‘Practitioner Research...the way forward for social work research in Ireland...a case example’

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Presentation Overview

- Research – the fear factor!
- Practice Based Research - why is it important?
- Obstacles to Practice Based Research
- Care and Connect Project - a practice based action research project
- Practice Implications of findings
Research - what are we scared of?
Fear Factor cont.

- To the uninitiated, research can seem very daunting and overwhelming...
- Statistical
- Removed from the real world
- Exploitation of research subjects
- Not relevant for social workers!!
Key principles which link all forms of research

1. All require an application of a common core of research skills
2. All formulate a research question or hypothesis
3. All collect/utilize data and analyze it in a way that addresses the research question
4. All interpret the findings
5. All communicate the results either written or orally (Fuller and Petch, 1990)

*HOPE TO HAVE AN IMPROVED UNDERSTANDING OF THE PHENOMENA UNDER STUDY*
Social Workers as Researchers

- Key principles of being a Social Worker is to have a questioning mind.
- Question taken for granted assumptions
- Challenge organizational and bureaucratic constraints
- Valuable insight into the social structures that impact on our clients.
- Expert interviewers and recorders of data!!
What is Practice-Based Research?

- Practitioners use of research based principles, designs and information gathering techniques, within existing forms of practice, to answer questions that emerge from practice in ways that inform practice (Epstein, 2001)

  “research by practitioners for practitioners”

- Practice researchers are people who are part of the world they are researching in the way that an academic researcher cannot be.

- This factor means that their perspective is very different to that of a traditional researcher.
Examples of Practice Based Research

- Describing current practices
- Investigating how policies are implemented.
- Identifying how service user experiences inform practice development
- Working with professionals who want to improve current practices
- Documenting the experience of practitioners
- Researching the evidence base of practice
The Future lies with you!

- The Council on Social Work Education mandates that practice-based research be covered in the curriculum.
- However, Kazi and Wilson (1996) cite a survey of social workers showing 88% of practitioners failed to integrate any evaluation/research strategies routinely into their practice.
- There is a significant ‘disconnect’ between what is taught in social work education and what is considered good practice in clinical settings (Wade and Newman, 2007).
Obstacles to Practitioner Research

- Time and Resources (individual, departmental and organizational level)
- Need for moral support and guidance
- Few, if any rewards for research activities
- Historically, also, practice based research has been used punitively in many agencies to question productivity or question ‘poor’ performance outcomes.
'Many other disciplines and allied health professionals see evidence-based research as the norm, whereas for us it’s very much outside the box and it shouldn’t be'
Research, Education and Practice

`high quality research that is practice credible that has validity both in the research world and the practice world`

- The Challenge?
  - Gap between university based research and practitioner research (JUC SWEC 2006)

- The Need?
  - *Research by practitioners for practitioners* (Epstein, 2008)

- The Alternative?
  - Practitioner research paradigm (Fook, 2002)
Care and Connect Project

- AMNCH and TCD initiative
- Practice/Research partnership.
- Half post devoted to casework in the Age Related Healthcare Unit of Tallaght Hospital and half devoted to conducting research on behalf of Trinity.
- Research post also has a strong teaching focus which includes helping to promote and encourage practice-based research within the social work profession.
Different Agendas-Care and Connect

- Political
  - Care of elderly, empowerment of clients

- Organisational
  - positions and funding
  - Partnerships/ collaboration

- Professional
  - strengthening social work research base
  - standards of practice in family meetings
  - need for evidence-based practice
  - interdisciplinary links

- Personal
  - motivation to be involved in research
  - commitment to social gerontology
  - Motivation to empower older vulnerable people
Background to Care and Connect Project

- To promote best practices in person-centered care planning for older people through a process of investigation, trial and consultation
- To promote partnership in decision making between older people, families and health care professionals and to gain a deeper understanding of this process
- Entail a process of action research focused on the systematic use of family meetings
- To develop a strong practice/research partnership for hospital based social work
‘Family Meetings’

- Used more frequently to determine care plans for older people, without:
  - any particular protocol for these meetings
  - consistency about the participation of the patient
    - Carter-Anand et al., 2009

- Are patients intentions / wishes maximised?
- How to balance role/input of family caregivers and wishes of patient?
Care Planning Meeting?

- ‘involves a number of family members, the patient and the hospital personnel in discussions concerning the patient’s illness, treatment and plans for their discharge or their care outside the hospital’
  - Hansen, P 1998

- Increasingly common decision-making forum in the hospital setting but there is limited research into the process and experience of such meetings. Although this forum is intended to encourage active participation and empowerment of older people and their families in decision making, doubts exist as to whether they effectively carry out this role
  - Efraimsson E, 2004
Health Care Practitioners

- Have divergent understandings of what constitutes a ‘family meeting’ and differing terms for this process
  - family meetings
  - family conferences
  - discharge planning conferences
  - care planning meeting

- HCP’s have a significant role to play in facilitating and enabling active participation of patients in these meetings, but need for education and training
  - Hedberg,B 2008

Griffith et al. 2004
Hansen et al. 1998
Efraimsson et al. 2003
Popejoy. 2005, Hedberg et al. 2008
Reports of patients having lower levels of influence over decisions in comparison with family members and health professionals raises the possibility that patients may be left out of the decision making process. (1)

Huby et al (1997) found that participation was a concept with little useful meaning and it didn’t feature in patients descriptions of their expectations and experiences of interactions with staff. (2)


Chosen to describe, evaluate and offer a mechanism for the development of service delivery as it is inherently practical, change orientated, cyclical and participatory in nature

le May & Lathlean, 2001

AR is ‘Any systematic enquiry, large/small, conducted by professionals and focusing on some aspects of their practice in order to find out more about it and eventually to act in ways that they see as better or more effective’ (Oberg and Mc Cutcheon, 1987, P.117)
ACTION RESEARCH CYCLE

Observation

Implement Change

Reflection/Analysis
7 distinguishing characteristics of Action Research (Hart and Bond, 1995)

- **It is educative;** this study strived to gain insights into the family meetings experience and through this process an education and training programme was developed for healthcare professionals.

- **It deals with individuals as members of social groups;** patients, family members and the MDT were examined as members of a social group as well as participants in family meetings.

- **It is problem-focused, context-specific and future-orientated;** family meetings were examined within the context of a hospital setting with the future aim of improvements to practice and increased participation levels of patients.

- **It involves a change intervention;** changes will be implemented based on the findings of each cycle.
It aims at improvement and involvement; an increased understanding of the role of the MDT within family meetings was gained through the fieldwork- the MDT then acted as co-researchers to agree on suggested improvements to practice.

It involves a cyclic process in which research, action and evaluation are interlinked; this study encompassed 3 cycles each consisting of a period of research, action and evaluation which then informed the next cycle.

It is founded on a research relationship in which those involved are participants in the change process; the MDT directly contributed to the change process through their role as co-researchers however patients and family members also contributed through consideration of their subjective experiences gained through interviews and also their recommendations/suggestions for improvement to current practices.
# Methodology: Phase I and Phase II

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<th><strong>OBJECTIVE</strong></th>
<th><strong>METHOD</strong></th>
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<td>Describe in rich detail the current processes that occur within Care Planning Meetings.</td>
<td>Participant Observation</td>
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<tr>
<td>Gain insight into the subjective experiences of older people and their family members during family meetings.</td>
<td>Questionnaires</td>
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<td>Examine staff members experiences of Care Planning Meetings and suggestions for improvements.</td>
<td>Staff Focus Groups (Phase I only)</td>
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Participant Profiles

- 10 Family Meetings
- In-patients over-65
- 7 men, 3 women
- 5 Stroke Service
- 5 General Medicine

- 8 assessed as cognitively impaired
- 5 out of 8 assessed as ‘without capacity’ and did not attend
- Family Member 2-7 attendees
- Staff 3-6 attendees
Observations

- Informal processes
  - body language, eye contact, seating arrangements, punctuality
- Jargon
- Processes/Interactions
- Information shared/given
- Decisions made
- Other
Participant Observations

- Consistently good eye contact between MDT and family members
- Eye contact often poor with patients, particularly with cognitive impairment
- Circular seating arrangements – inclusive.
- Demarcation - families on one side, staff on the other.
- Punctuality of MDT an issue in one third of observations
- Generally open body language
- Jargon seldom used, explanation if used
Findings - Information or Decision-Making?

- 1 meeting = decision making (medical intervention)
- 9 meetings= information sharing and discharge planning
- Meeting times 30 mins-2hrs.
- Social worker facilitated 8 meetings. Consultant facilitated 2.
- No appointed minute takers; each professional made own notes
- Meetings followed a general structure
  - opening phase with introductions
  - medical update and reports from MDT
  - negotiation phase including questions from patient and family members
  - decision making and closure.
- Half of all meetings no final decisions made.
Findings-Questionnaires

- Each meeting was first for participant and family
- 1 family were unclear about purpose of meeting
- All attending patients believed they had been included in decision-making process.
- 2 families believed final decisions had already been made by Medical Team and MDT prior to meeting
- 8 families reported they had been actively involved in the decision making process.
- All patients and family members felt they had been given adequate opportunities to ask questions and express their opinions.
Focus Groups-Emerging Themes

1. Descriptions of meetings
2. Pre-meeting preparation
3. Seating, meeting time and punctuality
4. Facilitation and minute-taking
5. Participation of patient and family
6. Decision-making process
Challenges

- Participation levels of Pt’s varied: those with higher levels of cognitive impairment (CI) had lower levels of participation.
- Family members - higher levels of participation than Pt’s
- Consistently good eye contact maintained between MDT and family
- Poor eye contact with Pt’s
- Pt’s with CI were often ‘talked over’ with usage of 3rd person by MDT and family members
- All attending Pt’s believed they had been included in the decision-making process
- All Pt’s and family members believed they had been given adequate opportunities to ask questions and express opinions
- Family members often surprised that older person with a CI included in the meeting
- Two family members believed final decisions had already been made by Medical Team and MDT prior to the meeting
- Only in one meeting were staff observed to be overtly checking Pt’s understanding and paraphrasing what had been discussed
Patients and families considered meetings to be a positive experience.

Some fundamental differences in opinion emerging between health care professionals about purpose and outcomes of family meetings.

? ‘tokenism’ of patient participation?

Need for more research into investigating how language and behaviours of HCP’s potentially impede patient participation through informal processes and poor communication.
Phase I: Changes Implemented

- MDT Critical Reference Group established.
- Patient Information Leaflet developed
- Name changed to ‘Care Planning Meetings’
- Further examine Care Planning meetings held with inpatients with cognitive impairment.
Phase 2-Action Research Cycle

- Inpatients of Stroke Service requiring Care Planning meeting
- All ages
- Cognitive impairment/communication difficulties.
- MMSE and Western Aphasia Battery
- 10 meetings
- In-depth semi-structured interviews with stroke patient.
- Semi-structured interview with nominated family member/support person
- Patient Profiles
- Feedback and Evaluation of Patient Information Leaflet
As this study examined the language used in meetings, a discourse analysis was also conducted. Language is the most ‘accessible phenomenon, accessible for empirical investigation’ (Alvesson and Karreman, 2000) and discourse analysis can be broadly defined as the interaction between the written and spoken word, talk and texts as part of social practices (Potter, 1996) which people use to construct meaning (Foucault, 1972).

Numerous readings take place where details of the text are seen as essential. Variability in content and forms of account and consistency in features that are shared by the accounts are used to search for meaningful patterns.

Final Analysis is an interpretation of how communication functions and affects the people involved in meetings and finally, a search in the data for evidence supporting the interpretation is carried out. The study of discourse therefore enables people to reflect on and modify their practices (Morgan and Sturdy, 2000).
Findings (II)

- Discourse Analysis (all data audio-recorded and transcribed)
- Inequalities found in participation levels - MDT dominated the discourse in all CPM’s observed-asymmetry in participation
- Pts with low level of verbal participation appeared to have high levels of non-verbal participation
- Barriers to communication; dominance of MDT and family members, usage of 3rd person, poor eye contact and praxis inconsistencies from MDT relating to addressing patients directly. All Pt’s reported a desire for involvement and participation, even those who exhibited little or no verbal participation during their CPM
- All Pt’s believed they were given adequate opportunity to participate, ask questions and voice opinions
- No association found between levels of CI and Pt participation within CPM’s.
MDT Involvement Phase II

- MDT form a Critical Reference Group where findings will be fed back and MDT will participate in analyses of data.
- MDT will become ‘co-researchers’ and work together to explore ways of further improving practice within Care Planning Meetings.
Discussion

- Main paradox; Pt’s exhibited low levels of verbal utterances but participation indicated by eye contact and body language. All felt they had been given adequate opportunity to participate, ask questions and voice opinions.
- Why are Pt’s not appearing to desire more active participation?
- Are they frail older patients who no longer want to actively participate (Ekdahl et al, 2010) or is it a strategic choice by Pt’s to empower themselves by allowing family members to assume a dominant role? (Huby et al. 2004)
- Our findings support literature which suggest that for older patients, participation means having the opportunity to ask questions and obtain information (Fisher et al, 2006)
- Participation should be defined by whatever level the patient is most comfortable with (Guadagnoli and Ward, 1998)
- To foster a climate encouraging optimal Pt participation, a framework promoting an individualised approach is also recommended.
Phase III

- Development and implementation of Education and Training Programme for MDT
  - Teodorczuk 2009, Kurtz, SM., 2009
What we can learn!

- What does the concept of participation mean for each individual patient?
- Is there a relationship between the participation levels of family members and patients?
- How does the role of healthcare professionals relate to the participation levels of patients?
- What are the barriers to participation for patients who have cognitive/communication difficulties?
- What can be learnt from the experience of trying to change the practice of healthcare professionals using an action research cycle?
- Will changes to practice result in a more positive and satisfying meetings experience for patients, family members and healthcare professionals?
What we can achieve!

- Improve our understanding of Care Planning Meetings as small group processes in a hospital setting.
- Develop best practice guidelines for Care Planning Meetings through staff training and development.
- Identify new ways of communicating with patients in meetings - implications for language and methods of communication in hospital settings.
- Improve and increase patient participation levels in Care Planning Meetings.
- Develop a framework for participation that can be applied to other clinical groups.
Research Challenges

- Small sample size (participant observations)
- Low attendance of patients at CPM’s in Phase I and data not audio-recorded
- MDT as Co-researchers
- PAR – but not truly participatory
- Preconceived ideas resulting from being a practitioner in study site
Practice Implications:

‘Everyone hears only what he understands’
Goethe

- Pre-Meeting preparation: elicit desire to participate/attend, ask individual to write down what they want to discuss/share/questions
- Turn to face Pt when addressing them and do so in 1st person
- Slow pace of speech, short pieces of information, simple language, good eye contact
- Body language
- Ask direct questions, check understanding
- Two way dialogue
Practice Implications cont.

- Look for sign of distress/ uncomfortableness
- Monitor EC for signs of engagement/distraction
- Look for indicators in body language that individual wants to talk, relaxed, frustrated
- Acknowledge sensitive issues and discuss directly with individual
- If possible, don’t read from notes/write during meeting
Closing Thought

‘...the skill and effort that we put into our clinical communication does make an indelible impression on our patients, their families and their friends. If we do it badly, they may never forgive us; if we do it well they may never forget us’.

Buckman BMJ 2002
Thanks to...

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