Working together to improve the care of older people: a new framework for collaboration

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Abstract

Aim. This paper is a report of a study identifying the care issues experienced by older people in the acute setting that could be improved through a collaborative approach to action.

Background. Actively involving consumers in the governance of healthcare organizations is viewed positively, although there is less agreement on how to do this. Co-operative inquiry is a useful approach to involve consumers and clinicians in structured dialogue about understanding and changing care, whereas traditional quality improvement methodologies are often singular in their dimensions of change.

Method. Using a co-operative inquiry approach, five workshops were facilitated over a 4-month period in 2008 with four volunteer older people, four clinicians and three facilitators (n = 11). All participants were actively involved in generating ideas and actions using a range of facilitation techniques and data collection methods.

Findings. There was increased awareness, understanding and acceptance of clinicians’ and consumers’ experiences and expectations of care. The complexity behind changing so-called simple care (providing warm drinks, appetizing food), which were the key concerns for consumers, relied on the active management and broader transformation of the system, including teamwork, communication processes and organizational and individual values and beliefs.

Conclusion. Consumers and clinicians put different emphasis on perspectives related to improving care of older people in the acute hospital setting. The disconnect between what consumers viewed as ‘simple’ organizational behaviours to change and what the clinicians viewed as complex, led to a recognition that the approach to organizational change needs to be reconceptualized.

Keywords: collaboration, co-operative inquiry, nursing, older people, quality improvement
Introduction

The impact of the aging population on health care is well reported (Butler 1997). As part of a state-wide Older Person Strategy, a tertiary hospital in South Australia established a project to improve the experience of older people going through the acute hospital (The Older Person and Improving Care Project, TOPIC7, Wiechula et al. 2009). The purpose of this TOPIC7 project was to determine whether, by using standard safety, quality and audit mechanisms, evidence-based standards of care could be introduced, in turn improving the quality of care experienced by older people in hospital. To complement TOPIC7, a co-operative inquiry research project was established. The aim of this strand was to understand how older people perceive and articulate care in the acute setting and whether, by being involved in structured dialogue with clinicians, both older people and clinicians could create shared understandings that would lead to more effective action and improvements in the service.

Background

Acute hospital settings are considered hostile places for older people (Kitson 2009). Initiatives such as the Hospital Elder Life Program (Inouye et al. 2000) have drawn attention to the potential hazards encountered by older people during acute admissions. Similar initiatives have been taken by western governments (Department of Health 2007, South Australia Health 2008) in which the potential harmful effects of the health environment are actively managed.

Most hospitals have active safety and quality management to improve patient safety and the quality of care (Pirone 2007). More recently programs focusing on organizational development or service improvement have emerged (Langley et al. 1996, Smith 2003, Ben-Tovim et al. 2007).

Contention exists as to whether these strategies improve outcomes of care while reducing costs (Shortell et al. 1998). Improvement is more likely to be successful when it occurs ‘within a supportive regulatory and competitive environment, when it is aligned with financial incentives, and when it is under the direction of an organizational leadership that is committed to integrating all aspects of the work’ (Shortell et al. 1998, p. 595). In contrast, there have been only a few descriptive or interpretive accounts of just how acute settings are choosing to engage older people in improvement processes (McCormack 2004).

As a consequence of this gap in the literature, the team decided to set up a study as part of TOPIC7 to test whether consumers and clinicians had the same view of what it was like to be an older person in an acute hospital setting.

Co-operative inquiry (Reason & Heron 2008) was chosen to facilitate the dialogue between consumers (older people) and clinicians. It is founded on the concept of researchers collaborating with participants by ‘contributing to both the decisions which inform the research and the action which is to be studied’ (Reason 2003, p. 205). The important element is acknowledging that everyone in the process brings their own experiences, knowledge and relationships.

The participatory approach results in researchers and participants co-creating a shared reality with a view to generating new evidence for practice (Tee et al. 2007). Reason believes that co-operative inquiry is ‘designed for any group of people who want to understand better some aspects of their life and work and who maybe want to find new ways of practice’ (Reason 2003, p. 18).

Co-operative inquiry, first proposed by John Heron in 1971 and later expanded upon by Reason (Heron 1981), describes four cycles the research process. A more practical translation of Heron is provided by Tee et al. (2007), resulting in five phases (see Table 1). The work of Tee et al. (2007) was a principal influence for the evolution of the Consumers and Clinicians co-operative method.

The study

Aim

The study aimed to identify the care issues experienced by older people in the acute setting that could be improved through a collaborative approach to action.

Methodology

A co-operative inquiry method was selected. Heron (1996, 2001) outlines the different categories of co-operative
inquiry that can be undertaken including: who initiates the inquiry; level of involvement; degree to which individual roles within the group are explored; the focus of the inquiry from within the group or external to the group; whether ideas are developed using traditional logico-deductive approaches or a mix of representations; and whether the purpose of the group is to inform a process or to aim to achieve action.

Based on this taxonomy, the inquiry was researcher-initiated and designed to address an issue that emerged from a research interest. The main researcher and consumers were external to the system. Thus, the mix of professionals and consumers created an unusual combination of participants. Group members actively used experiences from multiple sources, and thus the data were external to group events. The process generally followed a clear analytical approach (particularly in the early stages), with some divergence towards the end.

Table 1: Overview of co-operative inquiry phases and the method used for four consumers for four clinicians

<table>
<thead>
<tr>
<th>Four consumers for four clinicians elements</th>
<th>Tee et al. (2007)</th>
<th>Descriptor</th>
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</thead>
<tbody>
<tr>
<td>1. Broad aims of the project</td>
<td></td>
<td>1. Participants to identify strategies for improving the way care is delivered to older people in the acute hospital setting</td>
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<tr>
<td></td>
<td></td>
<td>2. Evaluate the effectiveness of co-operative inquiry as a method (compared to other approaches used to involve consumers)</td>
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<td>2. Specific research questions</td>
<td></td>
<td>1. What factors help older people and healthcare professionals more effectively engage in identifying and actioning common issues that improve the service?</td>
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<tr>
<td></td>
<td></td>
<td>2. What are the benefits of healthcare professionals and older people going through this experience together?</td>
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<tr>
<td></td>
<td></td>
<td>3. How does this approach differ from other more routine methods that are used to elicit older peoples’ views?</td>
</tr>
<tr>
<td>3. Approach</td>
<td>Phase 1: Bring together the participants</td>
<td>1. Bring four healthcare professionals and four older people as consumers together for five workshops of 2 hours over 4 months. Facilitated group work supported by detailed note taking during session. Use of email exchange between workshops</td>
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<td></td>
<td>Phase 2: Define the focus of the inquiry and agree actions</td>
<td>2. Define focus of inquiry and agree actions at first session including determining the group rules</td>
</tr>
<tr>
<td></td>
<td>Phase 3: Apply agree actions and observe and record outcomes</td>
<td>3. Applying agreed actions and observe and record outcomes. All participants share personal accounts</td>
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<td></td>
<td>Phase 4: The group experience the consequences</td>
<td>4. Data collection of group discussions, feedback to group and explored further</td>
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<tr>
<td></td>
<td>Phase 5: The group learns from the experience and disseminate their findings</td>
<td>5. The group learns from the experiences via the data analysis process and disseminates findings within group and broader community</td>
</tr>
<tr>
<td>4. Results</td>
<td></td>
<td>1. Factors help older people and healthcare professionals more effectively engage in identifying and action common issues that improve the service</td>
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<tr>
<td></td>
<td></td>
<td>2. Benefits of healthcare professionals and older people going through this experience together to understand the complexity involved</td>
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<tr>
<td></td>
<td></td>
<td>3. Approach differs from other more routine methods that are used to elicit older peoples’ views moving towards a higher level of consumer participation in improvement</td>
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</table>

Participants

The goal was to recruit seven clinicians and seven consumers. For the consumers, older people were sought who had either been patients at the hospital or cared for an older person. They were offered reimbursement of costs in accordance with existing Consumer and Community Participation Guidelines (CNAHS 2008). Letters were circulated to the hospital’s Consumer Advisory Group soliciting expressions of interest. A letter was circulated widely throughout the hospital to target clinical staff. In addition, letters of invitation went to all members of the TOPIC7 interdisciplinary improvement teams (n = 7; participants = 42). This resulted in four consumers and four clinicians being recruited.

Data collection

A series of workshops were designed based on the work of Tee et al. (2007) to facilitate cycles of reflection and action.
according to the methodology. These were facilitated by an experienced facilitator (ALK) and by project team members with expertise in systems re-design (KZ) and organizational theory and teamwork (HG). Due to a number of factors, five workshops over a 4-month period were conducted.

An overview of the workshop contents and the group agreement about how participants wanted to work together is given in Table 2. Each workshop followed a similar format. At the end of each workshop, participants were given the opportunity to share aspects of the session that they would prefer not to experience again and aspects that they appreciated.

Comprehensive notes of the conversations and interactions were taken throughout each workshop session. These were circulated to the group within 1 week of each workshop for review. At the start of subsequent sessions any changes or alterations to the notes were made. Actions were agreed at the end of each session. In the final workshop, a set of preliminary themes were identified and small groups created visual representations of the themes in poster format. These pictorial themes formed the basis of a more detailed thematic analysis of the workshop notes, undertaken by the three group facilitators. Contact was maintained via email with all participants.

**Ethical considerations**

The study was approved by the hospital ethics committee.

**Data analysis**

Data analysis occurred in two ways. The group was responsible for reflecting upon and drawing meaning from the events in the meeting and the actions reported between meetings. The second phase of data analysis took place after the completion of the workshops. The transcribed notes from all workshops, together with the emerging themes, were reviewed by each of the three facilitators independently to identify main themes and sub-themes, with exemplars illustrating the categorizations. The facilitators then met to compare categorizations, and from this refining process developed a first conceptualization of themes (Table 3) followed by a more refined conceptualization (Table 4). As the analysis developed, versions were circulated to the co-operative inquiry participants and their comments were included in the ongoing analysis.

**Validity**

Validity within co-operative inquiry methodology relates to whether the results are well grounded in the ways of knowing that were used to derive the outcomes of the study. Of particular importance is undertaking sufficient reflection and action cycles to allow the outcomes to be refined and devoid of subjectivity or bias. Heron (1996) recommends that a variety of ways of knowing are used to get to the shared understanding, using facts, sharing experiences, talking about feelings and using different ways of communicating information. Another feature of validity of the process is the ability of group members to manage feelings of frustration and disappointment, and to be able to challenge each other in constructive ways. Issues of ensuring validity will be discussed below.

**Findings**

The four consumers who volunteered were all members of the hospital consumer group. They all had been associated with the hospital in various roles, both as volunteers and as carers of patients in the hospital. They were all women, over 70 years of age. The clinicians were full-time hospital staff members and represented allied health (dietitian, physiotherapist and occupational therapist) and nursing (one ward leader). The clinicians were all women aged from the mid-30s to mid-50s.

Workshop sessions revealed rich information relating to improving the care of the older person in the acute care setting. A number of themes were identified from the data, including ‘being old’, ‘being involved’, ‘patient in the room’, ‘food’, ‘lacking respect’, ‘working together’, ‘discharge’ and ‘the system’. These themes from the experiences of the participants were collated into a framework summarized in Table 3. Direct quotes from participants from the workshops or postworkshop feedback are used to illustrate key points with the meeting number in parenthesis (M3).

**Fundamentals of care**

**Food**

Two issues were raised by participants as root causes of the problem of food and older people in hospital: the first was the packaging itself, which older patients could not open easily; the second was the lack of accountability amongst food delivery or clinical staff for ensuring that patients could access and eat their food without the need for assistance. Eating appeared not to be considered an important part of treatment, in the way perhaps that medication was:

Responsibility for missing treatment for medication – could be a formal incident. For missing a meal – it is not considered a notifiable incident. (M4)
### Table 2 Co-operative inquiry workshop framework

<table>
<thead>
<tr>
<th>Workshop 1</th>
<th>Workshop 2</th>
<th>Workshop 3</th>
<th>Workshop 4</th>
<th>Workshop 5</th>
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</thead>
<tbody>
<tr>
<td>Welcome/ice breaker</td>
<td>Welcome and housekeeping</td>
<td>Welcome and discussion of framework of workshops from here</td>
<td>BREAK</td>
<td>Welcome and regrouping</td>
</tr>
<tr>
<td>Create a shared understanding of what it means to be an older person in an acute care setting</td>
<td>Sharing of personal reflections on the work/issues discussed in the first workshop</td>
<td>Discussion focused on the elements of the ideal. Especially in relation to the emerging themes</td>
<td>Sharing of participants progress on action items determined in previous workshop</td>
<td>Review of emerging themes</td>
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<tr>
<td>Explain the co-operative inquiry method</td>
<td>Then group members had 5 minutes uninterrupted time to share their story. Others in the group to listen, noting down thoughts/reflections. After 5 minutes, group members given the chance to ask questions and discuss issues</td>
<td></td>
<td>Group challenged to develop artistic visualizations through the use of metaphors of the themes</td>
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<tr>
<td>Determine group/project rules</td>
<td>Participants were asked to reflect on one aspect of the work/issues discussed and share reflections/thoughts with the group at the next workshop</td>
<td>Participants were provided with ‘A short guide to co-operative inquiry P. Reason and Heron (2008)’</td>
<td>A set of collaborative action items were determined for the participants to progress over the 10-week break</td>
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<tr>
<td></td>
<td>Group asked to reflect on the ideal situation/Team/hospital</td>
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**Group norms – how to work together**

- Confidentiality – respecting personal accounts, not attributing them outside of the room; insights/information of a personal nature (anonymized) can be used in other arenas as exemplars of work. Group can also bring stories to the group with permission of individuals
- Respect – for what the participants in the group have to say
- Equal air time – listening and talking both important elements of process. Facilitators given permission to monitor in sessions
- Time – start and finish on time. One person appointed as central contact and to be let known if someone is to be late or delayed
- Action – commit to do what we say will do
- Interruptions – principle of turning mobile phones off but if an individual needs access to their phone to seek group’s permission
- Clarifying data – determined a process and timeframes by which the notes are validated
- Publications and products from research is negotiated and owned by whole group
Although the organization’s capacity to provide food did not seem to be recognized as an indicator of quality, for the group it was seen as a central indicator:

View that technology and clinical excellence was totally distinct from an organization’s ability to deliver food effectively. (M4)

A further example of the lack of importance given to eating and nutrition was the continual loss of special technical aids for eating that an occupational therapist might order for a patient:

Appliances to help patients eat in general disappear because the kitchens are not designed to return them to appropriate patients. (M3)

Finally, attention was drawn to the lack of consideration given to the importance of food that was sufficiently attractive to tempt the appetite of a sick older person. Issues of presentation and degree of processing were of particular concern:

‘Colour of trays everything beige’ and ‘If I were sick I wouldn’t want that anywhere near me’. (M3)

Food became a continuing focus for discussion throughout the workshop sessions. It seemed to become the medium through which other themes were explored, for example respect, teamwork, communication and redesigning systems of care delivery.

Discharge

Discharge was a bone of contention for consumers and clinicians alike. Major elements of the discharge story included shared experiences of chaos and confusion, described as the ‘tangle of disorganization’ (M4).

Despite an ongoing attempt of the hospital to improve the discharge process, the patient experience was still often one of repetition, duplication, different and sometimes conflicting information being given, and feelings of embarrassment on the part of staff who had to defend systems that patently did not work for patients and their families. This systemic malaise was thought to be linked with the fact that discharge seemed to have a lower priority than treatment. Consumers particularly felt that this was the case, whilst clinicians equally felt that there was a lower emphasis on rehabilitation aspects of the service.

Communication again emerged as a major impediment to effective discharge, with several accounts describing the challenges of improvement. The group articulated the impor-
tance of acknowledging the emotional preparation needed concerning discharge planning. This was succinctly described as three different options faced by older people being discharged:

Home sweet home
No home to go to
Don’t know where I’m going. (M5)

Consumers described how older people would worry about which category they found themselves in, and would also be afraid of somehow migrating from one category to the other without being told or without being able to defend themselves.

Invariably, despite the efforts of the organization, discharge was thought to be a weak part of the care chain. As one consumer asked of her professional colleagues:

Is discharge only the icing on the cake at the end, or is it the cake and the essence of the experience? (M4)

Working together

During the course of the five sessions, the concept of ‘working together’ emerged, incorporating three sub-themes (see Table 3).

Working together: purpose, communication and teamwork

Both clinicians and consumers agreed that the purpose of working together involved effective communication, respect, advocacy and teamwork. Implicit was the desire to ‘improve things’. Respect was viewed as a central component of working together:

(You) need to empower people to be involved, connected and communicating. (M2)

The group also explored the different dimensions of effective communication: the way it was done (i.e. not distant), respecting each others’ positions, and how professionals communicate with each other. Consumers recounted many examples of being impeded in their ability to communicate with clinical staff, either by knowing too much or by being intimidated by technical jargon. This subsequently caused tension in the messages being conveyed to consumers – were they supposed to be self-caring, assertive individuals or were they still supposed to be deferential patients, and in particular, older deferential patients?

Teamwork was also broken down into a number of specific elements, with nine discrete areas discussed by the group. Consumers were disappointed at how little effective team-work they observed. Equally, clinicians acknowledged their ongoing frustrations at not being able to improve services because of intractable problems in the way in which teams were set up, how they operated and how leaders failed to address key issues.

The fact that teamwork produced nine different descriptors and itself was a sub-set of the broader concept ‘working together’ reflects the complexity of the system in which consumers and clinicians found themselves (see Table 3). They struggled to understand why teamwork – seen as such a fundamental building block – was so difficult to realize.

The system

Another theme was ‘the system’ – the hospital, both as a sanctuary and place of security and rest and as a hostile, fearful place. The hospital evoked emotions and memories in equal measure, both from consumers and clinicians; it was a fearful, frightening place where relatives had died, where wishes had not been respected, and equally it was a place some patients did not want to leave because they felt secure.

Three dimensions of the system were described:

• a learning organization
• (responsible for) disempowering individuals
• a dysfunctional organization.

It was clear from both clinicians and consumers that everyone wanted the system to work more effectively. Consumers wanted to be proud of their hospital, to work on its behalf and give of their energy, time and commitment. However, an interesting characteristic was the growing disappointment – or cynicism – in what some consumers described as the growing disconnect between policy and practice. This was voiced in various ways:

Policy doesn’t interpret itself at grassroots. For example, discharge planning – we’ve done a lot of that; we have a joint group (consumers and clinicians) but it doesn’t make a difference… (M3)

Another feature of the system was the tension several consumers and clinicians felt about not being able to speak up about situations of clinical/organizational concern because (paradoxically) they ‘cared about the place’. This discussion was focused particularly on the role of ‘professional consumers’ – that group of committed individuals who worked on behalf of the hospital. In their more cynical moments, several consumers voiced the concern that they were unable to challenge practices because they felt that they would be perceived as ‘being disloyal to the organization’ (M4). The disempowering effect this had on the ‘consumer’s voice’ was to make them feel that they were ‘rubber stamping’ actions and decisions that had already been taken and that ‘staff…come and tell us what’s happening’ (M4).
The dysfunctional aspects of the system, compounded by the bureaucracy, repetition and lack of effective teamwork, reinforced and augmented consumers’ and clinicians’ feelings of being disempowered.

**Respect**

**Lack of respect**

Respect was described in the context of relationships between the professions and between healthcare providers and patients. Lack of respect was described in relation to multiple key stakeholder relationships, including patients, clinicians and consumers (see Table 3).

A key example of disrespectful patient-centred behaviour was keeping patients waiting. Why was it acceptable to let people wait? This took the form of two dimensions:

‘Waiting-as-warehousing’ was older people’s experiences of being ‘shunted around’ different areas whilst waiting.

‘Waiting-as-lack-of-respect’ was a common experience. A story was shared about an older man who waited for over four hours to be admitted. After four hours ‘he hadn’t seen anyone; there was no information, no communication, no food’ (M3). The question arose as to why people tolerated such long waits and fear of missing their spot in the queue.

Not surprisingly, waiting was seen to provoke anger. As one consumer put it:

> We have signs up in the hospital saying: ‘Staff have the right to be treated respectfully’. Well, patients need to be treated with respect too! (M2)

Discussions about respectful waiting and the covert messages being communicated to older people related to seeming disrespect condoned by the system were issues for discussion and future problem-solving. This included the notion of the invisible older people in a busy and complex environment.

The other issue highlighted was lack of respect amongst the professions. This was attributed to role confusion and lack of ownership of behaviours in relation to how professions interrelate. Participants recounted experiences of when their professional advice was disregarded or members of the healthcare team ostracized.

Creating a culture of respect was described as ‘a two-way thing’ (M3). Respect was described as an important element of working together, which was seen to require team members, patients, carers and volunteers to value core aspects of advocacy and respect.

**Being old**

Defining the concept of ‘older person’ emerged from the experiences of participants of ‘being old’ and caring for older patients. The term was difficult to define as it had multiple meanings/interpretations, including experience, physicality, loss and perceptions of being old.

‘Being old’ was described as balancing wealth of life and richness of experience. Older people’s experiences could be overlooked because of their disabilities, but conversely there was much to be learned from their life experience.

Loss of physical independence was another element: the body not being able to do what the person wanted it to do due to varying degrees of physical disability. It was also seen as important to consider both the health of the individual and their age. ‘Being old’ was compounded by the loss of roles and of youth, strength, vitality and loss of past roles.

Chronological age was not strongly related to ‘being old’. ‘Being old is not a number, it is about how old an individual feels’ (M1). Although it is often more likely to be the perception other people have of the individual. The definition of older people was considered as ‘anyone who is 20 years older than me’ (M5)

**Being involved**

Being involved was described as lack of involvement rather than positive experiences of active involvement in decision-making. Lack of involvement was also identified for consumers/patient advocates/volunteers – the ‘public non-patient interface’ with the hospital:

> [volunteers are] not considered important in the patient care (M3)

and

> In the day-to-day running of the service, the consumer’s voice is not heard. (M3)

It also referred to the less-valued position of allied healthcare staff:

> Opinions (are) brushed aside – everyone [is] not respected for what they do. (M2)

Some consultants don’t refer because they don’t know what physiotherapists do. (M4)

The ideal scenario was depicted as working together as a team. This included nursing staff working with volunteers:

> (We) would like to work closer with nursing staff, but most of the time it feels like finding your own way. (M3)

It also included allied healthcare and medical staff:
Need respect in a team. (M2)

Finally, medical staff did not accept the role of patient advocates for older people:

Patients don’t like asking questions. (M2)

Patient in the room – communication

Absence of respect for and involvement of the broader patient care team was mirrored in views about communication. Participants said that professionals did not communicate effectively with them, but needed to do so for the benefit of patients. Consumers and clinicians both acknowledged problems in the flow of information and where it broke down. This was perceived to be at the multiple intersections of care – at professional, interpersonal, departmental and organizational levels. In particular, it was thought that medical staff were not communicating nor listening:

‘Doctors are excellent at fixing the practical/clinical stuff... but they are lousy communicators’ and ‘They have to learn to listen’. (M2)

Both sides of the communication relationship needed to be valued as part of good clinical practice:

Lack of/inability to communicate can lead to misdiagnosis. (M2)

The authority given to the position of physicians within the team was perceived as exempting them from having to respond to feedback on their poor communication skills:

Professional status determines their authority to speak and to know. (M4)

Poor communication took other forms. Consumers felt that their Consumer Advisory Forum was run ‘top down’ as an information-dispensing forum, without the opportunity for their input:

‘Experience of not being able to speak up because she cares about the place’ and ‘Couldn’t bring up the real issues’. (M2)

Finally, there was a general perception that communication was inadequate between interdisciplinary clinicians and between the interdisciplinary team caring for patients, and families:

[sometimes at discharge] she (allied health) will phone relatives and it’s the first contact from anyone at the [hospital]. (M2)

Despite people’s best efforts, experiences often came down to the inability to get hot coffee served to patients or to provide older people with appropriate meals. The tension concerned whether a system could be excellent technologically (which everyone acknowledged) if it was not able to deliver a consistent acceptable service in the basic areas of human need.

Most importantly, consumers collectively expected the hospital – the system – to be able to provide such things as respectful care, appropriate food, coordinated discharge, optimal teamwork and communication. There was surprise that clinicians in the group felt as powerless, frustrated and at times as defensive as consumers:

It often did feel like we mostly discussed problems and I felt rather down after the sessions, but I think that is because we wanted to improve things. (Consumer Postworkshop feedback)

It seemed that consumers expected professionals to ‘get the basics right’ (M2 and M5). They saw issues such as providing the right food, being able to discharge patients appropriately, and treating patients with respect as core aspects of professionalism. They were surprised when they heard that professionals felt equally vulnerable and unable to change things.

The frustration that spilled out from consumers at the final workshop was also a powerful catalyst for the facilitators to reflect where the frustration came from. As one participant said:

I am very disappointed. (I have a) sense that the other groups [TOPIC7] were doing something more worthwhile and practical, and that (yet again) the consumers had been engaged in a ‘talkfest’ that wasn’t going to go anywhere...I thought this was part of the process... There are aspects of this (process) that I’m not interested in. (M5)

These and similar comments pushed the whole group into a challenging phase of reflection, where they tried to understand why it was so difficult in a large system to ensure that the fundamentals of care were addressed satisfactorily. It was in reflecting on these seemingly obvious questions that the reconceptualization of the emerging themes developed into a framework comprising three discrete levels of interpretation and action (see Table 4). We hypothesized that the complexity of changing so-called ‘simple’ things was linked to the fact that the practical and pragmatic (i.e. offering warm, appetizing food) was like the ‘tip of the iceberg’. Behind this visible, practical act lay a host of deeper, more complex issues such as teamwork, processes and the values and beliefs of consumers and clinicians.

This meant that instead of being straightforward aspects of system improvement, there was speculation that some of the most stubborn aspects of care to change would be the so-called simple ones. That such change was heavily reliant on effective teamwork and a sharing of core values meant...
that competing priorities, politics and policies would invariably thwart the aspects of care that older people valued most.

Discussion

Study limitations and issues of validity

This co-operative inquiry was not without limitations. Participants acknowledged the absence of medical representation in the group. No medical practitioners volunteered to be part of the project, and it was decided by the group not to invite one as this was contrary to the volunteer principles. There was no male voice, nor one from a wider ethnic group. Further limitations to the process were the constraints of the timeframe. This was particularly challenging in terms of creating group cohesion and having sufficient time for reflection and action.

The structure of the group and workshops contributed to the internal validity and integrity of the inquiry process. Multiple ways of describing experiences were used. The desire to connect reflections to practical action was ever-present and created tensions between the consumers, who wanted to see things improve, and clinicians, who often defended their system. The fact such feelings were voiced and managed reinforced the validity of the process.

Developing the framework

The findings demonstrate the complexity behind change associated with simple care, which involved deeper issues

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<thead>
<tr>
<th>Table 5</th>
<th>Improving the fundamentals of care framework: validation and testing</th>
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<tbody>
<tr>
<td><strong>Being old</strong></td>
<td><strong>Food (+)</strong></td>
</tr>
<tr>
<td>The practical and pragmatic</td>
<td>Every time we speak he tells me the same story. He can’t eat much at site X but at the other site they serve it up fresh and he loves it</td>
</tr>
<tr>
<td>What’s seen and talked about</td>
<td>Nutrition poster</td>
</tr>
<tr>
<td>What’s experienced and felt</td>
<td>Nutrition poster</td>
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<tr>
<td>Working together</td>
<td>The system</td>
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<td>The system</td>
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<td>Peoples values and beliefs</td>
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<td>What’s valued</td>
<td>Respect</td>
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What is already known about this topic

- Actively involving consumers in the governance of healthcare organizations is viewed positively, although there is less agreement how to do this.
- Co-operative inquiry is a useful approach to involving consumers and clinicians in structured dialogue about understanding and changing care.
- Traditional quality improvement methodologies are often singular in their dimensions of change.

What this paper adds

- There was increased awareness, understanding and acceptance of clinicians’ and consumers’ experiences and expectations of care.
- The complexity behind changing so-called simple care (providing warm drinks, appetizing food), which were the key concerns for consumers, relied on the active management and broader transformation of the system, including teamwork, communication processes and organizational and individual values and beliefs.

Implications for practice and/or policy

- Healthcare providers need to consider how to engage staff and consumers and more actively in structured dialogue to identify improvements in the fundamentals of care.
- High priority needs to be given to working with people’s experiences, feelings, values and beliefs when embarking on quality improvement initiatives in acute care settings.

such as teamwork, processes of communication and entrenched values and beliefs, on the part of both consumers and clinicians.

The themes that were identified from the data including ‘being old’, ‘food’, and ‘discharge’ and the themes founded on relationships such as ‘being involved’, ‘patient in the room’, ‘lacking respect’, ‘working together’, and ‘the system’ highlighted the policy-practice disconnect, sense of powerlessness and parallel worlds experienced by clinicians and consumers on a daily basis.

An emerging conceptual framework was constructed which argued that the themes were layered in terms of visibility, reality and complexity (see Table 4). These layers helped in part to explain why practical improvements for what was considered by the consumers as straightforward aspects of care were not seen. To test the framework, positive and negative examples from the workshops were used to describe the different levels of engagement. Table 5 shows that the majority of exemplars were negative, illustrating current improvements to the basic elements of care fell short of consumers’ expectations. This had the compound effect of increasing the vulnerability of older people using hospital services and making them more cynical about the ability of professionals to support the basic aspects of care.

There seemed to be more dissatisfaction from consumers with the co-operative inquiry process compared to clinicians. This may have been due to the past experience of consumers in engaging with the hospital. Traditionally, consumer engagement had been founded on a premise of consultation rather than true participation. The notion of user participation has been described by Poulton (1999) as a series of levels, moving through information, education, consultation, satisfaction, participation to empowerment. This co-operative inquiry research has highlighted that traditional consumer engagement falls well short of participation and empowerment. There remains a ‘cultural divide’ between service users and practitioners that requires more ‘active facilitation’ (Poulton 1999, p. 1293). Co-operative inquiry in this setting has been shown to be a potentially practical form of active facilitation.

Insights into obstacles were drawn from the three levels of change outlined in the Improving Care Framework (Table 5). While improved teamwork, including communication and respect, are practical and easily visualized, they are not easy to achieve. Research suggests they are achievable but need a dedicated research and development agenda (Risser et al. 1999, West et al. 2003). Entrenched values and beliefs underpin current care practices, and were neither overtly acknowledged nor questioned.

Despite the concentration on negative experiences, the inquiry group did highlight examples of desirable practice. What was notable in these descriptions was that the behaviours associated with them were not extraordinary. They comprised ordinary clinical practice behaviours conducted against a different set of attitudes characterized by empathic responses and reciprocity in thinking. What was highlighted was the connection between the practical act (i.e. providing hot coffee) and the underlying values of the system (i.e. respecting the basic needs of patients), and that, despite the ongoing investment of the system, neither conventional improvement nor re-design processes acknowledge the multilayered approach to change. Our emerging hypothesis, therefore, is that in order to achieve change in fundamental services, there needs to be engagement at the level of ‘experiential learning’ (between consumers and clinicians) and the level of deeply-held values and beliefs.
Conclusion

The co-operative inquiry group embarked on a journey together, with some unexpected outcomes. The disconnect between what the consumers viewed as ‘simple’ aspects of systemic behaviour to change and what professionals experienced as complex, frustrating processes led the whole group to propose a new way of conceptualizing attempts to improve the fundamental aspects of care.

Instead of a straightforward process, from the starting point of a practical, pragmatic issue such as giving patients warm drinks, it was realized navigation through organizational aspects such as working together, improving systems and processes and also the underlying values and beliefs of the organization was required. Whilst these are not new elements, the insight created by this co-operative inquiry group has led to an argument for a stepwise approach to pragmatic problem-solving through these different layers.

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Conflict of interest

No conflict of interest has been declared by the authors.

Author contributions

AK & KZ were responsible for the study conception and design. AK, KZ, HG, EB, MC, CD, JF, SG, FR & AS performed the data collection. AK, KZ & HG performed the data analysis. AK, KZ & HG were responsible for the drafting of the manuscript. AK, KZ, HG, EB, MC, CD, JF, SG, FR & AS made critical revisions to the paper for important intellectual content. KZ provided administrative, technical or material support.

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