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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Outcomes from a pilot project on workplace culture observations: getting evaluation and outcomes on the agenda

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Abstract

Aims and objectives: The overall aim of this mini project was to collaboratively engage in a learning activity that would provide evidence about the workplace culture to be used to inform other aspects of practice development work. The objectives were: to enhance observation skills; contribute to a team development activity; share and develop critical questions for use with local practice development action planning and build up active commitment to practice development work within the group.

Design: A small pilot project embedded within a larger complex emancipatory practice development programme.

Method: An unstructured observation method was used and followed up with facilitated critical reflection and dialogue.

Results: The overall theme was Inconsistency and Contradictions. Seven contradictory sub-themes were found: light and dark; cleanliness and clutter; quiet and noise; calmness and busyness; conversation and chatter; communal and bedside; respect and disrespect.

Conclusions: This pilot project shows that multi-dimensional small scale outcomes can be identified very early on in practice development. Testing and developing a practice development method and processes for wider scale use in an organisation is an important feature of micro level practice development within healthcare organisations.

Implications for practice: A group of practitioners can learn to carry out and collate findings from observations within their own workplace. Becoming critically aware of context and culture is a process and it needs to be facilitated to ensure that learning progresses to collaborative action. Outcomes can be maximised by building in facilitation to promote reflection and dialogue. An observation method on workplace culture can form part of a diagnostic and evaluation portfolio at practice level which can contribute to larger scale evaluation, quality and clinical governance agendas.

Keywords: emancipatory practice development, evaluation, observation, facilitation, culture

Introduction

This small pilot project is part of on-going and larger, complex emancipatory and hopefully transformational practice development work being undertaken at a community hospital in the South East Coast region of England. This hospital is one of five similar in patient services within the organisation. Prior to this pilot beginning, the whole multi-professional team had spent some time on agreeing shared values and beliefs and a vision for the service. A multi-professional practice development group had begun to lead on the practice development work within the in-patient service of the hospital. The practice development group is comprised of nursing and therapy clinical leads in the hospital that are responsible for the transformation work in developing workplace culture and more effective patient care/therapy and is facilitated by a practice developer working within the organisation. The observation activity was introduced about four months into the portfolio of work. At the same time as this pilot on observations of the care setting was taking place, other practice development activity was also underway. The practice development work is taking on both a broad based approach aimed at developing a more effective workplace culture and a more targeted approach with specific aspects of practice and service delivery. For example, planning how to collect and analyse patient stories; coaching to enable multi-professional meetings to be more effective; clinical leadership role clarification; and a number of project specific working groups including rehabilitation skills; mealtime care and nutrition; documentation and record keeping; end of life care and patient experience. Over time, this work is expected to have an impact on the effectiveness of service delivery; for example, from reducing average length of stay and delays to discharge to improved patient experience and satisfaction. It is also testing and show casing the applicability of practice development methods and processes for wider use within the organisation.

Background

Manley et al. (2008) set out nine principles that inform all practice development activity. Principle three highlights work based learning with a focus on active learning and formal systems for enabling learning in and from work to transform care; whilst principle nine stresses that evaluation approaches must be inclusive, participatory and collaborative. Observations of the care setting is a method that combines both these core principles as well as contributing to broader individual and workplace cultural transformation (McCormack et al., 2009).

Observation as an ethnographic research method, has a long history according to Atkinson and Hammersley (1994). It is claimed that the value of observation is to permit researchers to study people in their environment in order to gain enhanced understanding from their perspective, because people are observed in context. Given the significance of context and culture, (Drennan, 1991; Manley, 2000; McCormack et al., 2002; Manley, 2004) and the 'micro' aspects of emancipatory and transformational practice development work (McCormack et al., 2008, p.21), this makes observation a good method for use (McCormack et al., 2009). Further, it can be argued that certain observational methods, such as phenomenological and hermeneutic observation, can intensify the learning that can be gained from undertaking observation. As Dewing (2009) and McCormack et al. (2009) have proposed and McCormack et al. (2010) amongst others, have demonstrated facilitation of emotionally connected learning is a core activity within practice development.

In most research where observation is used, the researcher is generally required to spend considerable time observing with the possibility of adopting various observational roles in order to gain a more comprehensive understanding of the people being studied. In many workplaces there are challenges in staff organising themselves to be and feel released from patient care, especially where the value of observation has not yet been proven to the local team. Beginning with shorter episodes of observation can be a way to get started. Unstructured observation rather than structured observation can be used to understand and interpret contextual and cultural behaviour.

Mulhall (2003) argues unstructured observation is based within the interpretist or constructivist paradigm that acknowledges the importance of context and the co-construction of knowledge by those involved. Although unstructured observation is a key method in anthropological and sociological research, it has been used less frequently in qualitative research in nursing where the principal data collecting method is probably still the interview method. Through the practice development literature it can be seen that observations of the workplace and observations of care are powerful learning experiences and evaluation methods (Brown and McCormack, 2011; Dewing et al., 2007; McCormack et al., 2010). As practitioners and managers become used to or en-cultured to their work and workplaces they stop noticing as much, or what is going on around them and take the attributes of their workplace culture for granted. Stepping back and seeing the environment, the team and how both work in synergy or where they don't work can be extremely revealing (Brown and McCormack, 2011). Observations of the workplace can enable team members to begin to see what they have not seen or have previously ignored. In terms of facilitating effective learning processes into collaborative action in practice, observation alone is not enough and it needs to be combined with (facilitated) critical reflection and dialogue with others. Consequently, when several people carry out observations simultaneously, it can enable a group of people to develop shared insights and learning into their workplace culture and the realities of current practice including allowing oneself to be 'touched' by a closer view of patient and family experiences. Further, these observations when systematically recorded can provide a source of local evidence about areas that could benefit from practice development and the impact of practice development activities. Thus observations are a part of a diagnostic and evaluation portfolio.

Method

The aim of this pilot project was to collaboratively engage in a learning activity that would provide evidence about the workplace culture and could be used to shape other aspects of the practice development work.

The objectives of this observation activity were to:

1. Enhance observation skills
2. Carry out and contribute to a team development activity
3. Share and develop critical questions for local practice development action planning
4. Build up active commitment to practice development work within the group
5. Collect local evidence/data about current practice to inform practice development

This was the first time many of the group members had engaged in observation within their workplace in the way being proposed, so a simple relatively unstructured observation method, as used in other practice development programmes and work, was introduced (McCormack et al., 2010). This method has been tested in previous practice development projects (Dewing et al., 2007; McCormack et al., 2010; McCormack and Dewing, 2011); it is used before engaging with a more formal and larger scale emancipatory observation method such as the Workplace Culture Critical Analysis Tool (WCCAT) (McCormack et al., 2009); and it also enables more team members to participate in the activity.

The method here drew on the observers' core senses: what they saw, heard, smelt and felt or imagined. No specific situations or times were required. Prior to beginning the observations, the group discussed the concerns members had about undertaking the observations. These ranged from concerns about what other team members would think of them and the method, to staff adapting what they were doing during the period of observation. At the starting point, some group members openly expressed a preference for covert observation. The reasons for this were that staff would be able to appear better than they usually were and skew findings. It may also be that group members felt unusually self-conscious and even exposed at carrying out observations in their own workplace.

Covert observation needed to be carefully discussed. The facilitator enabled this by referring to the values and principles of practice development to provide a backdrop for this ethical discussion. The group could then discuss the benefits of being open and how this was contributing to workplace culture transformation. Between October 2010 and January 2011, a number of 15-30 minute workplace observations were carried out by all the multi-professional members of the practice development group. Some of the members also went on to facilitate a number of other team members to carry out the activity as well, including registered staff nurses and an occupational therapy assistant.

There were 13 returned sets of observation notes from group members plus sets from an occupational therapy (OT) team member and from a band 5 (registered) nurse, giving 15 in total. Observations were mostly carried out on the larger of the two wards in the hospital (ML). A total of five and half hours of observations were collected. Formal research ethical approval was not sought for this piece of developmental work; however, a process mirroring research governance was adhered to. For example, posters were put up in advance to alert patients and visitors and staff about the observations. Written information was made available to teams prior to any observations commencing and team leaders responded to concerns or questions. Prior to the activity people were made aware that it was taking place and also when it had finished. Patients who expressed that they did not want to be included in the observation activity were not. A thematic data analysis was used (Thorne, 2000) whereby the data was read through to gain an overall feel. It was then reread and key descriptions and words highlighted. The highlighted words and descriptions were then put together to form similar categories. From these the sub themes were identified.

The overall theme; Inconsistency and Contradictions came from reflecting on the impressions that arose from the data or evidence as a whole. The sub themes were: light and dark; cleanliness to clutter; quiet and noise; calmness and busyness; conversation and chatter; communal and bedside; respect and disrespect. Group members all reviewed the collective theme and sub themes from the evidence they had individually collected. On first impression, group members felt the findings resonated with their experiences of the observations. Group members were facilitated to have a more in-depth discussion about the analysis and what the findings meant to them and how they could be drawn into other aspects of the work. Four members of the group also went on to provide more detailed contributions to the analysis.

Results

Table 1 shows the evidence that was collected across all the observation periods from the larger of the two wards (ML) in the project. The smaller ward has been omitted as the service was subsequently transferred to the larger ward and no longer operates as an in-patient service. On the larger ward there are two ‘wings’ referred to as East Wing (EW) and West Wing (WW).

Table 1. Evidence collected across all the observation periods.

Sensory Domain	**Evidence/Data**
What we saw	Night (WW): All patients were settled in bed or watching the TV in their rooms. Morning (ML): Registered nurses hurrying to and fro. Clutter in main area of Meadow Lodge. Lunchtime (ML): Lots of activity. Nurses bringing patients into the dining room for lunch. Lots of people walking through Meadow Lodge dining room. This is in addition to registered nurses, therapists etc. Patients 'on view' to all. Did not feel a restful mealtime, or to have privacy and dignity. Staff waiting for food to be served. Chatting amongst themselves. Lots of rushing. Lots of clutter, wheelchairs, hoists etc. Afternoon (EW): Cleanliness. Lack of natural light. Nursing staff at nurses' station talking to each other. Saw no patients. Pressure cushion left leaning against nurses' station. Wheelchairs/chairs – unused space 'lounge area' east end – wasted space. Space set up as lounge – but not comfortable looking and dark. Afternoon (WW): Pads left lying on top of the nurses' station. Nurse writing notes at the station - very short period, then nurses' station unoccupied. Caution wet floor sign by patient's room. No patient activity. One visitor going into a patient's room. Staff member returning to the nurses' station from patient's room, placing a box down, and then washing hands. Lunch (WW): Dining area - 2 tables with 4 patients at each table. 2 members of staff serving patients. Saw staff being helpful, cheerful, language used was polite and patients referred to by first name. Efficient with clearing of tables and serving second courses. Afternoon (ML): Patient admission. Staff nurse explaining what we do at ML: rehabilitation treatment programme, multidisciplinary team and what that entails lay out of the day, visiting hours. Offered opportunity for patient to ask questions. Patient too tired so she suggested that patient be shown around ward next day, apart from showing where the toilets are. Nurse unpacked luggage and offered tea/coffee. Language was plain and clear professional manner but friendly and welcoming. Observed that patient's anxiety levels were reduced. Night (EW): General lighting dull and drab. Work station lighting area also poor ... unwelcoming. Health care assistant emerges from a patient's room, walks to the clinical room and returns to the patient's room with various supplies. One patient walks past to the dining area. Afternoon (WW): Large box in corridor to fire door. Lots of notices stuck to the work station. Conversation in patient's room – noisy laughter chatter. Background television noise. Staff busy walking to and from patient's rooms. Cupboard doors squeaking - doors opening/closing. Paper rustling. Work station cluttered minimal space to work. Concentration of nurse at desk with paperwork. Shift changing with staff handing over. Visitors arriving and trying to find staff to talk to looking anxious and asking questions. Ambulance transport delivering patients – looking for staff –

	no one at the nurses' station to help. 2 staff carrying an armchair for a new patient. Afternoon (ML): Staff sitting in chair in the lounge area in discussion with man who supplies curtains. He is leaning against a window frame, with as tape measure. HCA walks into patient's room. 1 band 4 nurse is sitting at the desk another is standing, leaning into the gap. Visitors walk up to the desk and enquire about a patient's location. Staff nurse points as she informs the relatives, slightly rising from her chair. Afternoon (ML): Nurse on the phone through left ear, tape measure retracting and extending through right. Pleasant toned conversation, professional. Distant laughter from a patient's room. Phone rings twice, then stops. Discussion between nurse and HCA about a patient BMI at the desk. Spluttering and coughing after patient encouraged to drink. Nursing staff voice is very kindly. Hurried footsteps. "Have you done your observations? I tried to send mine but the attachment didn't work … she's down there, room no 8". Distant exclamations of greetings along corridor. Afternoon (ML): Nurse staring at the PC whilst talking on the phone. Puts the receiver down, writes a few lines on a post it note and hands it to an HCA. Returns to her paper work and writes in a focused fashion. HCA moves noiselessly along corridor. Nurse hurries up to desk with a tin foil packet in her hand. Starts talking to other nurse. Shows medication packet to nurse. HCA returns to the desk and leans patiently awaiting the end of the on-going conversation between the two nursing staff. The nurse with the medication packet turns swiftly and leaves. HCA gets a wheelchair and heads off down the corridor towards a patients room. Man walks energetically towards the desk; he has a wall clock in his hand. He removes the battery from its back, at the desk. Nurse gets up and walks with the man towards the office. HCA walks around the corner past the desk with a patient in a wheelchair.
What we heard	Night (WW): 4 rooms had 2 different programs so noise level was high. Night (ML) The bed pan washer was on and call bells were going off. Patients were asking for warm drinks and urine bottles to settle for the night. With one staff member to work with it was organised and a system was in place to settle everyone for the night. Night (ML): During the night there was a peaceful silence apart from staff talking. At one time 4 bells sounded in 10 minutes. It is like a domino effect when one bell goes off as it seems to wake patients and they become unsettled. Night (ML): There are periods of silence other than for the clacking of patient folders when writing care plans, under a dim table lamp. Night (ML): Then the hubbub of early morning. Lights on and action bells go crazy and it is nonstop noise for 1.5 hours until day staff arrive. Morning (ML): Door bell x3 while I am there. Deliveries arriving. Ward clerk busy and telephone is ringing. Patient Call bells ringing. Lunchtime (ML): Bells ringing either end. Afternoon (EW): 2 TVs on loud. Banging, beeping from the kitchen. Lots of

	discussions around swapping shifts at the nurses' station. Phone going – went unanswered. More kitchen noises – loud. "Sorry to interrupt, can I take your BP." Staff planning ahead – heating to be turned up. Some nursing staff talking from a distance to nurses' station – loud voices. Staff talking out loud to themselves. Afternoon (WW): Loud televisions. Staff voices – very loud. Furniture being moved – banging. Coughing. Crockery being sorted loudly. Other noises around dining area. Voices from dining area – audible in therapy office. Friendly 'hello' to a patient from a nurse/reassuring conversation. Nurse asking a patient about their choice for supper. Loud trolley being wheeled and banged. Feet squeaking on floor. Visitor conversation with patient (in room). Noise of medicine cupboard being opened/closed – keys jangling. Friendly staff interaction. "Can I take the BP machine?" Then a loud voice from nurses' station to dining area - "did you do the patients BMs or shall I do it?" Lunch (WW): dining area low level 'chatter' by patients. Staff asking questions e.g. are you comfortable? Staff assisting where needed e.g. opening condiment sachets, passing jug of water, cutting up food for patient with right sided weakness. Night: (EW): Mixed noises from televisions, on in the individual rooms. Some very loud. Coughing from Room One. Health care assistant assigned to East Wing talking to and offering reassurance to a patient in room 3, enquiring about the patient's day and encouraging her to walk to adjacent bathroom prior to going to bed. Bedpan washer making cycle noises in nearby sluice. Telephone rings, enquiry about a patient and requesting us to pass on a message. Bells ringing in various rooms. Afternoon (WW): Background noise of builders. Visitors asking about patients. Staff stating they are tired at end of shift – long day. Telephone calls to ward. Telephone calls made by staff. Afternoon (ML): Sister on telephone-respectful tone to caller. Paper rustling at desk. "Thank you very much John." Feet moving from lounge area towards office, past the nursing desk. Nurse requests HCA gives a message to a patient. Momentary silence at desk, voices heard along corridor chatting amiably from a room to the left. Nurse at desk starts to talk to herself in a conversational tone. Increased interaction along corridor. Enthusiastic voices and laughter. Quick footsteps toward nursing station. Voice commences before reaching East Wing desk. "Mr X's wife has just come in with this medication, but I can't accept it can I 'cos look- absolutely no labels or indication as to what it is. She says she knows what her husband takes. Oh no you're not recording this are you?" Afternoon (ML): Discussion between two nurses. Slightly mocking tone used when quoting patient's wife. HCA informs nurse of a request made by a patient to use the telephone. Footrests seen to bash into the side of a wheel chair. Discussion between two nurses. Afternoon (ML): Noises from visitors, bell ring, kitchen equipment, staff talking, HCA singing, phone ringing and nurses talking with each other. Afternoon (ML): Tea trolley very noisy; patient zimmer frame scrapping along floor; patient talking loudly about her condition to a visitor; patient calling member of staff

	'darling'. Nurse on the phone talking.
What we felt	Night (ML): Initially I felt very warm and light. Afternoon (EW): Bombarded by noise. Lack of natural air/light. Sluggish. Afternoon (WW): Overwhelmed by noise, distracted … staff activity all centred on the dining area. At the same time a lack of patient activity. Night: (EW): Stuffy and hot … no particular smells at the nurses' desk, but generally a hot and very stuffy atmosphere. The thermometer in the clinical room indicating temperature is at 28c. Afternoon (WW): I felt cold and draughty. Afternoon (ML): Hot, airless … Lighting was glaring-bright white. Very few shadows. Afternoon (ML): Nothing specific. Temperature stultifying (particularly without movement). Afternoon (ML): Soporific and dry.

Inconsistency and Contradictions

This is the overall theme that came out of the thematic analysis of the evidence. The range of what was seen and heard varied from person-centred to patient-centred and right across from task to staff-centred care. This means patients experience inconsistency in how the care setting is managed and in how care and therapy is delivered. For the team, it also probably means their experience of working in the same place can vary considerably from day to day. This does not contribute to the creation of stability or psychological safety within the team, something needed for an effective workplace culture (Brown and McCormack, 2011). The sub themes that evolved from the analysis are now discussed and illustrated with reflective material from six of the members of the practice development group.

Light and Dark

> *I think that décor is an important aspect of how a service is perceived... this opinion is based on a visit to a paediatric service. Whilst fundamentally the wing is for children, its décor is also pitched at adults to appear welcoming, bright and efficient. The wall colours there suggest/reflect a proactive, positive, pleasantly reassuring environment. Pictures on walls alone, do not have the same resonance for people as the 'wrap around' message conveyed by design.*
>
> *Lighting is dull and drab: the dining area is dark, even on a summer's day. Good lighting over the dining tables is also an area which could assist in making the food more attractive in presentation.*

The commentary here suggests that the care setting can be drab and may not have the design attention given to it that services for other groups such as children and their families have. The poor attention to lighting is further indicative of a lack of understanding of age related visual impairment.

Cleanliness and Clutter

> *Tidiness and clutter is an example of extremes [contradictions]. There might be a concerted effort to tidy up the dining room and conservatory, and yet a little while later clutter reappears, it seems it is easier to 'dump' wheelchairs, seat cushions, and mattresses than to put them away properly, especially as there is no 'comeback' on whoever did it. It is just allocated to the 'night staff' or the 'day staff'.*
>
> *Clutter in main area... this theme is well observed in my opinion. We do not seem to have much global awareness of how the unit should be perceived and as a team we seem inured to slovenliness! The observations seemed to flag up that some of the causes of disarray in that might be due to the pressures put upon staff and no physical sense of order outside of the regimen of medication and meal times.*

These comments by two of the group members indicate validation of this sub-theme and also offer several insights into the workplace culture. For example, being tidy is done for an imposed reason. Although not stated, this is often for the internal or external Patient Environment Action Teams (PEAT). This is a periodic assessment of inpatient healthcare sites in England and uses audit and a benchmarking method (Department of Health, 2010). It also reveals something about the low level of personal commitment within the team to the care environment and a lack of accountability within the team. However, when needed the team shows it can work together as members all contribute to the big tidy up.

Quiet and Noise

> *We are very task orientated so this must contribute to the noise. Things are done at certain times, mealtimes, drug rounds and so on. When these are complete then we are quiet again until the next task is due. The call bells are going a lot of the time. It takes too long to answer them and this must be an irritant for patients.*
>
> *Due to the layout of the unit there are often times when staff cannot be found. It is very likely that two staff may be in one patient's room and one in another. Communication between them is very difficult. There is no way of knowing where they are until they emerge or someone else knows which room they are in.*
>
> *I think that call bells as part of the noise intrusion is misplaced. Noise produced by call bells is easily drowned out by surrounding cacophony … chatter, TV and other background noise. So it's non- stop noise for 1.5hrs.*
>
> *In my opinion, noise is one of the most predominant [negative] features of this unit.*

One member wanted to say something about 'good noise':

> *The therapy gym is a noisy place ... some of the most intense activity in the unit takes place in that space. Some of the noise is music, introduced to try and establish a different atmosphere. Yet, when the gym is empty, the door is left open and the music contributes to the general cacophony.*

The commentary here indicates that the group members, at least to some degree, see, hear and believe the service is too task-centred. This has not always been the case. The year previous, when

the practice development work began, the collective thinking and commentary would have been about how short staffed the service was and how poorly managed it was and that these two factors were ultimately responsible for everything that was wrong about the service, care and therapy. The developing of critical awareness can take a good amount of time to the point where it can be more openly reflected on and dialogued over in a group. These conditions are necessary prerequisites for collaborative action to evolve.

Calmness and Busyness

> *Changes in the environment can happen quite quickly. One moment the dining area can be quiet, and the next the patients are brought through for their lunch and it is busy and noisy. Patients chattering, staff bringing patients through as catering and nursing staff serve the meal.*
>
> *Despite having protected mealtimes the dining area is a thoroughfare and everyone from maintenance staff to domestic supervisors and porters walk through. This is quite disconcerting at mealtimes as the patients must find the comings and goings very distracting ... all adding to the feeling of busyness and to the noise levels.*
>
> *The busyness could be perceived as chaos at times and at others stressful animation. Always task-centred and driven by goodwill, but counterproductive at times. Our expectation of compliance from patients is automatic rather than mutually generated.*

One group member challenged the notion that the team were task-oriented:

> *I would debate the premise that busy – quiet periods necessarily lead to the rather negative conclusion that we are task-oriented, but there is an issue of patient confidentiality in the comments about nurses talking about patients within earshot of patients.*

Conversation and Chatter

> *I have noticed this chattering together between staff members which does exclude patients. It is as if 'they' are different from 'us' ... As a relative you are often completely ignored here. I have experienced this feeling in other hospitals and care settings as one of these 'outsiders'. Entrenched attitude is a problem in the service as is the invisibility of the patients. An example of this is patients often have no choice but to hear our sometimes negative and inappropriate discussions, literally outside their rooms. Daily insensitive, raucous laughter and loud chat between staff.*

There are potentially serious comments here about the invisibility of patients and exclusion of relatives/families. This commentary could be seen to be digging deeper into the culture within the workplace. The observations related to the invisibility of patients are at odds with the values and vision developed by staff. Closing the gap between the contradictions or distortions with what is espoused and what is currently happening is the domain of critical social action (Kemmis, 2001); such as practice development.

Communal and Bedside

> *Here, I feel we are wasting precious hours of patients' time. They do indeed, sit inactive in their rooms for long periods in between minutes of high activity such as washing, physiotherapy and eating.*

> *We expect patients to 'jump to it' and be waiting for us to appear and for them to comply with our wishes.*
>
> *I'm in agreement with this ... boredom must be intense at times; this can lead to dis-enablement, disempowerment and probably depression.*

It is interesting that there was not a call to ensure that older people spent more time socialising with each other. This call is akin to saying that all older people need to be and should be socialising, because it's good for them and touches on ageist beliefs. Instead, the group members have focused on a deeper factor within the workplace culture, that of the busyness which in turn is underpinned by a task routine. The other notable feature was that there was no focus on the older people either being unsuitable for the service or being uninterested in what was going on around them. These reasons are often put forward for explaining why practice can't be different.

Respect and Disrespect

> *I have noticed since starting practice development how when I hear terms that would have seemed very mild to me a year or so ago, really grate with me now. And I think this is what is happening at differing rates to us all. As leaders in particular but to other staff too. Terms such as 'old boy',' she's a darling' and so on. We may not have thought there was much wrong with these terms before but now we do. They grate on us. There is obviously a lot of scope for improvement and it should come from the top, because without that lead the other staff will not change.*
>
> *There are examples of disrespectful language and mocking someone is an example of disrespectful. We are all prone to it but awareness of language and tone is emerging.*

In this sub theme one group member challenged the presence of this theme and reframed the naming of it:

> *Whilst the themes mostly do feel real for me, I don't feel so sure about respect and disrespect – I can't see the evidence for this as much as I can for the other themes. I can see evidence for friendliness and cheerfulness.*

Reframing of a different type and renaming is something that the group will focus on when looking at action.

Discussion

Clearly there are a number of limitations to a project of this size. If this was a traditional research study then these would now be discussed. However, as a pilot project within larger scale emancipatory practice development work this project achieved its aims and objectives. The multi-professional group collaboratively engaged in a learning activity that provided evidence about the workplace culture to be used to shape other aspects of the practice development work they are leading and facilitating. Group members learnt how to develop observation skills to a certain degree. Skills need to be further developed in order to make use of the WCCAT. Although there is some variance within the group about the degree to which the findings are problematic or indicative of a task-centred culture, the activity generated reflection and critical conversations within the group. It has enabled the group members who are clinical leads within the team to 'see' their workplace more as it is than as they hoped it to be. In turn, this is building up active commitment to practice development work within the group; and in addition, the group have collected local evidence/data about current practice. In terms of the overall emancipatory process, group members have achieved

learning outcomes that will contribute to enlightenment and hopefully, along with other interventions, to empowerment. One of the group members summed up her learning as: "*we do not always see ourselves as others see us"* and went on to elaborate:

> *I saw for brief periods how it all looks, smells and sounds to patients and visitors. A visitor can pick up a lot of information by using their senses; about other patients, about the staff and about the organisation we work in. How bewildering it would seem to someone who does not have all those senses and how frightened they could be. I also feel that as senior staff we are quite 'forgiving' of our surroundings and accepting of standards that have long been in place. We stop noticing that a staff member is wearing hoop earrings or that there are pieces of paper on the floor. We are occupied in managing the 'here and now', and do not see or hear what is around us.*

Other members added:

> *The findings do present a realistic picture during different periods of shifts on the ward. They are snippets of our observations as identified by members of the practice development group mainly involving staff and environmental issues. I feel what is missing in our care setting (apart from lunch time periods) is meaningful interaction between staff and patients such as that which would occur through helping patients with exercises or practising mobilising in the afternoon.*
>
> *The initial observations are quite negative with noise, horrid smells and the ward being cluttered. I feel things are less cluttered (most of the time) and noise levels have definitely decreased.*
>
> *I see we are observing different things. I believe the reason that the observations are often very different [in the group] is that those of us who made them are coming from different places at this point in our practice development work.*

The observers in this project were already immersed in the field of observation, which created a different set of issues than outside or external observers coming in. Group members alluded to anxieties about being able to do this activity, issues around gaining access to what was actually going on, power imbalance, self-identity, and personal fears. How issues such as these are facilitated will influence the practitioner/observers assumptions and practices within it. Critical thinking like hermeneutic thinking requires the asking of questions (Debesay, Naden and Slettebø, 2008). Moving between the observations with questions–answers and new questions all related to the subject is vital. The group had already been experimenting with learning how to develop critical questions of their own and working with these in the group and within their everyday roles and work. The critical questions that emerged from the group in this project were wide ranging and moved between technical, narrowly focused questions to broader more open questions that did not contain within them a predetermined solution and that could be explored by the group. Table 2 shows the critical questions generated from the observation analysis.

Table 2. Examples of critical questions.

- How can we see our practice more through the eyes of an observer?
- How can we observe our practice and care environment less selectively?
- How can we understand how the environment impacts on patient 'behaviour' – and how much is the patient then 'blamed or 'labeled' for this? e.g. patient is uncompliant/patient was verbally abusive
- How can we understand how this care environment of polar opposites impacts on patients and their ability/willingness to engage with rehabilitation?
- How will all feel pride in where we work and want it to look its best?
- How can we move away from being so task orientated and move towards being more person-centred?
- How can we be more patient focused and not forget all the things that have to be done?
- How can we encourage our staff to keep their own chatter to break time and to be much more focused on the person who is the patient?
- What can we do to keep patients occupied in between the activities we want them to do?
- How can staff be educated to initiate more involvement with patients i.e. patients to have opportunities to mobilise and exercise? How can we implement this?
- How can we ensure that patients do not feel isolated in their rooms?
- How can we ensure good communication between the team?
- How can we develop good communication with patients and family?
- How can we maintain good standards of cleanliness around the ward?
- How can we keep the noise levels down and have a fresh clean environment to work in?
- How can we maintain standards of care with the ever increasing pressure?
- How would knocking on a patient's door and awaiting a response before entering reinforce a sense of respect and dignity?
- How can we prevent over familiarisation in conversation?
- How can we stop patients being invisible?
- Would other times of the day given as 'protected times' for the patients instil a sense of focus on recovery?
- How can we offer the patients a sense of peace and privacy whilst eating their meals?
- How would a therapy timetable help patients have a stronger sense of purpose?

The critical questions need to be refined and prioritised. The refinement process will help consolidate a shared perspective within the group. These questions will then form the basis of action plans and help to build on the individual and group learning. The next steps are to ensure the group can work from the shared understanding they have achieved, to make use of the evidence they have generated as widely as possible across the other projects and more widely as part of broader conversations in the workplace. Central to all of this activity is widening the inclusion and participation of other team members to work towards a collaborative approach to action.

According to Mulhall (2003), observation as a method of collecting data in nursing research has been somewhat undervalued. Emancipatory practice development can help redress that imbalance. However facilitating the skills in practitioners to become effective observers of their workplace culture requires a systematic learning and developmental approach to be taken. Taking the hermeneutic process as an example, Naden (2010) proposes that pre-understanding, understanding, sensitivity, the fore-conception of completeness and language are all aspects for development and skills acquisition necessary for effective observation. Becoming skilled in workplace observation also

requires authentic participation (Gadamer, 1999) especially for personal transformation. This suggests that observation skills can be developed to a very high, even expert level. The stance taken by the team members observing is vital. It is not as simple as being an insider observer as there are numerous variations that can evolve in being an insider observer. The variances become more obvious when a group undertakes observation at the same time. The balancing of consistency with personal style is another feature of the work that needs facilitation. Repeating the observation method at regular intervals will enable practitioners to keep evolving. Referring to Gadamer (1999) again, the more explicit the practitioners pre-understanding is, the more they may identify or acknowledge what is new (even if it was already there before) and what is consistent with their pre-understanding. Baker (2006) suggests that the literature on observation reveals how complex, challenging, and creative this research method is. This author goes on to say that observational methods require specialised training on how to observe, what and how to record the data, how to enter the field and leave it, and how to remain detached and involved at the same time. Finally, Baker (2006) adds, the use of one's senses, as well as other data collection techniques, make observation a more holistic type of research that allows the researcher to gain a better understanding of insiders from their own perspective.

As observation is a developmental process, practitioners can in the beginning, be unconsciously selective about what they see; this means they may not see or they may continue to ignore detail and simply capture an overview of the possible available evidence. It is not until later that they really see beneath the surface of the workplace culture and record more detail. Self-discovery can therefore be a longer process and a more uncomfortable one than the traditional external audit process. Of course, it can be argued that the learning taking place is more significant and meaningful. Further, the findings from observations, where it is simply passed on as information will not remedy an ineffective workplace culture. It is how the observation method is used to promote individual and collective learning and action within the workplace that makes the difference. Engaging practitioners in collecting the evidence in the first place increases the opportunity for emotional investment and commitment to the findings and then to action that will address negative patterns and strengthen positive patterns in the workplace culture. Bevan, (2011) identifies the potential of knowing about patterns within our workplaces and what to do about them.

Bevan (2011) states that patterns are principles that have been used before, often in a different context. This is similar to what Plesk (2001) states. In the United Kingdom, the National Health Service Modernisation Agency has identified 20 patterns for healthcare improvement. They are said to be reliable solutions to commonly occurring problems. An example of this, Bevan (2011) gives as the 80/20 rule, in which it is claimed that around 80 per cent of the effects generated by any large system are caused by 20 per cent of the factors in that system; therefore, the majority of results derive from a minority of causes. Healthcare improvement worldwide requires more rigorous processes to identify our patterns; to categorise and reuse the learning from the most successful change processes to get better, quicker outcomes across the whole system (Martin et al., 2011). Looking at the work by Brown and McCormack (2011) it may be that the complexities and power of social structures and patterns within teams and their workplaces is not fully recognised in what Bevan (2011) and Martin et al. (2011) set out. Instead it is the tailoring of learning argue Melton et al. (2011), that will enable optimum learning outcomes and consequently result in greater engagement in practice development and its aims. Observation will provide an opportunity to uncover some of the patterns that exist in a workplace thus enabling them to be the focus for critical social action. This should contribute towards more person-centred care through building a more effective workplace culture. However, on its own it won't be sufficient. Those involved in introducing new working practices need to be alert for any opportunities to find ways to integrate new practices with existing systems and they need to look for opportunities to prove the value of new practices to others. This work requires that practice developers or champions of change, not only to understand

the technical details of new practices, but also can facilitate social networks and their processes and engage in the daily politics of the workplace culture and even of organisational life (Fenton-O'Creevy, 2007). This author draws on work by Reay et al. (2006) who discuss how to sustain change beyond the implementation phase. Reay et al. (2006) take for granted that examples of the new way will be fitted into established social structures. This of course assumes that the social structures and its patterns are positive ones. Practice developers would argue, where social structures and patterns are not positive and effective, new practices do not easily fit in and are therefore not sustained. Consequently, it is also necessary to be working on transforming the established social structures and patterns at the same time as introducing new practices. An emergent pattern might be that new patterns must be tailored to each context. It is easy to criticise small scale practice development work for having little or time limited impact. Depending on the organisational and workplace context and existing patterns, some practice development work does begin in a small way. Indeed, no matter how large scale the work is, all practice development ultimately consists of small scale 'micro' level cultural work. Principle eight (Manley et al., 2008, p.5) states that practice development is associated with a set of processes that develop a specific skill set required as near to the interface of care as possible. This requires practice developers to learn how to be effective in demonstrating and sharing short term outcomes that will contribute to the skill set that is desired by managers within the service.

Conclusion

It is important that practice developers appreciate the complexities and also the multiple benefits from engaging with small projects at a micro level within an organisation. Being able to produce evaluation evidence, such as through observations of the care setting, is one way of ensuring practice development makes a positive contribution in an organisation and produces some relatively quick outcomes. In this pilot project a practice development facilitator assisted a group of practitioners to undertake, critically reflect and discuss observations of their workplace. This was a collaborative process that enabled the group and individual members to develop (through raising consciousness) and become more likely to feel empowered and want to do something with the evidence to make a positive difference to some of the patterns in their workplace.

Implications for practice

Producing findings from observations of the care setting and or from practice can provide both powerful learning experiences and also evidence for immediate use in a service and can contribute more widely within quality and governance work within an organisation.

In this workplace the learning contributed to the overall critical intent as it enhanced group member's broader awareness of their workplace culture and the rationale for practice development.

Observations of this unstructured nature can prepare the ground for more formal workplace observation using the Workplace Culture Critical Analysis Tool (WCCAT).

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