



ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Realising participation within an action research project on two care innovation units providing care for older people

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Abstract

Background: On two care innovation units in the Netherlands, staff, students and lecturer practitioners work intensively together to provide care, create a rich learning environment, and to foster innovation and research. In striving to advance the quality of care and to develop person centred cultures, a preference is given to participative forms of research in which diverse experiences and different types of knowledge are valued.

Aims and objectives: The research described here had two overarching aims: the improvement of practice situations and the encouragement of the integration of work and learning. This article focuses on our actions and learning with respect to fostering participation during this project.

Design and methods: Within the action research methodology used, participative work-forms and research methods were chosen. For example, a responsive approach to evaluation of practice, use of narratives and the stimulation and use of creativity to help in exploring and sharing feelings, values and different forms of knowledge. In this article we use Arnstein's (1969) ladder of citizen participation to frame our reflection on enabling participation within this project.

Results: Participation took various forms and vacillated throughout the project. In addition to particular facilitation strategies, three factors emerged as influential in enabling or inhibiting aspects of participation among stakeholders: individual motivations and interests, the make-up of and atmosphere within the group, and the time made available to engage in research activities.

Conclusions: Participation in research is both more complex and dynamic than Arnstein's (1969) typology suggests. Moving 'up' the ladder may not be appropriate as a goal in and of itself. Instead, meeting and responding to each other's situations, as stakeholders, seems a more appropriate focus. Taking responsibility, as facilitator, for certain research activities, can free other participants to focus on elements which interest them and from which they derive satisfaction.

Implications for practice:

- Laying groundwork and building relationships at all levels of an organisation is essential to enabling participation during an action research project.
- Democratic, person-centred and creative work-forms are effective in enabling participation among stakeholders in both homogeneous and heterogeneous groups.

- The forms and levels of participation within any one action research project are many and will vary during the life of the project.
- Enabling participation for a particular group, or groups, of stakeholders may form a barrier to the participation of other stakeholder groups.

Keywords: participation, action research, facilitation, Arnstein's ladder, enabling factors, barriers

Introduction

To promote integration of theory and practice and to foster excellence in care, an organisation providing residential care for older people in The Netherlands has set up two care innovation units, in collaboration with two schools of nursing. A care innovation unit is a unit in which healthcare providers collaborate intensively with a large group of students to combine care, education, innovation and research (Frost and Snoeren, 2010). The overarching aims are the development of a challenging workplace for team members (i.e. all nursing and care staff on the unit, whether qualified or still students) and advancing the quality of care using principles of practice development, which Manley et al. (2008, p 8) define as 'a continuous process of developing person-centred cultures'. This process is facilitated by lecturer practitioners who support team members in the development of their knowledge and skills and facilitate processes aimed at transforming the culture and context of care (Garbett and McCormack, 2004; van Lieshout and Cardiff, 2006).

One care innovation unit, Magnolia Unit, has places for 34 residents with complex and/or intensive support needs, including palliative care. The other, Hawthorn Unit, has 22 places where people with age related mental health conditions stay temporarily for observation, rehabilitation or during crisis. Each care innovation unit accepts 20 to 26 students on clinical placement, working mainly morning and afternoon shifts. The students are studying for various qualifications: healthcare assistant, enrolled nurse or registered nurse at both diploma and degree level. About 27 qualified healthcare assistants and nurses are employed in each care innovation unit, covering all shifts, the majority qualified as enrolled or diploma level registered nurses. Because of the unusually large numbers of students, each qualified nurse is also a work-based learning coach to at least one, but often two or three students. In addition, each care innovation unit has a junior lecturer practitioner working three days a week.

We, Miranda and Donna, were involved in the care innovation units as more experienced lecturer practitioners. For three years Miranda worked two days per week in both care innovation units, mentoring and coaching the junior lecturer practitioners, supporting the care innovation units in the areas of innovation and research, and initiating the action research described in this article. Donna worked one day per week for 12 months, augmenting lecturer practitioner support to the teams and junior lecturer practitioners during preparation for and establishment of both the care innovation units and the action research. Donna provided critical peer review for Miranda in the early stages of the research as well as practical support, for example as an extra facilitator during group meetings. While Miranda's position could be described as 'insider' (Coghlan and Brannick, 2005), Donna's was closer to that of 'friendly outsider' (Greenwood and Levin, 1998).

The action research described here had a double aim:

- The improvement of practice situations in both care innovation units
- The encouragement of the integration of work and learning

We focus here on our actions and learning with respect to fostering participation among stakeholders, particularly care innovation unit team members. By describing events during initiation

and establishment of the action research in sufficient detail, along with our interpretations of these events, we hope that our case will have learning potential (Abma and Stake, 2001) for other facilitators and action researchers.

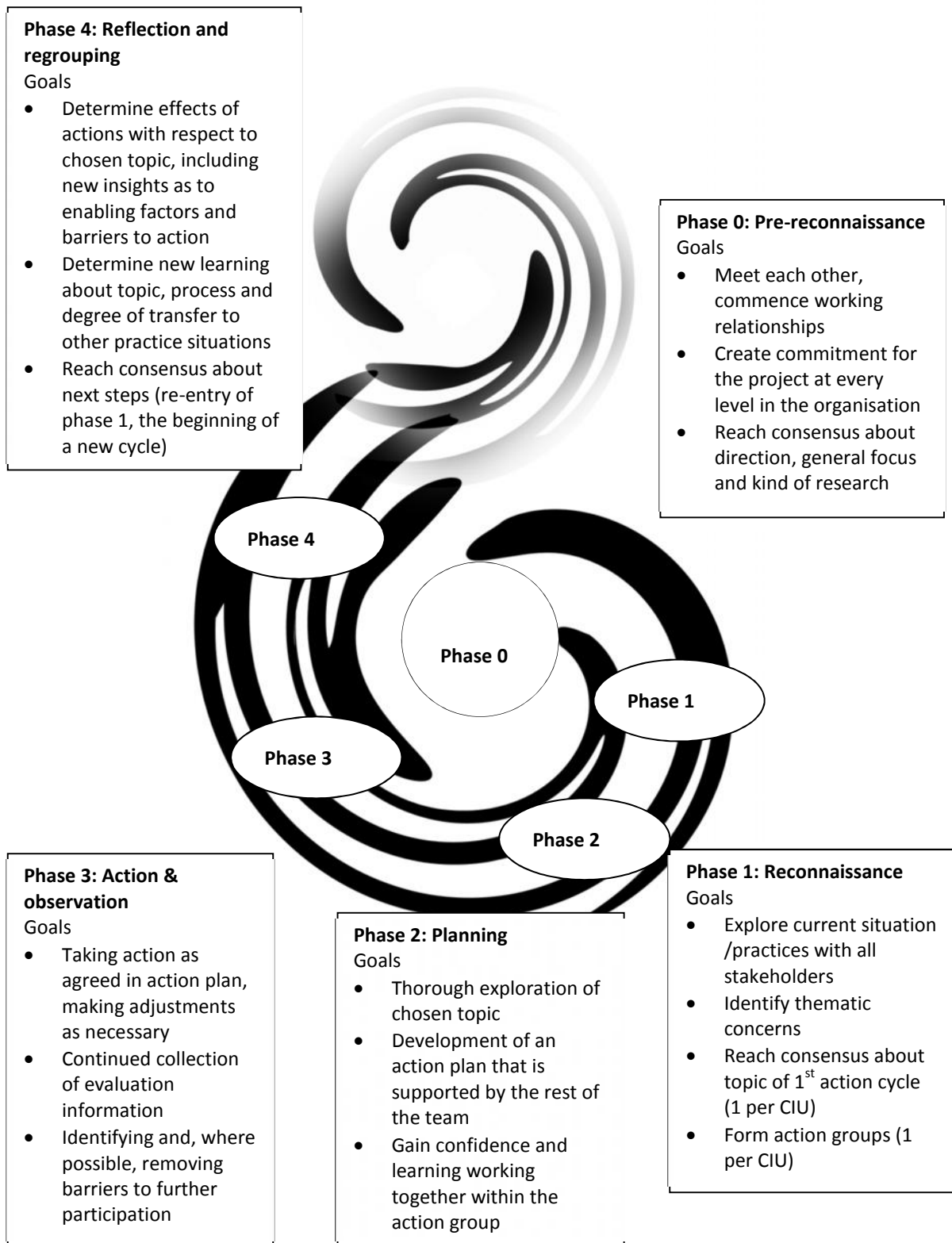
Methodology

In our work we are guided by certain principles and underlying values. As described by Heron (1996) and Guba and Lincoln (2005), we believe that individuals have the right to influence processes which affect them and/or in which information is gathered about them. Such processes are greatly determined by the social context, and in all social contexts there exists the potential for imbalances of power to develop or be maintained (Carr and Kemmis, 1986). Differences in power are often seen as 'normal' and therefore accepted by the people concerned. In working together to redress power imbalances and improve social situations we value the diversity of opinions, knowledge and skills that individuals and groups bring to the situation. We believe that adequately facilitated active (Dewing, 2008) and work-based learning (Manley et al., 2009) are important contributors to transformation of individual, group and organisational practice.

These principles influenced our decision to use participatory action research as a methodology with which to realise the care innovation unit aims. This approach demands a democratic and participatory process and has an emancipatory function (Kemmis and McTaggart, 1988; Fals-Borda, 2001). The intent is research with, for and by people in order to rediscover a more equitable power balance in an educative manner, whereby the capabilities of participants can increase (Reason, 2006). By enabling people in an organisation or community to actively participate and share experiences in a dynamic process of action, reflection and collective research (Reason and Bradbury, 2001), the improvement of practice is integrated with the development of (scientific) knowledge in a cyclical process.

In the care innovation units we used Kemmis and McTaggart's (1988) framework to shape the research process. They describe a spiral model, consisting of a number of phases. The process begins with; (1) the reconnaissance phase in which a thematic concern is identified and further analysed. From this point one or more action cycles develop, each consisting of the phases; (2) planning; (3) acting and observation and; (4) reflection. In the literature there is usually little (explicit) attention given to the preparation for action research, such as meeting interested parties and the creation of social conditions (Migchelbrink, 2007). For this reason we added a phase 0, or pre-reconnaissance, namely learning to know and trust each other and laying the groundwork for the project. The phases and related goals with respect to the first action research cycle are presented in Figure 1. The multiple brushstrokes in the spiral represent the diversity of and overlap between particular activities as they occurred.

Figure 1. The phases and goals of the first action research cycle



Phase 0 began in November 2008 and the first action cycles were completed in June 2010, at which time a second action cycle was already in progress on one of the care innovation units. While Miranda remained involved throughout the first and several subsequent action cycles, Donna was principally involved in phases 0 through 2 of the first action cycles and had left the setting before phase 4 of the first cycle was initiated. Miranda's involvement ceased in July 2011, but action cycles continue, now facilitated by the junior lecturer practitioners and other permanent team members on the care innovation units.

Methods

Due to the cyclical character of action research, the research process cannot be planned in detail in advance and an 'emergent' process develops (Reason and Bradbury, 2001). Thematic concerns and concrete methods and techniques for the evaluation of action cycles are determined during the research process in consultation with those involved. We used, for instance, stakeholder stories, (participant) observation, (group) interviews and questionnaires. We also collected data that transcended the action cycles, about how the process was experienced by those involved, by holding (group) interviews on several occasions. In addition, Miranda kept a methodological and reflective logbook with the aim of continuous reflection on the process and to record and justify the choices made.

Ethical considerations

This type of research falls outside the provisions of the Dutch law on medical research with people (Ministerie van Volksgezondheid, 2006). It is therefore not possible to apply for review of the project by a local Medical Ethics Review Committee. The organisations in which research occurs, and the researchers themselves, must ensure compliance with ethical principles of research. In this case Miranda presented the project to the Ethical Committee within the organisation and gained permission to proceed. Unit involvement in projects of this kind is explicitly discussed with care innovation unit staff before they join the team. Although all team members will be affected by the research on the unit, they are free to participate, or not, in specific research activities as they wish, as are clients and their families. Process consent is used, in which the researcher negotiates consent at each new stage in the study (cf Gerrish, 1997; Majjala et al., 2002; Clarke, 2006). The principles of anonymity (for example when collecting data about the current situation on the unit) and confidentiality (for example with respect to group discussions) are employed and new research participants are made aware of these ethical principles. This action research is carried out as part of Miranda's work towards a PhD; she is therefore supervised academically and engages in periodic peer review and critique of her research activities.

Participation

As well as its cyclical character, action research is distinguished by intensive relationships between the initiating researcher and others involved in the change and research process (Hart and Bond, 1995; Waterman et al., 2001). The researcher supports other participants in investigating and changing the situation (Migchelbrink, 2007), and facilitates their participation in as many aspects of the research as possible. According to Arnstein (1969) and others (e.g. Bishop and Davis, 2002) the label 'participation' can be applied to various forms of engagement, or ways of working together, some empowering but others in fact disempowering. Arnstein stresses the need to be aware of the kind of engagement we are achieving or enabling, particularly when power imbalances are present. As we wanted other participants to experience an increase in personal power and empowerment, Arnstein's typology (see Figure 2) proved useful in reflecting on the varying kinds of participation occurring within this project.

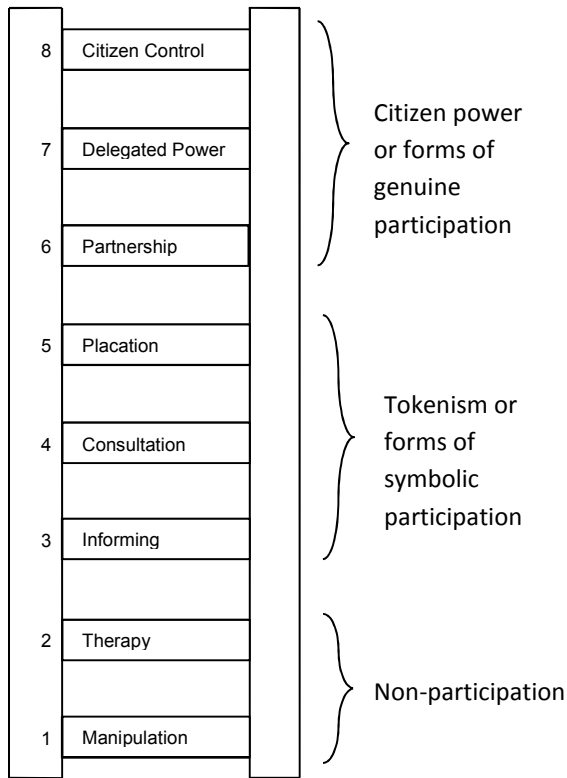


Figure 2. Ladder of citizen participation, based on Arnstein (1969, p 217)

Arnstein’s ladder of citizen participation

Arnstein (1969) identified eight levels of citizen participation (in political and policy processes), arranging them on a ladder, or continuum. Lower down the ladder represents a lower degree of participation, with the first two rungs, in fact, designated as ‘non-participation’. In Arnstein’s view, (citizen) participation is about transfer of power. When only superficial involvement in decision-making processes occurs, knowledge and lasting influence remain in the hands of a powerful person or group.

Translated to the situation of an action research project, informing potential participants of the object and method of the research, on the basis of which they can decide whether or not to take part, occurs at rung three. Consulting participants and taking, if possible, their opinions into account within the research process occurs at rung four, and rung five if opinions are consistently taken into account but the whole project is still designed and led by more experienced (and therefore more powerful) researchers. Only from the sixth rung can we talk of real participation or power-sharing. At rung six the decision-making processes are structured so that negotiation between participants and those in power comes into being. Consensus is the aim, whereby neither participants nor researchers can unilaterally enforce their point of view. With delegated power (rung seven) the participants have a dominant role and a majority voice in the decision-making processes and they initiate, organise and lead (defined) research activities, while on the eighth rung the participants have full sovereignty over and responsibility for the organisation, execution and monitoring of the whole research.

Participation within this action research project

It was our intention to enable forms of engagement that could be described as genuinely participative. In practice the advancement of participation was not always straightforward and we encountered – or engendered – various levels of participation throughout the project. Detailed information follows about the strategies we used to encourage participation in each phase of the first action research cycle (see Figure 1). Quotations from interviews illustrate how the action research took shape and was experienced by those involved. The changing nature of participation in this process will be examined with reference to both Arnstein's (1969) typology and theoretical perspectives in the literature around participative research.

Pre-reconnaissance: acquaintance and preparation (phase 0)

Chenoweth and Kilstoff (2002) emphasise the importance of commitment and involvement at all levels of an organisation when initiating and establishing participatory action research. From the beginning of phase 0 these aspects had our attention whereby we attempted to fit in with the existing hierarchy of the organisation.

Commitment at managerial level

From six months before the actual opening of the care innovation units, we exchanged ideas about doing research with higher management and junior lecturer practitioners, followed by middle management. The concerns of these stakeholders about engaging in research were discussed, such as research being time consuming and results being merely filed away. In relation to levels 3 and 4 (inform and consult) of the ladder of participation, we explained action research, participation within it, and shared our ideas about giving it form on the care innovation units.

The practice-oriented and intentionally participative character of the project appealed to those involved at this stage. A shift in views about research took place; trust grew at management level and was openly expressed, along with approval to continue. The importance of support at higher and middle management level has been emphasised by a number of authors (e.g. Hart and Bond, 1995; Hoogwerf, 2002; Boomer and McCormack, 2007), making this an important first step. In addition these meetings helped Miranda develop her own ideas about the research and to make these explicit in a research proposal. The dialogues with others were often reciprocal and conform to participation level 5 (placation, or conciliation) on Arnstein's ladder.

Another important result of phase 0 was the formation of a research group, originally consisting of both junior lecturer practitioners and ourselves (lecturer practitioners) and, after the opening of the care innovation units, augmented with staff from both units. This group met each month and had the job of organising, supporting and monitoring the action research in both care innovation units, beginning with informing and involving team members and (para)medics via a series of meetings.

Informing and involving team members and (para)medics

The research group organised eight team meetings for each care innovation unit, beginning in February 2009. Five were preparatory, held before the care innovation units had opened. Each lasted 2½ hours and as many of the (future) care innovation unit staff members as possible were able to attend all the meetings. Preparatory meeting participants considered what a care innovation unit is and what the underlying concepts of learning, mentoring, innovation and research mean. Steps were taken towards creating a shared vision of care and those present endeavoured to give more concrete form to organisation of care and ways of working together on the care innovation unit. Important in facilitating participation in these processes was our use of creative work-forms, such as working with metaphors, making collages together, sharing experiences and points of view using a picture or an object, and the use of drama (Mienczakowski, 1995). The stimulation and use of

creativity helped in exploring feelings, values and different forms of knowledge that could lead to new insights, as discussed by Fish (1998), Boomer and McCormack (2007) and Higgs et al. (2007). *Sharing* knowledge and insights was also easier and cooperation was strengthened (cf. Stuckey, 2009; Titchen, 2009).

It [using creative work forms] stimulates you to do things that you wouldn't normally choose to do. It teaches too, to cross a particular threshold [...] It teaches you more about yourself [...] You're all together, you're not on your own and it teaches you to develop things.
(Staff member, group interview evaluation of preparatory team meetings)

During the meetings possibilities were created for people other than ourselves to facilitate parts of the meetings. We wished to move towards participation not only in terms of 'content' and decision-making but with respect to facilitation of group and research processes (Heron and Reason, 2001).

I have really developed in respect of facilitating big groups. And in improvisation too, because although you have your planning yet things go the way they are at that moment. How do you improvise then?
(Junior lecturer practitioner, group interview evaluation of preparatory meetings)

This principle, of wanting to reduce dependence on the lecturer practitioners in relation to conducting research on the care innovation units, is evident in many of the actions we describe in this article and is a common aim within action research (Greenwood and Levin, 1998; Reason and Bradbury, 2001).

The meetings were also used to let those involved *experience* how, together, we could examine own and care innovation unit practices. For example, we collected data about the meeting content, such as the views expressed on care, and the process, such as evaluations of the work-forms used. Our analyses were fed back and checked in the next meeting and we used the information to inform the content and process of subsequent meetings. By making these activities explicit we tried to demystify the idea of 'researching practice' and illustrate how research processes and methods could be flexible and responsive. In the fifth meeting the action research itself was the focus, looking at ways to organise it in the care innovation units and the roles stakeholders could play in this. Ethical aspects were discussed, for example that it was not compulsory to take part, deciding one's self the degree to which one wanted to participate and the safeguarding of anonymity during data analysis and feedback.

Information sharing and inviting team members and paramedics to give their input and to share in decision-making were crucial processes, both practically and in terms of acting according to our values. A degree of trust and enthusiasm for working in a care innovation unit and for the proposed research was created. Participation at the levels of partnership and shared power (rungs 6 and 7) was realised with members of the research group and, for example, with a group of students who co-facilitated one of the meetings. With many of the other team members forms of symbolic participation developed, and sometimes, in areas that concerned content of care, partnership.

Reconnaissance (phase 1)

After the care innovation units had opened, the focus of the team meetings moved from preparation for opening to the exploration of the present situation on the care innovation unit. Using democratic processes team members reached consensus about a thematic concern (Kemmis and McTaggart, 1988) to be addressed in an action cycle. The research group played both a research and facilitating

role in this process, which is explored below. 'We' had now acquired another meaning: 'we', as Miranda and Donna, had shifted to 'we' as a research group.

Identifying a thematic concern: data collection and analysis

Several months after opening, the views of stakeholders about residing and working in the care innovation units were sought. We used a responsive evaluation approach (Abma, 2005), aimed at increasing personal insight and mutual understanding among individuals and stakeholder groups. Interaction and dialogue between the various parties is central and occurs first in homogeneous and then in heterogeneous groups.

The research group, and some students under supervision, approached each stakeholder group (clients or their families, staff, students and paramedics) separately to hear what members of each group found important. We used (group) interviews and questionnaires adapted to the particular group and bearing in mind what was practically attainable. A research group member made notes during the interviews, which were also audio-taped as a back-up to the notes.

Much of the data was analysed with members of the research group, and when possible with other care innovation unit team members. The joint analysis from both insider and outsider perspectives was valuable. We learned from each other and acquired new (personal) insights into the meaning given to the data collected. We did face, however, a number of difficulties here. This manner of analysis took a great deal of time and team members could not always be available due to the demands of care delivery on the unit. Our own schedules also presented obstacles to arranging meetings.

Democratic decision-making and reaching consensus

The results of the joint analysis were fed back in team meetings which were similar in style to the preparatory meetings. Two stakeholder groups, clients and their families, were not present at these meetings. There were various reasons for this. Staff said that attending the meetings would be too taxing for clients and, due to the temporary character of admissions in the Hawthorne Unit, family members were often only superficially involved with the unit. Team members also felt that some themes did not concern clients and/or their families, for example those not dealing directly with care, but with learning and mentoring. We return to this point later.

The results were discussed in homogeneous groups (students, staff and (para)medics). Each group identified a number of improvement themes and together decided which two themes had the highest priority for them. These two themes were fed back, with supporting arguments, to heterogeneous groups. In this way the voice of each stakeholder group among the staff could be heard and considered. There was movement toward more equality of opportunity between those involved.

...I thought that was really good, because you can bring something up and something is really done about it [...] I mentioned something from the list and you discuss it and then you come up with other ideas. We came up with a solution together [...] I've not been a student here for very long, but was able to bring up something like that. I think it is really good that you are listened to. I think I really learned something.

(Student, group interview evaluation of team meetings)

In the heterogeneous groups dialogue developed, for instance between students and staff about the mentoring of students, or between team members and (para)medics about the quality of

multidisciplinary care. This active participation enabled not only the exchange of ideas but increased involvement in the decision making process.

In small groups you are stimulated to contribute. If you have a big group then there are always some people who don't say anything because they won't or daren't, or don't manage to get a word in. If the groups are smaller then everyone gets a turn, it is safer that way I think"

(Staff member, group interview evaluation team meetings)

Afterwards, anonymously and individually, everyone voted for the proposed theme they thought most deserving of attention. The theme for the first action cycle was thus decided by majority vote. For Magnolia Unit this was 'communication among members of the care team', and for Hawthorn Unit 'appropriate daily activity for clients'.

There was little difficulty in reaching a consensus. Those present felt that they had been listened to, that their voices had been heard by the rest of the group. The resulting active involvement and degree of motivation continued after the meetings. A number of people from each care innovation unit were willing to take part in an action group, which would take the initiative in tackling the thematic concern.

It came to life after that, people started to think about it. Certainly after the last team meeting, with the action group, a lot came of it: we can do this and that, plan this and that. It came alive. It got people thinking and doing. People are enthusiastic; the items that come up in the team meeting come alive in the unit. [...] On every side you just hear about it and find enthusiasm to start doing things and to be active in action groups and to learn. You notice too that cultural direction of the care innovation unit is beginning to change. I have the idea that people are changing their attitudes: open, wanting to learn, listening to each other, discussing.

(Staff member, group interview evaluation of team meetings)

A number of Arnstein's (1969) levels of participation can be distinguished during this process. In the reconnaissance phase the research group helped determine the basic research questions and methods of data collection; they also participated in collecting and analysing data. Partnership and shared power came into being. Some members of the research group also prepared for and facilitated the team meetings. Other stakeholders, particularly in the phase of data collection, were merely heard. Their opinions were considered, but on the ladder of participation this did not get further than symbolic participation. Only later in the process, during the team meetings in which improvement themes were decided and they had a voice in the decision-making, did partnership with these parties develop. According to Heron (1996) these differences and fluctuations are to be expected as individuals and groups gain familiarity with the proposed methodology and as a safe space is established in which group members can begin to let themselves 'be seen'. The facilitators' influence early in a participative project is likely to be strong, and appropriately so; their relevant knowledge and experience means that it 'is a mistake to suppose that there can be a simple parity of influence and to try to achieve it' (Heron, 1996, p 65). As the research group and other individual stakeholders were learning with respect to action research and facilitating group processes, a degree of dependence on our input existed at this stage, so that higher rungs on the participation ladder were not yet attainable.

The increasing engagement of those present and our strategy of adapting as much as possible to the wishes, needs and worries of team members had unintended consequences. Reservations about inviting clients and their families to the team meetings meant that the participation of these stakeholder groups were reduced from 'being heard' during the data collection phase to non-

participation in the decision-making. As Ife (2003) reminds us, strong, well developed communities are often exclusive. We recognised a challenge; that of helping team members to increase their level of participation while working towards inclusivity for other stakeholders. Heron (1996) talks about becoming emotionally competent, as individuals and as a group, learning to deal with differences and disagreements while maintaining trust in each other as fellow participants. At this stage in the action research our skills as facilitators were stretched when it came to enabling others to recognise, value and draw on the diversity present within the group.

Planning, acting and observing, and reflection (phases 2, 3 and 4)

On the basis of interest and volunteering, an action group for each care innovation unit was formed. The action group 'communication' (Magnolia Unit) started with three enrolled nurses and two nursing degree students. When their placement finished these students were replaced in the action group by an enrolled nurse student, and a diploma level and degree level student. The action groups 'daily activities' (Hawthorn Unit) had an unchanging membership and was heterogeneous, consisting of an activities co-ordinator, degree level nurse, healthcare assistant, ward assistant and ward volunteer. Both action groups were supported by the unit junior lecturer practitioner and Miranda, who formed a link with the research group. Donna assisted as needed during absences of the other junior lecturer practitioners and with particular peer review, coaching or analysis activities. The duration of the action cycles were one year and eighteen months, respectively.

A narrative method (Abma and Widdershoven, 2005) was used in both action groups to share, examine and begin to understand unit practices around the thematic concerns. Input from other team members and (para)medics, along with facilitation strategies such as asking direct questions, guided reflection and confrontation, were helpful in further analysing and delineating the problem. Focused goals were set, within the action groups, in relation to the thematic concern agreed to by the rest of the team. In Magnolia Unit these centred on improving the manner of communication (process) and synchronisation of tasks (content) during handover moments. In Hawthorn Unit this was the intentional encouragement of particular occupational (leisure and/or housekeeping) activities to help meet the admission objectives of individual clients.

On both units, the action groups' problem analysis and the stated goals were put before the other team members for testing. Action group members decided how this would be done, for example via newsletters, personal communication, a questionnaire or discussion of the problem analysis in small groups. Particularly the discussions of the problem analysis appeared to contribute to a growing involvement of the team members in the action planning process and to increasing insight among stakeholders concerning the problem.

Various brainstorming activities followed with the care innovation unit teams, to identify potential actions with which to tackle the thematic concern. The action groups recorded and clustered the ideas for action, eventually choosing and operationalising certain action strategies. In order to support more structured handover moments, for example, the Magnolia Unit action group set up workshops and theme weeks, and treated daily discussion and handover moments as learning situations. The Hawthorn Unit action group designed a visioning activity for the team with respect to daily occupational activities for clients and mapping out needs and wishes of the clients in this regard.

Miranda and the junior lecturer practitioners worked out a broad evaluation plan as an example for action group participants. This showed what evaluation could consist of and how it might look, enabling the action groups to include evaluation in their comprehensive action plans. These plans were discussed with the team, who made suggestions for refinements or additions. This rounded off

the planning stage and was also the 'kick off' for phase 3, acting and observing. Action group members and certain team members who had agreed to take a lead monitored the implementation. They endeavoured to lead by example, began discussions about the theme within the team and gave feedback to their colleagues. In action group meetings the progress was evaluated and where necessary actions were adjusted. During the meetings we also paid attention to how members of the action group could support other team members in making changes in their practice.

Evaluation data was collected from various stakeholder groups including clients and their families. The data collection and analysis, for the most part, was carried out by the members of the action group, supported by the junior lecturer practitioner or Miranda. Outcomes were discussed with the team, achievements evaluated in terms of objectives, and decisions made about how further to proceed.

With respect to the degree of participation, we can say that there was partnership (rung 6) and delegated power (rung 7) in the action groups. Rung 8, the full control of the organisation, execution and monitoring of the research, was never achieved. This was related to inexperience of the action group members in carrying out research and differences in knowledge between the members of the action groups and the initiating researcher so that, unintentionally, there was always a degree of inequality (cf. Heron, 1996; Heron and Reason, 2001). Furthermore the degree of participation changed during the process and varied between the action groups. Apart from our manner of facilitating this had to do with a number of factors dealt with in the following section.

Reflection on factors that influence participation

As facilitators, our ways of working within the action groups were influenced by both our moral intent to encourage participation in decision-making and research activities, and the stated goals, for example working towards the integration of learning and working. Participants in the action groups had their own motivations for joining the project and, as we came to recognise, their own moral intentions. They wanted, for example, to improve the experience of care delivery for clients. These factors were at least as influential in determining the ways in which the action group members participated in the research as our facilitation strategies. As is common in action research, group members contended with obstacles to their participation; it became evident that our attempts to promote participation in a range of research and project activities were themselves potential obstacles for some group members. The participation of action group members was related to their individual motivation to participate in the group, the make-up of and atmosphere in the group and the time available for participation in the research group.

Motivation and personal interest

Differences in personal interests, and therefore in the motivation to take part, influenced both the degree and manner of participation.

In the Magnolia Unit action group there was a basis for concentrating on one's own learning in relation to doing research. The junior lecturer practitioner and students, for example, wanted to learn how to facilitate, so that our lecturer practitioner role shifted from facilitating meetings to supporting the other participants in facilitating meetings with the action group and the team. Participants generally took part in determining the process and shared responsibility for informing and involving other team members. This degree of participation (delegated power) continued during each phase of the action research. In contrast, the Hawthorn Unit action group pulled back and 'slipped down' the participation ladder during certain phases. Here there was less need to give one's own learning a central role. In this group the motivation to take part was bound up with the desire to offer the clients more activities and sometimes also with obstacles participants had experienced

personally, such as finding it difficult to motivate clients to take part in activities. Action group members took part out of an intention to improve practice and their own competence *in practice*, as opposed to improving competence in research activities. They preferred coming up with solutions and carrying out actions to analysing the problem or planning the actions. Although developing skills that could support the process, such as learning to take minutes or speaking in a large group, seemed important to us as facilitators, these activities had less meaning for the Hawthorn Unit action group participants, who were satisfied to leave the responsibility for the process with the junior lecturer practitioner.

It's all fun setting learning goals, but you just want to start. All those other things attract me less.

(Participant Hawthorn Unit action group, individual interview)

You [facilitators] are of course used to considering and developing plans properly, and putting everything on paper, from creating programmes, monitoring processes and so on. That is very good, that is your job, isn't it?

(Participant Hawthorn Unit action group, individual interview)

Facilitator attempts to stimulate the Hawthorne Unit action group in this area had a reverse effect; action group members became more uncertain and took less initiative even in the activities that were important to them. Accepting the responsibility, as junior lecturer practitioner, for process-orientated factors, removed some of the obstacles to participation (albeit on a lower rung,) for action group participants. Hayward et al. (2004) also emphasise that *why* people participate and the *results* of their participation are important influences on the kind of participation that is appropriate. While acknowledging that non-participation (or participation on the lower rungs of the ladder) can indicate social exclusion, it is certainly not always the case. Choosing non-participation or participation within certain self-defined boundaries may be more indicative of empowerment than Arnstein (1969) suggests.

This was evident in the Hawthorne Unit action group. While maintaining motivation was challenging during the problem analysis and planning phase, enthusiasm and level of participation increased during the action and evaluation phases. Group members were active, motivated and determined in the preparation and implementation of actions, particularly when directly aimed at the improvement of the daily activities of clients. Participants made choices about actions, how the team should be informed about these and were active in propagating the value of client-orientated activities.

My motivation came back. [...] That was the doing, wasn't it? Then I thought: 'Now things are really going to happen'.

(Participant Hawthorn Unit action group, individual interview)

Group composition

Group composition also appeared to influence the kinds of participation realised. Magnolia Unit action group participants were all directly involved in giving care. Student participants served as an example to the staff in terms of using the action group and the research process for their own learning. This stimulated staff members to do the same so that the shared responsibility for the process increased. In addition, changes in group membership kept group members alert and meant that the division of tasks and roles was frequently discussed.

In the Hawthorn Unit action group the participants had varying functions and backgrounds. This heterogeneity stimulated learning from each other. The stories of the activity co-ordinator about

how she encouraged clients to participate in activities helped other members of staff to consider how they could also achieve this. At certain times, however, the heterogeneity of this group also proved a hindrance to taking part in the research. For example, several participants questioned the value of their own part in the process as soon as the process had no direct connection with their own function.

The discussion with all those disciplines, admission committee,[...] , I didn't feel at home there. That is really a long way from 'home'. [...] Then you think 'Am I really useful, as a volunteer, eh?'
(Participant Hawthorn Unit action group, individual interview)

Atmosphere within the group

The participants felt that a positive group (learning) atmosphere was one of the most influential factors in the degree to which they learned and participated. They reported that the democratic processes in both the action group and the team stimulated a safe and open atmosphere in the group, which encouraged equality, learning and participation:

It was a great group, a safe situation as well. [...] You learn more easily in a positive and friendly group, and you are more inclined to clarify things that are unclear without thinking 'can I ask this?', 'what will they think?' There were no thresholds to cross.
(Participant Magnolia Unit action group, individual interview)

This led to personal growth and new insights in regard to communication (Magnolia Unit) and involving clients in activities (Hawthorn Unit).

... When I look back at how we got on with each other, I think we've all grown. We're easier and more open with each other. Dare to say more, are less cautious about what we say. Due to this we get further than in the first two meetings. I also experience less direction, fewer tips and pushes from the junior lecturer practitioner and lecturer practitioner. I've got more self confidence. I see this in the unit too.
(Participant Magnolia Unit action group, evaluation of an action group meeting)

As participants increasingly took initiative and responsibility in both the action group and the unit they noticed their role on the care innovation unit changing:

Now, because I have taken part in this, I feel more confident. [...] I feel too that I am someone in the forefront. Because I took part in this I know things more clearly than the rest (of the team). It stimulated me to get the others on board. [...] I am, myself, doing more with people, doing activities with them. I am now more consciously occupied with this.
(Participant Hawthorn Unit action group, individual interview)

Time available for participation

Participants often experienced the demands of action group membership as frequent and pressuring. Giving priority to the action research meant leaving the daily affairs and responsibilities on the unit and having to create time for meetings or the activities arising from them. One of the action group participants has expressed this with a photo of herself being pulled and 'stretched' in all directions (Snoeren and Frost, 2010). Hayward et al. (2004) also stress that the cost of participation can be high; participants may see their other activities suffer and be forced to make choices. In the present action research, such pressures led to absences from, or even cancellation of, some meetings; continuity of learning and participation then came under threat. If action group members were no longer fully informed, time, already scarce, had to be spent revisiting previously

considered items and decisions made. The level of participation then decreased to informing, consulting or placation. To the junior lecturer practitioners it felt like marking time and that the responsibility for maintaining momentum was theirs alone. There was also the danger, as discussed by Jacobs (2010), of resorting to traditional power relationships in order to 'push' the research forward. Certain strategies, for example emphasising the results already achieved, celebrating successes, demonstrating understanding for work pressures experienced, and adapting to the possibilities and intentions of the participants, were successful in maintaining everyone's motivation, including that of the junior lecturer practitioners, and increasing, once more, the level of participation of Hawthorn action group members.

Conclusions and challenges

In this article we have presented an example of a participatory action research project within care for older people. We have illustrated giving form to democratic processes and trying to encourage participation, recognising that commitment and involvement at all organisational levels are necessary if the principles of democracy and participation are to be realised in action. The groundwork laid in the preparatory phase of such a project is vital to the successful facilitation of participation in later phases of the research, as Snoeren et al. (in press) also argue.

In addition to the facilitation strategies used, four other factors emerged as influential in enabling or inhibiting aspects of participation among the stakeholders in this research. These were individual motivations and interests, the make-up of and atmosphere within the group, and the time made available to engage in research activities. The degree to which participation was realised and the various forms this took vacillated throughout the project; stakeholders moved up and down on the ladder as circumstances changed. This process seemed to be continuous, leading us to a conclusion shared by (Tritter and McCallum, 2006), that participation in the diverse aspects of the research process is both more complex and dynamic than the ladder of Arnstein suggests. Adapting to the motivations and intentions of participants can mean that, for at least a part of the process, the responsibility for considering certain options and making certain decisions remains with the initiatory facilitators. Moreover, enabling participation for one stakeholder group can form a barrier to participation for another group, demonstrated in this project by the non-participation of clients and their families in team meetings and action groups in the first action cycles.

As facilitators we consider it important, therefore, to remember that climbing the ladder of participation is unlikely to be a linear process. Attaining a higher rung on the ladder may not even be appropriate as an ultimate goal, or ideal, in and of itself. Instead, meeting stakeholders where they are at, adapting to their (changing) motivations, wishes, needs, tempo and learning styles all become more influential in the research process. Leaving participants free to focus on the elements of the project in which they are interested and from which they derive satisfaction may require that the facilitator be willing to take (back) responsibility for certain activities, perhaps intentionally taking action that will decrease the degree of stakeholder participation at a particular point in time. This requires courage on the part of the facilitator as well as a willingness to no longer privilege one's own values, assumptions and ideals. Our experience has taught us that this approach, together with good preparation and the sinking of strong foundations, gives participative ways of working with staff and researching practice within the care for older people a chance to succeed. Such participatory processes can lead to new learning and research that is conducted with, for and by the people involved.

References

Abma, T.A. (2005) Responsive evaluation: its meaning and special contribution to health promotion. *Evaluation and Program Planning*. Vol. 28. No. 3. pp 279-289.

- Abma, T.A. and Stake, R.E. (2001) Stake's responsive evaluation: core ideas and evolution. In Greene, J.C. and Abma, T.A. (eds.) (2001) *Responsive Evaluation (New Directions for Evaluation No. 92)*. San Francisco: Jossey-Bass Education. pp 7-22.
- Abma, T.A. and Widdershoven, G.A.M. (2005) Sharing stories: narrative and dialogue in responsive nursing evaluation. *Evaluation and the Health Professions*. Vol. 28. No. 1. pp 90-109.
- Arnstein, S.R. (1969) A ladder of citizen participation. *Journal of the American Planning Association*. Vol. 35. No. 4. pp 216-224.
- Bishop, P. and Davis, G. (2002) Mapping public participation in policy choices. *Australian Journal of Public Administration*. Vol. 61. No. 1. pp 14-99.
- Boomer, C. and McCormack, B. (2007) *Creating the Conditions for Growth. Report on the Belfast City Hospital and The Royal Hospitals Collaborative Practice Development Programme*. Belfast. Belfast Health and Social Care Trust.
- Carr, W. and Kemmis, S. (1986) *Becoming Critical: Education, Knowledge and Action Research*. Victoria: Deakin University.
- Chenoweth, L. and Kilstoff, K. (2002) Organisational and structural reform in aged care organisations: empowerment towards a change process. *Journal of Nursing Management*. Vol. 10. No. 4. pp 235-244.
- Clarke, A. (2006) Qualitative interviewing: encountering ethical issues and challenges. *Nurse Researcher*. Vol. 13. No. 4. pp 19-29.
- Coghlan, D. and Brannick, T. (2005) *Doing Action Research in Your Own Organisation* (2nd edition). London: Sage Publications.
- Dewing, J. (2008) Becoming and being active learners and creating active learning workplaces: the value of active learning in practice development. Chapter 14 in Manley, K., McCormack, B. and Wilson, V. (eds.) (2008) *International Practice Development in Nursing and Healthcare*. Oxford: Blackwell Publishing. pp 273-294.
- Fals-Borda, O. (2001) Participatory (action) research in social theory: origins and challenges. In Reason, P. and Bradbury, H. (eds.) (2001) *Handbook of Action Research: Participative Inquiry and Practice*. London: Sage Publications. pp 27-37.
- Fish, D. (1998) *Appreciating Practice in the Caring Professions: Refocusing Professional Development and Practitioner Research*. Oxford: Butterworth Heinemann.
- Frost, D.M. and Snoeren, M. (2010) Het ontwikkelen en integreren van diverse vormen van kennis: de rol van de Lecturer Practitioner [Development and integration of diverse forms of knowledge: the role of the Lecturer Practitioner.] *Onderwijs en Gezondheidszorg*. Vol. 34. No. 4. pp 6-10.
- Garbett, R. and McCormack, B. (2004). A concept analysis of practice development. Chapter 2 in McCormack, B., Manley, K. and Garbett, R. (eds.) (2004) *Practice Development in Nursing*. Oxford: Blackwell Publishing. pp 10-32.
- Gerrish, K. (1997) Being a 'marginal native': dilemmas of the participant observer. *Nurse Researcher*. Vol. 5. No. 1. pp 25-34.
- Greenwood, D.J. and Levin, M. (1998) *Introduction to Action Research: Social Research for Social Change*. Thousand Oaks: Sage Publications.
- Guba, E.G. and Lincoln, Y.S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In Denzin, N.K. and Lincoln, Y.S. (eds.) (2005) *The Sage Handbook of Qualitative Research (3rd edition)*. Thousand Oaks: Sage Publications. pp 191-215.
- Hart, E. and Bond, M. (1995) *Action Research for Health and Social Care: A Guide to Practice*. Buckingham: Open University Press.
- Hayward, C., Simpson, L. and Wood, L. (2004) Still left out in the cold: problematising participatory research and development. *Sociologia Ruralis*. Vol. 44. No. 1. pp 95-108.
- Heron, J. (1996) *Co-operative Inquiry: Research into the Human Condition*. London. Sage Publications.

- Heron, J. and Reason, P. (2001) The practice of co-operative inquiry: research 'with' rather than 'on' people'. In Reason, P. and Bradbury, H. (eds.) (2001) *Handbook of Action Research: Participative Inquiry and Practice*. London: Sage Publications. pp 177-188.
- Higgs, J., Titchen, A., Horsfall, D. and Armstrong, H. (eds.) (2007) *Being Critical and Creative in Qualitative Research*. Sydney: Hampden Press.
- Hoogwerf, L.J.R. (2002) *Innovation and Change in a Rehabilitation Unit for the Elderly Through Action Research*. PhD thesis. Division of Nursing Science. University Utrecht.
- Ife, J. (2003) *Community development and human rights*. Keynote address, Strengthening Communities Conference: People, Place, Partnerships. Sydney, April 2003. Retrieved from: <http://info.humanrights.curtin.edu.au/local/docs/StrengtheningCommDevelop.pdf>. (Accessed 16th October 2011).
- Jacobs, G. (2010) Conflicting demands and the power of defensive routines in participatory action research. *Action Research*. Vol. 8. No. 4. pp 367-386.
- Kemmis, S. and McTaggart, R. (1988) *The Action Research Planner (3rd edition)*. Victoria: Deakin University.
- Lieshout F. van and Cardiff, S. (2006) Lecturer Practitioner: een nieuwe rol voor verpleegkunde. [Lecturer Practitioner: a new role for nursing.] *Tijdschrift voor Verpleegkundigen*. Vol. 116. No. 4. pp 12-19.
- Maijala, H., Astedt-Kurki, P. and Paavilainen, E. (2002) Interaction as an ethically sensitive subject of research. *Nurse Researcher*. Vol. 10. No. 2. pp 20-37.
- Mienczakowski, J. (1995) The theatre of ethnography: the reconstruction of ethnography into theatre with emancipatory potential. *Qualitative Inquiry*. Vol. 1. No. 3. pp 360-75.
- Migchelbrink, F. (2007) *Actieonderzoek voor professionals in zorg en welzijn*. [Action research for professionals in healthcare.] Amsterdam. Uitgeverij SWP.
- Ministerie van Volksgezondheid (2006) *The Medical Research Involving Human Subjects Act (WMO)*. The Hague. Ministry of Public Health. (Guideline number 2).
- Reason, P. (2006) Choice and quality in action research practice. *Journal of Management Inquiry*. Vol. 15. No. 2. pp 187-203.
- Reason, P. and Bradbury, H. (eds.) (2001) *Handbook of Action Research: Participative Inquiry and Practice*. London: Sage.
- Snoeren, M.W.C., Niessen, T.J.H. and Abma, T.A. (in press). Engagement enacted: essentials of initiating an action research project. *Action Research*.
- Stuckey, H.L. (2009) Creative expression as a way of knowing in diabetes adult health education: an action research study. *Adult Education Quarterly*. Vol. 60. No. 1. pp 46-64.
- Titchen, A. (2009) Developing expertise through nurturing professional artistry in the workplace. Chapter 12 in Hardy, S., Titchen, A., McCormack, B. and Manley, K. (eds.) (2009) *Revealing Nursing Expertise Through Practitioner Inquiry*. Oxford: Wiley-Blackwell. pp 219-243.
- Tritter, J.Q. and McCallum, A. (2006) The snakes and ladders of user involvement: moving beyond Arnstein. *Health Policy*. Vol. 76. No. 2. pp 156-168.
- Waterman, H., Tillen, D., Dickson, R. and Koning, K. de (2001) Action research: a systematic review and guidance for assessment. *Health Technology Assessment*. Vol. 5. No. 23. (Monograph).

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