Workplace Culture Critical Analysis Tool

The WCCAT has been developed to help people involved in the development of practice to undertake observational studies of work place settings in order to inform changes in practice. The tool is suitable for use by anyone who has some experience of practice development including the observation of practice. The tool has been developed from an analysis of our experience of leading and facilitating practice development programmes over many years.

Observation is one of the key tools used in emancipatory practice development – a form of practice development that is concerned with changing the culture and context of practice in order to develop sustainable person-centred and evidence-based workplaces. Seeing practice, raising consciousness about taken for granted practices and reflecting on taken for granted assumptions are key components of comprehensive observation. This tool is designed to help you develop a systematic approach to undertaking these activities.

We encourage you to use this tool and would welcome your feedback on its relevance and usability in your practice development work.

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Introduction and Background

Emancipatory practice development (PD) is a well established methodology that focuses on changing the culture and context of practice in order to develop sustainable person-centred and evidence-based workplaces (Manley & McCormack, 2004). In a concept analysis of PD Garbett & McCormack (2002) articulated the interconnected and synergistic relationships between the development of knowledge and skills, enablement strategies, facilitation and systematic, rigorous and continuous processes of emancipatory change in order to achieve the ultimate purpose of evidence-based person centred care. Manley & McCormack (2004) articulate these elements of PD in a model called 'emancipatory PD'. Emancipatory PD (EPD) recognises, acknowledges and works to overcome obstacles and generate new understandings about context and culture and how to overcome barriers within them.

The key elements of emancipatory practice development are:

- Working with values, beliefs & assumptions, challenging contradictions
- Developing critical intent of individuals & groups
- Developing moral intent
- Focusing on the impact of the context on practice, as well as practice itself
- Using self-reflection & fostering reflection in others
- Enabling others to 'see the possibilities'
- Fostering widening participation & collaboration by all involved
- Changing practices

Facilitating these processes involves cycles of reflective learning and action, so that clinicians:

- Become aware of how they practice & the things they take for granted
- Develop an awareness of how the system impacts on the way they work
- Identify the contradictions between what they espouse and what they do
- Challenge the system in which they work to create the potential for better patient care
- Actually change how they practice to reflect individual and collective beliefs and values
- Continually refine action in light of new understandings gained through reflecting on practice.

These facilitated processes help clinicians break down barriers to action and enable cultures of effectiveness to be developed. Key to enabling the development of these cultures is the observation of practice.

Observation methods have their origins in 'ethnographic research' methodology. Ethnography involves the researchers entering the area being researched and thus gaining multiple perspectives in order to identify links with the culture and thoughts and feelings of the people at the centre of the research (Morse1991). The essence of ethnography is to understand another way of life from the native point of view and involves learning from people (Ersser 1997). It enables the observation of taken for granted aspects within health care so that they become visible (Leininger 1995). In a two year practice development programme with nurses from a range of surgical settings, Boomer, McCormack & Henderson (2006) found that helping participants to develop a systematic approach to observing practice in their own and in their colleagues' practice settings was a key strategy to informing cultural changes. Analysing the processes and outcomes used in

this project and compared with findings from previous PD programmes of work, resulted in the development of the WCCAT.

The WCCAT has been informed by a number of theoretical frameworks and development processes (Table 1):

Framework	**Contribution to the WCCAT**
The Person-Centred Nursing Framework (McCormack & McCance 2006)	The person-centred nursing theoretical framework has identified five care processes for patient-centred care and six attributes of the care environment. These care processes and attributes have informed the observation foci.
Critical Companionship (Titchen 2001)	Critical companionship is a framework for developing helping relationships. It describes strategies for enabling enlightenment, empowerment and emancipation. In particular the strategies of observing, listening and questioning have informed the facilitation strategies in the WCCAT.
Culture (Schein 2004)	Schein describes a conceptualisation of culture that moves from superficial to deeper levels of understanding. The three stages of analysis outlined in the WCCAT are based on this analysis of culture.
Workplace Culture (Manley 2000 a & b)	Manley developed a set of staff, patient and workplace indicators that she suggests need to be in place for an effective person centred and learning culture. These have been integrated into the observation foci
Essence of Care (Department of Health [England] 2001)	Patient Focused Benchmarks for Clinical Governance. Nine fundamental aspects of care derived from what patients consider important. Elements of these benchmarks have been integrated into the observation foci.

Table 1: Theoretical frameworks and development processes underpinning the WCCAT

The use of these theoretical perspectives are illustrated in the conceptual model below (Table 2). This model demonstrates the linkages between the different levels of culture (superficial, middle and deep) and how the phases of observation, reflection and feedback that underpin the WCCAT enable a deep understanding of workplace culture to be achieved and developed in a practice development action plan.

	CULTURE LEVELS (AFTER SCHEIN 2004)		
	Superficial level - *What is seen* **Symbol/artefacts** Routines Actions Interactions	**Middle level** - ***What is lived*** **Consciousness raising and** **Problematisation**	**Deeper level** - ***What does it mean*** **Clarifying assumptions through** **reflection and critique**
FACILITATION STRATEGIES (AFTER TTITCHEN 2001)	• *Observing and listening*	• *Questioning* • *Articulation of craft knowledge*	• *Feedback* • *Challenge & Support* • *Critical dialogue*
Observation Areas For example, Physical Environment Communication Privacy & Dignity Patient Involvement Team Effectiveness Risk & Safety Organisation of care Learning Culture NB: these observation areas may change according to the context within which the WCCAT is used	**The observers adopt the attributes, reflexivity and skills of a qualitative researcher, in observing and listening to clinicians at work in their every day working environment.** Using the WCCAT guidelines and the observation proforma, the observer systematically records aspects of practice relevant to the focus of the observation.	**The purpose here is to check out if what has been observed matches clinicians' experience, and in so doing facilitate consciousness raising and problematisation.** Consciousness-raising is a way of enabling practitioners become more alert with respect to daily practice and to their knowledge embedded in it. The observer poses questions about what has been observed thus getting clinicians to articulate their craft knowledge. This helps the clinician to surface the tacit understandings that have grown up around repetitive and habitualised practice. Problematisation is making problematic that which had previously been assumed to be satisfactory. It may also refer to the observer pointing out or questioning things not being attended to.	**Feedback about what has been observed is offered to clinical teams using strategies of high challenge and high support as a catalyst for learning.** **Observers then engage clinical teams in critical dialogue with respect to this feedback.** Critical dialogue promotes collaborative interpretations, critique and evaluation of data and validates clinician' judgment (where appropriate). This fosters clinician's self-awareness, reflective and critical thinking. Challenging taken-for-granted assumptions beliefs, values, expectations, perceptions, judgement and actions in a constructive, interested, supportive way helps clinicians gain new understandings of situations.

Table 2: WCCAT Conceptual Model

PROCESS FOR USING THE WCCAT

The WCCAT adopts a five (5) phase process to undertaking an observation study, analysing the data, feeding back to clinical teams and developing action plans. The five phases are:

1. Pre-observation
2. Observation
3. Consciousness Raising and Problematisation
4. Reflection and Critique
5. Participatory Analysis and Action Planning

Phase 1: Pre observation

Step 1: Preparing the Clinical Area for Observation

Preparing a clinical area for observation is an important phase of the process. Staff anticipation of being observed can generate heightened anxiety and concern. It is therefore important to undertake preparatory work in order to reduce anxiety, clarify processes to be used and engage staff in planning for periods of observation.

In order to reduce anxiety and prepare for the observation study, it is important to:

- Discuss the overarching practice development project and the place of cultural analysis in this work.
- Clarify ethical principles underpinning the processes, such as evidence of ethical approval[1]. If you do not require formal ethical approval then you should still have evidence of approval from the management team. Consider also how you will ensure confidentiality, anonymity and non-interference with ward activities. You will need to secure 'process consent', i.e. at each observation period seek verbal consent from patients and staff for the observations being undertaken.
- Explain the processes to be used in observation, (e.g. where you will be positioned, number of observers, number of observations to be undertaken, frequency of observations and the types of notes you will maintain. Wherever possible, negotiate these arrangements with staff.
- Written information about the study and the procedures should be provided.
- Answer all questions openly and honestly.

[1] Observations of practice that are part of routine practice development projects do not usually require formal ethical approval from a research ethics committee. In some settings, 'quality approval' will be required. However, should you be intending to develop the practice development work into a research project and/or publish the findings of your project, then formal ethical approval will be required. Please check the need for ethical approval with your local ethics committee.

As well as negotiating and explaining the observation procedures, it is also important to identify staff beliefs and values, as a means of identifying the espoused beliefs and values of the team. Values clarification is a complex and often lengthy process and in this phase it would be impossible to undertake a values clarification to this extent. However, undertaking a values clarification as a component of step 1 will enable you to understand the team's values at a superficial level and provide a benchmark for considering the data collected during the observations and how this relates to the values that staff want to underpin their practice. In having this awareness, then feedback can be structured (phase 4) in a way that is meaningful and less threatening. If the clinical setting does not have an available set of clarified beliefs and values (such as a stated philosophy of care), then you will need to facilitate a values clarification process with team members about their practice – see appendix 1 for a suggested values clarification process and also refer to Manley (2000 a), Wilson (2005) or Boomer at al (2006) for explanations of the process.

Step 2: Preparing yourself to Observe

In order to systematically gather detailed and accurate information you (the observer) need to develop specific skills in observation including the ability to concentrate in often busy environments, to stand apart from the context you are observing and to defer any judgements you may wish to make about what you are observing. It is also important for you to take into account the role your own subjectivity plays in the observation process (Fawcett 1996). Whilst practice helps the observer obtain the necessary skills, a deeper understanding of the intricacies of observation is developed through such things as group discussions, self directed learning and critical reflection.

The following practical guidelines (adapted from Fawcett 1996) will assist you in preparing and undertaking an observation using the Critical Analysis of Workplace Culture Tool. The observation is phase one of the critical analysis and relates to what is seen happening in the clinical setting including such things as the routines, the actions and interactions. The findings are used as a basis for critical discussion with staff about what you have seen and heard, and how this connects to their experience of practice.

Guideline	Rationale
Preparing for Observation	
(1) What is the focus of the observation e.g. medication administration	It is not possible to observe everything within a multi-sensory environment. You need to choose a focus for your observation. You may be required to observe on a number of occasions (at different time periods) to build up a picture of what is happening in a workplace. You need to take into account the environment, verbal and non verbal communication, actions, events & people
(2) How will you document your findings?	It is helpful to develop a system for documenting your findings that enable you to capture data during the observation in a timely manner. Consider what abbreviations or codes you may use to document findings. Having large margins allow you to capture your thoughts during and after the observation. You will need to take note of things such as place/date/time (see the example below)
(3) Gaining access to the site	You need to negotiate access to the site, think about us how often and how long you might want to observe practice. You also need to inform staff about the purpose of your observation and obtain consent where appropriate.
(4) Preparing yourself	It is best to observe with a colleague in order to validate your findings and agree on key issues. When choosing a partner for observation, consider the

	need for an insider/outsider approach (i.e. if you are insider to the setting then perhaps someone from outside the setting would be most appropriate as a partner [and vice versa]). Consider having a 'practice observation' with a colleague, that way you can both observe the same thing and then compare notes about what you observed.
Undertaking an Observation (1) Positioning yourself (+ other observer if required) (2) Time (3) Recording data	Think where the best advantage point is for you to observe practice. You need to take into consideration such things as how easy it is for you to observe what is happening without being 'in the way' or highly visible As you are developing your observation skills you may find that you can only spend 15-20 minutes observing practice at a time as a high level of concentration is required. As you become proficient this time can be increased Try to capture as much data as possible. Ensure notes are clear and concise.
After the Observation (1) Review your notes (2) Review the process (3) Do you require more observation (4) Preparing notes for the next phase	Write any additional comments as soon as possible after the observation period as well as any questions you are posing about what you have observed. Compare notes with the other observer to develop a greater understanding about what was happening. This can be done as an individual or group activity. What worked well during the observation? What things could you improve upon? What did you learn about observation skills and techniques? What impact did your own value judgements have on what you observed? It may be helpful to capture your answers (and future development opportunities) for your learning portfolio. Consider whether you (and any other observers) have enough material at this stage to move onto the next phase. If not you need to consider what the focus of future observations will be, when it will take place and who will undertake the observation If you feel you have enough material to undertake phase two (consciousness raising and problematisation) then you need to prepare your observations for feedback to staff and to facilitate a discussion in relation to what you observed

Example of Observation Record

Name of Observer: Jo Smith ***Unit:*** Ward 4 E

Focus of Observation: Communication during ward rounds ***Date:*** 5th August 2006

Time	***Observation Notes***	***Observer comments/questions***
09.15	Medication round in progress. The nurse approaches AS's bed and checks how the patient's night has been. Inquires about her pain and uses the pain assessment tool to get an accurate indication of the level of pain. Offers analgesia. JRMO approaches nurse as she is getting the medication from the trolley and questions her re another	Interruptions of nurses during medicines rounds seems to be a significant issue on this ward. Is there a relationship between these interruptions and drug-errors? I wonder how the nurses feel about

09. 17	patient. JRMO leaves and the nurse appears flustered. Seems to be unsure what she was doing.	these interruptions – are they aware of them or are they a 'norm'? This would be useful to explore in the feedback session.

Phase 2: Observation
Observation of the workplace culture should be undertaken at the negotiated time by two trained observers using the WCCAT observation proforma. Who the observers are may be different in each project in which the WCCAT is being used and may include different combinations of internal and external observers. Observers should maintain field notes about the experience as a process for reviewing the effectiveness of the observation undertaken.

Phase 3. Consciousness Raising and Problematisation
When the observation is finished you (the observers) should firstly clarify with individual team members anything you are unsure of. You should also discuss with staff specific aspects of the observation data that you want to further clarify or gain a deeper understanding of. Start by asking them open questions relevant to each of the eight observation areas in turn as outlined in the WCCAT proforma. This will help you gain insight into the practice context and minimise the risk of you making false assumptions about what you saw. You should use questions such as 'what is it like to work in this *environment*?' how effective is *communication* here? How is *care organised* here? Tell me about how *learning* takes place here etc. You should make notes/record all responses.

Phase 4: Reflection and Critique
Both observers compare their observations and agree a common set of issues to feedback to the ward team. During the feedback session, a critical dialogue is facilitated by the observers with staff. This is done by the observers presenting their 'common issues' as impressions only and putting them up to challenge by staff. Each observation area is discussed in this way and the discussion includes the comparing of the issues raised with the espoused philosophy/values and beliefs/empirical evidence. By the end of the critical dialogue a common set of issues is agreed between clinical staff and the observers and these issues form the basis of:

1. Further investigation into specific areas using focused observation instruments, such as Nursing Handover/Mealtimes/Privacy & Dignity or Audit of specific aspects of practice, for example Infection Control, Care Records etc.
2. Formulation of a practice development action plan.
3. Development of a staff development action plan.

Process for engaging in the critical dialogue session

To avoid interruption and to enable the critical discussion to take place, observers/facilitators and members of the clinical team, at an agreed time, should move to an appropriate quiet area. Facilitators should reiterate the purpose of this session, which is to collectively make sense of what has been both observed and articulated with a view to the clinical team agreeing the areas of practice that need either further exploration or development. Staff may be feeling apprehensive, so it is important to set a positive tone in terms of acknowledging their contribution to the process thus far. It may be helpful at this stage to establish ground rules for the session to enable dialogue. It is important that facilitators do not appear to be 'sitting in judgment' on the ward team, but rather are offering their observations for critical reflection and discussion to enable insight and learning. The Critical Companion Relationship Domain supports the need for facilitators to 'work with' the ward team demonstrating 'graceful care' in a collaborative spirit of 'giving and receiving'.

One method of feeding back may be to offer some general feedback first (using the 'praise sandwich' technique - positive first, then the less positive, and finishing with positive again), then actively engage with staff by focusing on a number of specific areas for more in-depth exploration. In this exercise observers/facilitators are attempting to challenge practice by drawing attention to the differences between values espoused and those observed in practice in order to enable staff to see things from a different perspective. For example:

> *"Your philosophy states you aim to provide patient centred care yet in practice we have observed that getting the task done seems to be more important than stopping to listen to patients, what might be going on here? How does that observation make you feel? What is being valued here? Why is that? What is that saying about the culture you work in? What would person-centredness look like? What might be hindering the team from being able to undertake that? What would help the team to provide care in that way?*

Processes used for example in action learning sets should be employed, such as attending and active listening, one person speaking at a time, open questioning, probing, reflecting back, non-confrontational challenging and using positive affirmation to give support. To achieve closure it may be helpful to evaluate the critical dialogue session in terms of what they found most useful, least useful and one thing they are taking away that they have learnt.

Phase 5: Participatory Analysis and Action Planning

Once you have the information from phases 2-5, the next stage is to make some sense of it and try and understand what it is telling you and staff on the ward. The process for doing this is to theme the data.

The data analysis phase should be undertaken as a participatory analysis with the ward staff. As many of the ward staff as possible, or a representative sample of staff should participate in the analysis of the data (It is essential that the Ward Sister/Charge Nurse/Nursing Unit Manager are included). Themes for action planning are arrived at by going back and forth between the different data sets and identifying similarities and differences. Participants in the data analysis are asked to identify impressions, feelings, metaphors, key words and images that reflect the data. This process helps to develop an intimate knowledge of the data and an 'embodiment' of it, i.e. how the data feels. Initial impressions are noted and a list of tentative themes and common issues are noted. The themes are then revised and refined and narrative or examples of what was observed are selected to link the themes. Theme statements are then written based on common characteristics. All findings are compared for patterns, commonalities, differences and unique happenings. A six-step process adapted from McCormack (2002) is set out below. Participants in the data analysis process should undertake steps 1-5 independently of each other and step 6 should be undertaken together:

1. Look at all the information you have and read it though a few times. A few things may stick out in your mind such as something that happened more then once or something that you thought was really good or concerned you.
2. Devise an 'image' (could be a collage, a poem, a collection of metaphors, movements etc) that captures the 'essence' of the data <u>overall</u> for you. Each participant does this and shares their image with other participants. This stage helps to ground the holistic nature of the data and provides a tangible representation of the whole data set before the next stages occur and during which the data will be segmented.
3. Return to the data and as you are reading it through, think about how the data is linked, for example you may have noted that a person was given choice about when they wanted to get up and that the nurse took time to listen and follow the persons wishes. Another time a nurse, asked a person where they would like to sit in the lounge and gave the person time to make their decision. You could theme this as 'Patient choice' or 'Respect for the individual'. Another example may be that screening was inappropriate around a person's bed and it was noted by the observer that they could see behind the curtains whilst the patient was having personal care. Another time a nurse

walked behind the curtain without asking. These you can theme as 'lack of privacy or 'lack of respect for the individual'.

4. Go through all the data developing the themes and keeping in mind your 'image' which is a representation of the essences of the whole data set. Consider the linkages between the themes you are developing and the image. Do the themes help to add detail to the whole image? Is there a relationship between the image and the individual themes? Are some themes stronger than others?
5. Refine the themes. Each participant in the workshop shares their initial themes and any explanations that might help make sense of the themes for others. Do not worry if you have lots of themes at first, by reading and reviewing the themes these will become less. The themes are then synthesised/reduced by using postit notes. Firstly the themes are written on flipchart paper. Each person, using postit notes suggests where there are overlaps, shared meanings and areas of commonality. It is easy to think that some things are obvious and do not need including but remember that it is this everyday taken-for-granted information/data that is important.
6. Once you have some tentative shared themes discuss them in the group and agree that these are shared themes. Identify the individual data sources that are linked to these themes and note them.

You now have your list of themes and can go on and develop the action plan.

Process for Devising Action Plans

When you have a finalised list of themes, plan an action planning workshop with the ward sister/charge nurse/nursing unit manager and the staff of the ward (as many as possible to attend or a representative sample of staff, but it essential that the Ward Sister/Charge Nurse/Nursing Unit Manager is included) to develop an action plan.

Each theme should be considered as an area for action. However, some themes may be combined and actions developed to address the combined themes. Alternatively you may find that an identified action(s) may address a number of themes. Whatever way you structure it, you action plan should include:

1. Focus of the action (the theme)
2. The specific actions being taken, i.e. state "set up weekly team meetings" as opposed to "establish better communication in the team".
3. Consider any policies in the organisation that need to be considered/implemented/adhered to.
4. Identify the person(s) responsible for taking the action.
5. Agree achievement dates
6. Agree review dates
7. Have the action plan approved by the relevant line manager

Congratulations, you have completed the full observation cycle.

Workplace Culture Observation Proforma

Observation Area 1: Physical Environment

Observer Prompts	Observation Notes	Questions Arising
• What impression do you get from looking at the setting? *(You should consider various areas within the ward/department, for example patient rooms, nurses station etc)* • What do you see, hear and smell *(consider noise levels, lighting, dominating smells and activities that appear to shape the culture)* • Are call bells answered promptly? • Who does the environment privilege? Consider how patient friendly it is, or how staff friendly it is? Are there forbidden patient areas? Is there adequate seating for visitors etc?) • How is space used / furniture arranged / layout? (For example are chairs placed convenient and ready for use when staff are communicating with patients; also consider equipment location. Is the space cluttered? Are lockers and bedside tables clean and tidy? Is there space for visitors to sit and be with the patient?) • Who takes responsibility for the environment?		

Observation Area 2: COMMUNICATION

Observer Prompts	Observation Notes	Questions Arising
• When and where does communication take place? • Who communicates with whom? *(Include staff-patient, staff-staff etc identifying professional type)* • How effective is nursing hand-over? *(Pay attention to the quality and type of information handed over, as well as to the focus of the report, its location etc)* • What type of language is used? *(This refers to staff communicating generally as well as during nursing hand-over, is the language used patient centred, biomedical, or industrial type language more associated with production lines?)* • How are patients talked about? *(Include all professionals – see note above)* • How do staff refer to each other? *(Include all professionals – with respect/distain etc?)* • How do staff engage with each other? *(consider tone of voice, pace, pitch of voice; consider how different staff participate/don't participate in ward rounds)*		

What messages does staff body language convey? *(Between staff, between staff and patients)* Are visitors made to feel welcome? *(how Are they greeted and treated?)* What tools are used to enable communication? *(Here you should note the various systems in use, written documentation, computers, whiteboards etc)* What importance is placed on the tools of communication? *(Here you should consider the attention that is paid to the various communication means)* Is confidentiality respected? Do staff have meaningful engagement with patients or fleeting/task oriented conversations?		

Observation Area 3: PRIVACY & DIGNITY

Observer Prompts	Observation Notes	Questions Arising
• Is patient privacy respected during specific procedures? • How is the valuing of diversity demonstrated *(including attitudes and behaviour towards minority groups, e.g. black and minority ethnic communities)?* • Are individuals needs and choices ascertained and continuously reviewed? • How is the acceptability of personal contact (touch) identified with individual patients /clients? • How are the patient's /client's personal boundaries identified and respected and communicated to others? • How is clinical risk handled in relation to complete privacy? • Note how privacy is effectively *maintained e.g. curtains, screens, walls, rooms, use of blankets, appropriate clothing, appropriate positioning of patient etc* • Note how privacy is achieved at times when the presence of others is required • Note how modesty is achieved for those in transit to differing care environments • How are patients/clients views and needs ascertained and recorded? • Is information adapted to meet the needs of individual patients?		

Observation Area 4: PATIENT INVOLVEMENT

Observer Prompts	Observation Notes	Questions Arising
• Is there evidence of patients being able to make choices? • Do staff involve patients in planning and evaluating their care? • Do staff involve patients in making plans for their discharge from hospital? • Do staff have a rapport with patients? • *(General easy communication)* • Is there evidence of staff developing meaningful relationships with patients? • *(Note with whom)* • Is there evidence of patient education occurring as a part of everyday practice?		

Observation Area 5: TEAM EFFECTIVENESS

Observer Prompts	Observation Notes	Questions Arising
• Do different staff groups have respect for each other? • Do staff work as a team? • Is there evidence of a hierarchy between and among staff? • Do staff have a clear sense of purpose? • Do staff freely question, challenge and support each other? • Is there evidence of staff initiating changes in practice? • Is decision making transparent, participative and democratic? • What style of leadership is in evidence? • Do the staffing levels seem appropriate to the workload in order to deliver quality patient care? • Is the skill-mix appropriate? • Is there praise and recognition for a job well done?		

Observation Area 6: LEARNING CULTURE

Observer Prompts	Observation Notes	Questions Arising
• Is there evidence of resources for learning being available (*consider evidence of staff having access to computer, books, journals etc)* • Are opportunities for learning maximised? (*For example at hand-over or through reflective conversations during daily activity etc)* • Is there evidence of a staff performance development/appraisal system in place? • Are policy and practice guidelines used to inform practice decisions? • Are there mechanism for formal learning? (*Study leave, induction programmes, mentorship, etc)* • What kind of learning is privileged – e.g. technical skills or holistic practice knowledge? • Is there evidence of critical reflection happening (*consider evidence of critical questioning between staff; action learning, critical companionship; clinical supervision; workplace coaching).* • Do staff engage patients/families in learning about their illness/health and social care needs and approaches to self or assisted care?		

Observation Area 7: RISK AND SAFETY

Observer Prompts	Observation Notes	Questions Arising
• Is equipment, used, maintained and monitored appropriately? • Are patients able to gain staff attention when needed? *(buzzers being attended to etc)* • Are assessments of risk used and acted upon? • Are the levels of risk taken appropriate to the practice context? • Is hand washing consistent with accepted standards? • Are open medicine trolleys left unattended? • Do staff check patients' armbands when administering medicines? • Are appropriate procedures for the handling and removal of used laundry in place? • Are bathroom areas maintained appropriately? • Is the environment free from risk?		

Observation area 8: ORGANISATION OF CARE

Observer Prompts	Observation Notes	Questions Arising
• Is the organisation of care patient centred? • Do patients have an individualised plan of care (including discharge plan)? • Do nurses demonstrate care for patients? *Make note of how they do (or do not)* • Is the system of nursing hand-over consistent with the method of organising care? • Is care delivered consistently ? *(Here you should check if nurses, irrespective of what shift, deliver care <u>consistently</u> to individual patients, for example by paying attention to the care plan etc)* • Are nurses visible in patient areas? • Do nurses demonstrate responsibility for practice? *(here you are looking to see follow through, active communication, checking mechanisms etc)* • Are meal times given priority? • Are patients who need help with eating and drinking given the appropriate help? • Is off duty planned around the needs of patients? • Are patients content with visiting arrangements?		

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