and then I think they* [other nurses] *were more conscious of walking the patients and asking for help when they needed it...'*

Dave agreed that the change was not *'earth shattering'* but in his assessment patient care had improved and importantly less experienced nurses on the ward felt more comfortable approaching others for advice and direction. Dave argued that:

'I think things have changed a bit [as a result of the in-service program] *but it is hard to say, some nurses have really taken it on board and it is not unusual for them now to come and find me and ask questions, I have always encouraged that and like people to have a go* [at developing new skills] *so I guess that is the same as I have always been...but they* [others nurses] *are asking more...'*

Such comments supported the subtlety of change which was also observed and discussed at the end of stage three. Such findings suggest that one of the aims of the research, to improve care provision to persons with COPD has been achieved to a degree.

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The fact that change took place at all represents a significant shift in the historical workings of the ward. A reactive and defensive posture was apparent when ARG members initially commenced discussing their practice and together with claims that they could not change the situation, suggested that they felt trapped by a form of institutional inertia. Yet following their engagement in dialogue and critical reflection in the context of the research meetings where they initially explored their practice, the ARG members' position shifted and they began to imagine possibilities for improvement. This was evident in the degree to which members considered how, where and when they would deliver the in-service education program, which was in stark contrast to their initial position of doing nothing.

The changes in practice as a result of ARG activities were small, but were intended to provide a platform for future development. Unfortunately, the ward setting and staff members were further disrupted by the move of physical location, and continuing their efforts was impossible. Yet despite this, members stated at the end of stage three that they now had the capacity to consider practice in a different light. As Carla claimed:

It [the research] *has really made us think in a different way, so now instead of just complaining- I question what is really going on here. I ask myself what else can I do? What is happening here? I even ask other nurses to consider what they can do in the circumstances...'*

The ability to ask questions which have an explicit intent to challenge taken for granted understandings about practice is reflective of members' assuming a more critical position in relation to their work. Such questioning highlights a further shift in approach, as they also embraced a belief that change was possible, and such belief is illustrative of an emerging sense of empowerment. In effect the new position of group members in relation to questioning practice reflects what Lather calls a 'praxis of the present'(1991, p. 80) which is reflected in action research when members of the group enter into a collaborative process and by their very engagement individual and group change is fostered (Carr & Kemmis, 1986, p. 188).

8.1.2 Changes in Language: New Understandings

The change in language is reflective of group members changing understandings of their situation and is an important marker of emerging sense of empowerment (Kemmis & McTaggart, 1988, p. 25). The development of new understandings and belief that change was possible, among the ARG members, and an ability to move forward from the abdication of responsibility for care deficits establishes as Taba & Noel (1988) suggest, the importance of time spent by the group on critical reflection and collaborative dialogue. At the beginning of the research, group members needed time to engage with the research process and to develop their understandings of the situation prior to undertaking action. As Taba & Noel (1998) suggest this was 'consistent with the demands of the situation...and the needs and capacities of the persons involved'. A change occurred over the life of the project where participants increasingly embraced a dialogical engagement between group members where they sought to make sense of their practice and the issues that impacted on care provision to people with COPD nursed on the ward. The early stages of the research were important to assist group members' to develop skills for what Hall (2001, p. 175) describes as 'learning to listen or learning to hear each other in new ways'. Such activities were increasingly embraced by group members as a way to move forward. Yet, the time spent on eliciting views and understanding was reportedly frustrating for some members. As Carla stated:

'...overall the process at the beginning [of the research] *was frustrating, we never seemed to get anywhere, and we were always complaining, but you* [researcher] *couldn't make us what we weren't, you couldn't change that, in some ways we had to go round and round, we were what we were, so we went round and round and then realised we had to make choices not to be like that anymore...'*

Carla's comment captured the experience of her membership of the ARG and demonstrates changes in understanding of group members resulting from activities undertaken in the context of a collaborative endeavour (Habermas, 1990, p. 100). As such there were changes in language used to describe the world of acute care nursing, which was initially characterised by negative, complaint laden language which altered significantly in the latter stages of the project to an optimistic language in which positive outcomes, such as the workshop success, were celebrated. Drawing further on Carla's

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comment, the need for the agenda of the research to be driven by group members is also highlighted, as forcing the group to move forward from 'going round and round' prematurely would have negated opportunities for group members to come to terms with the need for change. Kemmis & McTaggart (1988) describe the need to engage research participants and for the researcher to recognise them as 'knowing subjects, willing and able to determine their own roles in the improvement process'. Within the context of this research members of the ARG determined their role in improvement based on the new understandings revealed during dialogic encounters.

Providing a catalyst for group members to progress the research, the reconnaissance data considered in workshop one presented compelling evidence that change in practice was needed. During workshop two, the continuing development of new understandings, and a resolve to reject the status quo, is characterised by a movement away from the negative, and 'toward hopeful energising possibilities' (Ludema, Cooperrider, & Barrett, 2001). Such activities are illustrated by work during workshop two and subsequent meetings where members of the ARG articulated their sense of empowerment and readiness to move forward to action. Concurrently, significant changes occurred in the language used by ARG members to describe practice, from the negative constructions where group members situated themselves as powerless to effect change, to positive energised language which was hopeful, anticipatory and forward looking. New understandings which were formed by ARG members are representative of a key interest of participatory research, that is both 'discovery and creation' (Fals Borda, 2001, p. 32). Group members had opened up to an exploration and discovery of connections between theory and practice as it related to their own local setting (Griffiths & Clark, 2004, p. 70). As they engaged in the action research process changes in relationships between group members and the broader care provision team also became evident.

8.1.3 Changes in Social Relationships and Organisation

As members of the group worked together in the context of the research they further developed relationships within the group and the broader practice setting. Without the development of such relationships the activities of the ARG would not have been possible.

At the inception of the research there was evidence to suggest that the ARG members were disengaged from their own practice. There was a feeling articulated by the group that nurses on the ward came to work, attempted to do the best they could (knowing it was not good enough), and went home, only to return again to do more of the same. The sense of hopelessness was evident when group members described their activities and activities of other senior nurses on the ward as the 'way things were'. The disengagement from practice was also demonstrated in patient care delivery where ARG members reported nurses on the ward would focus on care for patients assigned to them for the shift, and held limited concern for other nurses or patients also on the ward. Not surprisingly concepts of 'reciprocity and respect' for other members' knowledge and understanding which were shared within the context of the group (Lather, 1991, p. 57), were not instantly adopted within the group. Initially they contributed to the group by sharing individual accounts related to practice and concerns with patient care. Yet as group activities unfolded the ARG members moved toward greater collaboration and teamwork. As Carla stated:

'it made us think in a deeper way, it made us question ourselves and in some ways we all had to decide what we wanted together...no one person could go and do it [make change]...*and the other thing was that it* [action] *was owned, not by one person, but was shared...*

As all members increasingly embraced this approach, acknowledging the need to speak openly and honestly about issues, to challenge claims, to reframe understandings and to work collaboratively (Habermas, 1990, p. 100), the group continued to build on the core tenet of participatory action research, that of shared ownership of the project (Kemmis & McTaggart, 1988).

As a result of the collaboration and improved relationships in the group, there was a flow on effect within the workplace. Workplace relationships were impacted by ARG activities, with a particular focus on action plan four, where members of the group sought and received help from the broader nursing team to deliver and support the in-service education program. Such a step was unimaginable at the beginning of the research, as Jess argued:

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'...it is great what has happened with the in-service, everyone had a role, and the people on the ward have all done something, either run them, attended or made sure others attended...'

Indeed the ARG would not have been able to deliver the program without the support which was provided by staff external to the group. The changes in relationships contribute and reflect the ARG members' movement through action research processes over time, which include mastery of the action research approach.

8.1.4 Mastery of Action Research

The focus of this research was to explore the possibilities for a group of acute care nurses to collaborate in developing their practice to better serve the needs of people with COPD nursed on their ward. Nurses in the research setting had not previously participated in collaborative research to improve practice, so this project presented a unique opportunity. By engaging practitioners as collaborators in the research project the people were assigned as Freire (2005, p. 126) says 'a fundamental role in the transformative process'. During the researcher facilitated process (Chapter Five) a number of nurses agreed to participate in the ARG to improve the care provision to persons with COPD which involved examination of current practice. My role was one of facilitation of both critical reflection and knowledge of action research processes. The difficulties faced by group members at the end of that stage heralded an important crossroads for the ARG members, where they wrestled with new and highly challenging information (reconnaissance document). There was a sense of emerging empowerment in this stage which is realised as the members recognise an imperative to take action. Subsequently the new understandings of both the practice setting and a desire to move forward to action, represents an emerging sense of empowerment evident in their desire to take action and improve care delivery to persons with COPD admitted to the ward. Hence within this research the mastery of action research is apparent in the context of ARG activities as members took up their central role as co-researchers. In doing so members of the group were forced, as Fals Borda (2001, p. 32) describes, to grapple with what was happening in *their* practice in the context of what *they* understood should be happening.

On working together they emerged as a group with a demonstrated 'readiness to face difficulties realistically' (Lewin, 1988). Decisions made by the group about how they would proceed were shaped by their knowledge of the precarious nature of their activities, which had been impacted by difficulties meeting and changes in membership of the group. Hence as they moved forward to take action there was an understanding that commitment to the group and group activities was central to their success. Group members were able to strengthen their role as co-researchers, and in the process, participated in what Kemmis (2001, p. 92) describes as practical decision making as they strategised to develop the next stage of the project. The strategic planning and implementation of action described in Chapter Seven provides evidence of the growth of the ARG to a point where they were able to take action and were empowered to take action to develop their practice in ways that might better serve the needs of people with COPD admitted to the ward.

As a result of the newly realised sense of ownership, a strong engagement in developing an intervention to address the identified problems emerged. The level of planning by group members is evident from the painstaking dissection of what it would take to develop and provide an in-service program. As group members became increasingly engaged, the rising energy of the group was palpable. It was members themselves who argued for an in-service program as the central action of the group and as such the decision to do so was based on agreed understandings. Despite my misgivings and personal doubt about the likelihood of success of the program, the group collaborated and subsequently agreed on the key focus of action.

The group members adopted a strategic approach in planning and implementation of action which, in effect, was built on recognition of the contextual limitations of the practice setting. The key concern of group members became twofold, to address low levels of knowledge of less experienced nurses and to increase levels of support provided to this group by more experienced members of staff. Yet it must not be forgotten that the key value which underpinned the concern of ARG members was to improve care provision to persons admitted to the ward with COPD. The framing of concern is in keeping with preparation for action described by Kemmis & McTaggart (1988, p. 65)

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where practitioners are advised to consider action in the light of underpinning values which inform the work. Group members had in mind that by improving education to less experienced members of nursing staff on the ward they would improve patient care on the ward. By thinking strategically they produced an 'effect compatible with sustaining the struggle of reform' (Kemmis & McTaggart, 1988, p. 65), avoiding action which was thought to be detrimental or presented risks to sustainability of the group.

8.2 Reflections on the Role of Action Researcher

As I set off on the action research journey armed with the knowledge I had been able to extract from the work of well respected established action researchers, centrally those of Kemmis & McTaggart (1988, 2003) and Annette Street (1995, 2003), together with the advice of my supervisors, I felt well prepared to enter the field. Indeed after spending time drafting research proposals, ethics applications, reviewing the literature and familiarising myself with action research I was anxious to 'get something really happening here' and was 'excited at the prospect of getting back to the ward and making a real difference' (researchers journal 30/01/2006). Now at completion, my reflections have revealed my journey as researcher has mirrored that of my fellow ARG members, encompassing challenges, gains and hope.

Straker & Hall (1999) have also written of the challenges in undertaking collaborative research with practitioners, describing the journey as *'from clarity to chaos and back'*. They argue that research facilitation is 'not just a question of surmounting practical difficulties' but also 'coming to terms with feelings of crisis and cognitive dissonance' (p.419). Their description of setting out on the research journey with 'clarity' about methodology and problem solving, being faced with the 'chaos' of the research setting and collaboration, prior to coming 'back' to make sense of what has happened in the research, resonated with my own experience. Such description also shares similarity with the work of Street (1990), who, drawing on the work of Schon (1983), describes theory as 'high hard ground' and nursing practice as a 'swamp'. In common with my own experience, when Straker & Hall (1999, p.421) encountered difficulties in their respective research projects, which were not easily surmounted, it challenged the very essence of the research

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and the researcher's confidence simultaneously. During this research, I had cause to question myself and my role as researcher many times as difficulties with progressing the research occurred exemplified at the end of stage one, when the ARG could not meet to discuss the reconnaissance findings. As I wrote in my journal following a further failed attempt to identify a meeting time:

'I am not sure where I have gone wrong, perhaps I provide them with too much leeway. It is hard wearing two hats, nurse and researcher, I know that it is hard on the ward, and when they say they can't come to meetings I accept that, perhaps if I was someone more important they would make the effort, can't help feeling I have been too soft...I should have said they had to come to meetings or insisted a bit more about attendance... perhaps the research is only important to me- that is even worse, the whole thing is meant to empower them and it might have no meaning at all??' (3/12/2006)

The issues which presented during the research were predominantly around meeting attendance, meeting scheduling and maintaining the group membership. Although the research was eventually completed, albeit prematurely, I experienced a sense of uneasiness through the whole process in response to ongoing issues and barriers to the research agenda. Meyer (2003) also describes this as self doubt experienced by the researcher which is not uncommon. As I reflected on what had occurred over the life of the project I came to realise to what degree such issues had impacted. As my journal entry documents, there were also many questions:

'...if I had known then what I know now, how different would the journey have been? Of course I cannot know, perhaps I would not have done it at all...it is just that is was so hard, and now I feel a sense of relief, that I do not have to go back...Although the group was doing everything I was still hovering and all the time experiencing doubt about the project, how long could we keep going? What obstacle would occur next? Well I guess the ward closing has made the ultimate statement...GAME OVER' (17/08/2007)

As I continued to reflect on this account, which was written as the ward moved, I came to understand that such relief was a result of the difficulties and subsequent doubts raised for me, as the facilitator of the group who felt responsible for success or otherwise of the project. My own journaling adds to analysis of ARG activities with respect to power, my position as a researcher and changes related to understandings, relationships and mastery of the action research process.

8.2.1.1 Researcher position and power

The position of power that the researcher might occupy within an action research endeavour was discussed in Chapter Three. Indeed if, as argued by Gaventa and Cornwall (2001) knowledge is power, which can also be reflected in the position occupied by researcher then I was in a position of power within the research group. The position is evident as I was the person in the group who had knowledge of the research process, and other ARG members looked to me to facilitate the meetings of the group, and to provide information related to the action research framework. Yet as the research unfolded I became aware of other factors which also contributed to my position of power. During the action research process I was in what Meyer (1993, p. 1070) describes as 'the invidious position of recipient of much personal knowledge a result of participants voluntarily sharing information with me both through formal and informal means'. Meyer (1993) cautions that such knowledge can be threatening to others. I had not given this much thought in the time leading up to the project but I developed increasing awareness as the group and I experienced actions of others which undermined the group activities. Whilst such activities did not originate within the group, they undoubtedly impacted. The most overt example of this was when I wanted to attend a ward meeting which is documented in my journal:

'Dave told me there was a meeting to be held about the future of the ward. All staff had been informed and there was a sense of expectation, rumours had been circulating and now management was coming to tell them what was happening. Dave thought I should attend...I turned up to the meeting about 10 minutes before only to be told very publicly by CNM that the meeting was for team members and I was not part of the team....' (August 2007)

I found out later that Dave had also had a very public 'dressing down' from the CNM for inviting me to the meeting which occurred in front of patients and other staff. On a background of a ward under stress, with the impending but undetailed move I posit that the teamwork and collaboration which had been achieved though the ARG activities was threatening to the CNM, as she had not been able to achieve this previously and was held responsible by other hospital managers for staff dissatisfaction and resignations. Yet, from within a changing and tense work environment it was possible in the context of this research to move toward developing a research culture on the ward.

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8.2.1.2 Developing a Research Culture

Reflecting my unrealistic expectations of the process of action research, at the beginning of the journey I anticipated that the nurses in the ARG would embrace critical reflection, become empowered and act in a reasonably quick time frame, believing they would spend much of their time in action cycles to improve the situation for patients with COPD admitted to the ward. As the work of the ARG unfolded it is evident that most of the time in group activities was spent in discussions and what Freire (2005) terms 'alienating blah' or dialogue for dialogue sake. I was at time frustrated by the constant rehashing of similar issues, but now realise such dialogue was necessary for the group to come to terms with the situation and then move forward. Indeed I despaired at some stages that the group would ever do anything. I wondered if expecting engagement from acute care nurses who occupied a practice area which was chaotic and demanding, in a research endeavour had been wise or realistic. As my journal reflects:

'I am not sure we will ever achieve anything with the group, each time I go to the ward and hear the same stories and the same urgency to return to practice, actions which say this [research] is not important... and I wonder, is this the right way to go...is it simply they need more nurses and more help in practice, not research...(25/6/2006)

At the beginning of the research journey, for at least the first twelve months the ARG faced many obstacles to developing a research culture. Yet demonstrating the value and impact of an action research approach, as ARG members increasingly engaged with the research agenda, they took up a leading role in the direction of the research and became increasing enlivened by the experience. My own reflections have bought me to a place where I now realised there was a greater need for me at the beginning to 'have faith and trust in the possibility and probability of change' which required 'comfortableness with both stormy and becalmed waters' (Wadsworth, 2001, p. 427). Such insights reflect my own position as novice researcher and the manner in which my own journey developed over time. As the group were able to develop confidence and, more importantly could see very real possibilities for change, they also undertook decisions in order to pursue success for the research.

Following workshop one and two, the group members acted decisively to hold meetings external to the ward, and followed this with a very firm commitment of attendance thereby indicating a change in the way they regarded the research endeavour. As such, this step also heralded a challenge to hegemonic power relations which had operated within the ward environment, as the demands of clinical practice (and just about anything else) repeatedly undermined research meetings. The step is considered as I further examine the impacts on the capacity of the group.

8.3 Capacity of Acute Care Environments: Time and Space for Research

A range of tensions within the hospital environment were evident as ARG members struggled to become active participants in the research. They included a lack of time, poor resourcing and inadequate support which highlight well documented difficulties faced in the engagement of practitioners in a collaborative research agenda (Street, 1995, p.82). Despite what the group managed to achieve over the life of the projects, such tensions presented persistent and significant barriers. The most considerable impact arose because the ability of group members to critique and challenge taken for granted everyday activities of nurses providing care to persons with COPD on the ward was dependent on the opportunities afforded to them by the ward setting and, by extension, the hierarchical structure of the setting. The capacity of group members to meet was critical in this project, to actually bring practitioners together so they could engage in sharing stories and critically reflecting on issues raised and to identify opportunities for action. Yet the opportunities of ARG members' to engage in these highly creative encounters was limited by working on a ward where such activities were not privileged and where there was a hierarchy of priorities firmly established. Because we were attempting to open up a space for dialogue and examination of practice through action research, which was new and not well established in the context of acute care, the activities of the group were assigned a low priority. Robinson (1995) would argue that such findings reflect 'subjugated position of nurses within health care' which results in 'nursing practices which frustrate possibilities for transformative change'.

The processes of enacting a collaborative imperative required the ARG members to regularly meet together to pursue a research agenda. Yet in direct opposition to such a need the complex and demanding milieu that is an acute care ward presented an unpredictable and difficult context in which to facilitate such meetings, a point highlighted by Street (1995, p. 85). The very nature of acute care nursing meant nurses worked an array of shift patterns and times. Invariably one or two members of the ARG were on night shift or rostered days off at scheduled meeting times. Poor staffing and inexperience of the nurses on the ward further frustrated their attempts to meet. As members of the ARG represented the most experienced nurses on the ward, their rostered shifts were extended across the working week to provide an even spread of expertise across shifts. Further, the unstable nature of the workforce was an additional impediment to advancing a research agenda, with several members of the ARG resigning their positions during the course of the project which resulted in changing membership of the group. On a background of such changes and what the group reported to be a chronic problem with understaffing the capacity of all ARG members to pursue a strategy to roster themselves on to a shift in order to facilitate attendance at meetings was undermined.

The limited opportunities which existed for acute care nurses to collaborate in this kind of project also highlights economic rationalist agendas which situate nurses as a commodity whose primary function is to provide care to patients (Weinberg, 2004). The commodification of nurses represents and ideology where managers concentrate on the bottom line to improve economic efficiencies and attain the most efficient level of patient throughput, which reflects a broader governmental imperative to manage economies of care, not patient care (Gordon, 2005). Such effects are evident in this study as nurses from the ARG orient their work as senior nurses on the ward to have a key focus on bed management, admissions to the ward and timely discharge, with an attempt to achieve smooth running and co-ordination between these activities. Gordon (2005, p. 290) offers further critique of the way that economic rationalist agendas shape practice which resonated with my findings where the ward environment is a 'workplace is made up of a shifting case of characters constantly on the move'. The imperative for through put and management of resources to support it, including commodification of nurses, means that

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issues around professional practice, or practice development including the role of nurses in improvement of care to patients is marginalised within the context of a broader agenda to improve efficiencies.

Subsequently the effects of the work environment and the central concern with smooth running of the ward relegate attendance at research meetings down the list of competing priorities of the acute care nurse. This was revealed through hegemonic understandings that nurses could be summoned from research meetings when the needs of a busy ward environment dictated such action. In accepting this situation ARG members were, as Kincheloe & McLaren (2001, p. 405) suggest 'unwittingly implicated in the reproduction of systems of oppression' as they accepted 'their social status as natural and necessary'. In this sense the members of the group accepted that participation in collaborative research projects was assigned low importance in the context of a busy ward agenda. And that acceptance reflects the operation of hegemonic power relations in an environment where their need and desire to be engaged in a collaborative research agenda, and to improve care to persons with COPD admitted to the ward, was assigned low importance and subjugated to that of the reactive setting of acute care.

8.3.1 Taking on the Challenge

It was not until they had critically engaged in a dialogic encounter (Crotty, 1998) that members of the group were able to expose and challenge such taken for granted understandings of what it meant to be a nurse on the ward. Highlighting the emerging sense of empowerment of the ARG members during this project, they were able to confront such understandings and subsequently prioritise the importance of attending research meetings. Such a step represented a direct challenge to institutional power relations. Choosing to meet in a location external to the ward assigned further significance to the meetings by reminding ward colleagues of the significance of attendance. Shumsky (1988, p.82) suggests that the risk to individuals who challenge the status quo, in the case of this research, leaving the ward to attend a research meeting, was reduced as it became a 'whole of group' activity. The step was only possible through the strength of group relationships and group action. I would argue that the significant change

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in attendance at meetings and the engagement of ARG members in the research process represented a successful challenge to the status quo which opened up possibilities of transformative shifts in the practice setting realised through the delivery of the in-service education program.

8.3.2 Making sense of Events

Without a doubt the culture of acute care nursing is complex and multifaceted. The narrative provided by ARG members as they struggled to make sense of events and move toward improvement in practice situates the ward setting as chaotic. Benner (cited Gordon, p.289) encapsulates the struggle which nurses faced as she states:

'The most expert nurse will perform sub optimally in an environment in which he or she is denied resources, which is chaotic, and which is plagued by problems of shortage'

Nurses in this study accepted their place within the hierarchy of ward politics, and in this sense they were captive to hegemonic understandings which were underpinned by a range of powerful and dominant interests, including medical, economic and governmental interests. As a consequence, people who are oppressed and caught within the web of power relationships will take on the central imperatives of the system, in which they work (Kemmis, 2001, p.94). In such a setting, attainment of particular goals becomes the focus rather than the delivery of evidence based practice. Operating through what Kemmis (2001, p.94) names as 'rational-purposive action' hospital goals are aligned with success measured through economic and politico-legal systems, and in so doing the organisation of acute care defines the goals, and the means through which attainment of goals are measured. These imperatives result in ward nurses 'being judged on their ability to control the environment and absence of complaints' in a setting where the bed space has become a 'space of production' and patients themselves 'may feel like interlopers' (Latimer 2000, p.14). The point is further highlighted in the comment by a patient respondent to the questionnaire in reconnaissance which indicated an awareness she was discharged because the hospital 'needed the bed'. Nurses in this study reported the pursuit of system goals had impacted their work practices which were increasingly more supervised and more assessed, and subsequently more controlled' (Herr & Anderson, 2005, p. 65). Hence we see the work of acute care nurses was focused on bed

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management and was subsequently controlled by a series of audits which were aligned with efficient running of the ward. In attempting to place patient care as the central focus of the research the work of ARG members challenged the focus on production and was 'essentially a political move' (Herr & Anderson, 2005) .

Yet the change that was effected saw the ARG members strategise to challenge those understandings and the construct of their role, both as researchers and as central care providers to persons with COPD. Yet the machinations of the establishment remained impervious to the change and importance assigned to the research. Nowhere is this more apparent than the decision to move the ward with scant regard for the nurses who worked in the ward, the research being undertaken or indeed the patient care to be delivered. As Dave argued:

'...you can see the hospital has no regard for us or for the patients. We know there are big problems with patient care and staffing and experience on the ward, and their solution is to move us to a different ward. Well yes they will have more beds but there will not be better patient care...We are unhappy with the ward, we are bleeding staff, and they don't even care...My guess is that care will be worse, we will be unhappier but hell...the ward will be bigger and there will be more beds...'

Dave's comment highlights a perception of disregard for staff satisfaction and quality patient care evident in the directive of the ward move, which in turn privileges the needs of the system to increase beds available in the hospital. During their research discussion ARG members undoubtedly saw the hospital system as an institution which they perceived as imposing rules and procedures in a disinterested manner which in effect was indifferent to personalities and interests of the individual inhabitants.

8.3.3 Identity of Acute Care Nurses

Nurses' engagement in research has been the subject of much debate. Indeed nurses have been criticised for not including research in practice. The debate is not new, but has arisen out of tensions between theory and practice, which have been examined extensively (Street, 1990). More recently there has been an increase in calls for translational research which has come not only from those engaged in social research methods but also from those who have previously relied heavily on the area of positivist paradigms to direct

change (Silagy, 2001, National Institute of Clinical Studies, 2010). An emerging awareness that, in order to effect change in practice, there is a requirement for more than just generation of evidence to guide health care providers' decision making processes has led to a greater focus on translational research. Translational research offers the opportunity to enhance the application of evidence in practice by asking those who will deliver the care questions which relate to the how, why and when of integration of research findings or evidence into practice.

8.3.4 Limitations of the Study

A range of new insights are provided through this study, which are particularly focused on the potential of acute care nurses to develop care provision to persons with COPD in the context of an acute care environment. In addition, the research journey has also revealed a range of views related to care provision to people with COPD, from stakeholders who included patients and carers, nurses, allied health, community and acute care providers, which were further informed by an audit of care documentation. However there are limitations to the study which must be considered.

Firstly, the range of stakeholder data gathered from those external to the ARG and audit, utilised to inform understandings and actions of the group were small in number. The ability of the data sources to inform the action of the group was predicated on triangulation of data collection and the critical dialogue of ARG members which further developed understandings. In effect the findings were pertinent to this setting only and transferability of the findings arising from the research, which related to patient care to other settings, should be viewed with caution. The very different health care settings and structures of hospitals, which exist to deliver as part of their brief, care to COPD patients and families, would suggest collection of local data and engagement of local stakeholders in any research intended to improve care is a necessary step.

The findings related to the capacity of acute care nurses to engage in activities to improve care and to engage in a transformative research agenda, are also to be viewed with caution. This study adds to a growing body of literature which highlights the value of activities

such as action research and practice development and as such suggests the approach is valuable. Each study should be examined carefully for applicability in other settings. The findings of this study relate to the ability of acute care nurses in one setting in one hospital as they worked to improve care provision to persons with COPD. There remains a need to pursue other similar studies in order to continue building the evidence for collaborative research agendas.

8.3.5 Possible Futures

The limitations of this study herald a need to further explore ways in which to improve care provision to persons with COPD. Given that the literature review identified a range of gaps in service provision and understanding of service provision, more work is needed. It is not known if the findings in this thesis are reflected in other hospital settings, or other areas, regional or rural. Further investigation in the area is highlighted as important when the increasing number of persons with chronic disease and the impacts of an ageing population are considered. As Wagner (2001) highlights acute care systems and health care generally must align to provide improved care. Nurses will remain care providers to persons with COPD at high levels and greater examination of the potential to improve is still required. At the same time there is a need for nurses themselves to highlight the valuable role they do take on. As possibilities for change in this study were further constrained by lack of support or recognition of the value of research I would suggest further action research projects should also include managers in the process to enable greater change to occur.

8.4   Final Comment

Overall this research study, like the methods employed to engage acute care nurses in the development of their own practice, beckons with the possibilities of hope. Should one small group who encountered multiple barriers and interruptions to their attempts to engage in a research process to improve care to persons with COPD, be able to succeed in small but significant ways, then others in a similar situation may also be inspired. What was missing in the context of this research study, which is increasingly being recognised as important, is a hospital wide or systems approach to embracing action research and

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practice development strategies (Griffiths & Clark, 2004; Osborne & Gardner, 2005). If that had been the case the ARG would have had a broader organisation wide support and recognition for the work they undertook. Single researchers, like me who work with small groups of practitioners within the area of health care will seemingly be overlooked and undervalued by the broader imperatives of the system.

Together nurses who work within acute care can work with the hospital to move toward improved patient care, which is not only the remit of nursing care, but also usually features within the broader value statements of hospitals and health care providers. Recognising, as the acute care nurses in this study did, that there were many possibilities for improvement of care provision to persons admitted to the ward, may lead to further initiatives in the future.

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Appendices

1. COPDX elements & evidence levels

2. Steering committee terms of reference

3. Information sheet and consent ARG members

4. Interviewee information sheet and consent

5. example of PREPARED survey tool

6. Ward nurse survey (action cycle four)

7. Information and consent community nurse focus group

8. Audit of ward documentation tool

9. Example of competency assessment (action cycle four)

Appendix 1. COPDX Elements & Evidence

Levels of evidence

THE KEY RECOMMENDATIONS and levels of evidence incorporated in the COPDX guidelines are based largely on the Global Initiative for Chronic Obstructive Lung Disease (GOLD), which used the evidence ranking system of the US National Heart, Lung and Blood Institute (NHLBI).[6] The

NHLBI scheme is shown in Box 1. For comparison, the National Health and Medical Research Council (NHMRC)[5] levels of evidence are also shown, along with the equivalent NHLBI categories.

1: Levels of evidence

a) National Heart, Lung, and Blood Institute (NHLBI) categories

NHLBI category	Sources of evidence	Definition
A	Randomised controlled trials (RCTs) — extensive body of data	Evidence is from endpoints of well-designed RCTs that provide a consistent pattern of findings in the population for which the recommendation is made. Category A requires substantial numbers of studies involving substantial numbers of participants.
B	Randomised controlled trials (RCTs) — limited body of data	Evidence is from endpoints of intervention studies that include only a limited number of patients, post-hoc or subgroup analysis of RCTs, or meta-analysis of RCTs. In general, category B pertains when few randomised trials exist, they are small in size, they were undertaken in a population that differs from the target population of the recommendation, or the results are somewhat inconsistent.
C	Non-randomised trials, observational studies	Evidence is from outcomes of uncontrolled or non-randomised trials or from observational studies.
D	Panel consensus, judgement	The panel consensus is based on clinical experience or knowledge that does not meet the above criteria.

b) National Health and Medical Research Council (NHMRC) levels of evidence and corresponding National Heart, Lung, and Blood Institute categories

NHLBI category	NHMRC level	Basis of evidence
A	I	Evidence obtained from a systematic review of all relevant randomised controlled trials.
B	II	Evidence obtained from at least one properly designed randomised controlled trial.
C	III-1	Evidence obtained from well-designed pseudorandomised controlled trials (alternate allocation or some other method).
C	III-2	Evidence obtained from comparative studies (including systematic reviews of such studies) with concurrent controls and allocation not randomised, cohort studies, case-control studies, or interrupted time series with a control group.
C	III-3	Evidence obtained from comparative studies with historical control, two or more single-arm studies, or interrupted time series without a parallel group.
C	IV	Evidence obtained from case series, either post-test or pre-test/post-test.

Summary of the COPDX guidelines

	Evidence level
C Confirm diagnosis and assess severity	
■ Smoking is the most important risk factor for COPD	A
■ Consider COPD in patients with other smoking-related diseases	A
■ Consider COPD in all smokers and ex-smokers older than 35 years	B
■ The diagnosis of COPD rests on the demonstration of airflow limitation which is not fully reversible	B
■ If airflow limitation is fully or substantially reversible, the patient should be treated as for asthma	D
O Optimise function	
■ Inhaled bronchodilators provide symptom relief in patients with COPD and may increase exercise capacity	A
■ Long-acting bronchodilators provide sustained relief of symptoms in moderate to severe COPD	A
■ Long term use of systemic glucocorticoids is not recommended	A
■ Inhaled glucocorticoids should be considered in patients with a documented response or those who have severe COPD with frequent exacerbations	B
■ Identify and treat hypoxaemia and pulmonary hypertension	A
■ Prevent or treat osteoporosis	A
■ Pulmonary rehabilitation reduces dyspnoea, anxiety and depression, improves exercise capacity and quality of life and may reduce hospitalisation	A
■ In selected patients, a surgical approach may be considered for symptom relief	C
P Prevent deterioration	
■ Smoking cessation reduces the rate of decline of lung function	A
■ General practitioners and pharmacists can help smokers quit	A
■ Treatment of nicotine dependence is effective and should be offered to smokers	A
■ Pharmacotherapies double the success of quit attempts; behavioural techniques further increase the quit rate by up to 50%	A
■ Influenza vaccination reduces the risk of exacerbations, hospitalisation and death	A
■ No medication has yet been shown to prevent the long-term decline in lung function	A
■ Long-term oxygen therapy (> 15 h/day) prolongs life in hypoxaemic patients (PaO_2 < 55 mmHg, or 7.3 kPa)	A
■ Inhaled glucocorticoids are indicated for patients with a documented response or who have severe COPD with frequent exacerbations	B
■ Mucolytics may reduce the frequency and duration of exacerbations	B
D Develop support network and self-management plan	
■ Pulmonary rehabilitation increases patient/carer knowledge base, reduces carer strain and develops positive attitudes towards self-management and exercise	A
■ COPD imposes handicaps which affect both patients and carers	B
■ Multidisciplinary care plans and individual self-management plans may help to prevent or manage crises	B
■ Enhancing quality of life and reducing handicap requires a support team	C
■ Patients and their family/friends should be actively involved in a therapeutic partnership with a range of professional disciplines	C
■ Patients should be encouraged to take appropriate responsibility for their own management	C
X Manage eXacerbations	
■ Inhaled bronchodilators are effective treatments for acute exacerbations	A
■ Systemic glucocorticoids reduce the severity of and shorten recovery from acute exacerbations	A
■ Non-invasive positive pressure ventilation is effective for acute hypercapnic ventilatory failure	A
■ Exacerbations with clinical signs of infection (increased volume and change in colour of sputum and/or fever, leukocytosis) benefit from antibiotic therapy	B
■ Multidisciplinary care may assist home management	B
■ Early diagnosis and treatment may prevent admission	C
■ Controlled oxygen delivery (28% or 0.5–2 L/min) is indicated for hypoxaemia	C
■ Involving the patient's general practitioner in a case conference and developing a care plan may facilitate early discharge	C

UTAS

Facilitating the continuity of care for elderly people hospitalised with chronic lung disease

A Steering Committee will be established to oversee and facilitate an action research project designed to investigate and develop ways of improving continuity of care for older persons hospitalised with chronic lung disease, within the Royal Hobart Hospital.

Steering Committee Terms of Reference

The steering committee will have the following functions:

1. To montor and review the activities and progress of the research team on a regular basis

2. To provide support by facilitating communication and information networks

3. To Promote access to decision making committees as required

4. To make recommendations on any matter of concern to the committee

UTAS

Facilitating the continuity of care for elderly people hospitalised with chronic lung disease

Chief Investigator:

Dr Andrew Robinson, Senior Lecturer, Tasmanian School of Nursing and Midwifery, University of Tasmania.

Associate Investigator:

Dr Richard Woodbaker, Senior Lecturer, School of Medicine, University of Tasmania

Helen Courtney-Pratt, PhD candidate, Tasmanian School of Nursing and Midwifery, University of Tasmania

Purpose of the study:

This study is being conducted to develop a thesis in total fulfillment of the requirements for the degree of Doctor of Philosophy in Nursing. The aim of the study is to develop nursing practice on an acute medical ward specialising in respiratory nursing to more fully meet the needs of patients with chronic lung disease related to continuing care.

Criteria for inclusion in this study:

You are invited to participate in this study, which will include registered and enrolled nurses, who provide care to patients with chronic lung disease. You are required to have at least 6 months experience in providing care to this group of patients.

The study procedure:

If you agree to participate in the Action Research Group you will be invited to engage in group discussion, in order to analyse data and identify key issues associated with delivery of care to patients with chronic lung disease within the unit. You will be involved in collaboratively planning, implementing and evaluating action, which will be initiated and developed to address the identified concerns

The Action Research Group will meet fortnightly for the duration of the study (   )

Version 4 dated January 2005   -5-

School of Nursing & Midwifery
Private Bag 121
Hobart TAS 7001

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Each meeting will be audio taped and transcribed by the research student before being considered by the action research group for collaborative analysis.

Possible risks of discomforts:

Most people find it therapeutic to discuss their experiences, however you may feel anxious or distressed as you describe your experiences, or as you discuss the findings or interviews and document analysis utilised in this study. If this occurs you will be offered the services of a trained counselor.

Confidentiality:

Any information divulged within the group will be treated as confidential, both by the research student and by others members of the action research group.

Information used in printed thesis or published literature will be disguised so you cannot be identified.

Freedom to refuse of withdraw:

Your participation in this study is entirely voluntary and you may withdraw from the study at any time without prejudice.

> Thankyou for you consideration of this information. Your participation in the study is greatly appreciated.

If you have any concerns about the study please contact:

Dr Andrew Robinson
Tasmanian School of Nursing and Midwifery
Tel. 62264735

OR

Dr Richard Woodbaker
Tasmanian School of Medicine
Tel: 62264855

If you have any concerns in relation to the ethical nature or complaints to the manner in which the study has been conducted please contact:

The Chair of the University Ethics Committee
Professor Roger Fay
Tel:63243576

School of Nursing & Midwifery
Private Bag 121
Hobart TAS 7001

UTAS

Consent Form (Action Research Group)

Study Title: Facilitating the continuity of care for elderly people hospitalised with chronic lung disease

1. I have read and understood the "information sheet' for this study
2. The nature and possible effects of the study have been explained to me
3. I understand that being a participant in the action research group of the study involves the following procedures

   Attendance at a group discussion held once a fortnight in the unit.

   The discussion will last approximately one hour, during which time I will participate in analyzing research findings in order to help plan, implement and evaluate action designed to further improve transition of care for elderly people with chronic lung disease.

   The interview will be audio taped and transcribed by the research student

   At the completion of the study, following evaluation of the findings, the tape will be erased.
4. I agree that information gathered for the study may be published provided I cannot be identified as a participant.
5. I understand that I may or may not feel anxious or distressed as I participate in the action research group process
6. Any questions that have asked have been answered to my satisfaction
7. I agree to participate in this investigation and understand that I may withdraw at any time without any prejudice, and if I so wish, may request that any personal data gathered be withdrawn from the research

Name of
participant:_____

Signature of
participant_____Date_____

Appendix Four: Information sheet and consent for interviewees.
Information Sheet (RN, Medical, Allied Health)

Study title:

> Facilitating the continuity of care for elderly people hospitalised with chronic lung disease

Chief Investigator:

> Dr Andrew Robinson, Senior Lecturer, School of Nursing and Midwifery, University of Tasmania.

Associate Investigator:

> Dr Richard Woodbaker, Senior Lecturer, School of Medicine, University of Tasmania

> Helen Courtney-Pratt, PhD candidate, Tasmanian School of Nursing and Midwifery, University of Tasmania

Purpose of the study:

This study is being conducted to develop a thesis in total fulfillment of the requirements for the degree of Doctor of Philosophy in Nursing. The aim of the study is to develop nursing practice on an acute medical ward specialising in respiratory nursing to more fully meet the needs of patients with chronic lung disease related to continuing care.

Criteria for inclusion in this study:

You are invited to participate in this study, which will include registered and enrolled nurses, from both the acute and community sectors, allied health staff and medical staff who provide care to this group of patients. You are required to have at least 6 months experience in providing care to this group of patients

The study procedure:

If you agree to participate in this study, you will be invited to participate in an interview conducted by the research student. The interview will take place at a

location of your choice. The interview will take approximately one hour. During the interview you will be asked to describe your experience of providing care to patients that move from hospital to community. You need only reveal information you are comfortable with.

The interview will be audio taped and transcribed by the research student and used to inform nurses theoretical knowledge and to facilitate the planning, implementation and evaluation of changes to care provided to patients with chronic lung disease.

Possible risks or discomforts

Most people find it therapeutic to discuss experiences. However, you may feel distressed or anxious as you recount you experience of caring for patients who move from hospital to home. If this happens, the interview can be terminated and the services of a trained counselor will be offered.

Confidentiality:

Any information you provide will be treated as confidential. Information that is presented to others, in a printed thesis, or published literature will be de-identified so you cannot be identified as a participant.

Freedom to refuse or withdraw:

Your participation in the study is entirely voluntary, and you may withdraw from the study at any time without prejudice.

> Thank you for your consideration of this information. Your participation in this study is
>
> greatly appreciated

If you have any concerns about the study please contact or send to:

Dr Andrew Robinson
Tasmanian School of Nursing and Midwifery
Locked Bag 121 Hobart
Tel. 62264735

If you have any concerns in relation to the ethical nature or complaints to the manner in which the study has been conducted please contact:
The Chair of the University Ethics Committee
Professor Roger Fay
Tel:63243576

OR

Executive Officer of the Human Research Ethics Committee (Tasmania)
Ms Amanda McAully
Tel: 62262763

Results of the study:
At completion of the study you will be invited to a general information session that will discuss results

You will be given copies of the information sheet and statement of informed consent to keep

Consent Form (RN, Medical, Allied Health)

Study Title: Facilitating the continuity of care for elderly people hospitalised with chronic lung disease

1. I have read and understood the "information sheet' for this study
2. The nature and possible effects of the study have been explained to me
3. I understand that the study involves the following procedures

    A single interview will be conducted at a location of my choice

    The interview will last for approximately one hour

    I will be asked to discuss my experiences of providing care to patients that move from hospital to community.

    The interview will be audio taped and transcribed by the research student

    At the completion of the study, following evaluation of the findings, the tape will be erased.

4. I agree that information gathered for the study may be published provided I cannot be identified as a participant.
5. I understand that I may or may not feel anxious or distressed as I discuss my experiences
6. Any questions that have asked have been answered to my satisfaction
7. I agree to participate in this investigation and understand that I may withdraw at any time without any effect, and if I so wish, may request that any personal data gathered be withdrawn from the research

Name of
participant:_____

Signature of
participant_____Date_____

8. I have explained this project and the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation

Name of
investigator_____

Appendix Five: Example of PREPARED Survey:

PREPARED

COMMUNITY SERVICE PROVIDER COMMENTS ON DISCHARGE PLANNING

office use only

me of Community Service_____ ._____

ur classification (community service provider answering survey)_____

calling the last client from your service, who was admitted to the public acute care sector, with chronic g disease please answer the following questions:

When were you made aware that the client was to be discharged from hospital?   *Please tick*

Client was still in hospital	π
On day of discharge	π
Within 1-2 days after discharge	π
Within a week after discharge	π
Longer than a week after discharge	π
Not at all	π

Was this sufficient notice for your organisation to respond to this client's immediate post-discharge needs?   *Please tick*

More than sufficient	π
Sufficient	π
Less than sufficient	π
Not at all	π
	π

Did you have an opportunity to accept or reject this referral?   *Please tick*

Yes	OO
No	

Was anyone in your organisation involved in planning this client's discharge from hospital?   *Please tick*

Yes	O
No	O

What was the nature of this involvement? ....

....

---

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· Does the client or carer know why they have been referred to you?   .... *Please tick*

Yes   O

No   O

· Who organised the referral to your service? *Please tick as many as required*

Client   O

Carer / family member   O

ACAT team   O

Hospital staff member   O

GP   O

Other health or community service worker? (*whom?*).........   O

....

· If your service has a standard referral form, was this used for this referral?

Standard form used   OO

Standard form available, but not used   O

No standard form   O

How did you receive the referral for this client?   *Please tick as many as required*

ı.

Telephone call   O

ɔ.

Fax   O

c.

Electronic mail system   O

ı.

Letter   O

e.

CIARR (Client Information and Referral Record)   O

f.

Other (*Please specify*)   O

....

ı. How adequate was the referral information about this client's post-discharge needs?   *Please tick*

More than adequate   O

Adequate   O

Less than adequate   O

No information   OO

ɔ. If the information accompanying the referral was <u>not adequate</u>, what further information would have been helpful?   ....

....

· Were the referral practices culturally appropriate for this client? *Please tick*

Yes   OO

No

If No, please comment...

....

ı. Are (will) your staff (be) able to provide adequate support for this client or carer?   *Please tick*

Yes   O

No

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			O
b.	Are (will) your staff (be) able to provide culturally appropriate services for this client or carer? . *Please tick*	Yes / No	OO
c.	Were you given the client's language information? *Please tick*	Yes / No	OO
.	Did you have to refer the client or carer to service(s) more appropriate to his/ her post-discharge needs? *Please tick*	Yes / No	OO
0.	Were you made aware of any occupational health and safety issues for your service in providing support for this client or carer? *Please tick*	Yes / No	O / O
1a	Has an advocate (other than a family carer) assisted the client to contact your services? .... *Please tick*	Yes / No	OO
1b	In your opinion, was advocacy an effective way of organising appropriate community services for this client? ...*Please tick*	Yes / No	OO

Please provide details if relevant.......... ...…..

....

....

....

2a.	Does the client (&/or carer) recall being provided with sufficient information about available community services? *Please tick*	More than sufficient	O
		Sufficient	O
		Less than sufficient	
		No information	OO

2b.   In your opinion, what further information should the client &/or carer have received?....................

....

....

3.	Has the client &/or carer formally taken up your service? *Please tick*	Yes / No	OO

If **NO**, what reason was given? ....

....

4a.	If the client &/or carer has taken up your service, has the service commenced? ....*Please tick*	Yes / No	OO
4b	If **YES**, how long was the waiting time before the service commenced? *Please insert number of weeks*		*weeks*
4c	If **NO**, how long will the waiting time be before services commence? *Please insert number of weeks*		*weeks*

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. In your opinion, how adequate were the discharge plans to assist this client to safely and successfully return to community living?

.... *Please tick*

More than adequate   O

Adequate   O

Less than adequate

No discharge plans   OO

Please comment ....
....

a. Overall, how prepared did you feel the client was for returning home from hospital?

Please tick

Sufficiently prepared   O

Could have been better prepared   O

Unprepared

O

5b If the client <u>has a carer</u>, how prepared did you feel the carer was for the client to return home?

Please tick

Sufficiently prepared   O

Could have been better prepared   O

Unprepared

O

----

c. Was the referral to your service because the <u>carer</u> was unprepared? .... *Please tick*

Yes   O

No

O

----

7. What aspects of this client's referral process were well performed?

....
....
....
....
....

----

8. How could the client's referral process have been improved? ....

....
....
....
....
....
....

THANK YOU FOR TAKING THE
TIME TO COMPLETE THIS QUESTIONNAIRE

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Appendix Six: Survey Ward Nurses (Action Cycle Four)

Appendix five: Ward Survey
Part A: General Information

Todays Date: ---/---/2007

Your Age: ( ) <20   ( ) 20-24   ( ) 25-29 ( ) 30-34 ( ) 35-39 ( ) > 39

Time worked on 2BN:____yrs____mths

Qualification: (please circle) RN   EN

Time since qualification: ____yrs _____mths

Post graduate qualification? Y . N   If yes, please specify_____

Part B: Practice

Please read **each** statement carefully and circle the number that relates to **your** own practice. One indicates a very low level of knowledge, confidence or skill and five indicates a very high level of knowledge, confidence or skill.

	Very low	Low	Satis-factory	High	Very High	Un Sure
My knowledge & understanding of oxygen use is	1	2	3	4	5	6
My confidence in managing patients with oxygen is	1	2	3	4	5	6
My skill related to oxygen management is	1	2	3	4	5	6
My knowledge & understanding of inhalers use is	1	2	3	4	5 .	6
My confidence in educating patients related to inhaler use is	1	2	3	4	5	6
My skill related to assisting patients with inhaler use is	1	2	3	4	5	6
My knowledge & understanding of VPAP is	1	2	3	4	5	6
My confidence in managing patients with VPAP is	1	2	3	4	5	6
My skill related to VPAP management is	1	2	3	4	5	6
My knowledge & understanding of the use of pulse oximetry is	1	2	3	4	5	6
My confidence in managing the use of pulse oximetry is	1	2	3	4	5	6
My skill related to the use of pulse oximetry is	1	2	3	4	5	6
My overall knowledge and understanding of COPD is	1	2	3	4	5	6
My confidence in managing patients with COPD is	1	2	3	4	5	6
My overall skill related to COPD care provision is	1	2	3	4	5	6

PartC: Learning Environment

Please read **each** question carefully and circle the most accurate answer related to **your** experience during the **last three months**.

In respect to facilitating your ongoing professional development & education on 2BN, do you find the permanent staff

very supportive	supportive	neutral	unsupportive	very unsupportive
very helpful	helpful .	neutral	unhelpful	very unhelpful
very interested	interested	neutral	uninterested	very uninterested

2. Do you consider the provision of professional development & education on 2BN to be?

very adequate   adequate   neutral   inadequate   very inadequate

3. Do you consider the amount of time allocated to professional development & education on 2BN to be?

very adequate   adequate   neutral   inadequate   very inadequate

4. Do you consider the unit as a whole to regard the provision of professional development & education as

Very important   important   neutral   unimportant   very unimportant

5. Do you consider the resource materials provided for your ongoing professional development & education on 2BN as

Very adequate   adequate   neutral   inadequate   very inadequate

Very easy to locate   easy to locate   neutral   hard to locate   very hard to locate

6. How many in-service or education sessions have you attended within the last 3 months?

( ) None   ( )   1-2   ( ) 3-4   ( ) 5-6   ( ) 7-8   ( ) >8

7. How many of these, if any were provided by 2BN? (please write number)

8. Please write any suggestions or comments related to the provision of education & learning within the unit, in the space below.

_____
_____
_____
_____
_____
_____

Thank you for your participation and completion of this questionnaire
Please now place in return envelope and post to:

2BN Action Research Group
Private Bag 121
School of Nursing & Midwifery
University of Tasmania
Hobart Tas 7001

Appendix Seven: Information and Consent for Focus Group Participants

Information Sheet (Focus Groups)

Study title:
> Facilitating the continuity of care for elderly people hospitalised with chronic lung disease

Chief Investigator:
> Dr Andrew Robinson, Senior Lecturer, School of Nursing and Midwifery, University of Tasmania.

Associate Investigator:
> Dr Richard Woodbaker, Senior Lecturer, School of Medicine, University of Tasmania

> Helen Courtney-Pratt, PhD candidate, Tasmanian School of Nursing and Midwifery, University of Tasmania

Purpose of the study:

This study is being conducted to develop a thesis in total fulfillment of the requirements for the degree of Doctor of Philosophy in Nursing. The aim of the study is to develop nursing practice on an acute medical ward specialising in respiratory nursing to more fully meet the needs of patients with chronic lung disease related to continuing care.

Criteria for inclusion in this study:

You are invited to participate in this study, which will include registered and enrolled nurses, from both the acute and community sectors, allied health staff and medical staff who provide care to this group of patients. You are required to have at least 6 months experience in providing care to this group of patients

The study procedure:

If you agree to participate in this study, you will be invited to participate in a focus group conducted by the research student. The focus group will be conducted in your workplace. The focus group proceedings will take approximately one and a half hours. During the focus group you will be asked to discuss your experience of providing care to patients that move from hospital to community. You need only reveal information you are comfortable with.

The focus group proceedings will be audio taped and transcribed by the research student and used to inform nurses theoretical knowledge and to facilitate the planning, implementation and evaluation of changes to care provided to patients with chronic lung disease.

Possible risks or discomforts

Most people find it therapeutic to discuss experiences. However, you may feel distressed or anxious as you recount you experience of caring for patients who move from hospital to home. If this happens, the focus group will be suspended and the services of a trained counselor will be offered.

Confidentiality:
Any participant in the focus group is requested to maintain the confidentiality of the group however this cannot be guaranteed. Information that is presented to others, in a printed thesis, or published literature will be de-identified so you cannot be identified as a participant.

Freedom to refuse or withdraw:
Your participation in the study is entirely voluntary, and you may withdraw from the study at any time without prejudice.

> Thank you for your consideration of this information. Your participation in this study is greatly appreciated

If you have any concerns about the study please contact or send to:

Dr Andrew Robinson
Tasmanian School of Nursing and Midwifery
Locked Bag 121 Hobart
Tel. 62264735

OR
Dr Richard Woodbaker
Tasmanian School of Medicine
Tel: 62264855
If you have any concerns in relation to the ethical nature or complaints to the manner in which the study has been conducted please contact:
The Chair of the University Ethics Committee
Professor Roger Fay
Tel:63243576

OR
Executive Officer of the Human Research Ethics Committee (Tasmania)
Ms Amanda McAully
Tel: 62262763

Results of the study:
At completion of the study you will be invited to a general information session that will discuss results

You will be given copies of the information sheet and statement of informed consent to keep

UTAS

Consent Form (Focus Groups)

Study Title: Facilitating the continuity of care for elderly people hospitalised with chronic lung disease

1. I have read and understood the "information sheet' for this study
2. The nature and possible effects of the study have been explained to me
3. I understand that the study involves the following procedures
4. Participation in a focus group
5. The focus group will last for approximately one and a half hours
6. I will be asked to discuss my experiences of providing care to patients that move from hospital to community.
7. The focus group will be audio taped and transcribed by the research student
8. At the completion of the study, following evaluation of the findings, the tape will be erased.
9. I agree that information gathered for the study may be published provided I cannot be identified as a participant.
10. I understand that I may or may not feel anxious or distressed as I discuss my experiences
11. Any questions that have asked have been answered to my satisfaction
12. I agree to participate in this investigation and understand that I may withdraw at any time without any effect, and if I so wish, may request that any personal data gathered be withdrawn from the research

Name of
participant:_____

Signature of
participant_____Date_____

1. I have explained this project and the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation

Name of
investigator_____

Signature of investigator_____

School of Nursing & Midwifery
Private Bag 121
Hobart TAS 7001

Tel 03 6226 4750   Fax 03 6226 4750   Web
www.utas.edu.au/nursing

Appendix Eight: Documentation Audit

Audit Tool COPD Nursing   Date: Patient Unit:

	Day of Admission	1	2	3	4	5	6	7	8	9	10
	AUDIT ITEM										
1	**Assessment**										
	Carer Status										
	Discharge Risks identified										
	Previous community providers identified										
	Enduring Guardian status identified										
	Discussion re future care undertaken RPC or EG										
	Pre-admission ADL status										
	Falls Risk assessment										
	Skin integrity assessment (Braden Score)										
	Depression assessment										
	Cognition Assessment										
	Weight Recorded										
	Weight loss/gain noted										
	Vaccination status recorded										

	Smoking status recorded											
	O2 written on drug chart											
	Recording of O2 sats on air											
	Frequency of TPR/sats obs											
2	**Multidisciplinary Care**											
	Respiratory Nurse referral											
	SB Respiratory Nurse											
	Physiotherapist referral											
	SB Physio											
	Dietician Referral											
	SB Dietician											
	Social Worker Referral											
	SB Social Worker											
	Occupational Therapist Referral											
	SB OT											
	Additional referral (specify)											
	Pulmonary rehab/CDSM											
	Multidisciplinary meeting discussion											

	Patient discussions											
	Carer discussion											
3	**Treatment**											
	Weaned off nebs to home delivery device											
	O2 titrated to spo2 readings											
	O2 ceased >24 hrs prior to discharge (except home o2)											
	Exercise documented											
4	**Education**											
	COPD package distributed											
	Chair exercises											
	Delivery device type documented											
	Technique checked											
	Energy conservation/breathing control/ relaxation											
	Smoking Cessation											
	Home Oxygen											

Discharge and Follow up										
Discharge destination										
Discharge plan documented										
Patient knowledge of COPD checked										
Carer knowledge checked										
Medications explained										
Pharmacy counseling sheet										
Competent with delivery device										
Understand fluvac etc										
Knows when to see doctor for follow up										
Describes deterioration symptoms (when to see doctor)/ Management plan documented?										
Home visit organized										
Community support organize										
Community nursing										
Meals on wheels										

Carer support										
ACAT										
Details of support requested: (ADLs, smoking cessation, further assessment etc)										
Medical discharge summary complete										
Medical discharge summary posted										

Location code:

DC=Drug chart
PN= progress notes
M=medical
N=Nursing
PT= physiotherapy
OT=occupational therapy
SW= social work
Di= dietician
SRN=specialist respiratory nurse
AA=admission assessment
QID=four times day
DEMN=DEMNotes

MM=mini mental
LOP=letter community provider
LGP=letter GP
CHR=community health referral
MDS=medical discharge summary
CC=clinical chart TPR
Ph= pharmacy
COPDPW=COPD pathway
NRT=Nicotine assessment
AHR=Allied Health referral form
D=daily
BD= twice day

Appendix Nine: Example of Competency Assessment (Action Cycle Four)

Competencies

2. Oxygen Management

Rationale - this assessment is to cover the minimal competencies required by nursing staff to what
flow rate is required , monitoring of oxygen and the protocols and procedures to maintain a high standard of care in oxygen management

Element	Performance criteria	Assessment	c	nyc	comments
2.1 Demonstrates understanding of policy for oxygen therapy	Assessment	verbal & discussion			
	Doctors orders	verbal & discussion			
	Written in medication chart	verbal & discussion			
	Emergency use	verbal & discussion			
2.2 Monitoring of patient on oxygen	Routine observations for O2	verbal & discussion			
	Weaning oxygen	verbal & discussion			
	Signs & Symptoms toxicity	verbal & discussion			
	Signs & Symptoms O2 retainer	verbal & discussion			
	Cautions for COPD pts	verbal & discussion			
2.3 Identify different oxygen devices	Nasal prongs	Direct observation			
	Simple mask	Direct observation			
	Venturi mask	Direct observation			
	Non rebreather mask	Direct observation			
	Humidification	Direct observation			
	Oxygen blender	Direct observation			
2.4 When to use different oxygen devices	Nasal prongs	verbal & discussion			Includes flow rates, time frames, humidification requirements, patient preferences
	Simple mask	verbal & discussion			
	Venturi mask	verbal & discussion			
	Non rebreather mask	verbal & discussion			
	Humidification	verbal & discussion			
	Oxygen blender	verbal & discussion			

2. Oxygen Management					
2.5 Precautions when using each delivery device	Nasal prongs	verbal & discussion			
	Simple mask	verbal & discussion			
	Venturi mask	verbal & discussion			
	Non rebreather mask	verbal & discussion			
	Humidification	verbal & discussion			
	Oxygen blender	verbal & discussion			
2.6 Humidification	Reasons for use	verbal & discussion			
	Dangers of use	verbal & discussion			
	Monitoring of patient	verbal & discussion			
	Assembling of humidification	Demonstrate			**Must demonstrate**
	NP bubble through humidifier	verbal & discussion			
2.7 Oxygen cylinders	Tell when empty	demonstrate			**Must demonstrate**
	Changing cylinders	demonstrate			
	Safety issues	demonstrate			
	Turning off & on	demonstrate			
2.8 Oxygen Blender	Assemble	demonstrate			**Must demonstrate**
2.9 Home Oxygen	Criteria for home oxygen	verbal & discussion			
	Delivery service	verbal & discussion			
	Reason for home oxygen	verbal & discussion			

Signature of Participant
Signature of Assessor
Date
Comments