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COMMENTARY

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

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This study presents, with great clarity, the way that lecturer practitioners and their colleagues used action research cycles with multiple participants to improve the quality of care in two residential settings for older people. The foundation for practice development was a collaboration between education/learning (schools of nursing) and healthcare delivery in settings that were termed 'care innovation units'.

It resonates strongly with my own attempts to facilitate quality improvement projects in a variety of mental health settings across England in the mid – 1990s in the process of developing a toolkit for clinical audit in mental health (Balogh et al., 1996). The use of triangulation in multiple respects – of data collection tools, data 'sources', data 'collectors' and data analysts is exemplary, as is the careful consideration given to the needs of participants, e.g. in providing opportunities for them to work in homogenous and heterogenous groups at different times.

The introduction of 'phase 0' – a preparatory phase - to the action research cycle, and a critical examination of degrees of participation over the course of the action research cycles in relation to Arnstein's 'ladder of participation' are explored with rigour and sensitivity and offer useful insights to practice developers and action researchers alike. While I would agree with the authors that preparatory stages of action research are in many ways the most deserving of investment in time and effort, I would not support the assertion that this is under-explored in the literature. Indeed Kemmis, in the paper they cite (Kemmis, 2001) says: 'the first step in action research turns out to be central: the formation of a communicative space...' On the other hand, I do believe that this issue of initial work towards the establishment of communicative spaces has been better explored in the action research literature in settings other than health (e.g. in community development and in education).

This leads me to my main comment on this paper, namely that the insights deriving from the two linked projects would have benefited from a more thorough consideration of the contexts – framed as complex social systems - in which they took place, and deeper referencing to the research they cite on practice development and action research in residential settings with older people. These are environments that bring their own special challenges and their own issues over the distribution of power, alluded to but in my view insufficiently explored. Such 'thickening' of the descriptions that are offered would, in their socially situated particularity in fact help the reader to draw parallels more effectively. Sometimes we confuse the requirement to generalise with the need to remove those aspects of context that positivist research deems 'confounding', but which action research proposes as illuminative.

I think that the analytic use of Arnstein's 'ladder' works well as a tool for identifying levels of participation, although it ought to be more explicitly emphasised that the ladder refers to a limited group of stakeholders which did not fully embrace patients and carers. The way that the authors demonstrate points at which they felt the project 'fell back' on to lower rungs of the ladder is useful, yet once more I felt some further examination of the context - its constraints and taken-for-granted assumptions - would have illuminated some of the specific forces at play. It also reveals the aspirational nature of such ideas and the complexities of realising them in practice, and reminded me of a similar analysis that also came out of work in The Netherlands, by Gaby Jacobs in health promotion where she explores the difficulty of developing empowerment in a setting that she identifies as 'bureaucratically controlled'. Similar difficulties, framed in terms of power relations, led her to propose the notion of 'bottom-up empowerment' as 'a 'contrafactual' principle: an ideal we will never reach but that nevertheless offers a vision and direction ... and makes sure we ask the right questions: participation by whom, in what, and for what outcome?' (Jacobs, 2006, p 578).

Finally, I was prompted to consider an underlying issue that is posed but not fully stated by the authors but which for me emerges strongly in their analysis of 'factors that influence participation'. They divide their observations into three themes: 'individual motivation to participate'; 'the make-up and atmosphere in the group' and 'the time available for participation'. All of these seemed legitimate analytic categories. But the text reveals some clear differences in orientation – and resistance - to engagement in 'learning', and more especially a desire among some care-givers to move quickly into the sphere of action. I have encountered this tension myself on several occasions and have tried different ways of tackling it. I have come to believe that Kolb's adult learning cycle (Kolb, 1984) with its emphasis on 'immersion in experience' at the outset provides a useful theoretical approach for overcoming resistances of this sort, so that 'learning' is allowed to emerge from the process instead of leading it. A critical analysis of learning processes among the different participants would, I feel, offer a rich source of further insight that would be of interest to a wide range of readers, and – as in all good action research – to those who take part in it. However this, perhaps, offers another avenue for the authors to explore, another series of questions, and another paper...

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