

## International Practice Development Journal

Online journal of FoNS in association with the IPDC (ISSN 2046-9292)



### CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

#### Reflecting on action research exploring informal complaints management by nurses and midwives in an NHS trust: Transformation or maintaining the status quo?

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Submitted for publication: 3<sup>rd</sup> July 2012

Accepted for publication: 25<sup>th</sup> September 2012

#### Abstract

*Background:* Little is known about how nurses and midwives manage informal complaints at ward level or if effective communication at this level can improve service delivery and reduce the number of formal complaints in NHS trusts in the UK.

*Aims and objectives:* Working in partnership with a local NHS trust, the RESPONSE project uses action research methodology to explore the role of communication in the management of informal complaints in the trust. The aim of the project is to develop a guide for best practice. This paper presents a critical reflection informed by transformative learning theory on the use of action research methodology in this context.

*Conclusions and implications for practice:* Action research is a valuable tool for transformative learning, practice development and improved patient experience in acute NHS trusts. It requires a high level of commitment to 'power sharing' and perseverance. This is particularly so in relation to sustained participation, a core premise of action research, which necessitates:

- An inclusive, pragmatic, flexible and creative approach
- A continuous questioning and pre-empting of participants' needs
- An acceptance of the fact that participation may vary over the course of a project and that this in itself may facilitate participation

**Keywords:** Acute NHS trusts, action research, informal complaints, midwives, nurses, participation, transformative learning theory

#### Introduction

The ongoing three-year RESPONSE project (Responding Effectively to Service users' (patients and carers) and Practitioners' perspectives On care concerns: developing Sustainable responses through collaborative Educational action research) explores how junior and senior nurses and midwives manage complaints at ward level by using action research. The aim is to develop a guide for best practice that fosters effective informal complaints management leading to an improved patient experience.

The RESPONSE project has been approved and given a favourable opinion by the appropriate ethics committees.

This paper reflects on using action research methodology in partnership with an acute NHS trust, and on whether this methodology is likely to achieve the aims of the project, which are to improve patient experience through practice development. The reflection is informed by transformative learning theory.

### **Action research**

The methodology has been used for more than half a century in areas such as organisational development and is increasingly being used in health and social care contexts (Bradbury Huang, 2010). Action research is seen as useful in nursing, where traditionally there have been issues in translating theory into practice, which can thwart practice development (Holter and Schwartz-Barcott, 1993). The methodology can facilitate practice development in nursing through promotion of insight, learning and implementation that are embedded in practice. The term 'action research' covers a number of related research approaches but all have in common that they should 'effect desired change as a path to generating knowledge and empowering stakeholders' (Bradbury Huang, 2010, p 93).

The cornerstones of action research are participation and equality (Bradbury Huang, 2010) or 'democratic values' (Hilsen, 2006, p 24). Snoeren and colleagues (2011, p 190) also see it 'as an essentially participative and democratic process that also contributes to the empowerment of people'. Waterman and colleagues (2001) argue that, above all, a cyclic nature normally involving some form of intervention (although this is not a requirement) and partnership working define action research, and that reflexivity is an important part of the process.

### **Transformative learning theory**

Transformative learning theory holds that it:

*'Involves transforming frames of reference through critical reflection of assumptions, validating contested beliefs through discourse, taking action on one's reflective insight, and critically assessing it.'*

(Mezirow, 1997, p 11).

This theory was developed in the context of adult learning in order to change and improve teaching methods in higher education. Promoting transformation of frames of reference, or perceived meanings, is key in this theory, where it is assumed that there is a link between understanding and behaviour (Mezirow, 1997). The link between perceived meanings and behaviour is well recognised (Brown, 1989; Merton, 1968; Thomas and Thomas, 1928). Mezirow (1997, p 5) argues that our understanding of the world is two dimensional and made up by 'habits of mind' and 'a point of view'. The former consists of shared values or symbols and the latter relates to how we interpret those symbols in particular contexts. This has echoes of symbolic interactionism, with its concern for meaning and shared symbols through which we understand the world (Blumer, 1969). It is in the second dimension that transformation is most likely to occur, although understandings can change in both dimensions through critical reflection on our own or others' basic beliefs.

Transformative learning theory was developed with individuals in mind but is increasingly applied to organisations as well (Yorks and Marsick, 2000). It could be argued that action research embodies the spirit of both individual and organisational transformative learning, and that there is a pronounced affinity between this theory and the philosophical underpinning of action research (Gravett, 2004; Yorks and Marsick, 2000) and our project aims.

### **Project background**

A local NHS acute trust approached the research team to work with the trust to explore how response to informal complaints in the wards could be improved in order to enhance patient experience. While evidence suggests that poor communication is a key factor contributing to service user dissatisfaction and complaints (The Information Centre for Health and Social Care, 2011), it is unclear what exactly it is about communication that results in service user complaints, or whether poor communication after an informal complaint leads to a formal, written complaint. There is no evidence about the role effective communication and a positive response to complaints at the verbal, informal stage, has in improving service delivery and in reducing formal, written complaints.

### **Project design**

The ongoing project has a complex design with two phases and a number of different forms of participation. The first (scoping) phase has involved information gathering through a literature review, in-depth interviews with key trust stakeholders in one acute NHS trust, and the collection of trust complaints data as well as data logged by the Patient Advice and Liaison Service (PALS) and data separately logged by the midwifery services from follow-up sessions with service users. The scoping phase provided information about key issues in healthcare complaints from one acute NHS trust and from a national and international perspective to inform the second phase, which uses interventions with nurses and midwives. The interventions are described below in connection with a discussion about participation. The first phase also involved the development of a scale to measure nurses' and midwives' perceived ability to manage informal complaints and the degree of transformation at different points during the interventions.

### **Reflections**

The basic assumption of the RESPONSE project is that informal complaints management by nurses and midwives can be improved and that this might have a positive effect on patient experience.

We will first reflect on transformative learning from a general perspective in relation to our project and then focus on our experience of sustaining participation.

The transformative learning in this project simultaneously takes place on both individual and organisational levels in the research organisation and the NHS host organisation. First, the research team and its NHS collaborators involved in the running of the project are learning what it means to use action research methodology in this context, with its cycles of action and critical reflection. At the same time, as data is collected and processed, everyone learns about informal complaints management in the trust and can reflect and build on this. The groups of nurses and midwives taking part in the interventions try to make sense of their experiences at ward level, thus embarking on transformation individually and at group level. However, transformation also needs to pervade to trust level. Unless there is general 'buy in' from staff, and continued support and training provided from the managerial level, the transformation is unlikely to continue (Gravett, 2004; Yorks and Marsick, 2000). Perhaps this is particularly true in a non-homogenous acute NHS trust. The issue of how to facilitate transformation at trust level and if and how such a transformation could be measured will be discussed by the action research group described below and may require additional methods to be incorporated into the research design. The involvement in, and support for, this project at trust managerial level, is likely to help the escalation of the transformation.

The challenge providing the steepest learning curve has been recruitment and sustained participation, which is noteworthy given that one of the core values in action research is participation; in this context, this means the degree to which participants are enabled to collaborate in the research process. However, participation is not prescriptive and can take many forms, from a

sustained and extensive engagement with the research process to the occasional participation in discussions on the part of the participants (Bradbury Huang, 2010; see also Waterman et al., 2001).

Participation in the RESPONSE project takes a number of forms. As well as the academic project team, an advisory group consisting of academics, practitioners and service user representatives, and an action research group were set up during the first phase of the project. The latter, which is central to the project, consists of academic researchers, junior and senior practitioners, complaints staff and teaching staff from the trust. All have the opportunity to be involved on a regular basis in the entire research process and the decisions that are made. This involves the group working its way through various iterations of planning, acting, observing and reflecting. The interventions in phase two, aimed at exploring how nurses and midwives manage informal complaints at ward level and how this could be improved, involved recruiting senior and junior nurses and midwives to participate. By intervention we mean 'any changes in understanding, beliefs, values and behaviour' (Waterman et al., 2001, p 12).

After agreeing to lead this project with the trust nursing director, the principal researcher sought and received support for the project from a number of other sources: key stakeholders/managers in the main participating NHS trust, other NHS trusts expected to contribute data and academic colleagues, and representatives from the local Strategic Health Authority. The project also appeared to be congruent with an ongoing development agenda in the main trust. Snoeren and Frost (2011, p 4) refer to this 'pre-reconnaissance' as a necessary step to ensure mutual trust going forward with an action research project and to agree on fundamental issues. We had anticipated that this broad support would facilitate future collaboration and engagement, as well as the recruitment of participants throughout the project. Nevertheless, we realised early on in the project that continuity would become an issue in relation to the action research group when some trust staff, who were group members, unexpectedly moved to new positions at short notice – which also had an impact on further recruiting of participants. Some trust staff have also found it difficult to attend meetings. In other words, reality in a busy acute trust means high workplace mobility and competing demands on staff with regard to short term service demands and staff development. This has affected the project.

We have, however, continued to run the action research group meetings as planned where at least one representative for the trust has been present. We have endeavoured to keep all stakeholders informed about developments and have provided plenty of opportunity for participation and input. There have also been numerous informal contacts with stakeholders outside the meetings for updates and discussions, which have been noted and followed up in emails and further discussed in research team meetings. The principal researcher also spends time on a regular basis in the trust and therefore has access to stakeholders. Action research group members who have replaced those who have left, while not having been able to attend action research group meetings, have engaged in the project in different ways, primarily through supporting and assisting with recruitment of staff for interventions and facilitating the practical arrangements surrounding the interventions. The group members who were replaced because they left for new positions have continued to be involved in the project as valued members of the advisory board and thus are still engaged and provide continuity.

We had planned to recruit 40 nurses and midwives to divide into multiple groups for two cycles of interventions in the second phase of the project. Again, the reality of a busy acute NHS unit produced challenges. Extensive recruiting only brought ten staff members. To encourage participation, staff were informed that they could participate in work time and that participation would contribute to their continued professional training requirements. Efforts were made to organise interventions to fit in with shift patterns. Out of the ten members of staff recruited,

between three and five have attended monthly interventions thus far, only one of whom is a nurse. The reasons for these difficulties are probably slightly different than the difficulties with the action research group participation, where a number of people are key stakeholders/managers who were engaged in the project right from the start and have more autonomy over their diaries. In their action research project on care for older people in the Netherlands, Snoeren and Frost (2011) found that personal motivation, the nature of a group and time available informed the extent to which participants engaged in their research. While these factors probably also influenced the nurses' and midwives' decisions about participating in the RESPONSE project, it is possible that the sustained nature of the required commitment has been a major barrier. These nurses and midwives have little control over their shift patterns and it is probably difficult for them to plan ahead and try to fit a long term commitment into their busy work schedules as opposed to, for instance, attending a single interview. It is noteworthy that the participating midwives outnumber the nurses, given that the pool of nurses at the trust is considerably larger than the pool of midwives.

We have continued to run one group according to the research plan and the meetings are providing a platform for mutual exchange and learning. Given the logistical difficulties of organising meetings with midwives and nurses with differing shift patterns, we are holding two meetings every month for the duration of the interventions to facilitate participation. We will also be discussing other solutions to make up for multiple groups with the action research and advisory groups.

As well as logistical reasons it is also possible that these difficulties could be partly attributed to the inherent paradox in action research – that the focus and initial design of the project had by necessity already been decided by the research team beforehand, although we claim participant engagement and inclusiveness (Ospina et al., 2004). Participants may have perceived a mismatch between the espoused philosophy of participant engagement versus the reality, making them feel less engaged and thus less likely to participate. Svenkerud Aasgard and colleagues (2012) also argue that it is essential to adhere to democratic values in action research because otherwise participation may become merely emblematic.

Although some activities, such as the interventions, have taken place on trust premises, the action research group meetings have not. It is possible that if they had, this would have been more practical for trust staff and it could have better promoted equality and democratic values and further embedded the project in practice.

### **Concluding remarks**

The challenges we have experienced may have different explanations. First, we relied on the initial broad support we had established and underestimated the effort needed to sustain participation. It could perhaps even be questioned if, in view of these difficulties, we should have chosen a more conventional methodology for this project. However, other basic premises of action research are that it is non-prescriptive and cyclic in nature, which allows for adapting to and learning from issues that arise. Using Mezirow's assumption about transformative learning and the 'point of view' dimension discussed above, it could be argued that we have been able to reflect on and successfully address unexpected problems and to learn from them for future reference (Mezirow, 1997, p 5).

In spite of these challenges, we believe there is clear value in using action research in this context to facilitate transformation and improve patient experience. The NHS is a huge, non-homogenous organisation in perpetual flux that is not susceptible to overnight change, and action research methodology is sufficiently flexible to be a catalyst for transformation in this context. We anticipate that the change we are setting in motion in this acute trust will continue beyond the limits of the project, for instance by the trust using data from the project to inform future staff training to continue the transformation.

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## Acknowledgements

The RESPONSE project is funded by the Midwifery Training Council at the University of Surrey Trust.

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