

# **Sustainability in an Action Research project: 5 years of a Dignity and Respect Action Group in a hospital setting.**

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## **Abstract**

In March 2004 we delivered a new module entitled 'Fostering Dignity and Respect in Health Care Settings. This was a collaborative venture between Anglia Ruskin University lecturers and Southend University Hospital Staff and was the first step in our Action Research project. We had expected the project to be a short term one terminating with the first 3 deliveries of the module. However the education programme led to the formation of a Dignity and Respect Action Group within the hospital that continues to this day alongside deliveries of the module and thus the Action Research project continues.

This article outlines the achievements of the Action Research study and identifies some of the features that we believe have sustained it over a period of five years. These factors were not always the consequence of planned strategies but often arose as we responded to events during the trajectory of the project. Issues relating to dignity and respect are to be found in many large institutions and we maintain that Action Research can be useful in harnessing and focussing the necessary commitment to bring about long-term changes in a hospital setting.

## **Key words:**

Dignity, Respect, Action Research, Sustainability, Collaboration, Change, Empowerment

## **Introduction**

Action Research has been recognised as being particularly appropriate for studies in health care settings that involve the improvement of health care practice and seek to empower practitioners and service users (Waterman et al 1995, Rolfe 1998 Bellman 2001). There are many different definitions of Action Research (Hart & Bond 1995, Cropper et al.2007) but most commentators are agreed that amongst its defining characteristics are those that involve: *"The study of a social situation carried out by those involved in that situation in order to improve both their practice and the quality of their understanding."* (Winter and Munn-Giddings 2001:8)

Winter and Munn-Giddings (2001:8) also highlight the democratic and participatory nature of Action Research:

*“For Action Research, hierarchies of power and status (between academic and practical knowledge, between researchers and practitioners, between professionals and their clients, between experts and lay persons) are seen as inhibiting and impoverishing the creation and distribution of knowledge.”* (Winter and Munn-Giddings, 2001, p.8)

It is generally agreed that Action Research has a cyclical nature involving identification of a problem, action planning, action taking, evaluating and specifying learning and understanding (Susman, 1983). Munn-Giddings et al. (2008) list the advantages of such a methodological approach as being problem-focussed, grounded in the reality of practice, empowering for practitioners, bridging the theory-practice gap and being able to be carried out as part of, rather than alongside, practice.

It was all these factors that made Action Research an attractive format for this practice-based project when we were approached to develop an education package to promote dignity and respect in a hospital.

Elsay and Lathlean (2006) in their article on using Action Research to stimulate change in health services identify the approach of their studies as falling between what Hart and Bond (1995;40-44) identify as the ‘professionalising’ and ‘empowering’ types of Action Research. ‘Professionalising’ Action Research is characterised by Hart and Bond as being practitioner focussed in that it addresses a problem identified by practitioners with an aim to improving practice. In contrast the ‘empowering’ type of Action Research is seen as enhancing user control with the definition of the research problem being identified through the experiential knowledge of less powerful groups. In retrospect we can see that our own project began in the ‘professionalising’ type and developed further into an ‘empowering’ one as we sought to empower the ‘grass-roots’ staff and service-users of the hospital.

Our previous experience with Action Research had been with time-limited projects and we saw this one as a short-term project involving the 3 authors in the development, delivery and evaluation of an education package that would conclude naturally after the evaluation of the first 3 deliveries of the module. However, as Iain’s (one of the authors) reflections illustrate, as we began to unravel the issues raised by the module evaluation we realised we had opened a Pandora’s Box:

*‘The whole project started to take on a life of its own and grow and grow into a monster that at times I felt suffocated by. I quickly realised that there was no beginning, middle and end to this issue, no band-aid for a quick fix, no single answer to the problem. What was staring us in the face was more questions and seemingly insurmountable issues that didn’t just cut through individual, professional or organisation boundaries but challenged the very culture and way of working within a caring organisation.’*

At this point, as planned, we could have brought the project to an end but we embarked upon another cycle of the Action Research because we all saw a real prospect of bringing about change and improvement in practice with regard to dignity and respect. We were also reminded of Kemmis’ (2001) assertion that Action Research needed to move beyond cosy reflections with fellow-travellers to tackling more uncomfortable and difficult issues in less familiar territory (Crow et al. 2006). The project thus began to incorporate more features of the ‘empowering’ type of Action Research as we shifted the power of decision making to the newly formed ‘Dignity and Respect Action Group’.

What we discuss in this article are the factors that we believe have helped us to sustain a longer term project than originally envisaged. The passion for the subject of dignity and respect in ourselves and in others is identified as one of the most crucial factors. In discussing some of the

other sustaining features we acknowledge how they were not always the consequence of planned strategies but rather arose from 'on the spot' decisions as we responded to events in the trajectory of the project.

### **Description of the project**

In 2003 in response to the results of a service user focus group, the hospital commissioned an education package to improve the dignity and respect shown to its service users. This was a collaborative venture between Iain Keenan, then Practice Development and Research Nurse at Southend Hospital and Anglia Ruskin University lecturers Jayne Crow and Lesley Smith and led to a jointly developed and delivered module entitled 'Fostering Dignity and Respect in Health Care Settings'. Open to all hospital staff regardless of profession or status, the module included awareness raising through reflective discussion and observational exercises in practice. Students were also encouraged to write a pledge to make an improvement in their area to enhance dignity and respect.

The development of this module was undertaken as an Action Research project and was evaluated carefully (Crow et al. 2006, 2007). The students on the first 3 deliveries of the module reported that the module had reignited their enthusiasm and passion for promoting dignity and respect for their service users and they had plenty of ideas for improving this aspect of care. However they stated that at the end of the module when each went back to their own work area they often felt isolated and powerless to carry their ideas forward. They identified a need for a space within the hospital where they could meet with like-minded 'champions' of dignity and respect. This space could also be used to nurture and sustain the enthusiasm and ideas that they said became 'swamped' by other demands on them when they returned to their clinical areas.

Thus in Sept 2004, in response to this need, the Dignity and Respect Action Group was formed as part of the ongoing Action Research project between Hospital and University staff to provide continuing education, inspiration, motivation and practical help to all those trying to promote dignity and respect in Southend Hospital. The Aims of the group were written at this point and have remained relatively unchanged. They are:

- To support champions of dignity and respect
- To present and discuss ideas, problems and issues of dignity and respect
- To find ways forward
- To share good practice

Originally formed by and for hospital staff members, albeit drawing on patient accounts and their own experiences as service users, the group, after some discussion decided we needed to work in collaboration with other service users. It was felt that this would further enrich and inform discussions in order to meet our aims. Thus the group is now open to anyone who wishes to attend who is a staff member, volunteer or service user of Southend Hospital. Many people come to meetings with issues they have identified as compromising dignity and respect. These may be practices/systems/environments they have witnessed or experienced either as staff or as service users. By sharing stories in this forum and collaborating to find solutions the group empowers individual champions to not only be heard, but take forward ideas to bring about change and improvements.

Membership of the group is fluid with some people attending most meetings and others dipping in and out as they see the need. The group aims to be non-judgemental and positive in a search for solutions. In this supportive environment we find that individuals volunteer to take on different responsibilities to move an initiative forward or to contact others who may be able to help or advise. In this way, at any one time, several dignity and respect projects throughout the hospital are moved forward by staff acting in their own area but supported by, and feeding back to, the group. On occasions members of the group have undertaken shadowing exercises or observation exercises in order to feed back to the group on particular issues.

There is managerial involvement in the group on an occasional basis including the Associate Director of Nursing and representatives from the Facilities department. Where we need particular expertise or authority to act we invite managers from other relevant departments to attend the group to help us find a way forward. A Non-Executive Director has also participated in the group almost since its inception.

The group has had no budget allocated to it and members have had to find funding from elsewhere in the hospital to implement innovations that required finance. We will return to this issue in the final discussion section as it has been a contentious one throughout the project.

The group has met regularly since 2004 (initially every month and then, from 2008, every 6 weeks). Attendance has ranged from 9-23 participants with a mean of 14 and during this time it has:

- Provided a forum for 'champions' of dignity and respect in the hospital and helped maintain their motivation and belief in the importance of the improvements they are trying to make
- Discussed and written the benchmarks for the 'Essence of Care' dignity and privacy benchmarks in the hospital
- Raised awareness of dignity and respect issues and projects within the hospital through in-house publications, holding open days and through its own group membership network
- Supported students on the Fostering Dignity and Respect module to fulfil their dignity 'pledges'
- Initiated and monitored many changes to improve dignity and respect in the hospital. We list some examples in Table 1.

<b>Table 1. Examples of Dignity and Respect-related innovations initiated and monitored by the Dignity and Respect Action Group</b>
Introduced 'roving' volunteer guides to look for and assist service users 'lost' in the hospital pioneered, piloted and included in the privacy benchmark document, the use of 'Privacy Pegs' for securing bed curtains together and to indicate to staff that they are entering someone else's personal space
Raised concern and initiated review about the unsuitability of porters being responsible for carrying out 'out of hours' viewings of deceased patients by relatives
Established greater patient choice in allowing patients to wear their own clothes for some local anaesthetic procedures in the Day Surgery Unit
Improved signage to 'difficult to find' areas of the hospital
Initiated 'volunteer visitors' for patients who have no visitors and would like to be visited
Initiated the provision of rain-proof covers for wheelchair users
Initiated the provision of fold-up chairs on walls in the long corridors for patients to rest on as required
Initiated the provision of screens in the Special Care Baby Unit to provide privacy for mothers visiting/feeding their newborn babies
Promoting the allowing of paper pants or own underwear (if necessary) for patients going to theatre in order to preserve their dignity
Promoted the provision of quiet-closing bins in patient areas to cut down on noise levels

Some improvements have been quickly achieved but others have taken months or, in the case of improving the hospital nightwear and gowns, years of perseverance.

### **Factors influencing the sustainability of the group:**

Having given the reader an outline of the group and its work we will now focus on identifying the factors that the group feels have contributed to its survival and effectiveness over a period of 5 years. In the tradition of Action Research we have identified these factors which are discussed below, by reflecting on data from a number of sources:

- Past documentation of the group proceedings.
- Our own reflective writing.
- Data from an evaluation of the Action Research project carried out by one of the authors (Keenan, 2006).
- Verbal and written reflections of various group members.

### ***A 'bottom-up' approach developed in a favourable political context.***

When the group first met in 2004 dignity and respect in health care was only beginning to emerge as an important issue on the government agenda. By 2006 its profile both locally and nationally was considerably higher particularly after the Department of Health's Dignity Campaign introduced in November 2006. However by this time we were well established as a group in the hospital via our grass-roots initiative. We believe it was this 'bottom-up' approach which enabled us to take advantage of the increasingly favourable political context because when the 'top-down' dignity and respect initiatives did gain prominence and authority within the hospital (DoH 2005, 2007) we were in a good position to use them to aid our cause rather than feel they were just another imposition from on high.

An example of this occurred when the group was charged in 2005 with leading on the hospital's Essence of Care (DOH 2003) Privacy and Dignity benchmarking exercise. We were able to use this 'top-down' initiative to further embed dignity and respect into practice. Thus what could have been a paper exercise became one of the group's successes providing us with an opportunity to clarify our own thinking about dignity and respect and enabling us to be confident that the finished document was grounded in hospital staff and service users' experiences.

Whilst the fact that 'dignity and respect' has become a topical issue, has so far helped to sustain the project, it also means that if, and when, it drops down the political agenda then the legitimacy of the group may well be questioned and we will again have to rely on other factors to sustain it.

### ***Optimising the role and contribution of individual group members***

As described earlier the original project team comprised of the authors collaborating on a small education Action Research project and as the project developed to include the Dignity and Respect Action Group we were aware of the danger of over-reliance on a few individuals. This was exemplified by the issue of who should chair the meetings. The group was initially chaired by the original project team and because the membership was so fluid there was a concern that it would remain too dependent on these individuals. To further embed the group and empower the staff, a 'revolving chair' system was adopted whereby a ward sister, a member of the Patient Advice and Liaison Service (PALS) and 2 health care assistants were elected to share the role of chair and vice-chair of the group. We seem to have succeeded in minimising the impact of 'Founder's Syndrome' because the group continues to thrive despite the fact that Lesley has retired and Iain has left the hospital. We still attend meetings though and foresee that the group may face new challenges when the current chairpersons step down as they can also be seen as founder members. Another period of uncertainty faces the group as others need to be found to replace them. If the key roles in the group are filled by individuals who are perceived to be part of, or acting on behalf of, the senior hierarchy of the hospital there is a danger that the group will be perceived as just another 'committee' with a 'top-down' agenda.

Elsley and Lathlean (2006) in their article on using Action Research to stimulate change health services, stress the value of making use of different types of knowledge in the Action Research group and this recognition and use of the range of knowledge and skills of the various participants in the group has indeed been an important factor in sustaining it. For example participatory facilitation skills have been important in the group to recognise and address the power dynamics and encourage more equal participation in a very mixed group within a traditionally hierarchical setting. We also have members with political, organisational, administrative and IT skills and just one example of such benefit is a member who is currently co-ordinating the development of a web-page for the group to publicise both its activities and examples of good dignity and respect practice within the hospital. It is envisaged that a blog or discussion area will enable areas of concerns about dignity and respect to be aired and discussed by a wider audience.

As important as these practical skills are, the attitudinal approach and mind-set of members were identified as being key to sustaining the group:

*'The team often goes over and above their roles because they are so passionate and enthusiastic about making changes for the benefits of patients. They are very tenacious about not only identifying issues but looking for solutions. This means a lot of work in their own time. Many staff attend the group in their own time'. (Group member).*

Such observations as these have led us to consider what characteristics members have in common that sustain them as group participants. Over the course of the project particular people, in what were considered key roles in the hospital, have been invited to join the group. Many have attended but only some have continued to contribute to the group beyond their initial meeting. Thus the group membership has been largely self-selecting but what it is exactly that brings people back has been a subject of debate:

*'It is something about being passionate about bringing forward changes in dignity and respect combined with being quietly rebellious'. (Group member).*

*'Why does the Dignity and Respect Action Group companionship restore the soul a bit? My pet theory is that the workers who drop into the meetings seem to be people, who at least during the session, take an awful lot of pleasure in consensus rather than winning an argument'. (Group member).*

Whatever the defining characteristics of those who continue to attend the group are, it is certainly the case that they attend on a voluntary basis. A danger however, of a higher profile within the hospital is that staff will be 'allocated' to attend the meeting or feel that their role requires them to attend. Whilst this could be seen as a positive move in widening participation, it may well dilute the commitment, passion and enthusiasm that have characterised the group meetings and which our reflections suggest have been pivotal to the sustainability of the project.

### **The culture of the group**

Although individuals have been very important, equally significant has been how these individuals have interacted with one another to create a particular ethos and culture within the group. We aimed to recreate the welcoming and empowering environment of the 'Fostering Dignity and Respect' module that had been so useful in eliciting ideas and enthusiasm in staff:

*'I found the experience [of the Dignity and Respect Group] to be positive and empowering. I was able to step outside my comfort zone and take an analytical view of the environment I work in as well as my relationships and interactions with patients, relatives and other members of staff'. (Group member).*

*'One of the reasons I think, now and again people dock into the Dignity and Respect Action Group meetings is, not just to talk about dignity and respect but to polish it up, practice it, air*

*their silly ideas and know that others will laugh with them rather than at them'. (Group member).*

Many group members contrasted the atmosphere within the group with that of some other hospital meetings that often took place in a more formal or even sometimes, adversarial settings. Members valued the trust engendered by the Group as they felt free to 'speak from the heart':

*'No 'sensible' topic is barred from discussion. The environment in which discussions take place is a risk-free one.....As a Non-executive Director, I get the opportunity to know what items are of interest to the staff and patients without any 'spin'. (Group member).*

The emphasis on 'taking action' on the issues raised in the group's discussions was identified throughout the reflective data as a significant part of the ethos of the group:

*'Most importantly they listened to the stories of patients and staff and took action on the issues they raised. The emphasis of the group is on action and finding solutions through a great deal of hard work and innovative thinking. This is the crucial difference between many of the groups I have attended as suggestions always get followed up and are not lost in an ether of hierarchy'. (Group member).*

Although the problems relating to the functioning of hospital committees and the hospital culture are highlighted in the reflective data, our own feeling is that this is not because all other committees are disrespectful but that the Dignity and Respect Action Group has deliberately set out to create a reflective space for the practising of dignity and respect in a way that can easily be lost in any large organisation.

Most hospital committees are convened as 'top-down' initiatives. They are usually chaired by managers and there is often a formality to the proceedings which may inhibit the participation of those who perceive themselves to be lower down the hospital staff hierarchy. The formation and running of the Dignity and Respect Action Group as a 'bottom-up' democratic and participative entity has empowered the original membership who were from many different sectors of the hospital. These people and many of those who have joined them, have attempted to maintain the space within the Dignity and Respect Action Group as one that is perceived as a 'safe' place to discuss ideas and concerns. Moreover it is a place where 'speaking up' in a meeting is not so intimidating and where participants are more confident of an encouraging reception within the group.

### **Membership, Fluidity and Diversity of the group**

The fluidity of membership of the group has posed challenges in maintaining the culture that is discussed above. This is discussed elsewhere in the Action Research literature (Reed 2005). New people joining the group who have not attended the 'Fostering Dignity and Respect' module do not necessarily understand or 'buy into' the culture we have established. The group has tried to convey the culture to members by their own behaviour but on some occasions, where there have been many new people in attendance, we have 'told the story and history of the group' in order to make the group's intentions explicit.

However unlike Elsey and Lathlean (2006) who found fluctuations in attendance of the group to be predominantly problematic we have generally seen the fluidity of the group as helpful in sustaining the project because of the constant flow of new ideas and enthusiasm injected by new participants. Of equal significance was the diversity of the group's membership and the fact that it had attracted members from many different sectors within the hospital: ward staff, out patient department, accident & emergency staff, operating theatre staff, portering staff, radiographers, facilities managers, PALS staff and volunteers to name but a few.

In July 2005 the Dignity and Respect Action Group was opened up for the first time to service users. This was a decision that was not made lightly. Members were already totally convinced of the need to hear service users' stories and to this end stories from PALS were a regular feature in meetings. In addition the staff were all hospital service users themselves as they lived locally and they regularly drew on their experiences as such to highlight both good and bad practice with regard to dignity and respect in the hospital. However concerns were voiced as to whether the addition of service users to the group would make staff less open and possibly even defensive. There were also concerns that the group which staff saw as a 'blame free haven' would become a forum for complaints and the empowerment that staff reported gaining from the meetings would be lost.

Thus when service users first attended the group, pains were taken to explain the origin, purpose and ethos of the group. Emphasis was placed on the importance of sharing stories but equally on collaborating to find solutions thus empowering the individual champions to not only listen and be heard, but take forward ideas to bring about change and improvement. The group has settled down with service users valued contributions as an integral part of it and the fears previously expressed proved unfounded.

*'There is a rather attractive inclusivity about the group rather than the prevalent cliquey exclusivity of much of hospital life'. (Group Member).*

### **Creating a balance between being inside and marginal to the organisation**

We established the Dignity and Respect Action Group on our own initiative and as such were 'outsiders'. We simply booked a room and held the first meeting. Thus from the outset of the group we were aware of the need to tread a fine line between being part of the hospital hierarchy and part challenger to it.

*'We began on the outside and the group began its work in isolation from the rest of the organisation and out of sight. Slowly, as issues were raised and solutions sought and found, the group gradually started to come to the attention of senior management'. (Group Member).*

This seeming invisibility was useful but Iain, particularly, was also careful to insist the meetings kept formal minutes that were circulated widely and to appropriate hospital committees (Crow et al 2006). We felt the group had considerable power to improve dignity and respect practice through the direct action of individual members but at the same time we recognized that we had to work within the hospital's organizational structure to maximize our effectiveness.

*'However the group must continue to proceed with caution and learn to walk the fine line between being challengers and being viewed as an asset to the organization otherwise the group will be viewed as an outsider and be marginalized and forced sit outside the organization it seeks to serve.....We need the organization more than it needs us. We can't survive without it, yet it can most certainly survive without us'. (Group Member).*

In the life of the group there have been moments where its existence has been threatened by the hospital hierarchy. For example at one point when the group was raising difficult issues its standing within the organisation was questioned by the then senior management. Classically the group reacted by standing even more strongly together. We were aware however that the danger of this reaction was to demonize elements within the hospital which if continued would have adversely affected our effectiveness and contradicted the dignity and respect ethos of the group. Thus the balance we have sought to tread has been a fine one, demanding on the part of the group members that we reflect on our actions particularly on those occasions where our initial impulse has been to be drawn into a 'them and us' discourse. Equally, as senior management have begun to see the benefits of the group we have been aware of the very real danger that



control of the group may be taken from the participants and that it may simply become part of the establishment taking on a more traditional format and operating primarily to implement 'top-down' initiatives. If this happens the group is almost certain to lose the ethos that has served us so well.

### ***The link between the University and the Hospital***

The link between the Dignity and Respect Action Group and the 'Fostering Dignity and Respect' module from which it sprang remains a key factor in the sustainability of the Group. The symbiosis works at two levels. The first is the collaboration between Hospital and University staff which has enhanced the module and enabled observational exercises in practice to be an integral part of the module delivery. The close working of University and Hospital staff in making these exercises meaningful to students has been evaluated by them as important in applying theory to practice (Crow et al 2006).

The second important benefit of the link between University and Hospital that has helped sustain the group is the way in which deliveries of the module provide a source of enthusiastic dignity and respect champions to the group to rejuvenate it and provide a constant source of fresh observations and ideas for improvement. As the module continues to attract staff in different departments those too are made aware of the Action Group and its work.

The funding of future module deliveries is an area of sustainability that is most uncertain and if we fail to provide new champions in the form of students from the module there will be a fundamental break in the education/practice link that will change the nature of the Action Group and we believe may jeopardise its future.

### ***The balance between action and reflection in the Action Research project***

We have been in a predominantly Action phase of the research for some time and as highlighted in Crow et al. (2006) we have perhaps suffered from the difficulty of maintaining reflective space in the meetings in the face of the frenzy of action.

*'The continual focus on problem solving has meant a number of actions have been carried out and this has led to less time for reflection than we may have wished. However it has focused hearts and minds on problem solving which has probably been an important contributory factor sustaining the project'. (Group Member).*

This is not to say that reflection has not taken place by individuals and undoubtedly such reflections have helped to sustain their involvement:

*'During the process of battling hard to secure funding for the module and ensuring its and the Action Group's continuation I have personally experienced disgruntlement and only through reflecting on this and recognising it have I managed to keep it together and resist the urge to say 'Stuff it. It's not worth it. I'm fighting a losing battle', a sentiment frequently expressed by the participants in both parts of the project (the University and the Hospital) in relation to their own workplace and initiatives they have put forward'. (Group Member).*

The catalyst for finding more time for reflection within the group and thus re-visiting a reflective phase of the Action Research has been the invitation to write this article and the fact that the Dignity and Respect Action Group has been nominated as a finalist for the NHS Health and Care Awards (2009). Both of these occurrences has required group members to reflect on and discuss the progress of the Group. It is significant that this catalyst has come from outside the group and in retrospect the impetus for further reflective input should have been self-initiated by the members of the Group. The recent process has been reinvigorating and rejuvenating for many of the Group and for us it has highlighted the need to ensure that we do not neglect the evaluative and reflective aspects of the Action Research process (Hart and Bond 1995).

### ***Creating success and building on it***

Underpinning all the other influences above was the key factor that we were successful in bringing about tangible improvement in dignity and respect in practice within the hospital.

We collected ideas brought to the group and monitored their implementation and dissemination by group members. As members reported back on individual successes such as raising awareness of dignity and respect in ward meetings or providing screens for bottle-feeding mothers as well as breast-feeding mothers in the Special Care Baby Unit, the group gained confidence that it could make a difference and we began to tackle larger more complex issues. Table 1 shows a selection of the initiatives that have arisen from the group and Crow et al (2006) outline the longstanding struggle to improve the nightwear in the hospital which involved the renegotiation of a very large and longstanding supply contract. Systematic monitoring and evaluation of so many initiatives has been problematic and with no dedicated funds or research staff we have had to rely primarily on audits and evaluations carried out by other hospital departments. This is not ideal and remains a challenge to the project.

Having to continually fight hard to do the right thing can lead to disgruntled staff and it is this perceived lack of control that is often the catalyst for the helplessness, low motivation, decline in morale and eventually burnout experienced by staff (Burke & Richardsen 1996). The Dignity and Respect Action Group has enabled members to see that their struggles to improve practice can be successful and that seemingly small changes can make a huge difference to service users' experience. Success breeds success.

*'It is refreshing to see tangible benefits for patients and that staff have an outlet to voice evidence of good practice which increases satisfaction for everyone'. (Group member).*

Equally the organisation needed to see successes in order to be convinced of the desirability of the project and the changes it generated (Kotter 1995). Making sure that successful initiatives such as 'privacy pegs' were submitted for quality improvement awards, constantly submitting articles in the hospital magazine, using e-mail shots, attending conferences both within the organisation and outside and circulating the minutes of the Dignity and Respect Action Group have all served to keep the issue of dignity and respect in the forefront of people's minds and on the organisation's agenda.

### **Discussion**

As we discussed in our introduction, this project was originally envisaged as a short-term piece of Action Research and sustainability was not initially a guiding principle. Various authors have identified stages of Action Research projects (Hart and Bond 1995, Birmingham and Porter 2007) and we have recognised some of these in the process of our project. However perhaps because the project has lasted so long it did not progress in a neat and tidy way through to an end point with our disengagement from the scene. It has gone through a whole series of engagements, on-going engagements and re-engagements (Hart and Bond 1995). We do however recognise and endorse from our own experience the steps in the process of change identified by Kotter (1995) particularly the importance of forming a powerful coalition of individuals who embrace an idea; in this case one of improving dignity and respect in care in the hospital. In retrospect we believe this to be the strongest element in sustaining this project in that it was a 'bottom-up' approach that benefited from the passion of its members for the subject.

We have noticed that the staff's conviction that individuals can make a real difference to dignity and respect by their own actions or by small changes is remarkably fragile in the face of day to day stress and organisational demands. As we have discussed, it is all too easy, particularly within large organisations to feel overwhelmed by bureaucracy and institutionalised practice (Hart and Bond 1995). Fortunately these 'crises of confidence' do not all occur at the same time in

every individual and the peer support that the group offers confirms the conviction that individual actions are worthwhile.

Throughout the project the degree to which the authors have controlled the direction of the project has varied. At the beginning we exercised strong directional control in what we saw as a primarily 'professionalising' Action Research project in which we were researching our own practice as educators. However after the formation of the Dignity and Respect Action Group we gradually stepped back to empower the group members and the project approach became more 'empowering'. This has not always been comfortable for us and there have been occasions where we have intervened more strongly when we have felt it would be beneficial to do so. For example in making the original purpose of the group very explicit to new members. However, equally there may have been times when we should have intervened and did not; For example we feel we should have lobbied for more reflective discussion in the group and perhaps a refreshment of the informal, story-telling inclusivity element that can become endangered as the group struggles with the logistics and practicalities of making changes happen.

Like any grass roots organisation the danger remains for us that if the group becomes institutionalised within the organisation its democratic and participative ethos and distinctive culture is likely to be subsumed within the hierarchy of the hospital. This is why we strongly believe that any Action Research project that seeks radical change must strive to maintain the balance between being inside and marginal to the organisation if it is to be self-sustaining.

We have asked ourselves whether the lack of a budget allocation for the group has been problematic in sustaining it and certainly looking for money to make changes has taken up considerable time. Some members have felt that the group has been disempowered by this lack of control over funds and this may be the case. Eley and Lathlean (2006) suggest that one solution to such problems is to target budget-holders as group members. However not having responsibility for a budget has allowed the group to be free to keep dignity and respect at the top of the agenda without having to prioritise the ideas for funding purposes. Our role has been to constantly respond to problematic dignity and respect situations and look for solutions regardless of whether they need funding from a variety of departments. This may, in retrospect have been a strength. However in saying this we are aware that our own project benefited from taking place in a favourable political context on both a local and national level which may have expedited the finding of funds for particular dignity and respect improvements.

Having identified and discussed the factors influencing the sustainability of our project we should make it clear that we are not offering a blueprint for future projects relating to dignity and respect or indeed on any other subject. Inevitably Action Research takes on a life of its own and as our example shows it is difficult to pre-empt the development of the project as it responds to particular circumstances. We do however, hope that our experiences and reflections will help and inspire others to engage in similar projects tailored to their own settings.

### **Key Points**

1. Ensuring a 'Bottom up' approach. The commitment and passion of the participants is a key factor and the democratic and participative running of the group by grass roots staff is important and empowering.
2. Creating a balance between the project being inside and marginal to the organisation. The autonomy of the group from the usual organisational hierarchy makes it more challenging but has also made it more effective and more useful to it.
3. Collaboration between University and Hospital staff maximises the effectiveness of both parties. Having an outsider's perspective available is useful in both directions and the range of skills available to the group is increased.

4. Individuals make a difference; Success in small things is worthwhile and can make a major impact on the experience of service-users. Success needs publicising in order to sustain enthusiasm and hope. The empowerment of individuals through peer support and successful group action is key.
5. The ethos of the group is important. The culture of the project must exemplify dignity and respect in the participants' behaviour and actions thus helping to create a supportive and reflective space in which to share ideas and learn.

## Conclusion

Whilst Action Research has often been associated with small, time-limited projects in health care practice settings (Winter & Munn-Giddings 2001) it is important that, where appropriate, Action Researchers grasp the opportunity to develop these into larger and more sustainable projects. This was particularly the case in our own project which related to dignity and respect in health care where we were addressing fundamental practice and cultural issues. We needed to galvanise staff and improve practice in a way that required engagement of hearts and minds across the organisation. The Action Research model with its underpinning values of democracy and participation lent itself to this situation where a 'bottom up' approach empowered individuals and offered them peer support to address issues that needed sustainability:

*'The group wholeheartedly feels that dignity and respect should not just be a flavour of the month strategy but always high on the agenda for the benefit of all.'* (Group member).

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