An action research study with health care professionals aiming to improve preparation for childhood hospitalisation.

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CERTIFICATE OF AUTHORSHIP/ORIGINALITY

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Student

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Abstract

Preparation for hospitalisation is a right of all children and its practice requires improvement. Preparation benefits children and their families because it provides information and appropriate support known to be crucial for positive outcomes. Optimal preparation practice is both difficult to define and challenging to provide. This thesis reports on an action research study undertaken when the concerns of a group of health care professionals at one major children's hospital presented me with an opportunity to work with these staff to improve preparation for childhood hospitalisation. Applying critical social theory as a model of change helped the action group to understand how to negotiate the bureaucratic structures that can inhibit but also enable change in a hospital setting. The processes of engaging as a group with a shared goal of improving preparation practice highlighted some important challenges and opportunities in relation to the realities of collaborative action within health care settings. A survey of children and their parent/guardian regarding preparation for childhood hospitalisation and an audit of hospital staff's preparation practices helped to identify children's and families' preparation practice experiences and preparation practices occurring at the hospital. As a way of mobilising collective action for desired change the action group facilitated the reinstatement of an approved preparation for childhood hospitalisation booklet.

The most important findings of this study fall into three broad areas: the need for inclusive models of collaboration in complex and dynamic health care settings, the need for transformational approaches to leadership that consistently and explicitly support the engagement of staff in collaborative processes of ongoing practice improvement; and the need for transformational approaches to facilitation, which enable person-centred ways of working together and shared professional power and responsibility. To enable sustainable, evidence-based change the workplace must explicitly support staff's continued engagement in critical reflection on their practice and provide staff with opportunities for taking collaborative action on issues of concern. Collaborative, evolving workplace cultures need to be sustained by inspired

leadership at all levels of the organisation. Training and support are critical factors for attaining the inspired leadership required to transform the health care setting into an effective, efficient and supportive workplace.

Keywords: preparation for childhood hospitalisation, critical social theory, action research, inclusive models of collaboration, transformational leadership, transformational facilitation.

Chapter One – Introduction to this thesis

Childhood hospitalisation is a significant event and experience in the life of children and their families that has an unpredictable impact and may have enduring consequences. The United Nations convention on the rights of the child (United Nations General Assembly, 1989) identifies the importance of informing children about what will happen to them as a right of all children in all circumstances and preparation for childhood hospitalisation is an important form of information provision to children. An enormous amount of research and clinical effort has gone into understanding the impact of childhood hospitalisation and the best ways to prepare children and their families for it. Although the impact of hospitalisation is reasonably well understood, clinicians are challenged to provide the best preparation for children and their families in their care because the outcomes of these endeavours are far from straightforward. Despite the complexity of the outcomes there is clear evidence that children and their families, clinicians, and organisations benefit when preparation 'goes right'. It is not surprising that preparation practices vary according to the knowledge and experience of the individual clinician and the contextual realities surrounding the admission and health care treatment of the children.

Given the absence of clear guidelines for preparing children and their families for hospitalisation, clinicians need to collaborate to share their knowledge and experience and their desire to improve preparation practices. Such collaborations are hard to achieve and maintain because of the multiple perspectives and contextual factors, including the different needs of different age-groups, different parental needs, available time, variations across specialty areas, variations across reasons for and types of hospitalisations. The aim of the research reported in this thesis was to explore the need for changes to local practices for preparing children for the experience of hospitalisation and to generate knowledge about existing practice in order to mobilise collective action for change. This thesis provides insight into the challenges and learning of one

group of health care professionals who sought to achieve positive improvements in preparation practices at their hospital.

1.1 Introduction to this chapter of the thesis

The influential research of Vernon and colleagues (Vernon, Foley, Sipowicz, & Schulman, 1965; Vernon & Schulman, 1964; Vernon, Schulman, & Foley, 1966) in the United States of America (USA) and Haslum (1988) in the United Kingdom (UK) emphasised the enduring nature of the impact of hospitalisation on children. Although at that time and place it was different to hospitalisation today, it is still pertinent to consider that this significant event and experience may have a positive and/or negative impact on children, and their families, initially and for many years to come. The impact can be distress and anxiety that can differ according to a number of factors such as the individual characteristics of children and their families, the length of time that the children are hospitalised, the health care staff, the type of hospital involved and the reason for and type of hospitalisation (Vessey, 2003).

There is evidence that appropriate preparation has benefits for all involved: children and their families, health care professionals charged with caring for children and their families, and hospital organisations. However, there is no evidence that any approach to appropriate preparation produces better outcomes than any other (Bar-Mor, 1997; Cohen & MacLaren, 2007; Courtney, 2001; Franck & Spencer, 2005; Heaton, 1997; Jaaniste, Hayes, & von Baeyer, 2007; LeRoy et al., 2003; Li & Lopez, 2008; Melamed, 1998; R. H. Thompson, 1986; Vernon et al., 1966; 2003). The differences in the approaches have contributed to inconsistencies in recommendations concerning the form of preparation that is most likely to be effective. That is, there are questions to do with what, when, how and for whom preparation should be designed (Melnyk, 2000). There are also inconsistencies in the extent to which preparation is provided and the form that it takes, within and across pædiatric hospitals and general hospitals which admit pædiatric patients (Association for the Welfare of Child Health, 2005).

The benefits of preparation for children and their families have been researched in a number of disciplines for more than sixty years (Bowlby, 1952; Brewer, Gleditsch, Syblik, Tietjens, & Vacik, 2006; Forsyth, 1934; Franck & Spencer, 2005; Justus et al., 2006; MacMaster & Rosenberg, 2008). Researchers have shown that preparation is beneficial for children and their families because it enhances their coping (LaMontagne, 2000), and their resilience (Bolig & Weddle, 1988) and reduces their distress and anxiety (Caldas, Pais-Ribiero, & Carneiro, 2004; Lau, 2002). Broadly, preparation has been shown to enhance children and their families' understanding of the events and experiences of hospitalisation, and to facilitate their ability to make sense of them (Huddleston, 2005).

Health care professionals benefit from preparation of children and their families for hospitalisation, both ethically and practically. The ethical dimension is demonstrated through health care professionals valuing of access to quality health care for all people, as outlined in the various professions' codes of ethics (for example Australian Nursing and Midwifery Council, 2008). Health care professionals, as advocates for patients, have an ethical imperative to ensure that patients have access to the best evidence-based care, and that includes access to preparation for hospitalisation that research has shown to be beneficial (Penticuff, 1990). The practical benefit for health care professionals is that caring for well-prepared children and their families is not as time consuming or as difficult as caring for unprepared patients (Cohen & MacLaren, 2007). Prepared patients are more likely to understand events and experiences, are more able to make sense of them, and therefore tend to be less distressed by hospitalisation (Higson & Finlay, 2010; Uzark, LeRoy, Callow, Cameron, & Rosenthal, 1994).

Hospital organisations also benefit from the preparation of children and their families for hospitalisation (Association for the Welfare of Child Health, 2005). Shorter length of stay, less demand for analgesia, and fewer health care staff required for difficult patients, benefit hospitals because of cost containment

(Cohen & MacLaren, 2007; Garretson, 2004; Kain et al., 2007). Preparation that increases patient and family satisfaction with the hospitalisation experience also benefit hospitals and their management (Association for the Wellbeing of Children in Healthcare, 2009). Patient satisfaction is an important indicator that is used by hospital management to ensure appropriate service delivery and to benchmark the organisation's performance.

Despite the fact that there is a good deal of literature to support preparation of children and their families for hospitalisation, there is an acknowledged gap between the knowledge that has been generated over the years and the use of existing evidence in day-to-day practice (Association for the Welfare of Child Health, 2005). While many preparation approaches exist, there are enormous differences across hospitals in their application in practice (Wynn, 1997). The result is that often preparation becomes the responsibility of individual clinicians who have very little guidance for preparation practice.

Involving health care professionals through collaboration, to explore, generate knowledge and potentially improve the practice of preparation for childhood hospitalisation may lead to recommendations at the local level. The purpose of this thesis is to report on the findings of a group of health care professionals interested in improving preparation practice through collaboration to change its practice.

1.2 The field of study

This study acknowledges the developing environment of children's health care in which the potential advantages and disadvantages of various models of health care provision create a tension for children, their families and health care professionals. Models include the medical model, the professionally centred model and the family centred care model (Shields, Pratt, Davis, & Hunter, 2007). Although the family centred care model is the product of the developmental changes in children's health care since about 1950 (Carter, Shields, & Hunter, 2008), and is currently the favoured model of health care

provision for children, its effectiveness has not been measured systematically (Shields et al., 2012). Consideration is being given to alternate ways to provide for children's emotional and developmental needs and overall family well-being that include further research to ensure that the whatever model is used is implemented correctly. The current study was situated in this developing environment and focussed on the preparation of children and their families for the experience of hospitalisation through the collaborative efforts of a group of health care professionals.

Children and their families need access to preparation that is best able to meet their needs to optimise their hospitalisation experience and its consequences. Securing the proven benefit of preparation by improving its provision is an important matter for health care researchers and professionals. Since Bowlby's (1952) report to the World Health Organization in 1952, evidence from the literature has been accumulating about the effects of hospitalisation on children and their families and how it influences their experience (Coyne, 2006).

Revelation of evidence about the effects of hospitalisation has resulted in some very significant changes in the management of childhood hospitalisation as a response to improved knowledge (Ben-Amitay et al., 2006). A notable example is the minimisation, as much as possible, of the separation of children from their families and their familiar environment. In the 1950's family visits to hospitalised children were restricted to one hour, once per week (Shade-Zeldow, 1977). Gradually restrictions to visits were only limited to the Intensive Care Unit or the anaesthetic (pre-surgery) or recovery (post-anaesthetic) room (Giganti, 1998). Today, there is encouragement and support of continual family presence during hospitalisation. This move represents a significant change in practice. Currently there is an expectation that families accompany their children during hospitalisation as well as encouragement of parental presence during procedures for which there is practical support (Association for the Welfare of Child Health, 2005). Also the physical appearance of children's hospitals and children's units in general hospitals has become less clinical, making them child-friendly and less different to the familiar environment of

children and their families. These changes in the management of childhood hospitalisation have resulted from the knowledge about separation of children from their families generated by research.

Some of the research on childhood hospitalisation is concerned with discovering what it is about it that causes challenges for children and their families (Bates & Broome, 1986; Bonn, 1994; Foley, 2000; Lambert, 1984; Sheldon, 1997; Shields, 2001; R. H. Thompson, 1986; Vernon & Schulman, 1964). Knowledge of the challenges has led to development of various approaches to preparation and the literature describes in detail which approaches are possible for meeting preparation for hospitalisation needs and producing better outcomes (Ferguson, 1979; MacMaster & Rosenberg, 2008; Melamed, 1982; M. C. Roberts, Wurtele, Boone, Ginther, & Elkins, 1981; Vernon & Thompson, 1993; Visintainer & Wolfer, 1975).

The existing evidence about approaches to preparation is varied and this is partly due to the complexity of responses to childhood hospitalisation. There are many variables that influence the effectiveness of preparation, some of which relate to the individuals who need to be prepared and others that relate to the environment for which they are being prepared (Vessey, 2003). Outcomes of preparation can be quite different according to differences in the needs of children and families and the preparation approaches employed. Ideally, well prepared children and their families benefit by experiencing less distress and anxiety during and after their hospitalisation; however for some, poor short and long term outcomes result from inappropriate preparation (Li & Lopez, 2008). The differences in the needs of children and their families, the preparation approaches and the outcomes for the preparation participants and the health care professionals who care for them results in enormous variability in the practice of preparation for childhood hospitalisation.

The needs of children and their families for preparation are different in terms of many factors. Children who are to be hospitalised for a brief time for a straight-forward surgical procedure have quite different needs to children who are to be

hospitalised for many months of medical therapy to treat a long term or chronic health problem (Association for the Welfare of Child Health, 2005; Battrick & Glasper, 2004; MacLaren & Kain, 2008). They and their families need preparation to enable them to manage the event and the experience of hospitalisation optimally and that acknowledges the variables that influence their response to hospitalisation.

Health care professionals may choose particular preparation approaches according to their clinical judgment of the circumstances of the children and the hospitalisation. The list of approaches used ranges from actual or virtual hospital tours, to role play using video models or actual models, to information provision using face-to-face or web-based sessions, to books, pamphlets and/or videos (Mitchell, Johnston, & Keppell, 2004). Similar preparation approaches used in different locations or with different samples of children and families have produced different outcomes (Vessey, 2003). It seems that not only the content of preparation but also the when and how of its delivery impacts on its outcome. Effective preparation practice continues to be a challenge because of the variability that is the reality of the real-world of clinical practice.

Apart from the approaches used, other factors may conspire against practice change. Broader organisational responses such as policy changes or increases in funding may be more useful in changing hospital preparation practices than strategies focused at a hospital and/or unit level. Practice change also requires a change in organisational culture as recommended in the practice development movement (Manley & McCormack, 2003), in action research (Dick, 2005) and in team-led approaches to change (Greenhalgh et al., 2005). The underlying assumption in each of these approaches is that practice needs to change through addressing barriers to change within the organisational culture (Cohen & MacLaren, 2007). Identifying and addressing barriers is a fundamental challenge to changing practice and collaboration with people within an organisation may be a way to achieve change in practice.

Researchers and clinicians have tackled changing clinical practice to improve it with mixed results (Baker et al., 2010; Ely, 2001; Lindeman et al., 2003; Shaw et al., 2005). They have used various change theories to shed light on difficulties in changing clinical practice to get direction about how to change practice and how to sustain changes. Change theories suggest that one approach to practice change is to work collaboratively with practitioners at a local level. Given that positive improvements were sought by a group of clinicians it seemed reasonable to take advantage of the opportunity to work with them in order to uncover and address the gap between the knowledge about preparation practice and the availability of preparation at their hospital. Therefore, this study uses a collaborative research approach in order to improve preparation for childhood hospitalisation practice at one major children's hospital.

1.3 Situating myself in this field of study

I am a nurse, a clinician, an academic, a researcher and a parent with an interest in preparation of children and their families for hospitalisation and I want to make a difference for these people. The difference that I hope to achieve is an improvement to their experience of hospitalisation through improved preparation.

The present study, informed by critical social theory, used action research methodology to address the issue of concern. I have therefore provided a detailed account of my background and perspectives so that readers are aware of my experiences and philosophical stance. In doing this I believe that I am being true to the critical social theoretical framework that enabled me to use an action research methodology to study preparation for childhood hospitalisation.

My interest in the issue has grown as I have developed in response to the life decisions that have shaped me as a person. I chose nursing because it offered an opportunity to make a difference and I began my studies in nursing, qualifying first as a general nurse, then as a pædiatric nurse and then as a

midwife. Following these accomplishments, I worked for a number of years as a clinical nurse with children and their families. I also worked in nurse education, as a facilitator supporting and enabling nursing students' learning in the clinical setting. I continued my interest in nurse education by becoming a lecturer in nursing, with a particular interest in teaching and promoting pædiatric nursing to undergraduate nursing students.

In conjunction with my focus on pædiatric nursing, I am a parent who holds the place of family in the highest regard, especially the role of family in nurturing the maturation of happy and healthy adults. Some developmental theorists have consistently shown that family is one of the most influential determinants of the development of children (Bandura, 1986; Erikson, 1950; Piaget, 1952). Others contend that other social influences such as peers, schooling and the media are equally, if not more important (Santrock, 2006). I believe that all life experiences contribute to making us who we are, and that as a pædiatric nurse, educator and researcher, I can affect the development of children who are hospitalised in a positive way by improving their experience of hospitalisation. Consequently, my preparation for the present study has been my interest in preparation for childhood hospitalisation and my experiences as a pædiatric nurse, a nurse educator, a researcher, and a parent.

I have seen the effects of hospitalisation on children in my role as a pædiatric nurse and it seems to me that these effects can be positive and negative. I believe that positive effects should be maximised and negative effects should be minimised. These effects will occur inevitably as part of the hospitalisation process (Ben-Amitay et al., 2006) and I believe that health care professionals need to incorporate an awareness of these effects into their practice. By acknowledging and managing the effects of hospitalisation, it is possible to optimise the outcomes for children, families and health care professionals. Observations of the positive effects of hospitalisation have been made by a number of researchers and include achievements of children such as an increased sense of mastery of difficult situations and an increased sense of autonomy (Caldas et al., 2004; Gordon et al., 2002; Vernon & Schulman, 1964).

Research into the negative or harmful effects of hospitalisation is much more extensive and includes anxiety, poor educational outcomes and anti-social behaviour (Board & Ryan-Wenger, 2002; Caldas et al., 2004; Haslum, 1988; MacLaren & Kain, 2008; Wright, 1995). The negative effects on children concern me most of all, and it is here that I think that I can make a difference by contributing to improving preparation for childhood hospitalisation. I have worked alongside clinicians who are caring for children experiencing the unexpected, painful and often frightening events and experiences of hospitalisation and I have seen that these clinicians share my concern about these negative effects. I have also seen the positive outcomes that preparation can have on the hospital experience for children, their families and the clinicians working with the children. Paradoxically, preparation does not always seem to help and this has raised many questions. Seeing these things has captured my interest, intellectually and emotionally. I support preparation because I consider that it enables management of positive and negative effects of childhood hospitalisation and optimises the outcomes of the experience.

Given my interest in improving preparation for childhood hospitalisation and the associated paradoxes, I conducted an initial exploratory study to learn more about preparation. It evaluated a pre-hospitalisation tour for children and their families booked for surgery. The peri-operative unit of a private general hospital, where I worked as a pædiatric nurse, offered the tour. Data collection for the study took three months and included data collected from two groups of participants. One group was fifty children and their parents who had attended the tour and then underwent planned pædiatric surgical procedures. The other group was the nurses providing health care to them while they were in hospital. Three tools, developed specifically for this project, were used to collect data. One was a brief observation of children on their return to the pædiatric unit following surgery, completed by the attending nurse. The other tools were two questionnaires completed just prior to discharge, one by the parent and one by the attending nurse, see Gordon (1991). Analysis of the data revealed that in general the tour seemed to be effective in preparing children through

information provision and role modelling. Nurses rated children and parents who had attended the tour to be more co-operative and easier to care for than those who had not attended. Parents, who had participated in the tour with their children, expressed higher levels of satisfaction with the whole experience. However, some children were still very distressed despite having attended the tour.

This apparent paradox lead to a review and synthesis of the literature about preparation of children and families for hospitalisation, see Gordon (1993). The literature review showed that preparation for childhood hospitalisation is complex and it is difficult to predict what might help adequately prepare children and their families for hospitalisation. Identification and classification of influential factors resulted in two categories: individual differences and shared features (Gordon, 1993). The individual differences were age, developmental stage, temperament, previous experience, coping and locus of control. Individual differences between children are incredibly important in determining their responses to hospitalisation; they affect the impact of hospitalisation in the short and long term. They may also influence children's and their families' preparation needs.

Influential factors in the shared features category were separation, pain, parental response and nursing care (Gordon, 1993) on, the things that were common to the experience for most children were also very important in influencing the response to hospitalisation and the need for and effectiveness of preparation. They were also influential in determining the most appropriate type of preparation. Understanding that children are both similar and different has affected the way that I nurse children and the way that I teach nursing students about nursing children. I emphasise the differences among individual children but also the similarities in their responses particularly to hospitalisation.

I continued to pursue my interest in preparation for childhood hospitalisation as a research nurse collecting data for a randomised controlled trial (RCT) that tested a debriefing intervention for unexpectedly hospitalised children.

Unexpected hospitalisation is particularly distressing for children (Basso, 2010; Goymour, Stephenson, Goodenough, & Boulton, 2000; Moorey, 2010). The complexity of preparation for childhood hospitalisation became even more evident to me because the findings of the RCT were not as predicted. I delivered an intervention at the end of the children's hospitalisation that provided preparation after the fact through three strategies: individualised delivery of information, an opportunity to develop a sense of mastery, and an opportunity to debrief about the hospitalisation.

The study participants were 106 girls and boys aged between 7 and 12 years of age unexpectedly admitted via the Emergency Department to one of four metropolitan hospitals. Two hospitals were children's hospitals and two were general hospitals with pædiatric units. Random assignment of the children using a random number table, to either the intervention group or to the routine health care group, occurred after both children and their parent/s had given consent to participate in the study. Standardised measures were used to evaluate the intervention by collecting data related to all of the children's ratings of their pain, distress, worry, anxiety, coping, medical fears, personal control and uncertainty. I collected data once the attending doctor had given approval for hospital discharge. Another researcher collected the same data from all children in the study four weeks after discharge in the family home. Comparison of the analyses of the results for the debriefing intervention group and the control group revealed no difference.

When providing the intervention my perception was that each of the children responded positively, and yet the benefit was not apparent in the outcome measures employed to assess effectiveness. It is possible that the sample size was insufficient to show a statistical improvement in the children's experiences, and/or that childhood hospitalisation is a complex phenomenon requiring more sophisticated assessment processes, such as in-depth discussions with the children and their parents.

Given these unpredicted findings, I decided to enrol in doctoral studies in which the debriefing intervention would be investigated further. I planned to try to develop the intervention to be more appropriate to the needs of unexpectedly admitted children and their families. The RCT methodology would be used to test the revised intervention. I hoped that the revised intervention and additional measures would show a significant improvement for children and their families who had been hospitalised by preparing them for their experiences after the fact.

In undertaking doctoral studies, the original intention was to use the positivist research paradigm to conduct an RCT, which is an evidence generating approach with a statistical rationale for justifying a particular intervention. I have used a number of research methods and have discovered that the effect of childhood hospitalisation and the preparation for it are more complex than is captured by statistical analysis. It had become apparent to me that although my proposed research might add to the body of literature, and indeed evidence, it would not necessarily lead to a change for the better in preparation for childhood hospitalisation. Given the inadequacy of my previous findings and the persuasive nature of the evidence about making changes that improve practice (McCormack, Manley, & Garbett, 2004) I used a different research paradigm.

Improving practice was and still is congruent with a desire to make a difference and to improve that part of the world over which I might possibly have some influence. I developed this desire through a school education that exposed me from a young age to social justice issues and the possibility of doing something to improve them. Post-school education, particularly in pædiatric nursing convinced me that a person's early years could be very influential in forming the person that they become. I believe that all experiences have the potential to influence development (Piaget, 1952; Santrock, 2006) and outcomes will vary according to contributing factors and the relative effect of each factor for that individual, throughout life (Vessey, 2003). However, optimum circumstances can and should be in place to enhance experiences and maximise the beneficial

effects of those experiences. My involvement in the study described in this thesis was my attempt to optimise the experience of childhood hospitalisation.

An opportunity arose at a major children's hospital to work with health care professionals who had voiced concern about preparation for hospitalisation at their hospital. They had identified "a dichotomy between the real and the ideal" (Crotty, 1998, p. 158) of preparation for childhood hospitalisation at their hospital. Although, I was not an employee of the hospital at that time, and therefore an outsider (Titchen & Binnie, 1993), I was interested in working with this group of health care professionals to investigate the issue of preparation for childhood hospitalisation. The motivation to participate in the project was that the action research methodology enabled me to collaborate with the hospital staff to bring about change in hospital preparation practices. By taking the opportunity, I was able to approach the issue of changing preparation practice from within the organisation therefore identifying and addressing barriers that may have existed to enable improvement. The methodology of the present study had changed to collaboration with health care professionals who were involved in preparing children and families for hospitalisation. The health care professionals and I collaborated to try to understand the existing preparation for hospitalisation practice and then to try to improve that practice by making changes to it.

Action research uses collaboration among affected people to address issues of concern (Reason & Bradbury, 2008). The philosophical position of action research is to work with others concerned about similar issues through a collective, democratic and empowering process, and where possible, to assist them to address the issues (Reason & Bradbury, 2006). The methodology is critical because it explores the issues of concern in order to discover what causes the concern, so that it can be addressed (Kemmis, 2006). Action research occurs in social settings and is a practice-based research methodology that is outcome focused (Hart & Bond, 1995). The preparation issues faced by hospitalised children and their families as well as health care professionals caring for them might be uncovered by using the action research

methodology. I believed that action research would allow us to discover, collectively, the most beneficial hospital preparation approaches and their delivery in different contexts within the hospital. It was important to me to approach the issue in such a way that enhanced the possibility that practice improvement would follow. A critical rather than positivist theoretical framework seemed right for the present study. Therefore, the decision to employ action research underpinned by critical social theory to address preparation for childhood hospitalisation was a change in my philosophical orientation to the study.

1.4 Situating the action group in this field of study

It was not surprising to me to find a group of health care professionals, referred to from this point as the action group, who wished to ensure that children and families were optimally prepared for their hospital related experiences. The complexity of preparation and the uncertainty clinicians work with as they care for children and their families inspired their desire to prepare them optimally. The action group felt that sometimes less than optimum preparation was causing distress and anxiety for children and their families and therefore for themselves.

The present study was a collaborative research effort with the action group, firstly to collectively understand the issues that children and their families faced in preparing for hospitalisation and to secondly act to improve the hospitalisation experience for them through optimum preparation practice. The action group were concerned that that there was inequity of service to consumers of health care at the hospital in relation to the provision of preparation for hospitalisation. Although both the hospital management and the health care professionals practicing at the hospital recognised preparation for hospitalisation was important there were no established processes in place to ensure that preparation for every hospitalisation was available to all children and their families. Individual health care professionals found that preparation often became their responsibility, because they became aware, during their

delivery of health care, that there had not been any preparation prior to the hospitalisation, either received or sought, and they believed that there should have been.

The action group observed that children and their families who had not been prepared were much more difficult to care for than those who had been prepared because they were distressed and anxious. The action group was quite sure that there was a noticeable relationship between preparation and a better outcome in terms of well-being during and after hospitalisation. Sometimes preparation for hospitalisation was either not available or not accessed by some children and families treated at the hospital. For instance, the opportunity to participate in a preparation programme was possible prior to admission for booked surgery but sometimes children and their families did not access it. However, there was no formalised preparation available for children booked for invasive radiological investigations. Some families contacted the Play Therapy Department and received individualised preparation, while others were unaware of the service provided and therefore did not make a decision to access it.

The action group chose to limit their exploration to this major children's hospital so that they could focus on their immediate circumstances. However, one of the challenges for the action group was the decision concerning which of the multiple groups of children admitted to the hospital would be the focus of the research. The groups included booked surgical and/or medical admissions, outpatient attendees, non-inpatient attendees, emergency department attendees and emergency admissions, either to the emergency department or to one of the various specialty units of the hospital. Alternatively, the primary variable in the research chosen by the action group could be groups of children according to age and/or developmental stage. Age influences preparation needs just as much as membership of a particular treatment group as noted in section 1.2. Each of these groups has unique needs for preparation for hospitalisation, as demonstrated in research (Board & Ryan-Wenger, 2002; Garretson, 2004; Mansson & Dykes, 2004; Mitchell et al., 2004; Small, 2002;

Vessey, 2003). The action group had expressed their concerns about local preparation practice and there had been some informal sharing of concerns but no formalised efforts to address them. The present study is about the formalised collaboration that the action group engaged in to research preparation for childhood hospitalisation practice change.

1.5 Overview of this thesis

This thesis describes a study undertaken using action research to improve preparation for childhood hospitalisation practice at a major children's hospital. Chapters Two and Three analyse two bodies of literature. The first is the literature about preparation for childhood hospitalisation and the second is about practice change in health care settings. The literature reviews highlight what might be useful in the practice change literature when considering changes to the practice of preparation for childhood hospitalisation.

Chapter Two provides an analysis of the literature related to childhood hospitalisation and preparation practice for it. The review shows that there is a lot of literature available that indicates the topic has been of interest since the middle of the 20th century and continues to be until the present day. The literature focuses on the impact of hospitalisation on children and their families, and on the range of strategies researched to ameliorate the negative impact of childhood hospitalisation. Health care professionals caring for hospitalised children have sought guidance from the literature to identify strategies to implement to minimise the negative impact of childhood hospitalisation for children and their families and for the health care professionals who care for them. However, because of the range of variables involved in the response to childhood hospitalisation, studies in the literature only address one or some but not all of the variables. Gaps in the literature leave health care professionals with challenges of application of the knowledge identified in the literature to their day-to-day practice of caring for hospitalised children and their families.

The literature reviewed in Chapter Three relates to change and shows how hard change is to achieve, particularly in organisations. Exploration of organisational change processes leads to the identification of the most commonly adopted practice change processes in organisations and in health care. One of the change processes that has been useful in health care is known as diffusion of innovations. There is evidence in the literature that the action research methodology has operationalised the diffusion of innovations in health care. However, there is also evidence that efforts to improve health care practice encounter enablers and barriers to practice change and the literature cites strategies designed to enhance enablers and address barriers to enable change to occur. The proposal in the practice change literature of group work as a means of overcoming barriers to practice improvement led to the adoption of collaborative group work using the action research methodology to improve the practice of preparation for childhood hospitalisation.

Chapter Four provides a description of the methodology selected. It discusses the research methodologies that are potentially useful in facilitating practice change in preparation for childhood hospitalisation. The research paradigms that might lead to practice change are discussed, which leads to the explanation of the use of critical social theory as the theoretical framework for the study. An outline of the research methodologies that employ action strategies follows, as suggested by the critical social theory framework. The process of selecting the action research methodology and how it offered a way forward to achieve the study aims is explored. The theoretical basis of action research in critical social theory is also provided: describing its focus, evolution and the arguments of the main advocates for its use to enable change. To support the applicability of action research to the present study, relevant examples of its use and the circumstances of successful action research studies are presented. Finally, my particular interpretation of action research and its use in shaping the study and interpreting the outcomes is clarified.

Having established the congruence of action research to the study aims, Chapter Five provides details of the action research study procedures. There is

a description of the study design, the study setting and participants, and how they became involved in the study. The chapter introduces the way in which action cycles are fundamental to the present study, and how the framework of planning, action, observation and reflection assist in understanding the study's complexity. In this chapter there is also explanation of the data collection and analysis procedures and how these were employed to evaluate the study outcomes.

Chapter Six describes the first action cycle in the study, called *mobilisation of engagement of the hospital community in the study* that lasted for one year. The chapter makes explicit the processes followed in establishing the study within its context, and in setting up the study to enable the action group to act to improve the practice of preparation for childhood hospitalisation. The processes used in the present study involved four phases of action research: planning, acting, observing and reflecting. As is the case with action research, the fourth phase of reflection on the first cycle led to the start of the next cycle (Reason & Bradbury, 2001).

Cycle two, called *the steps towards practice change*, describes the actions that the newly formed action group undertook together to explore preparation for childhood hospitalisation at this hospital, and is the subject of Chapter Seven. The second cycle of action research lasted for two years, and comprised monthly meetings during which review and analysis of plans and actions took place. Cycle two started with an investigation of what was currently happening at the hospital and the action group used this information to develop plans, instigate actions, observe these activities and then to reflect on all of this to inform the next cycle. An important aspect of the action group's investigation of what was currently happening at the hospital with regard to preparation for childhood hospitalisation was the action group's realisation that preparation for planned and unplanned hospitalisation was quite different. In the first instance the action group chose to focus on children and their families who have a planned admission to hospital, and to use learning from this focus to enable possible improvements to unplanned hospitalisation.

The third cycle, called *mobilisation of collective action for change*, is described in Chapter Eight and lasted for almost a year. The chapter outlines how the action group analysed findings and ensured the continuation of the implementation of one practice change to planned hospitalisation. Finalisation of the work of the action group is described in the chapter and includes the acceptance by the group that the group had not yet addressed the possible changes that could be made to preparation for unplanned childhood hospitalisation. Chapter Eight also analyses the effectiveness of the use of action research to change practice.

Chapter Nine is an analysis of how the study unfolded and of the study outcomes. The chapter concludes all aspects of the thesis summarising the study background, key issues identified in the literature, the study methodology and its philosophical foundations, and the study processes and outcomes. It reflects on the action research methodology in relation to the literature, and there is a discussion of the usefulness of the action research methodology in facilitating change to the practice of preparation for childhood hospitalisation. The discussion uses reflection as a tool to cast into sharp relief the important learning that has taken place throughout the study, both at the level of the action group and more widely for action research and for health care practice change. Chapter Nine then provides my recommendations for future work and my concluding remarks about the study.

This thesis describes and analyses an action research study that was undertaken by a group of health care professionals and myself because of our enduring commitment to improvement of the practice of preparation for childhood hospitalisation. The following chapters outline why and how we collaborated, what our collaboration involved and the outcomes of our collaborative endeavours at one major children's hospital.

Chapter Two – Literature Review – Preparation of children and their families for hospitalisation

The chapter exists for three reasons. The first is as a product of many years of my work in seeking research evidence and deeper understanding of the topic at hand; hence, the chapter captures the understandings and learning that I have gained over that period. The second is to provide the readers of this thesis, some of whom may be relatively new to the area, with insight into the complexity and challenges presented to clinicians and researchers seeking to find ways forward in preparing children for hospital admissions and invasive procedures. The third is to show readers the information that was available to the action group members of the study reported within this thesis.

2.1 Introduction to this chapter and key concepts reviewed

There are two major areas of concern that influence the conduct of the present study. The first area of concern is what is known and can be relied upon to guide preparation for childhood hospitalisation. The other area is what can be done to ensure that health care professionals incorporate such evidence into their practice. In this chapter and the next, there is a review of the literature about these two key areas of concern of the present study. This chapter, therefore, focuses on literature about preparation for childhood hospitalisation; the next chapter focuses on literature on health care practice change in order to highlight the challenges of bringing about change in this area.

The two reviews differ because of the characteristics of the two bodies of literature. The preparation for childhood hospitalisation literature is extensive but reported studies have limited rigour in terms of validity and reliability and therefore provide little clear evidence regarding ‘best practice’. Whereas the health care practice change literature, although extensive, is general in nature and so needs to be applied to the area of preparation for childhood hospitalisation; no studies could be found in the literature that have focused specifically on changing preparation for childhood hospitalisation practices.

Both of these bodies of literature informed the conduct of the present study into changes to the practice of preparation for childhood hospitalisation.

Specific guidelines or even recommendations for preparation for childhood hospitalisation practice derived from systematic reviews that bring together the research evidence are hard to find. These might provide a clear evidence base for practice choices by those working with children and their families who are facing hospitalisation. For example, clinicians may wish to provide optimum preparation for an invasive procedure for a six-year-old girl. However, no synthesis of the evidence regarding the timing of preparation, the most effective approach, the best person to provide the preparation, and the specific information required for six-year-old girls is available (2007). Busy health care professionals need access to the evidence if they are to deliver best practice to the children in their care. Additionally, the adoption of evidence-based recommendations relies upon more than simply their existence; their adoption relies on a context that encourages practice change through thoughtful implementation of evidence.

A literature review of preparation for childhood hospitalisation is the first place to go in search of guidance in its practice; or, in the absence of clear guidance, to seek a better understanding of the issues surrounding preparation. The literature developed in response to an awareness that hospitalisation was an event that had unpredictable and often negative outcomes for children and their families (Platt, 1959). Interest in childhood hospitalisation started in the middle of the twentieth century and slowly accelerated up until the 1990's when many theorists and researchers were involved in seeking to develop simple recipes to prepare children for hospitalisation, using a wide range of approaches. Since the mid 1990's researchers have addressed specific kinds of hospitalisation using preparation approaches that are individualised to the needs of specific children. Research continues into preparation for childhood hospitalisation; however, the topic does not attract as much research interest today as twenty years ago. The reason for the decline in research interest in this issue may be

the challenge of generating meaningful research evidence to support practice change.

The preparation for childhood hospitalisation literature is of varying quality with very few examples of studies reporting high levels of evidence. One of the criteria for this search was the identification of the best evidence for practice improvement change. Guidelines for intervention studies published by the National Institute for Health and Clinical Excellence (2006) hereafter referred to as the NICE guidelines, are the framework used in this thesis to determine levels of evidence. Due to the lack of studies that demonstrate high levels of evidence, this literature review is a comprehensive review rather than a systematic review of studies that demonstrate high levels of evidence. Presentation of the literature in this way emphasises the complexity of the issue and the difficulty that health care professionals have in drawing conclusions about their practice of preparation for childhood hospitalisation.

The complexity of preparation of children for hospitalisation derives from the various elements that affect children's responses to hospitalisation. Vessey (2003) developed a model of the many elements that she argues contribute to children's psychological responses to hospitalisation. The model clusters the variables that she identified around three developmental science domains classified as influential factors: maturational and cognitive factors, ecological factors, and biological factors (Figure 2-1).

Although the Vessey model captures the complexity of preparation for childhood hospitalisation, it was not used for this literature review because it was important to organise the literature in a way that was accessible to the action group. The organisation of the literature review had to make sense to them and be in line with what they required to explore preparation for childhood hospitalisation and the associated practices.

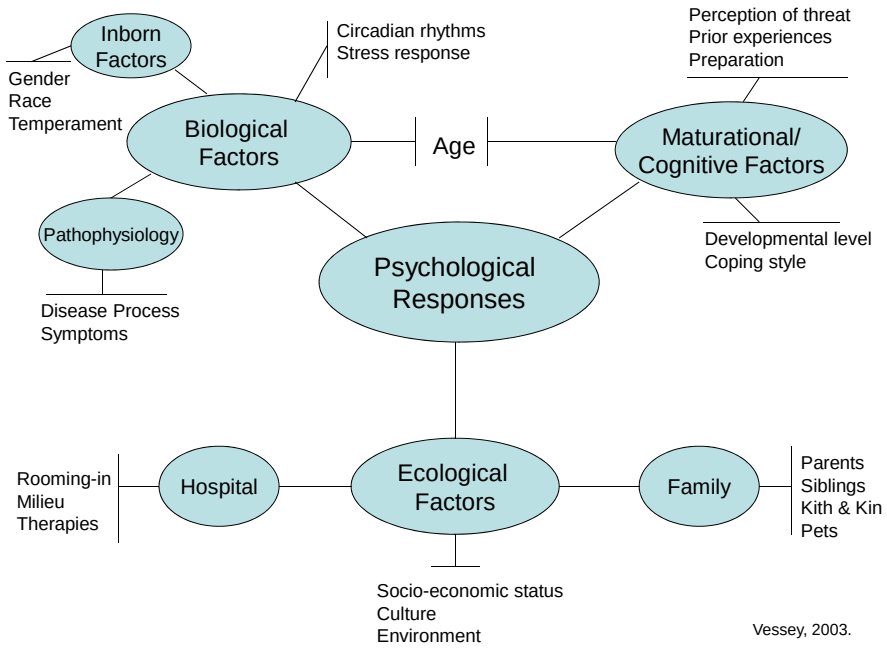

Figure 2-1 Variables that contribute to children's psychological responses depicted according to three developmental science domains (Vessey, 2003, p. 179)

The interaction of the elements seems to complicate both the effects of hospitalisation and the development of strategies that have tried to mitigate these effects. Preparation strategies aim to allow for growth promoting effects rather than provoking anxiety and distress that lead to poor post hospitalisation outcomes, such as those identified by Haslum (1988) and others (Bonn, 1994; Foley, 2000; Strachan, 1993; Wright, 1995). However, the Vessey (2003) model shows just how complex the issue is and why developing and sustaining effective preparation strategies seems so challenging.

There is evidence that implementation of appropriate preparation for all children, every time they are hospitalised, does not occur (Association for the Welfare of Child Health, 2005). The resultant inconsistency is of concern to some health care professionals, including myself, because some children and their families are receiving less than optimal preparation and therefore their hospitalisation experience may be less than optimal. The review gathers

evidence that the issue is complex, and consequently, clinicians need to come to terms with the detail of that complexity and then find a way to work with that in their day-to-day health care practice.

2.2 Literature search strategy

The search strategy followed recommendations in relation to the implementation of evidence-based pædiatric nursing practice (Hockenberry, Wilson & Barrera, 2006). These recommendations assume that evidence-based practice (EBP) will become part of the delivery of health care and that all health care professionals must became adept at accessing and utilising EBP in order to improve the quality of health care provision. This approach to reviewing the available literature is congruent with the objectives of the study.

The criteria for the literature search were:

1. To identify evidence of effective preparation approaches to childhood hospitalisation
2. To use the NICE guidelines to determine levels of evidence

Figure 2-2 shows the selection process suggested by Jeon, Merlyn and Chenoweth (2010) that used a five-step approach that was adapted to examine the research publications assembled over more than twenty years.

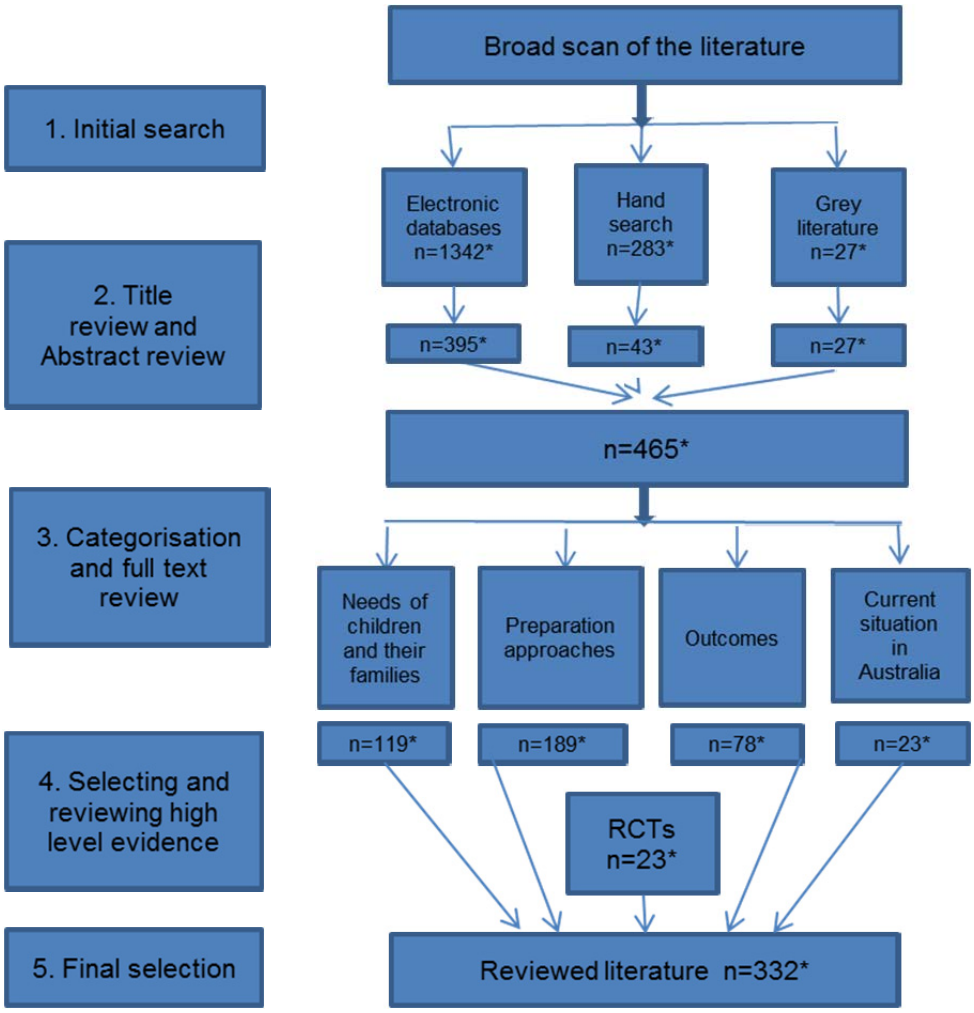

Figure 2-2 Selection process (adapted from Jeon et al., 2010, p. 56) * indicates approximate numbers are due to time iterative nature of the review over a prolonged period

The selection process followed these steps:

Step One - The initial search: The available literature on preparation for childhood hospitalisation was broad and used electronic databases to retrieve publications. The literature included all publications published in English from 1950 to 2011 that related to children, hospitalisation and preparation. Selection of keywords took place over a twenty year period in which a range of words were searched with some searches being retained and other searches being rejected as their relevance to preparation for childhood hospitalisation became more or less apparent. The keywords used in the search were: *children or*

paediatric, hospitalisation, preparation, surgery, pre-operative information, control, coping, resilience, temperament, illness concepts, intervention and *strategies*. All relevant combinations and spellings of these keywords refined the search. Please see table 2-1 for detail of how the relevance of some keywords was related to the topic of preparation for childhood hospitalisation. The Cumulative Index of Nursing and Allied Health Literature (CINAHL) database search used the EBSCO search engine. Repetition of the search in the Medline and PsycINFO databases used the OVID search engine with slight differences according to the electronic database requirements (see Table 2-1).

Following the search of electronic databases, a hand search was conducted that consisted of two strategies. The first was inspection of the content lists of specialist journals that consistently published articles related to preparation for childhood hospitalisation. The journals were: *Paediatric Nursing, Pediatrics, Journal of Pediatric Nursing, Children's Health Care, Child Health Care, Neonatal, Paediatric and Child Health Nursing and the Journal of Pediatric Psychology*. The second strategy was scanning of the reference lists of all citations, in particular those renowned as influential studies, to find any literature relevant to the study.

A review of publications retrieved from database searches directed searching to provide relevant grey literature. Both electronic database and hand searching identified a small number of publications that constituted the grey literature, such as government and consumer reports from websites that included information about the preparation of children and their families for hospitalisation. The Association for the Wellbeing of Children in Healthcare (AWCH) and the NSW Department of Health websites were two Australian bodies that had websites that were part of the grey literature that were relevant to the study.

Qualitative and quantitative studies, theoretical articles, and government and non-government reports allowed for different types of evidence in the review. Non-research publications provided a background for the research studies of

the review period. Examination of all publications for their relevance to the present study, for the depth of information, and for the robustness of the research findings in terms of their validity and reliability, took place. Publications excluded were those that focused only on disease/illness management, clinical pathways, and patient care management or were not in the English language. The search strategy resulted in journal articles (peer reviewed and non-peer reviewed), books, theses, systematic reviews, government reports, consumer group reports and conference proceedings.

	Keywords	Results
Search 1 – CINAHL (EBSCO)		
1	Child or children or paediatric or pediatric or pædiatric	284,134
2	Hospitalisation or hospitalization or hospitalised or hospitalized	29,944
3	Preparation or preparation programme or preparation program or procedural preparation or pre-operative preparation or patient orientation	16,564
4	1 and 2 and 3	158
5	Narrowed by subject age 0-18 years	136
6	Surgery or ambulatory surgery	136,075
7	Preoperative information or pre-operative information or preoperative education or pre-operative education or preoperative preparation or pre-operative preparation	1,431
8	1 and 6 and 7 (limited to English language, peer-reviewed, subject age 0-18 years)	42
9	Control or coping or resilience or temperament (limited to English language, peer-reviewed, subject age 0-18 years)	46,646
10	1 and 2 and 3 and 9	27
11	Illness concepts	43
12	1 and 11	10
13	Intervention or strategy	194,550
14	1 and 2 and 3 and 13	37
Search 2 Medline (OVID)		
1	Child or children or paediatric or pediatric or pædiatric	1,728,385
2	Hospitalisation or hospitalization or hospitalised or hospitalized	161,654
3	Preparation or preparation programme or preparation program or procedural preparation or pre-operative preparation or patient orientation	396,627
4	1 and 2 and 3	540
5	Narrowed by subject age 0-18 years	494
6	Surgery or ambulatory surgery	703,023
7	Preoperative information or pre-operative information or preoperative education or pre-operative education or preoperative preparation or pre-operative preparation	2,304
8	1 and 6 and 7	146
9	8 (limited to English language and subject age 0-18 years)	101
10	Control or coping or resilience or temperament	2,599,032
11	10 limited to English language, peer-reviewed, subject age 0-18 years	332,095
12	1 and 2 and 3 and 10 and 11	128
13	Illness concepts	70
14	1 and 13	26
15	Intervention or strategy	609,338
16	1 and 2 and 3 and 15	86

17	16 limit to English language	75
Search 3 PsycINFO (OVID)		
1	Child or children or paediatric or pediatric or pædiatric	495,536
2	Hospitalisation or hospitalization or hospitalised or hospitalized	40,474
3	Preparation or preparation programme or preparation program or procedural preparation or pre-operative preparation or patient orientation	24,871
4	1 and 2 and 3	128
5	Narrowed by subject age 0-18 years	128
6	Surgery or ambulatory surgery	17,836
7	Preoperative information or pre-operative information or preoperative education or pre-operative education or preoperative preparation or pre-operative preparation	85
8	1 and 6 and 7	16
9	8 (limited to English language and subject age 0-18 years)	16
10	Control or coping or resilience or temperament	469,419
11	10 limited to English language, peer-reviewed, subject age 0-18 years	441,322
12	1 and 2 and 3 and 10 and 11	52
13	Illness concepts	84
14	1 and 13	32
15	Intervention or strategy	230,510
16	1 and 2 and 3 and 15	42
17	16 limit to English language	38

Table 2-1 Electronic database keyword search strategy

Step Two – Title review and abstract review: The titles of the large number of publications retrieved were then examined to ensure that only relevant publications to the study were reviewed. Review of the abstracts of the remaining publications helped to identify papers that reported studies that provided high quality evidence. There are wide varieties of research methods that relate to the elements involved in preparation for childhood hospitalisation. The review sought to identify publications that provided evidence of successful approaches to preparation practice and other publications that did not meet these criteria were excluded.

Step Three – Categorisation and full text review: In this step there was pooling of selected publications from the three sources; electronic databases, hand searches and grey literature. The large amount of relevant literature was categorised according to four themes to enable easier analysis of differences in the preparation for childhood hospitalisation literature. The first three areas of complexity regarding preparation were immediately obvious and these were: differences in the needs of children and their families for preparation for

childhood hospitalisation, differences in preparation approaches, and differences in the outcomes of preparation for participants and health care professionals. Having categorised the publications according to these three areas of complexity, a fourth theme that related to the current situation in Australian children's hospitals was identified and the fourth theme was added to the original three areas of complexity. Differentiation of the fourth theme was important because the objectives of the present study related to *local* practices for preparing children for the experience of hospitalisation. As this major children's hospital was located in Australia knowledge of local circumstances was vital. Once categorised according to the four areas of complexity, publications were read in full to consider selecting them for inclusion in the literature review.

Step Four – Selecting and reviewing high level evidence: One of the criteria for the search was to identify evidence of effective preparation approaches for childhood hospitalisation. After the initial broad search identifying any literature relating to preparation for childhood hospitalisation, the search focused on systematically identifying and critically appraising published systematic reviews and randomised controlled trials of studies in the field of inquiry. The Cochrane Library and PubMed were searched via OVID access. The Cochrane Library includes the Cochrane Library of Systematic Reviews, the Database of Abstracts and Reviews and the Cochrane Central Register of Controlled Trials. The first three keyword searches from the CINAHL database search were used in combination with each of the following terms, using all spellings of the terms to refine the search: *meta-analysis, systematic review and randomised controlled trial*. Steps 1, 2 and 3 of the search strategy were applied to these publications and a dearth of well-designed and conducted studies was revealed. Table 2-2 shows the Cochrane reviews search strategy.

Search 4 Cochrane EBM reviews (OVID)		
1	Child or children or paediatric or pediatric or pædiatric	3,477
2	Hospitalisation or hospitalization or hospitalised or hospitalized	1,644
3	Preparation or preparation programme or preparation program or procedural preparation or pre-operative preparation or patient orientation	1,888
4	1 and 2 and 3	287
5	Narrowed by subject age 0-18 years	287
6	Surgery or ambulatory surgery	2,342
7	Preoperative information or pre-operative information or preoperative education or pre-operative education or preoperative preparation or pre-operative preparation	22
8	1 and 6 and 7	6
9	8 (limited to English language and subject age 0-18 years)	6
10	Control or coping or resilience or temperament	6858
11	10 limited to English language, peer-reviewed, subject age 0-18 years	6858
12	1 and 2 and 3 and 10 and 11	286
13	Illness concepts	0
14	1 and 13	0
15	Intervention or strategy	6,866
16	1 and 2 and 3 and 15	287
17	16 limit to English language	287

Table 2-2 Cochrane reviews electronic database keyword search strategy

The selected studies were then reviewed for their level of evidence. Application of the NICE guidelines identified studies that provided high quality evidence for intervention studies (see the first three levels in Table 2-3). There were no relevant meta-analyses or systematic reviews or protocols based on reviews, which are level 1++ of the NICE guidelines (2006). The difficulty that clinicians have faced in seeking evidence of effective preparation for childhood hospitalisation approaches is emphasised because guidance from systematic reviews of high quality evidence is not available.

The search identified 52 reports of rigorous, controlled studies that provide evidence of preparation practices that have worked for childhood hospitalisation conducted between 1975 and 2010. Each report was allocated to either level 1+ or 1- level according to the NICE guidelines (2006). Each study focused on only some of the variables involved in preparation for childhood hospitalisation rather than on all of them. While not ideal, being both reductionist and simplistic, research into one or more variables is the only way to isolate the effects of different variables.

Levels of evidence	Types of evidence
1++	High-quality meta-analyses, systematic reviews, RCTs with very low risk of bias
1+	Well-documented meta-analyses, systematic reviews of RCTs, RCTs with a low risk of bias
1-	Meta-analyses, systematic reviews of RCTs with a high risk of bias
2++	High quality systematic reviews, or conduct of, case-control or cohort studies with a very low risk of confounding bias, or chance and a high probability that the relationship is causal
2+	Well-conducted case-control cohort studies with a low risk of confounding bias, or chance and a moderate probability that the relationship is causal
2-	Case-control or cohort studies with a high risk of confounding bias, or chance and a significant risk that the relationship is not causal
3	Non-analytic studies, e.g. case studies, case series
4	Expert opinion, formal consensus

Table 2-3 NICE Levels of evidence for intervention studies

Step Five – Selecting and reviewing research papers and other literature sources and assessing methodological quality: Even the most earnest attempts at scientific rigour usually fail to consider one or more variables that would make the findings of the study transferable and this includes the 52 randomised controlled trials identified in this search. Variables such as children's age, developmental stage, gender, reason for hospitalisation, type of hospital, pain experienced, timing of preparation and so on all have the potential to influence the effectiveness of preparation approaches. Therefore, the literature review takes a less critical approach to the diversity of studies available and includes case-control and cohort studies, non-analytic studies, expert opinion and formal consensus. Despite not meeting the criteria of the NICE guidelines for high levels of evidence, these publications illuminate the area of study by providing background knowledge that: enables exploration of the need for changes to local practices, provides a basis for generating knowledge about existing practices and permits collective action to be mobilised for desired change. Review of these studies informs understanding of the problems faced by clinicians and may assist health care professionals at this hospital to improve preparation for childhood hospitalisation practice.

The majority of publications found to be applicable to the study came from the United States of America (USA), the United Kingdom (UK), Canada and

Australia. Publications written about preparation for childhood hospitalisation in Hong Kong, Ireland, Portugal, Spain, the Netherlands, France and Thailand numbered only 10. There were contributions from nursing, play therapy, psychology and medicine and they focused primarily on the development and implementation of preparation for childhood hospitalisation approaches. Some of these publications reported their evaluation, however there were few publications reporting replication studies.

Shields (2001) noted that research about the effects of childhood hospitalisation on children and their parents and preparation for it was meagre in non-Western countries. The literature search for this review found that there was some preparation for childhood hospitalisation research conducted by nurses from Western countries who were working in non-Western countries and some studies undertaken by local nurses. The literature search also found that nursing was the only health care discipline that contributed to preparation for childhood hospitalisation literature and although medical researchers undertook most studies related to childhood hospitalisation in non-Western countries these related to morbidity and mortality rather than preparation for childhood hospitalisation.

Not surprisingly, both the focus and the quantity of publications related to childhood hospitalisation changed over time. Initially, from about 1950, papers described the effects of hospitalisation on children and their families. Then, from the 1970's, development, implementation and evaluation of various preparation for childhood hospitalisation approaches took place becoming more sophisticated, complex and prolific until the mid 1990's when they slowed down considerably. Many of the papers written since then have focussed on similar approaches to those used earlier, and made similar recommendations.

Experimental studies dominated the publications across the entire time span, and included papers written in all health care disciplines, although there were more studies conducted by nurses, particularly operating theatre or recovery room nurses. Play therapists, known as child life specialists in the USA and

Canada, also contributed to the body of work with analysis of the development, implementation, and sometimes evaluation, of preparation for childhood hospitalisation approaches. Papers written by doctors covered a wide range of topics related to childhood hospitalisation; however, the focus of most of these studies was on preparation for anaesthesia and surgery. Whereas, papers written by psychologists tended to theorise about what was problematic about childhood hospitalisation and suggested approaches to address these problems. Government and non-government reports were few in number but were significant because they reviewed the outcomes of preparation policy within health care.

The literature search strategy followed recommendations and processes used successfully by others to clarify the complexity of an issue. The search was guided by the need to capture the evidence of effective approaches to preparation for childhood hospitalisation and to demonstrate levels of evidence according to the NICE guidelines. The next section of the literature review considers the hospital experience for children and their families. The following section outlines a definition and provides an historical overview of preparation for childhood hospitalisation. Finally, there is analysis of the differences in childhood preparation practices according to the four areas of complexity that were identified in the literature search: the needs of children and their families for preparation for childhood hospitalisation, preparation approaches, the outcomes for the preparation participants and for the health care professionals and the current situation in Australian children's hospitals. The next section describes childhood hospitalisation and its potential effects on children and their families.

2.3 The hospital experience for children and their families

Health care researchers and theorists have studied childhood hospitalisation over the last six or more decades. They report that childhood hospitalisation is potentially harmful to children causing them anxiety and distress (Ben-Amitay et al., 2006; Board & Ryan-Wenger, 2002; Bonn, 1994; Foley, 2000; Haslum,

1988; Park, Foster, & Cheng, 2009; Piaget, 1952; Platt, 1959; Riffee, 1981; R. H. Thompson, 1986; Tiedeman & Clatworthy, 1990; Vernon et al., 1966; Vessey, 2003; Wright, 1995). Childhood hospitalisation continues to be a significant and potentially anxiety provoking and distressing event in the life of children and their families that seems to have inconsistent outcomes depending on many variables (Caldas et al., 2004; Pelander & Leino-Kilpi, 2010; Thurber, Patterson, & Mount, 2007; Vessey, 2003).

Because hospitalisation variables have a bearing on outcomes, most researchers have chosen to explore specific discrete types of hospitalisation rather than consider the issue in all its complexity as one issue, see for example Rossen and McKeever (1996). The problem of complexity of variables exists in behavioural research and is usually addressed by researching one variable at a time and controlling the other variables. Nevertheless, there is a common theme in the literature about the outcomes of hospitalisation for children and their families: that anxiety and distress before, during and after the hospitalisation is a routine finding (Melnyk, 2000; Wray, Lee, Dearmun, & Franck, 2011). The anxiety and distress of hospitalisation varies for different people and in different circumstances but anxiety and distress are features of the outcome of hospitalisation that are negative but also, importantly, amenable to change.

The outcomes of hospitalisation have been analysed through consideration of physical and psychological manifestations of the effects (Vernon & Thompson, 1993). Vessey (2003) argues that the physical manifestations are indicative of psychological distress. Children may exhibit developmentally regressive behaviour such as the inability to demonstrate a previously attained skill, for example toilet training. Further, Vessey (2003) argues that the temporary loss of developmental achievement is a physical outcome that is a manifestation of psychological distress caused by the anxiety of hospitalisation.

The type of hospitalisation, planned or unplanned, will influence the response to hospitalisation and the outcome of the hospitalisation. Planned hospitalisations

take a number of forms such as: for a scheduled procedure, for treatment of a known medical condition as an in-patient or an out-patient, for a diagnostic assessment of a health problem as a non-inpatient. Information provision and coping skills training are particularly effective for children who confront a planned admission to hospital because known elements such as the children's age can enable individualisation of the preparation strategy regarding timing and delivery of information and/or teaching of skills. Studies about information provision for planned hospitalisation have been shown to be effective (Jaaniste et al., 2007; Lowry, 1995). In addition, teaching skills designed to prepare children and their families to cope with hospitalisation have been widely tested and shown to be effective for planned admission to hospital (LaMontagne, 1993; Melnyk, 1994; Melnyk, Alpert-Gillis, Hensel, Cable-Beiling, & Rubenstein, 1997; Poster, 1983; Zastowny, Kirschenbaum, & Meng, 1986).

Unplanned hospitalisations also take a number of forms and are usually associated with unexpected events (Basso, 2010; Moorey, 2010). These include traumatic events such as motor vehicle accidents and non-traumatic events such as the acute onset of severe asthma. Preparation for unplanned hospitalisations only occurs in a very generic way through preparation programmes for well children, although this kind of preparation is only available to a small proportion of children. When preparation for unplanned hospitalisation does take place, children receive preparation in association with other educational activities at pre-school or school (Mather, 1984; McGarvey, 1983; Nelson & Allen, 1999).

The type of hospitalisation, planned or unplanned, and the reason for the hospitalisation are related because the reason has an impact on whether the hospitalisation is planned or unplanned. The reason for the hospitalisation lies on a continuum from simple to complex. For example, a simple reason might be for a routine pædiatric immunisation and a complex reason might be for open cardiac surgery and all that that might involve. Duff (2003) proposed an algorithm that incorporated psychological techniques into routine pædiatric immunisation to reduce distress related to children's perception of pain and

fear. He argued that responses witnessed clinically in children are not a fear of needles but anticipatory distress related to fear of pain and of the unknown. The finding indicates that although the reason for hospitalisation may be rated along a continuum, children and their families recognise all hospitalisations as potentially distressing. Perception of the importance of the reason for the hospitalisation by children and their family, and the wider community adds to the complexity of analysis of childhood hospitalisation.

The message throughout the childhood hospitalisation literature is that the use of preparation for hospitalisation is important. Many researchers, for example Eiser (1988), Ellerton and Merriam (1994), O'Connor-Von (2000), Vessey (2003) and Wakimizu, Kamagata, Kuwabara and Kamibeppu (2009), show that the anxiety and distress associated with childhood hospitalisation is significantly reduced before, during and after the hospitalisation when children and their families are well prepared for its events and experiences. The preparation strategies moderate the negative effects of the hospitalisation such as anxiety and distress (Mitchell et al., 2004). Preparation may also deliver benefits in terms of the development of skills useful during non-hospitalisation experiences (Vernon & Schulman, 1964).

Preparation strategies have not been consistently evaluated and they are often only available short-term, during the life of the research into them. However, inconsistent evaluation of strategies does not justify the abandonment of the attempt to prepare children and their families for the experience of hospitalisation. Rather, the inconsistency validates the continued search for a way to implement preparation for hospitalisation of all children and their families to optimise the experience.

2.4 Preparation for hospitalisation of children and their families

The focus of this thesis is the practice of preparation for childhood hospitalisation at a major children's hospital in Australia. Literature about preparation has been accumulating for at least 60 years and it has been

complex and complicated because of the number of variables involved and the number of disciplines with an interest in contributing to the literature. Clarification and simplification of the literature is provided in this section of the literature review.

Physical preparation refers to generic things like admission forms and information brochures given to children and their family prior to a forthcoming booked admission (Clough, 2005), rather than the information booklet specific to the reason for admission. Physical preparation is important and relevant to this review of the literature because physical preparation sometimes contributes to psychological preparation; however, the basis of this distinction is the problematic assumption that the two types of preparation are significantly different when in fact the boundary between them is very blurred. For example, information brochures (Lowry, 1995) that describe what to bring to hospital, a favourite toy, pyjamas and so on, is physical preparation. Physical preparation information may well start the psychological preparation process within children and their families because the trigger forces them to confront their own feelings about the forthcoming hospitalisation and confronting their feelings influences the outcome of the hospitalisation and the preparation.

Preparation that addresses psychological outcomes is about the experience rather than the event of hospitalisation. Psychological preparation aims to enable management of the many aspects of hospitalisation that potentially include unknown and frightening experiences. When the aim of a research study addresses psychological outcomes it usually implies that by preparation the researchers mean psychological preparation (Kain & Caldwell-Andrews, 2005). Psychological preparation may take the form of information provision or teaching of skills to cope with the anxiety and distress of hospitalisation.

2.4.1 A definition

Researchers from various health care and other disciplines have contributed to the body of literature about preparation for childhood hospitalisation using

various definitions. For the purposes of this literature review preparation for hospitalisation is defined as *all activities designed to enable children and their families to manage the events and experiences of hospitalisation*. The definition is very broad so that as much of the quality research as possible is included. One of the confounding aspects of reading the literature about preparation is that definitions are different in various studies and so comparison of findings is difficult when the opening premise, the definition, is not the same in studies that seem to use similar techniques to test similar preparation for hospitalisation strategies (Cohen & MacLaren, 2007; Sheldon, 1997). The very broad definition given above enables inclusion of a great deal of research and theoretical work.

2.4.2 Trends in recognition of the impact of hospitalisation on children

Hospitalisation can have negative effects for children and their families and these can be both short and long term. The negative effects of hospitalisation were identified by the landmark British report known as the Platt (1959) report: "The welfare of children in hospital". The Platt (1959) report inspired the large number of studies from many disciplines that have designed, implemented and sometimes evaluated strategies aimed at minimising the negative effects of childhood hospitalisation. In 1965 and 1966 Vernon and his colleagues (1965; 1966) published their works about the effect of hospitalisation on children. Since then, many researchers and theorists have written papers and books that have explored and synthesised all the sources of the effects of hospitalisation with a strong emphasis on the negative effects. Haslum (1988) wrote about poor psychological outcomes of childhood hospitalisation in her longitudinal study of the 1970 British births cohort in the UK. She noted the poor attainment of verbal and mathematical skills and the higher levels of anti-social behaviour in 10-year-old children who had been hospitalised before they were 5 years old.

Studies have measured physical symptoms occurring during or after hospitalisation such as bed-wetting or sleep disturbances (MacLaren & Kain, 2008; Vernon et al., 1966). The rationale is that physical symptoms of distress

act as a proxy for psychological symptoms in this population due to children's' limited ability to accurately demonstrate or self-report psychological symptoms. Papers have used psychological outcomes as variables to determine the extent of the negative effect of hospitalisation and/or to evaluate strategies (R. H. Thompson, 1986).

Bennett-Humphrey and his colleagues (1992) measured physiological markers of distress such as heart rate and hormone levels to show that the events and experiences of hospitalisation had an impact on children. Other researchers, for example Boyce, Barr and Zelter (1992), Kagan (1992), Lewis (1992) and Porges (1992), have measured physiological responses to stress in children but have not extrapolated a link between these and the effects of hospitalisation. The use of physiological markers to determine anxiety and distress in children has been a very contentious issue for many researchers over a very long time. However, for the purpose of this review, there is an acknowledgement that due to the limitations of children's ability to report anxiety and distress in the same way as adults do, either physiologically or psychologically, there are measurement problems involved in the accuracy of findings. The research does confirm that children do have physiological and psychological responses to stress, and that although these are difficult to measure, trying to quantify the stress responses is worthwhile. Furthermore, preparation aimed at reducing anxiety and distress can minimise the negative impact of hospitalisation (Vessey, 2003).

While there is a focus in preparation on the potential negative effects of childhood hospitalisation it can also bring with it an opportunity for positive outcomes. Researchers, such as Vernon and Schulman (1964), showed that a hospitalisation is an opportunity to develop new skills and abilities that may be useful in other aspects of children's lives. They contend that the learning involved in managing emotions through coping strategies when confronted by a new situation in hospital may be useful in managing emotions after hospitalisation. For example, coping with intravenous cannulation when in hospital by using positive self-talk, will be useful in coping with a routine

immunisation that is part of having usual health care because children may use similar coping strategies (Duff, 2003). Hospitalisation acquired coping strategies enable the acknowledgement and management of fears such as a fear of needles (Fernald & Corry, 1981; LaMontagne, 2000). In these situations, some of the effects of hospitalisation can be positive, because of the learning of new skills and the sense of mastery that children gain. Nevertheless, the development of preparation strategies results from the negative effects of hospitalisation.

Reports of strategies designed to address the negative effects of childhood hospitalisation show a discernible pattern of evolution in Western countries. In the 1960s the emphasis was on information provision and the facilitation of emotional expression and trust of the health care professionals, by both the children and their families (Vernon et al., 1965). By the mid 1970s modelling strategies (Melamed & Siegel, 1975) and stress point nursing (Visintainer & Wolfer, 1975) were being recommended. In the early 1980's two types of strategies were introduced. The first type was coping skill training (LaMontagne, 1993; Melnyk, 1994; Peterson, Harbeck, Chaney, Farmer, & Muir-Thomas, 1990; Peterson & Shigetomi, 1982). While the other type of strategy related to involvement of parents in the care of their children (Elkins & Roberts, 1983; Gill, 1993; Li, Lopez, & Lee, 2007b; Messeri, Caprilli, & Busoni, 2004; Romino, Keatley, Secrest, & Good, 2005; Vessey, Caserza, & Bogetz, 1990; Zastowny et al., 1986). Later in the 1980s child-life preparation was added to the mix of recommended strategies (American Academy of Pediatrics Committee on Hospital Care, 1993).

In Australia, the term *play therapy* preparation is used and broadly equates to child-life preparation and is known by other names in other countries (Rubin, 1992). Play therapy has made a significant contribution to the preparation of children and their families for hospitalisation (Brewer et al., 2006; Chan, 1980; Goymour et al., 2000). Play therapy preparation for hospitalisation delivered by play therapists has a holistic and developmental emphasis. Although strategies

have become more sophisticated over time, essentially they all relate to information provision, preparation for procedures and/or coping skill training.

One significant source that provides consistent information prior to hospitalisation is the consumer groups made up of concerned people in the community who want to improve childhood hospitalisation. Consumer groups have contributed significantly to preparation for hospitalisation of children and their families by lobbying governments to make changes in the management of childhood hospitalisation at a policy level. The Platt (1959) report, now more than 50 years old, was influential in mobilising people to form groups that were able to be more effective, than individuals had been able to be, in giving a voice to concerns about the effects of hospitalisation (Association for the Welfare of Child Health, 2005). These groups continue to be active in pressing for improvements in health care policy in regard to the needs of children and their families, particularly in relation to hospitalisation (Association for the Wellbeing of Children in Healthcare, 2009).

Consumer groups offer a range of services to children and their families that relate to hospitalisation. They also provide information to health care professionals and to the public about the impact of hospitalisation on children and strategies designed to ameliorate the impact. Generally, governments and public donations fund consumer groups. Examples of consumer groups in Western countries are:

- Action for Sick Children in the United Kingdom
- Association for the Welfare of Children in Hospital in Wales
- Association for the Wellbeing of Children in Healthcare (AWCH) in Australia
- Association Pour l'Amelioration des conditions d'Hospitalisation des Enfants (APACHE) in France
- Children in Hospital Ireland European Association for Children in Hospital (EACH) in Europe
- Landelijke Verenining Kind en Ziekhaus (National Association Child and Hospital) in The Netherlands

AWCH in Australia, whose patron is the Governor General of Australia, provides a number of services. These are outlined on their website, www.awch.org.au

which offers information and services to families who have internet access (Association for the Wellbeing of Children in Healthcare, 2009). Not all children and their families who are hospitalised have internet access and the latest Neilson statistics show that in August 2009 80.1% of Australians had internet access (Internet World Stats, 2011).

AWCH services include a specialist library on child health available to families and health care professionals. Another service is the Hospital Ward Grandparent scheme that supported 722 children in hospital in New South Wales and the Australian Capital Territory in 2007 (Association for the Wellbeing of Children in Healthcare, 2009). The scheme provides for volunteers to accompany children in hospital when their own parents cannot be there. AWCH supports families with children who have similar medical conditions and disorders by providing AWCH's Paediatric Support Link service to enable them to contact one another and participate in peer support. AWCH volunteers answer parent enquiries via the toll free Telephone Information Service. The consumer group also sells a Hospitalisation Familiarisation Program and hospitalisation resources such as calico dolls for medical play, *Check it out* a preparation for anaesthetic video, *Joel goes to hospital* DVD and activity books, and hospital play kits (Association for the Wellbeing of Children in Healthcare, 2009).

Services offered by consumer groups appear to be subject to the same issues of availability and accessibility as hospital based programmes (Association for the Welfare of Child Health, 2005). By 2000 the elements that affect the response to hospitalisation were established and most preparation strategies were successful in reducing anxiety and distress for children and their families (Carney et al., 2003). Health care disciplines such as nursing, psychology, play therapy, psychiatry, medicine, surgery, anaesthesia and health education, agreed that preparation strategies could be effective (Brewer et al., 2006; Clement & Wales, 2004; Cohen et al., 2001; Franck & Spencer, 2005; Hallowell, Stewart, de Amorim e Silva, & Ditchfield, 2008; Huth, Broome, & Good, 2004; Kain & Caldwell-Andrews, 2005; Vessey, 2003). Nevertheless, agreed

effectiveness has not led to consistent implementation of preparation strategies and that demonstrates a significant resistance to change.

Analysis of the areas of complexity identified in Step 3 of the literature search is useful in understanding the resistance to practice change of preparation for childhood hospitalisation. In that step, categorisation and full text review, the large amount of relevant literature was categorised according to four areas of complexity to enable easier analysis of differences in the preparation for childhood hospitalisation literature. Categorisation enabled analysis by the researcher, readers of this thesis and the potential participants in the action group. The four areas of complexity in preparation for childhood hospitalisation were: differences in the needs of children and their families for preparation for childhood preparation, differences in preparation approaches, differences in the outcomes of preparation for participants and health care professionals, and differences in the current situation in Australian children's hospitals. The following section outlines and analyses the areas of complexity in order to develop an understanding of the practice of preparation for childhood hospitalisation at this hospital. The analysis informed the first aim of the present study that was *to explore the need for changes to local practices for preparing children for the experience of hospitalisation*.

2.5 Differences in preparation for childhood hospitalisation practices

The following literature review focuses on what is known and can be relied upon to guide preparation for childhood hospitalisation. The review is organised around four areas of complexity that influence its practice and the first is differences in the needs of children and their families for preparation for childhood hospitalisation. Their needs for preparation vary according to a number of factors that are elaborated in sub-section 2.5.1 below, such as age and reason for the hospitalisation. The how, when, where and even why of preparation practice are influenced by children and their families' needs. The second area of complexity is the difference in preparation approaches that have been developed and tested to meet children's preparation for hospitalisation

needs and is expanded upon in sub-section 2.5.2. Both the needs of children and their families, and the approaches to preparation practice emphasise the complexity of preparation for childhood hospitalisation and the potential for a variety of outcomes.

The different outcomes of preparation for both the children and their families, and the health care professionals who care for the children represent the third area of complexity found in the preparation for childhood hospitalisation literature. Outcomes of preparation are difficult to quantify and that is partly due to the fact that different effects of hospitalisation variables (Vessey, 2003) are addressed by different preparation strategies. Sub-section 2.5.3 discusses the various forms of evaluation and the impact that they have had on consistent implementation of strategies.

The fourth theme of difference in the literature is differences in the current situation in Australian children's hospitals regarding preparation for childhood hospitalisation practice. The current situation in Australian children's hospitals is influential because the focus of the present study is on one major children's hospital in Australia and differences in local circumstances may affect local practice of preparation for childhood hospitalisation. Findings from the fourth theme of difference may assist the action group to improve preparation for childhood hospitalisation practice at this hospital.

Given the complexity of the literature the following table illustrates the use of the four areas of difference as an organiser of the search that enabled the action group to more easily access the outcomes of searching the literature.

Differences in:	Relevant issues
Needs of children and their families for preparation for childhood hospitalisation	Anxiety, distress, separation, play, age, developmental stage, timing, reason for and type of hospitalisation, hospitalisation setting, previous experience, parents
Preparation approaches	Information provision: Medical play, hospital tours, peer modelling, play modelling, distraction, information provision to parents, printed material, instructional films, oral summaries, computer programmes, interactive computer games, home visiting by a nurse, individualised preparation, preparation on non-inpatient children. Procedural preparation: Pre-operative, pre-procedural Coping skill training
Outcomes of preparation	For children and their families: Physical, psychological. For health care professionals: Ethical, practical, access to evidence-based guidelines, anecdotal experience, lack of sustainability, inconsistency of implementation.
The current situation in Australian children's hospitals regarding preparation for childhood hospitalisation practice	Inconsistency of implementation, inconsistency of evidence, shorter hospital stays, financial cost of preparation

Table 2-4 Search outcomes according to four areas of complexity

2.5.1 The needs of children and their families for preparation for childhood hospitalisation

Children and their families need to experience hospitalisation in a way that ensures that the anxiety and distress that accompanies any hospitalisation in minimised. Reduction and/or management of anxiety and distress can lead to an optimal outcome of the hospitalisation and preparation can accomplish the reduction as the evidence reviewed here outlines. Research studies have

defined optimal outcome of hospitalisation differently, however most of the research in the area has been about the prevention of psychological upset and reduction of poor post hospital adjustment (R. H. Thompson, 1986; Vernon et al., 1965). Being prepared for an anxiety provoking event is effective, however, preparation for childhood hospitalisation is especially important because children may not have developed appropriate knowledge and abilities to manage the effects of hospitalisation due to their age and developmental stage (Bibace & Walsh, 1980; Vacik, Nagy, & Jessee, 2001; Vessey, 2003). This is so particularly as hospitalisation is an event that requires certain knowledge and abilities, if the hospitalisation is to be experienced optimally. The different needs of children and their families influence how, when, where and even why of preparation delivery, and the extent to which optimal outcomes of preparation can be achieved.

The needs of children and their families for preparation for childhood hospitalisation vary for different people and in different circumstances. The needs vary according to the factors that are associated with the effects of hospitalisation that were discussed in section 2.3. The most significant of these in relation to preparation for childhood hospitalisation are associated with separation from family and familiar environment, the opportunity to play, the age and developmental stage of children, timing of preparation, the reason and type of hospitalisation, the setting in which they are hospitalised, and previous experience of hospitalisation. Each of these effects of hospitalisation is discussed in relation to the needs of children and their families in this sub-section.

Addressing some of the effects of hospitalisation has led to practice change that has had a positive impact on the needs of children and their families. Most notably, the impact of addressing issues related to separation, that were mentioned in Chapter One, can be seen in the improvements that have been achieved in the management of childhood hospitalisation. Shorter hospital stays and encouragement of parental presence throughout most health care

procedures has meant that the chance of children being separated from their family is minimised during a hospitalisation.

Play therapy addresses many needs of hospitalised children and their families including their preparation needs (Betz, 1983; Goymour et al., 2000; Li, Lopez, & Lee, 2007a; Woon, 2004). The recognition of the place of play in the normal growth and development of children (Haiat, Bar-Mor, & Shochat, 2003) has led to the establishment of Play Therapy as a distinct discipline within the health care professions (Rubin, 1992). Through play children practice for real events and experiences by engaging in non-threatening, unreal events and experiences, such as games that optimise the use of children's individual imagination (Moore & Russ, 2006; J. M. Wilson, 2006). Play therapy assists children to manage effectively the experiences of hospitalisation and so has an important role in childhood hospitalisation.

Addressing other effects of hospitalisation is not as straightforward as addressing separation and play. Age and developmental stage is very relevant to childhood hospitalisation, and many theorists and researchers have acknowledged the particular challenges presented to clinicians working in children's hospitals by children's different ages and developmental stages (Alsop-Shields & Mohay, 2001; Bray, 2007; Duff, 2003; Hodapp, 1982; Jaaniste et al., 2007; MacLaren & Kain, 2008; Vernon & Schulman, 1964). In their renowned research, Wolfer and Visintainer (1979) found that children between three and six years of age were more upset and less cooperative during the pre-operative blood test and medication administration than children undergoing the same procedures who were aged between 7 and 12 years of age. Regarding preparation for the experiences associated with hospitalisation a number of researchers have noted that younger children, less than six years of age, are best prepared through concrete experiences of what will occur and how they might feel, such as provided in a hospital tour (Avigne & Phillips, 1991). Older children are able to understand written and verbal descriptions that include information about why particular things will happen (Jaaniste et al., 2007; Jipson & Melamed, 2007; R. H. Thompson, 1986; Vernon & Thompson,

1993) and so require different preparation for hospitalisation. The correlation between age and the ability to manage the experience of hospitalisation is noteworthy.

Related to the issue of age and developmental stage is the issue of timing of preparation strategies (Buckley & Savage, 2010; Ross, 1984). According to the evidence reviewed by Jaaniste and colleagues (2007), preparation for forthcoming medical procedures should be provided at least five days in advance for children older than six years of age and no more than a week in advance for children less than six years of age. However, preparation strategies do not incorporate evidence about timing, possibly because appropriate timing of preparation is logistically very difficult to achieve. The individual differences among children, further complicate the timing of preparation strategies as, for example, some children who are less than six years of age may still have a better outcome if they are prepared for their hospitalisation *more* than one week in advance of the hospitalisation.

Different circumstances result in differences in the reason for the hospitalisation that influences preparation needs. Children hospitalised for a brief time for a straightforward surgical procedure have quite different needs to children hospitalised for many months of medical therapy to treat a long term or chronic health problem (Battrick & Glasper, 2004; Bentley, 2004; Callery, 2005; Mansson, Bjorkhem, & Wiebe, 1993; Rushforth, 1999; Sartain, Clarke, & Heyman, 2000; Smith & Callery, 2005). The connection between the home environment and the hospital environment was emphasised by Sartain and colleagues (2000) when they explored the experience of chronically ill hospitalised children. The researchers used a grounded theory methodology to elicit what 7 children and their families, aged between 8 and 14 years, thought about hospital. The researchers noted that the preparation needs of chronically ill children were complicated by the threat of repeated hospitalisations and the unpredictability of treatment, both in hospital and at home. The finding emphasised that the reason for hospitalisation will influence the outcome of preparation.

The reason for the hospitalisation may be made more complicated by different contextual factors related to the hospital environment. The environment may be a children's hospital, a general hospital, a rural or remote hospital, a metropolitan hospital, a hospital in a well-developed economy or in a poorly developed one. The hospital may or may not employ health care professionals who are actively encouraged and supported to provide preparation information. The hospital may have excellent facilities for the provision of preparation for hospitalisation or the hospital may have very few facilities, or the hospital may have a mixture of facilities. These preparation facilities may be easily accessible to all children and families or they may require particular skills to enable access, such as a certain level of education (Shields, 2001).

Contextual factors related to preparation for hospitalisation that link to the cultural environment are reported in the literature. When developing, implementing and evaluating a preparation strategy for children and their families in Hong Kong, Li and colleagues (2007b) acknowledged the contextual challenges when faced with providing effective preparation strategies in a country with a strong Chinese culture overlaid for several centuries by British culture. Alsop-Shields (2000) studied two Western countries, Australia and Britain, and two non-Western countries, Thailand and Indonesia, to determine what influenced parents and health care professionals beliefs about preoperative preparation for children. She found that cultural constructions are very important in non-Western countries regarding preparation for hospitalisation, but not so important in Western countries. Nevertheless, when Kathalae (2007) tested an intervention to prepare Thai children for a hospitalisation she found very similar challenges as those reported in Western literature such as challenges related to age and developmental stage (Kathalae, 2007).

Regardless of the context, the experience of childhood hospitalisation will probably include events such as meeting unfamiliar people (Gill, 1993; Romino et al., 2005) and experiencing unfamiliar events (Alsop-Shields, 2000; Cohen &

MacLaren, 2007; MacMaster & Rosenberg, 2008). Almost certainly, there will be a health care procedure that children and their families may perceive as painful (Bar-Mor, 1997; Kawaguchi, 1997; LeBaron & Zelter, 1984; LeRoy et al., 2003; Melamed, 1998; von Baeyer, Marche, Rocha, & Salmon, 2004). These events of hospitalisation cause anxiety and distress for them (Bentley, 2004; Board & Ryan-Wenger, 2002; Caldas et al., 2004; Haslum, 1988; MacLaren & Kain, 2008; Riffee, 1981; Tiedeman & Clatworthy, 1990; Vernon et al., 1966; Vessey, 2003; Wright, 1995).

Related to the context is the fact that frequently children are novices to the experience of hospitalisation. Everything is new and must be learned about if the hospitalisation is to have an optimal outcome. Many preparation strategies are effective for novices because they provide information (Ferguson, 1979; Mitchell et al., 2004). For example, in a study conducted by Ferguson (1979), 82 children between three and seven years of age who had no previous experience of hospitalisation, were randomly assigned to one of four groups. Two groups experienced a regular hospital admission procedure, one with a non-hospital related film (the control group) and the other with a hospital related peer-modelling film. Two other groups experienced a pre-admission visit from a nurse in their home prior to hospitalisation with one or other of the films. Ferguson (1979) found that the control group had significantly higher self-report anxiety on admission and demonstrated the highest incidence of undesirable post hospital behaviour as rated by their parents. Whereas, all the other children benefited from each of the three preparation strategies indicating that any preparation is preferable to none.

Some researchers have tested strategies that inform well, novice children who are not facing an imminent hospitalisation (Mather, 1984; McGarvey, 1983; M. C. Roberts et al., 1981). Short-term outcomes indicate effectiveness in terms of improved medical knowledge and fewer medical fears (Elkins & Roberts, 1984). McGarvey (1983) undertook a study of a hospital tour for 150 non-patient children. The mothers of three children who were subsequently hospitalised reported a smooth adjustment to hospital. There are no other follow up

evaluation reports of outcomes for well, novice children who are subsequently hospitalised.

As well as children apparently benefitting from the various preparation strategies, mothers of novices have benefitted from preparation strategies for their children's forthcoming hospitalisation (Caty, Ritchie, & Ellerton, 1989; McEwen, Moorthy, Quantock, Rose, & Kavanagh, 2007). When children are novices so are their parents, and other family members, even if they have hospitalisation experience with other children in the family. Given that children rely on their parents, especially when confronted by a new experience, preparation of parents is very important to preparation for hospitalisation of children (Caty et al., 1989; Ferguson, 1979; Li et al., 2007b; Stone & Glasper, 1997).

Evidence from the literature shows that families, but especially parents, need appropriate preparation for their children's forthcoming or current hospitalisation. For example, Kain and colleagues (2007) conducted an RCT of 408 children and parents assigned to one of four groups. The four groups were a control group, parents who were present before and during anaesthesia induction, the ADVANCE group who received family-centred behavioural preparation and a group whose children received midazolam prior to induction of anaesthesia. Parents in the ADVANCE group exhibited significantly lower anxiety before and during induction of anaesthesia than parents in the other three groups.

Non-novices, children with previous experience of hospitalisation, also benefit from the opportunity to receive information and to develop new skills (Faust & Melamed, 1984). Previous experience of hospitalisation may provide some information for children and their families; however, as every hospitalisation is likely to be different in some ways previous experience is not a reliable form of preparation. The previous experience may not have been optimal and either accurate or distorted memories about how difficult events were managed, successfully or not, interfere with realistic recall and so with the ability to use the

previous experience to manage the current one. The effect of previous experiences as a variable has led some researchers to exclude children with previous experience from their study to simplify findings, for example Li and Lopez (2008). Children with previous experience are less likely to benefit from generic preparation and may even experience negative outcomes from the preparation (Bates & Broome, 1986; Betz, 2006; Faust & Melamed, 1984). These children and their families probably need individualised preparation for their subsequent hospitalisations.

Differences in the needs of children and their families for preparation for hospitalisation related in this literature review have shown that the needs are complex. Needs differ in a number of areas and change in different circumstances (Runeson, Hallstrom, Elander, & Hermeren, 2002). The following sub-section explores research into the different types of preparation strategies and reveals evidence of their value as effective ways to prepare for childhood hospitalisation. However, selection of strategies should only occur after considering the different needs of children and their families.

2.5.2 Preparation approaches

Different approaches to preparation for childhood hospitalisation are available and have been used according to elements related to the specific hospitalisation. The majority provide information, either generically or in relation to a health care procedure (Clough, 2005; Kain et al., 2007; Keller, 2001; McEwen et al., 2007; Mitchell, Keppell, & Johnston, 2006; Nelson & Allen, 1999; Rassin, Gutman, & Silner, 2004; White & John, 1997). A smaller number focus on coping skill training (Gaynard, Goldberger, & Laidley, 1991; Huth et al., 2004; LaMontagne, 2000; LaMontagne, Hepworth, Johnson, & Cohen, 1996; Melnyk, 1995). Although, some researchers consider that coping skill training is a subset of information provision (Jaaniste et al., 2007) because coping skills training provides information about children's hospitalisation simultaneously with training children to cope with unknown events.

Combinations of these approaches are termed preparation programmes and describe preparation that comprises one or more strategies and is offered to groups at pre-determined times. However, combinations differ from programme to programme which adds to the difficulty of determining exactly what is, or is not, effective about the programme. For example, Wilson (1987) compared two methods of preparing 40 healthy fourth grade students for hospitalisation. The first step was allocation of subjects to one of four treatment groups, 10 per group. One group was a control group who received no preparation. The second group were prepared with a handbook that used verbal and pictorial means to explain hospitalisation. The third group were prepared with the slides, photographs and medical instruments of an existing hospital preparation programme. The fourth group were prepared with both the handbook and the programme. Multifactorial analysis of variance revealed no statistical differences among the groups regarding their preparedness for hospitalisation. Although the numbers of subjects in each group was small, the findings confirm the difficulty of determining what element/s of preparation is or is not effective.

The availability of programmes differs significantly from hospital to hospital. Some hospitals offer many discrete programmes, according to the reason for the proposed admission while others do not offer any programmes at all. For example, one hospital might offer a programme that focuses on the events and experiences related to an admission to hospital for surgical removal of tonsils and adenoids (Clement & Wales, 2004; Hatava, Olsen, & Lagerkranser, 2000). Another programme may describe the events and experiences related to a radiological procedure that does not require admission to hospital, however the procedure involves a significant interaction with the hospital and its staff (MacMaster & Rosenberg, 2008). Another hospital may offer only one programme related to the generic events and experiences of *any* hospitalisation (Carpenter, 1998; Wilkins, 1994).

How people find out about preparation makes a difference to the outcome of the approach. In some cases, the hospital advertises the programme/s in various media such as newspapers or a hospital website. Sometimes, the admitting

doctor will notify the prospective patient and family of the opportunity to participate in a pre-hospitalisation preparation programme (Wisselo, Stuart, & Muris, 2004). On other occasions word of mouth informs people of the programme and may include a personal critique of the value of the programme (Santen & Feldman, 1994). Inconsistency in notifying people about the existence of programmes leads to differences in availability and consequently to participation in programmes.

Many hospitals offer no programme at all (Association for the Welfare of Child Health, 2005). For children and their families admitted to these hospitals pre-hospitalisation information may, or may not, be received from a variety of sources including the admitting doctor, family and friends or the health care professionals caring for the children and their family whilst in hospital. Pre-hospitalisation information has the potential to be as variable as the source from which the information comes. Even when children and their families are aware of programmes and their potential benefit, some choose not to participate (Association for the Welfare of Child Health, 2005; Schreier & Kaplan, 1983). The reasons for non-participation are unknown and although there are a number of possible reasons for non-participation, there does not seem to be any research that has explored the phenomenon.

Preparation approaches differ according to the circumstances of a specific hospitalisation and consequently there is the potential for a variety of outcomes. The approaches are organised according to strategies that provide information, provide preparation for procedures or provide coping skill training. The boundary between these is not distinct and there is considerable overlap in their administration. The following three subsections outline the three types of preparation strategies reported in the literature.

2.5.2.1 Information provision

Key to preparation, either psychological or physical, is information provision and various methods of providing the information in ways which children and their

families can access have been implemented and sometimes evaluated. Table 2-5 divides publications of strategies into 12 commonly used formats.

Format	Publication of findings
Medical Play	Abbott (1990), Bolig, Yolton and Nissen (1991), Ellerton and Merriam (1994), Goymour, Stephenson, Goodenough and Bolton (2000), Hatava, Olsen and Lagerkranser (2000), Justus, Wyles, Wilson, Rode, Walther, Lim-Sulit (2006), Kain, Mayes and Caramico (1996), Li and Chung (2009), Li and Lopez (2008), Moore and Russ (2006), Wilmot (2007), and Woon (2004).
Hospital Tours	Atkins (1981), Avigne and Phillips (1991), Ellerton and Merriam (1994), Hallowell, Stewart, de Amorim e Silva and Ditchfield (2008), Holmes (2005), Holt and Maxwell (1991), Kain, Mayes and Caramico (1996), O'Shea, Cummins and Kelleher (2010), Peterson, Ridley-Johnson, Tracy and Mullins (1984), Santen and Feldman (1994), Tiche, Dobson and Olker (1984), and Wilkins (1994).
Modelling - peers	Melamed (1982), Melamed and Siegel (1975), O'Meara, McAuliffe, Motherway and Dunleavy (1983), Roberts, Wurtele, Boone, Ginther and Elkins (1981), and Robinson and Kobayashi (1991).
Modelling - dolls	Atkins (1981), Gaynard, Goldberger and Laidley (1991), Hatava, Olsen and Lagerkranser (2000), Kain, Mayes and Caramico (1996), Li and Lopez (2008), O'Meara, McAuliffe, Motherway and Dunleavy (1983), and Schreier and Kaplan (1983).
Distraction	Fanurik, Koh and Schmitz (2000), Kain, Caldwell-Andrews, Krivutza, Weinberg, Gall, Wang and Mayes (2004), Kleiber and Harper (1999), Patel, Schieble, Davidson, Tran, Schoenberg, Delphin and Bennett (2006), and Vessey, Carlson and McGill (1994).
Information to Parents	Franck and Jones (2003), Higson and Finlay (2010), Melnyk (1994, 1995, 2000), Melnyk, Alpert-Gillis, Hensel, Cable-Beiling and Rubenstein (1997), Miles and Mathes (1991), Robinson and Kobayashi (1991), Stone and Glasper (1997), Uzark, LeRoy Callow, Cameron and Rosenthal (1994), Vulcan and Nikulich-Barrett (1988), and Wisselo, Stuart and Muris (2004).
Printed material	Austin, Atwater and Waage (1986), Clough (2005), Felder-Puig, Maksys, Noestlinger, Gadner, Stark, Pfluegler and Topf (2003) Lowry (1995), O'Shea, Cummins and Kelleher (2010), Perry (1986), Stone and Glasper (1997), Tiche, Dobson and Olker (1984), Wallace (1983), White and John (1997), Wilson (1987), and Wolfer and Visintainer (1979).
Instructional films, videos, oral summaries, computer programmes	Demarest, Hooke and Erickson (1984), Edwinson, Arnbjornsson and Ekman (1988), Ellerton and Merriam (1994), Fernald and Corry (1981), Jaaniste, Hayes and von Baeyer (2007), Li and Lopez (2008), Mansson, Bjorkhem and Wiebe (1993), Melamed and Siegel (1975), Nelson and Allen (1999), O'Meara, McAuliffe, Motherway and Dunleavy (1983), Robinson and Kobayashi (1991).
Interactive computer games	Franck and Jones (2003), Mitchell, Keppell and Johnston (2006), and Rassin, Gutman and Silner (2004).
Home visiting by a nurse	Ferguson (1979), Sutherland (2003) and Wolfer and Visintainer (Wolfer & Visintainer, 1979).
Individualised preparation	Justus, Wyles, Wilson, Rode, Walther, Lim-Sulit (2006), and Visintainer and Wolfer (1975).
Preparation of non-patient children	Brett (1983), Elkins and Roberts (1984), Mather (1984), McGarvey (1983), and Nelson and Allen (1999).

Table 2-5 Information provision strategy formats

Testing of information provision formats shows rather unpredictable effects which may be due to a complex interplay of variables when devising a strategy targeted at improving the response to childhood hospitalisation (Brewer et al., 2006; Justus et al., 2006; Kain & Caldwell-Andrews, 2005; Mitchell et al., 2004; Smith & Callery, 2005; Vessey, 2003). To counter the unpredictability, sometimes two or more formats are combined in an effort to increase overall effectiveness (see Justus et al., 2006; P. Robinson & Kobayashi, 1991; Visintainer & Wolfer, 1975). Combination of strategies simultaneously addresses a number of elements involved in childhood hospitalisation. Nevertheless, information provision to children and their families continues to be inconsistent.

2.5.2.2 Preparation for procedures

Some of the preparation strategies tested in studies, including all the examples given above, can be categorised broadly into strategies that address particular aspects of the hospitalisation, or the type of hospitalisation. These studies tested various ways to address hospitalisation anxiety and distress of children and their families using information provision delivered through one or more of the 12 formats shown in Table 2-5. For example, there are an enormous number of investigations into pre-operative and pre-procedural preparation, some of which appear in Table 2-6.

Preparation type	Publication of findings
Pre-operative	Atkins (1981), Austin, Atwater and Waage (1986), Avigne and Phillips (1991), Bailey (1992), Betz (2006), Buckley and Savage (2010), Clough (2005), Courtney (2001), Demarest, Hooke and Erickson (1984), Edwinson, Arnbjornsson and Ekman (1988), Ellerton and Merriam (1994), Farrell (1989), Gorayeb, Petean, Pileggi, Tazima, Vincente and Gorayeb (2009), Hatava, Olsen and Lagerkranser (2000), Hathaway (1986), Higson and Finlay (2010), Holmes (2005), Huddleston (2005), Huth, Broome and Good (2004), Justus, Wyles, Wilson, Rode, Walther and Lim-Sulit (2006), Kain, Caldwell-Andrews, Krivutza, Weinberg, Gall, Wang and Mayes (2004), Kain, Mayes and Caramico (1996), Keller (2001), Li and Chung (2009), Li and Lopez (2008), Li, Lopez and Lee (2007a, 2007b), Lynch (1994), Mansson, Fredrikzon and Rosberg (1992), Margolis, Ginsberg, Dear, Ross, Goral and Bailey (1998), McEwen, Moorthy, Quantock, Rose and Kavanagh (2007), Mitchell, Keppell and Johnston (2006), Murphy-Taylor (1999), O'Shea, Cummins and Kelleher (2010), Peterson and Shigetomi (1982), Rassin, Gutman and Silner (2004), Robinson and Kobayashi (1991), Schmidt (1990), Schreier and Kaplan (1983), Sutherland and Bruce (1998), Sutherland (2003), Tiche, Dobson and Olker (1984), Visintainer and Wolfer (1975), Wisselo, Stuart and Muris (2004), Wolfer and Visintainer (1979), and Wynn (1997).
Pre-procedural	Bennett-Humphrey, Boon, Chiquit van Linden van den Heuvell, van de Wiel (1992), Fanurik, Koh and Schmitz (2000), Franck and Jones (2003), Hallowell, Stewart, de Amorim e Silva and Ditchfield (2008), Jaaniste, Hayes and von Baeyer (2007), Kleiber and Harper (1999), MacMaster and Rosenberg (2008), Mansson and Dykes (2004), Melamed (1998), and Santen and Feldman (1994).

Table 2-6 Procedural preparation strategies

An early study was an RCT conducted by Wolfer and Visintainer (1975) that tested strategies specifically targeted at children and their families prior to tonsillectomy surgery. Random assignment of 80 children aged between 3 and 14 years to one of four treatment groups or to a control group took place initially. The four treatment groups were children and their parents who were treated with: information provision for hospitalisation, information provision for tonsillectomy surgery, stress-point nursing and coping skills training. The researchers used pre- and post-testing employing a range of tools with well-established validity to measure effectiveness. Analysis of data collection indicated that stress-point nursing was the most effective. However, all the strategies were extremely time consuming and expensive to implement, particularly in terms of staff salaries. Therefore, their use did not continue after the study was complete. Wolfer and Visintainer's (1975; 1975, 1979) study has been referred to by many researchers in the preparation for childhood hospitalisation literature, citing two important lessons that have been learnt from

their work. One is that preparation is beneficial and the other is that cost containment is an important consideration in the sustainability of strategies.

2.5.2.3 Coping skill training

Coping skill training is a more complex form of information provision in which children and their families learn responses to hospitalisation experiences. A variety of formats is available to deliver the training. For example, Zastowny and colleagues (1986) showed that watching a video of a peer modelling coping strategies in the face of hospitalisation stress provided options for managing the same stress for children prior to their own hospitalisation. Treiber and colleagues (1985) made a similar finding with children prior to dental treatment.

The focus of the training is to teach coping skills to children who may not yet have developed coping skills required to manage the stress of hospitalisation due to their psychological immaturity. Children have less knowledge and fewer defence mechanisms, and they may have fears and fantasies that strongly influence their perceptions (Oldfield, 2001; Poster, 1983). Coping skill training developed as a response to Lazarus's transactional model of stress and coping processes (Lazarus, 1966) and specifically to the idea that children's individual coping style and temperament has a significant impact on the coping strategies that individual children might select to minimise stress (McClowry, 1990; Pate, Blount, Cohen, & Smith, 1996; Ruddy-Wallace, 1995; Ryan-Wenger, 1994).

There was intense research interest in the coping skills training approach during the 1980s and 1990s in a number of health care disciplines (Ellerton, Ritchie, & Caty, 1994; Kawaguchi, 1997; LaMontagne et al., 1996; Melnyk, 1995; Spirito, Stark, & Williams, 1988; Suls & Fletcher, 1985; Treiber et al., 1985; Zastowny et al., 1986). Coping skill training has certainly been shown to have a place in preparation for hospitalisation, although this approach to preparation has been found to be expensive and not always as effective as planned (Melnyk, 1994; Ryan-Wenger, 1994). The expense of the Wolfer and Visintainer (1975) RCT demonstrated lack of sustainability due to cost. Many years later researchers

found that developing a coping skills programme that was effective required individualisation of the training programme because of the individual differences in the coping skills that children had already developed prior to their hospitalisation (Bossert, 1994; Ellerton et al., 1994; LaMontagne et al., 1996; Oldfield, 2001; Small, 2002; Small, Melnyk, & Sidora-Arcoleo, 2009).

Related to individual differences in children is the concept of locus of control beliefs that can be a significant indicator of the ability to manage the stress of childhood hospitalisation (Caty, Ellerton, & Ritchie, 1984; LaMontagne, 1987; M. L. Thompson, 1994; S. C. Thompson, 1981). Locus of control is a concept that describes beliefs about the ability to control events and experiences in life. Some children may believe that they control everything that happens in their lives whereas other children may believe that events will occur irrespective of their wishes or attempts to control the events. The individual difference in the way that children regard their own hospitalisation will have an impact on how they manage and interpret the events and experiences. Individual differences will affect the outcome of coping skill training, as children may or may not believe that they can affect the outcome of the hospitalisation.

2.5.3 The outcomes for the preparation participants and for the health care professionals

The third area of complexity for preparation practice that inhibits consistent implementation of strategies to improve the practice is the differences in the outcomes of preparation for both children and their families, and the health care professionals who care for them. Evaluation of many strategies does not occur and so outcomes, particularly long-term, are unknown. The next sub-section analyses the variability in reported outcomes of preparation practice for everyone involved.

2.5.3.1 The evidence supporting the preparation for hospitalisation in achieving optimal outcomes for children and their families

According to the evidence, the impact of hospitalisation can be negative and positive. However, management of the experience through targeted preparation for the hospitalisation by children and their families is achievable (see Justus et al., 2006). The development of many strategies to address one or more of the elements involved show that most strategies deliver benefits for most children and families (see Huth et al., 2004). Reviews over the last 50 years suggest that various strategies and their combinations afford some benefit and indicate that universal practice of preparation is desirable (Kain & Caldwell-Andrews, 2005; Kain et al., 2007; Mitchell et al., 2004; O'Connor-Von, 2000; Purcell, 1996; Sheldon, 1997; Siegel, 1976; R. H. Thompson, 1986; Vernon et al., 1965). Nevertheless, preparation practice is not universal. Kain and Caldwell-Andrews (2005) when reviewing psychological preparation for surgery suggest that limited practice of preparation for childhood hospitalisation may be due to the lack of outcome studies of strategies on measurable, clinically important postoperative outcomes. The researchers refer to time taken to first oral intake, number of doses of post-operative analgesia and time taken to be ready for discharge from the recovery room as measurable, clinically important postoperative outcomes (Kain & Caldwell-Andrews, 2005).

Measurement of post-hospitalisation outcomes for children use a variety of tools, however the Posthospital Behavior Questionnaire (PBQ) developed by Vernon, Schulman and Foley (1966) has been the most consistently used to evaluate outcomes. Strategies that use the PBQ ask parents respond to each of the 27 items by comparing their children's previous behaviour to their current behaviour following hospitalisation. Different studies require administration of the tool at different times, from 1 week to 12 months post hospitalisation and sometimes more than once.

Vernon and Thompson (1993) conducted a meta-analysis of 22 studies of strategies that had used the PBQ to measure posthospitalisation outcomes, and

found that the benefits of preparation strategies persist for at least one month posthospitalisation. All studies show that prepared children had less behaviour change than did unprepared children with the exception of younger children, for whom no correlation between behaviour and preparation was shown (Gorayeb et al., 2009; Margolis et al., 1998; Melnyk, Small, & Carno, 2004; Patel et al., 2006; Rennick, Johnston, Dougherty, Platt, & Ritchie, 2002; Small & Melnyk, 2006; Small et al., 2009; Stargatt et al., 2006). The reasons for the findings in relation to younger children are unknown; possibly either the preparation was unsuitable for younger children or the PBQ does not effectively evaluate outcomes for younger children.

Some studies evaluate strategies without using the PBQ. For example, Rossen and McKeever (1996) conducted a qualitative study of pre-schoolers, aged three to six years, who had been briefly hospitalised (up to 48 hours) for tonsillectomy and/or adenoidectomy. The researchers interviewed 23 parents using a structured open-ended format that gathered information about the children's behaviour pre-operatively, post-operatively and following discharge, but did not use the PBQ. Eleven children and their families had attended the surgical preadmission programme one week prior to their scheduled surgery. The researchers found that regardless of attendance at the preparation programme, 83% of these younger children exhibited signs of distress according to their parents. The study provides evidence that hospitalisation distress is the likely finding in younger children regardless of the use of qualitative or quantitative methods to measure the distress.

There is very little evidence in the literature about children and families who do not benefit from preparation strategies. Most studies acknowledge that no preparation strategy meets the needs of all children and families who participate. Given the complexity of the variables involved in the response to hospitalisation, the lack of evidence of universal effectiveness is not surprising. Indeed, researchers do not expect that all children and their families will benefit from the preparation strategy that they test. Children with previous experience of hospitalisation do confound the analysis of studies (Bates & Broome, 1986;

Betz, 2006; Faust & Melamed, 1984) and some studies have chosen to omit them from their analysis in an effort to identify the effectiveness of strategies (Li & Lopez, 2008). However, no studies have explored the lack of effectiveness of strategies for some children and their families. There are no reports in the literature reviewed of negative outcomes of preparation strategies.

2.5.3.2 The outcomes for health care professionals

The outcomes of preparation for childhood hospitalisation for health care professionals are in two dimensions, ethical and practical. The ethical dimension relates to professionals valuing access to quality health care for all people. Essentially, health care professionals believe that optimum preparation will maximise good outcomes and minimise poor outcomes for children and families (Jaaniste et al., 2007). However, from a practical perspective minimisation of the potential for patients to be time consuming or difficult is important for health care professionals. Optimum preparation will have a positive effect on health care professionals' ability to carry out their professional role in the health care environment (Cohen & MacLaren, 2007) when ethical and practical dimensions are addressed.

The research evidence that exists does not assist health care professionals to determine the form of preparation that works best in different circumstances. Attempts to synthesise existing literature to find definitive instructions or clear guidelines often fail due to the differences in preparation needs, the differences in approaches researched, and the outcomes measured. Health care professionals generally understand that preparation does not always work (Justus et al., 2006) despite their awareness of the effects of hospitalisation on children and their families (Association for the Welfare of Child Health, 2005; Bonn, 1994; Foley, 2000; Loff, 2005; McClowry, 1988; R. H. Thompson, 1986; Vessey, 2003; Wright, 1995).

Health care professionals' awareness emanates from their own anecdotal experience; but also from a number of reviews that have synthesised the

available evidence about the effects of childhood hospitalisation from the research literature. For example, Vernon, Foley, Sipowicz and Schulman (1965), reviewed 208 articles from several disciplines including nursing, medicine and psychology that considered children's psychological responses to hospitalisation, although in the early days of interest in the issue. Twenty years later, Thompson (1986) reviewed 300 formal research reports also from a number of disciplines, but he considered psycho*social* responses. Both reviews simply categorised studies and provided a descriptive analysis of them, rather than a synthesis that may assist health care professionals in their everyday practice.

In 1993 Vernon and Thompson (1993) collaborated to write a review of strategies that had been developed to address responses to hospitalisation. They synthesised their findings, however they acknowledged that the complexity of the issue imposed limitations on the transferability of evidence. Vessey (2003) used a nursing and a developmental science perspective to critique 65 articles that considered children's psychological responses to hospitalisation, and not only analysed the studies but also synthesised them in order to develop a model that could be used by health care professionals when delivering preparation for hospitalisation (see Figure 2-1). Nevertheless, there is no evidence in the literature reviewed that Vessey's model is in use in health care practice.

Inconsistency of evaluation of research evidence has further confounded its use by health care professionals. Therefore, some prefer to individualise preparation according to the circumstances at that moment. Others, choose to provide individualised preparation for a variety of reasons including because they are unaware of the research taking place around the issue, but sometimes they choose not to provide any preparation at all (LeRoy et al., 2003). The ad hoc nature of all of these approaches result in inconsistency for children, their families, and the health care professionals who care for them.

Clinicians do not always take up the evidence that does exist of the benefits of preparation and the variety of strategies developed to provide a benefit, as a basis for their practice. The reasons for disregarding the evidence are unclear. Clinicians are aware of the extensive research into the various approaches to preparation over many years (Association for the Welfare of Child Health, 2005). However, they are also aware that there does not seem to be one approach that meets everyone's needs in all health care situations. Disciplines involved in children's health care including nursing, play therapy, education, psychology, social work, occupational therapy and medicine have all reached similar conclusions regarding the elusiveness of the best approach (Jaaniste et al., 2007; Justus et al., 2006; Li & Lopez, 2008; Li et al., 2007b; MacMaster & Rosenberg, 2008; Wisselo et al., 2004). Although many different strategies have been developed, implemented, and even sometimes evaluated, their implementation is often not sustained beyond the study period (Franck, 2010). The lack of sustainability, inconsistency of implementation and complexity of the evidence results in less than optimal outcomes for health care professionals as well as for children and their families.

2.5.4 The current situation in Australian children's hospitals

Universal practice of preparation for childhood hospitalisation does not exist in Australia paralleling the situation in the rest of the western world. The literature reviewed revealed that there were differences in the needs of children and families for preparation for childhood hospitalisation, differences in the preparation approaches, and differences in outcomes of preparation for health care professionals and for the children and their families. With so many differences, there is no surprise that preparation for childhood hospitalisation is not consistently practiced in children's hospitals, either in Australia or throughout the world.

The most recent report published in 2005 by the Australian Association for the Welfare of Child Health (2005) indicated that preparation for childhood hospitalisation is not consistently practiced in Australia. The report is an

Australian government sponsored survey report of all hospitals that treat children. The report revealed that one third of surveyed hospitals provided no pre-admission programme, although they indicated that they would if they had the resources. A further one third of hospitals indicated that they had no interest in providing a pre-admission programme. Therefore, it can be concluded that preparation for childhood hospitalisation is practised in one third of hospitals that treat children in Australia.

The report noted that most hospitals provided written information; however, it was of varying quality and often was in the form of physical preparation for the admission event rather than psychological preparation for the experience of hospitalisation. The report also indicated that preparation practice for tests, procedures and operations is neither comprehensive nor systematic. Although two thirds of hospitals reported that they prepare children by explaining what is going to happen, only 21% of hospitals used the techniques recommended in the preparation literature, such as coping skill training, filmed modelling and play therapy (O'Byrne, Peterson, & Saldana, 1997).

In the 2005 Australian report only one quarter of hospitals reported that an identified department of the hospital coordinated the preparation for health care procedures. That is, the management of three quarters of Australian hospitals that provide health care for children must not have a clear idea about whom, how, when and where children and their families are being prepared for hospitalisation. The report made a number of recommendations regarding consistent and universal implementation of preparation for childhood hospitalisation. However, the report did note that implementation of recommendations from the previous report regarding the preparation for childhood hospitalisation of culturally and linguistically diverse people still had not occurred 13 years later.

The report summarised the Australian current situation whereas 23 studies related to preparation for childhood hospitalisation reported individual studies conducted in Australia between 1990 and 2008. These studies are drawn from

the literature search described in section 2.2 and Australian studies are a sub-set of studies in other western countries. Studies focus on only some of the variables involved in preparation for childhood hospitalisation and do not meet the criteria of the NICE guidelines for high levels of evidence (Table 2-7).

There were no studies that met the criteria of level 1++, 1+ or 2++ according to the NICE levels of evidence guidelines. The vast majority of papers were categorised as level 4, that is expert opinion or formal consensus. Studies failed to provide high levels of evidence because they did not account for one or more of the variables involved in evaluating preparation for childhood hospitalisation. The following table ranks the studies according to the NICE guidelines.

Levels of evidence	Types of evidence
1-	Meta-analyses, systematic reviews of RCTs with a high risk of bias
1 study	Robinson and Kobayashi (1991)
2+	Well-conducted case-control cohort studies with a low risk of confounding bias, or chance and a moderate probability that the relationship is causal
2 studies	Hallowell, Stewart, de Amorin e Silva and Ditchfield and Stargatt, Davidson, Huang, Czarnecki, Stewart and Jamsen (2006)
2-	Case-control or cohort studies with a high risk of confounding bias, or chance and a significant risk that the relationship is not causal
1 study	Goymour, Stephenson, Goodenough and Boulton (2000)
3	Non-analytic studies, e.g. case studies, case series
1 study	Wisselo, Stuart and Muris (2004)
4	Expert opinion, formal consensus
14 studies	Alsop-Shields and Budd (1999), Alsop-Shields and Mohay (2001), Alsop-Shields and Nixon (1997), Jaaniste, Hayes and von Baeyer (2007), Keller (2001) Loff (2005), Mitchell, Johnston and Keppell (2004), Shields (2001), Shields and Nixon (1998), Whelan and Kirby (1998), Wilkins (1994), Wright (1995) and Wynn (1997).

Table 2-7 Australian studies grouped according to the NICE levels of evidence guidelines

Other western countries have reported the same issues around the lack of consistency of implementation of preparation strategies as reported in Australia (Association for the Welfare of Child Health, 2005). For example, in France the APACHE report Children's health in France (2005) was published by the consumer group interested in the quality of childhood hospitalisation

experiences. In the Netherlands the journal of the National Association Child and Hospital (2008), also a consumer group, produced a special edition, to emphasise the importance of the issue by outlining the complexity of the elements related to childhood hospitalisation that are involved. Publication of knowledge about the complexity of childhood hospitalisation is promising; however, these two reports also noted limited and inconsistent implementation of preparation programmes.

In their November, 2007 editorial for the journal Pediatric Anesthesia, American psychologists and pædiatric anaesthetists, MacLaren and Kain (2007), reported their research group's 1997 survey of 34 children's hospitals and 24 community hospitals in the USA. The survey showed that there was a wide variation in preparation programmes, there were few protocols for timing of preparation strategies and many centres were providing strategies that had very little empirical evidence for their effectiveness. Less effective strategies such as a hospital tour or printed material (O'Byrne et al., 1997) were offered. The original survey report released in 1997 by O'Byrne, Peterson and Saldana (1997) found that most children's hospitals in the USA used these less costly strategies, and MacLaren and Kain (2007) noted that there had been no change in the type of preparation offered in the following decade.

The worldwide trend to shorter acute care hospital stays for all acute care hospital patients (AIHW, 1998, 2011) has had an impact on Australian children's hospitals, contributing to changes in the management of childhood hospitalisation. Shorter acute care hospital stays for children possibly relate to government policy aimed at lowering health care costs, rather than to research evidence specifically related to childhood hospitalisation. Schmidt (1990) found that short stay hospitalisations had become increasingly common in the USA because they were considered less stressful for children and their parents. Day surgery, not requiring an overnight hospital stay, is common for pædiatric procedures. Fifty years ago, surgical removal of tonsils, a very common example, required a one-week hospital stay; today the procedure is a day surgery procedure (M. Sutherland & Bruce, 1998) that does not usually require

an overnight hospital stay (AIHW, 2011). Similarly, many pædiatric diagnostic procedures and treatments that previously required in-patient admission now require non-inpatient or out-patient hospital attendance only.

Shorter hospital stays of children and their families are effective in minimising exposure to hospitalisation; however, they do make the delivery of optimum preparation for hospitalisation even more challenging. When time is short, clinicians have difficulty addressing all the influential elements of children's psychological response to hospitalisation shown in Vessey's (2003) model (see Figure 2-1). Optimum timing of preparation as discussed by many researchers (Ferguson, 1979; Jaaniste et al., 2007; Mitchell et al., 2004; R. H. Thompson, 1986; Vernon & Thompson, 1993) is difficult when there is a reduction in the length of hospital stay and limited opportunities for preparation prior to hospitalisation.

Financial cost does seem to be one barrier to the implementation of evidence based recommendations that is mentioned in many reports of strategy implementation (see for example Justus et al., 2006). There have been studies that grappled with the issue of cost effectiveness in the design of the intervention (Peterson et al., 1984; Wynn, 1997), finding that even a low cost does not ensure implementation of an intervention (Pinto & Hollandsworth, 1989). Although noteworthy, there is no direct link between financial cost of preparation interventions and their implementation. The report published in 2005 by the Australian Association for the Welfare of Child Health (2005) does not indicate if financial cost is a barrier to the implementation of preparation for childhood hospitalisation.

The current situation in Australian children's hospitals in relation to preparation for childhood hospitalisation indicates inconsistency of delivery of strategies aimed at ameliorating negative outcomes and enhancing positive outcomes. Possible reasons for the inconsistency include the large number of elements related to childhood hospitalisation and the lack of recommendations designed to guide clinicians in their practice of preparation for childhood hospitalisation.

2.6 Summary

The amount of effort that has gone into theorising and researching the area of preparation for childhood hospitalisation that has occurred over the last 60 years has been enormous and the literature review provides evidence of this. The review identified and clarified the areas of complexity that affect children, their families and the hospital environment that are: the needs of children and their families for preparation for childhood hospitalisation, preparation approaches, the outcomes for preparation participants and for the health care professionals. The literature review also provides identification and clarification of the current situation in Australian children's hospitals. The literature review has also identified a number of barriers to the consistent implementation of preparation that include the complexity of the evidence, the lack of outcome research, financial cost, personnel costs, time constraints, cultural issues, shorter hospital stays and the related issue of optimum timing of delivery of preparation strategies.

Preparation approaches designed to ameliorate the negative effects of hospitalisation and even to optimise the positive effects have been developed, implemented and sometimes evaluated. However, practice of universal preparation of children and their families for hospitalisation does not happen. The next chapter includes a review of the health care practice change literature in order to increase understanding of barriers to changing practice in order to inform my work in the present study, with its goal of improving preparation for childhood hospitalisation practice at one organisation.

Chapter Three – Literature review – Practice change in health care settings

The literature reviewed in the previous chapter points to two major findings. The first is that the area of preparation for childhood hospitalisation is very complex indeed and the second is that the extent to which appropriate preparation is provided is inconsistent across settings. This chapter looks at concepts related to change in order to find the most effective way to change clinical practice, in particular preparation for childhood hospitalisation practice.

3.1 Introduction to this chapter and key concepts reviewed

There has been enormous growth in theoretical and empirical work seeking to understand the major challenges that exist around the transfer of research evidence into practice. The literature review presented in this chapter seeks to explore a portion of that literature that may relate to practice change in preparation for childhood hospitalisation. There is a focus on the challenges of achieving practice change in health care settings to inform the work of the health care professionals who sought to improve the practice of preparation for childhood hospitalisation at their hospital, in the present study. To enable the challenges of research utilisation and practice change to be addressed the literature related to organisational change is reviewed.

The major intention of this chapter is to outline some of the important issues associated with change in health care organisations. The chapter is organised in the following way. First, a congruent literature search strategy is outlined. Then there is a brief review of some of the major theoretical explanations of organisational change that is then linked to commonly adopted change processes. Next, the literature review seeks to uncover the enablers and barriers of practice improvement particularly in health care. The following section of the literature review relates to the effectiveness of collaborative group work in changing practice. Finally, an outline of the changes that would be beneficial in the Australian context completes the chapter.

3.2 Literature search strategy

As was the case in the literature review presented in Chapter Two, the search strategy followed recommendations by Hockenberry, Wilson and Barrera (2006) in relation to the implementation of evidence-based pædiatric nursing practice. The recommendations predict that EBP will become part of the delivery of pædiatric health care. The search strategy recommendations enable identification of the best evidence for change for improvement of the practice of preparation for childhood hospitalisation.

Figure 3-1 shows the selection process that was used to refine the literature search using a four-step approach, rather than the five-step approach that was necessary for the previous literature search. The process was simpler because although the literature related to change was general in nature, selection of relevant publications was limited to publications applicable to change of preparation for childhood hospitalisation practice. The literature selected addressed change concepts theoretically especially in relation to organisational change and dissemination of innovations that lead to practice improvement change. Selection of publications from literature related to health care practice change in organisations followed. The selection included examination of reports of the enablers and barriers to health care practice change. The part that group work plays in enabling change for improvement particularly in childhood hospitalisation practice then followed. Finally, there was selection of literature about the Australian context in relation to changes that would benefit Australian children and their families regarding preparation for childhood hospitalisation.

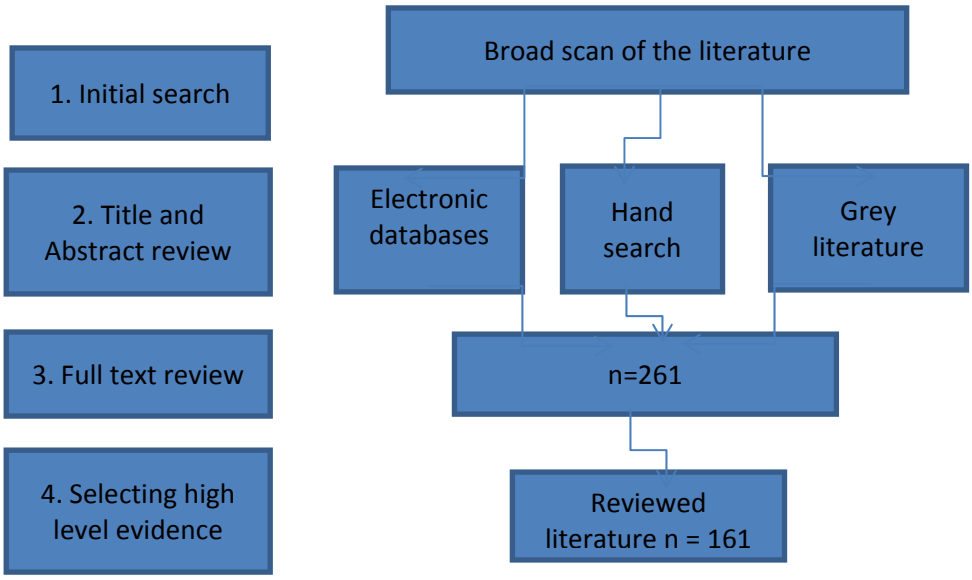

Figure 3-1 Selection process (adapted from Jeon, Merlyn & Chenoweth, 2010, p. 56)

The selection process followed these steps:

Step One – Initial search: A broad scan of the available literature on change and change in health care. The vast majority of publications included in the broad search were in English language and published within the last 30 years, possibly because during the last 30 years health care practice change has become an area of interest to health care professionals (Tiffany & Lutjens, 1998). The keywords used in the literature search were: *change, improvement, practice change or improvement, health care practice change or improvement, diffusion of innovation, barriers to change or improvement, enablers of change or improvement, team learning, practice development, evidence based practice, evidence based medicine and evidence into practice*. Application to the search of all relevant spellings and combinations of these keywords followed. As with the previous literature search, the Cumulative Index of Nursing and Allied Health Literature (CINAHL) database was searched using the EBSCO search engine. Medline and PsychINFO databases were searched using the OVID search engine (see Table 3-1). The results of these searches were combined with some of the keywords used in the review of literature of childhood

hospitalisation that were: *children, hospitalisation, and preparation programmes*. All elements of these keywords refined the search in combination with the keywords involved in health care change.

Simultaneously there was a hand search for other publications including grey literature. The reference lists of citations found in the electronic database searches revealed a number of influential works, in particular books written by experts in organisational change, change for improvement and change in health care services. These were included in the literature review.

The rationale of this literature review was to find literature that informed healthcare change. The literature review allowed for different types of evidence to be included, although exclusion of non-research publications from this analysis was because this review only aimed to identify directions to guide the improvement of preparation for childhood hospitalisation, not to review health care change more generally. The search strategy resulted in peer-reviewed journal articles, books, systematic reviews and government reports.

	Keywords	Results
Search 1 – CINAHL (EBSCO)		
1	Change or improvement	205286
2	Practice change or practice improvement	2362
3	Health care practice change or health care practice improvement	21
4	Diffusion of innovation	3849
5	Barriers to change or barriers to improvement	358
6	Enablers to change or enablers to improvement	2
7	Team learning	187
8	Practice development	2147
9	Evidence or evidence based practice or evidence based medicine	111044
10	Evidence into practice	577
Search 2 – Medline (OVID)		
1	Change or improvement	2140396
2	Practice change or practice improvement	1301
3	Health care practice change or health care practice improvement	1
4	Diffusion of innovation	11865
5	Barriers to change or barriers to improvement	316
6	Enablers to change or enablers to improvement	7
7	Team learning	74
8	Practice development	595
9	Evidence or evidence based practice or evidence based medicine	965971
10	Evidence into practice	329
Search 3 – PsychINFO (OVID)		
1	Change or improvement	102412
2	Practice change or practice improvement	183
3	Health care practice change or health care practice improvement	0
4	Diffusion of innovation	104
5	Barriers to change or barriers to improvement	56
6	Enablers to change or enablers to improvement	3
7	Team learning	101
8	Practice development	166
9	Evidence or evidence based practice or evidence based medicine	68373
10	Evidence into practice	53

Table 3-1 Electronic database keyword search strategy

Step Two – Title and abstract review: Examination of publications from the three sources, electronic databases, hand searches and grey literature, followed. They were examined for their relevance to the present study and for the depth of information provided by reviewing the titles and abstracts of the publications. The process enabled the removal of a number of publications that were not relevant to health care change, although retention of some influential work provided information about the principles of change more broadly. The selected publications were pooled for Step Three of the literature search.

Step Three – Full text review: Publications were read in their entirety and, in particular, for the validity and reliability of research findings. Publications included a number of books that provided theoretical information as well as reports of studies that tested the theoretical concepts both in organisations generally and in health care organisations. Journals mainly published reports of research studies, and the researchers commented on the successes and failures of various methods to enable change. By comparing reports from a variety of organisations, analysis of methods that were more likely to be successful in health care organisations was possible. Relatively few publications examined change in preparation for childhood hospitalisation practices; however, they were of particular importance in the full text review.

Step Four – Selecting high levels of evidence: Once again, the NICE guidelines produced by the National Institute for Health and Clinical Excellence (2006), see Table 2-3, was used in this literature review to rank the level of evidence that each paper achieved. The NICE guidelines provide a simple model that enables systematic identification and critical appraisal of publications. The keyword searches used in Step One assisted in the classification of publications according to major concepts. Step Four classified the publications according to their demonstration of evidence that would assist in determining the best methodology to use to improve the practice of preparation for childhood hospitalisation.

Most of the publications in this review emanate from western countries. Many of the experts in the field of change are in either the USA or the UK and write books based on their work about change for improvement. These experts are interested in organisational change, and some are interested in health care organisational change. People from many disciplines write reports of studies that have investigated change in the real world, however in the present literature review studies that investigate health care practice change predominate.

Interest in organisational change and in particular health care organisational change has been accelerating since early last century. Today the interest has intensified as knowledge improves and solutions to making changes for improvement are less elusive than they must have once seemed. However, although many change solutions are proposed, selection of the right solution for each circumstance continues to be the task of those undertaking the change. Many of the researchers who write papers included in this literature review take the advice of the experts when designing their study, nevertheless, that advice does not always assure them of success. The first section of this literature review outlines the advice of some experts.

3.3 Change for improvement

Change is an inevitable part of the human condition and yet many resist change very heartily, subtly or obviously. The first literature review provided the evidence that supports the importance of preparation for childhood hospitalisation and the evidence that preparation is not used in practice. The literature review provides evidence about practice change processes. Change is a concept researched and written about very thoroughly in many disciplines and presentation of the work that specifically applies to change in health care practice makes explicit the issues involved in the present study. The considerable literature about practice improvement change processes may help to illuminate the best way to facilitate change processes that implement optimum preparation practice for hospitalisation of children and their families.

3.3.1 Organisational change

Because the present study was about making change in a major children's hospital within a government department of health, the organisational change literature seemed to be a pertinent place to start to investigate what needed to be done and a review of this literature is now provided. Organisational change, researched and discussed from many points of view, is change within organisations that typify the way that people as social creatures arrange their

lives. Most organisational change literature is associated with the period since the end of World War 2 (1945) to today. Senge, an organisational psychologist, has written a number of books that analyse and synthesise organisational change and also state the understandings of many at the beginning of the twenty first century, with regard to change (Senge, 2006; Senge et al., 1999). Senge suggests that a team of people who are part of an organisation but who are also required to change the organisation carry out organisational change.

Senge and his colleagues (1999) contended that most change initiatives fail, at the beginning of their resource book designed for managers of organisational change. Despite the opening statement, the authors provide some advice about how to optimise the chances of change initiatives being successful. They, and others note, that *people* undertake organisational change and that people influence outcomes by, and because of, their individual characteristics (Hart & Fletcher, 1999; Lindeman et al., 2003; Rogers, 2003; Senge et al., 1999). Senge and his colleagues (1999) advise that taking individual characteristics into account as well as the other characteristics of change and of the site into which change is to be implemented optimises the chances of successful implementation of change.

Ten challenges to change were proposed by Senge and his colleagues (1999) that include challenges to the three phases of change that they identified: initiation, sustainability, and redesigning and rethinking. Challenges to the initiation phase are the perception by the initiators of no time, no help, irrelevance and the mismatch between behaviour and espoused values. The challenges, or opportunities, that they identify in the sustainability phase are both within and between the change team and the larger organisation. They are fear and anxiety of the team, assessment and measurement that may not match the traditional method of the organisation and the consistent misinterpretation of the team by others in the organisation. The three challenges of the final phase, characterised by Senge and his colleagues (1999) as redesigning and rethinking, occur when credible change initiatives confront the organisation. The first challenge is of governance, that is, who is to

implement the change? The second challenge is of diffusion of the change throughout the organisation so that others can build on the team's work. The third challenge is to address the strategy and purpose of the organisation after change has occurred.

Having identified these challenges, Senge then proposed the characteristics that addressed them. These he articulated as five learning disciplines (Senge, 2006): personal mastery, mental models, shared vision, team learning and systems thinking. The first four disciplines are about the characteristics of people and as such bring to the centre of this discussion the concept that people are fundamentally important to optimising change. He contended that people in a team must exhibit these fundamental characteristics or disciplines to make change within an organisation. Systems thinking, the fifth discipline, is a way of seeing the whole issue, not just its individual parts (Senge, 2006) and is fundamental to the success of Senges' approach to change. Systems thinking addresses complexity, such as the complexity of health care organisations. For over a decade Senges' set of practices known as the five disciplines (2006) and the ten challenges to change (Senge et al., 1999) that he and his colleagues proposed have guided change processes in organisational change.

As Senge and his colleagues (1999) pointed out, people are essential to change. Planning for change must include the people involved in the change (Schifalacqua, Costello, & Denman, 2009). Therefore there is a recognition that change within organisations, including health care organisations, is more likely to be successful if the change is voluntarily undertaken by people rather than imposed on them by others (Greenhalgh et al., 2005). Understanding and using the voluntary participation of people in the present study offered a way to enable practice change improvement.

3.3.2 Change involving innovation dissemination

An innovation is something new, and given that change is the substitution or succession of one thing for another, it follows that innovation and change share

many characteristics. However, when discussing change in health care and its implications for nurses, nurse managers and nursing, Pryjmachuk (1996) distinguished innovation and change by stating that innovation is a new way of doing things that usually has a positive connotation. Change on the other hand is not always welcome or easy. According to Pryjmachuk (1996) the dissemination of innovation/s into an organisation is complex and many factors influence whether the dissemination is successful or not. The process of adoption of innovation leading to change followed by sustained change in practice is the diffusion of innovation and involves people who are in social situations such as workplaces.

Rogers, one of the leaders in organisational change research, researched and wrote about the diffusion of innovations. In the fifth edition of his book Rogers (2003) reviewed the evidence about enacting change by citing many examples of both successful and unsuccessful efforts to make change. He described the four main elements of the diffusion of innovations concept as "an *innovation* that is *communicated* through certain channels over *time* among the members of a *social system*" (Rogers, 2003, p. 11, italics in the original). Since the first diffusion of innovation project in 1943, Rogers has conducted many studies and examined many others that aimed at making a change in the way things happen. He explained that for various reasons some people will adopt an innovation immediately, early adopters, and others may adopt the innovation after some time has elapsed, these people are known as later adopters. Rogers observed that people are vitally important in the accomplishment of successful dissemination of innovation and change, just as Senge had done.

Rogers identified many variables that influence the adoption, or not, of innovation. These included the characteristics of adopters of the innovation, the perceived relative advantage of the innovation, the compatibility of the innovation with the values and beliefs of the potential adopters, the complexity of the innovation, and the trialability and observability of the innovation's adoption (Rogers, 2003). However, as well as the characteristics of the adopters and of the innovation, the characteristics of the organisation also

influence the diffusion or dissemination of the innovation or change (Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004).

A study was reported that recommended Rogers' diffusion of innovation model to influence health care practice change addressed the characteristics of the organisation. Pearcey and Draper (1996) stated in their report that the methods used by the National Health Service in the UK to disseminate information might actually block research utilisation because they were authoritarian. The researchers described a study that used action research, with all participants being nursing staff in a surgical unit, to devise a protocol for preoperative information giving. The participants used the diffusion of innovation model to organise their data collection and analysis. Pearcey and Draper (1996) were more interested in the utilisation of the data analysis than on the implementation of any changes. However, although the researchers acknowledged that the results of the study were not generalisable, they did find that the diffusion of innovation model allowed all participants to contribute to addressing the characteristics of the organisation through action research.

Rogers' examination of the characteristics of the process of changing the way things are done is valuable as the examination helps to explain why some changes are not immediately accepted or sustained over time (Rogers, 2003). Senge and his colleagues also identified the uneven adoption of change and they proposed that time is an important consideration when evaluating the dissemination of change (Senge et al., 1999). Many of the elements of the context would influence the time taken for complete dissemination of change to occur, according to Senge and colleagues (Senge et al., 1999).

3.4 Practice improvement change process in health care settings

The focus of this thesis is on practice improvement change therefore this section will apply the literature about change processes to health care settings. In this thesis Senge's and Rogers' writings provide a background about organisational change and diffusion of innovations. Others have referred to

other experts in organisational change, for example Cork (2005) recommends Leavitt's writings to inform the development of a successful model for health care change. The principles of change and the methods used to enact change remain broadly similar. Nevertheless, Iles (1996) reminds us that change can cause a sense of grieving in the people involved in the change, especially she says, when the change is in health care. One technique to counter the potential for grieving is for the involved people to become familiar with the principles and methods of change. The diffusion of innovations proposed by Rogers (2003) and described in the previous section is one method successfully used in health care that addresses the sense of grieving described by Iles (1996) because it acknowledges the social system (Rogers, 2003) in which people function.

Rogers' theory is acknowledged as a useful approach to change in health care organisations by Greenhalgh and colleagues (2005) in a review of health care change in the UK. In the systematic review of 495 sources including full text articles and book chapters, Greenhalgh and colleagues (2004) derived a unifying conceptual model of diffusion of innovations to enable clarification of the 13 areas of health care research that they identified that had used Rogers' theory.

One of the first nursing studies to attempt to diffuse innovation into a health care organisation, using action research, was conducted by Towell and Harries (1979) in a psychiatric hospital in the UK. Towell and Harries' central theme was developing innovation from within, and they were able to improve the nursing care of psychiatric patients at their hospital (Towell & Harries, 1979). However, the sustainability of the change was not reported. In an effort to understand the diffusion of innovations into complex health care practice a group of health care researchers examined four case studies (Denis, Hebert, Langley, Lozeau, & Trottier, 2002). The researchers characterised the four case studies as examples of: success, overadoption, prudence and underadoption (Denis et al., 2002). The conclusion drawn by Denis and colleagues (2002) was that understanding the characteristics of the adopting

organisation is critical to how successfully an innovation is diffused into the organisation.

3.4.1 Commonly adopted practice change processes

In a systematic review of the change in health care organisation literature there was consideration of all aspects of the context of the site for the introduction of change; that is the characteristics of the people and of the organisation. Greenhalgh and colleagues (2005) who undertook the review, analysed developments in health care and applied the lessons learned about adoption of change to the challenges confronting health care organisations. The authors cite the enormous complexity of the health care context, both inner and outer contexts, as confounding prediction of outcomes. Greenhalgh and colleagues (2005) propose a conceptual model for the spread and sustainability on innovations in health service delivery that incorporates all elements that should be considered when attempting to facilitate change in health care practice. While recommending their model as an evidence-based framework to capture all necessary elements and their complex interaction, the authors also recommend applying the model to the specific local context and setting, as a pragmatic approach to enacting change.

The process of change in health care settings was studied by Hart and Fletcher (1999) who focused on what change is and how teams learn to change. They examined change in large health care and educational settings and concluded that change is a process that is collective, that is, that teams need to own the process in order make changes. They also observed the importance of the context in which the change is to occur, noting that successful change strategies are not necessarily transportable from private sector to public sector organisations, or from one industrialised country to another. A study that focused on the context of the research sought to find out more about modernising health care services in the UK was carried out by Hall (2006). The study found that team learning, that is health care professionals' learning, and change were reliant upon the context of the health care services provided and

that collaboration within the team is fundamental to the realisation of needed change (Hall, 2006).

There is evidence that local development and ownership of change will sustain health care practice change over time (Bellman, Bywood, & Dale, 2003; Suderman, Deatrich, Johnson, & Sawatzky- Dickson, 2000; Waterman, Webb, & Williams, 1995; Webb, 1989). A number of nursing research projects have found that involving nurses in the research process has led to sustained change when other research methods have not. For example, Suderman and colleagues (2000) found that involving bed-side nurses in the research process engaged the nurses' interest and enthusiasm. The nurses interviewed parents of hospitalised children to determine the parents' perceptions of their discharge preparation needs. The data showed that there was a discrepancy between the parents' and the nurses' perceptions. The nurses were able plan to change the discharge planning process and then evaluate the new process. Because the nurses had planned the action, acted on plans, observed the outcomes and reflected on the outcomes they owned the planned changes and were committed to their sustainability.

3.4.2 Enablers and barriers to practice improvement change

The things that affect the success or failure of change initiatives, generally referred to as enablers and barriers to change, are examined in this section of the literature review. The literature provides evidence of enablers and barriers and three examples in health care practice change follow. More extensive evidence for the barriers to change than for the enablers is provided in the literature possibly because researchers consider that they have more influence over barriers than they do over enablers.

Health care professionals behaviour change was examined in a systematic review of 15 studies of interventions tailored to overcoming barriers to practice change, to identify if the interventions reported were successful in realising the specified change (Shaw et al., 2005). The review showed mixed results for

tailored interventions, either for individuals or for the organisation. However, the review did identify the problem of the integration of change into health care professionals' practice because practice change is multi-faceted and context specific. The 2005 review was repeated and enhanced in 2010 (Baker et al., 2010). The 2010 review reported on 11 new studies as well as the original 15 and the second review indicated that tailored interventions could change professional practice. However, there was insufficient evidence of the most effective approaches to tailoring of interventions. The 2010 review recommended the use of low-cost tailored interventions until conclusive evidence of interventions tailored to identify and address barriers to practice change is available (Baker et al., 2010).

By addressing potential barriers to change at the outset clinicians were able to address changing practice for improvement in a study by Lindeman and colleagues (2003). Clinicians in residential aged care sought to improve the nutrition and physical activity of elderly residents at five residential aged care settings in Victoria, Australia (Lindeman et al., 2003). The clinicians began by identifying any barriers to change that existed in their setting. The main finding of the first phase of the project was the importance of involving all staff in the change process and acknowledging their knowledge and expertise in caring for elderly residents. The clinician researchers also identified enablers to change such as acknowledgement of the organisational context, the importance of management support and the empowerment of staff to make change.

Ely (2001) revealed a number of barriers to change in pædiatric nursing practice when she worked with a group of nurses to improve pain management practices in the pædiatric unit of a 240 bed community hospital in New England, USA. The study used an action research methodology that included group meetings with 16 clinical nurses on alternate weeks for a 10-week period, and documentation of the discussion data collected during the group meetings that was then analysed. The group meeting process resulted in the nurses' identification of three themes that were barriers to change in the setting. Each

theme was divided into a number of categories and the group used quotations from their meetings that exemplified each category (Ely, 2001).

The first theme was barriers and solutions to clinical practice change (Ely, 2001). The categories within the first theme were time constraints, inconsistencies in practice, issues with pain management orders, parental barriers and child characteristics. The second theme was organisational barriers to change (Ely, 2001) and the categories were change (in the work environment) sometimes referred to as churn (Duffield, Roche, O'Brien-Pallas, & Catling-Paull, 2009), job insecurity, perceived lack of power and falling morale.

These two themes mirror much of the evidence that is available regarding the barriers to change in clinical practice in health care (Bellman et al., 2003; Greenhalgh et al., 2005; Hall, 2006; Lindeman et al., 2003; Shaw et al., 2005; Suderman et al., 2000; Waterman et al., 1995; Webb, 1989). The group in the pædiatric nursing practice study identified a third theme that they called staff commitment toward pain management (Ely, 2001) and the third theme incorporated three categories: nurse empathy, pain assessment and positive change. The third and final theme was a fundamental endorsement of action research because the theme showed how consciousness raising through discussion and reflection had led to uncovering barriers to change that then enabled change to the clinical practice of pain management in their pædiatric unit (Ely, 2001).

Many factors influence the implementation of practice improvement change, and may be either enablers or barriers to practice improvement change. The Promoting Action on Research Implementation in Health Services (PARiHS) framework first proposed in 1998 organised the factors into three broad elements: evidence, context and facilitation (Kitson, Harvey, & McCormack, 1998; Rycroft-Malone, 2004a). Each element includes a number of factors that can be either enablers or barriers to practice improvement change. Each of these elements are conceptualised as being on a continuum from low to high

efficacy. It is proposed that the position of each element along its continuum relative to the other elements along theirs, will predict the extent of the success of the implementation. When each of the elements are high there is greater likelihood of successful implementation of change (Kitson et al., 1998). Rycroft-Malone and her colleagues (2002) revisited the PARiHS conceptual framework and they maintain the importance of the three elements that constitute the framework. However, their concept analysis of the sub-elements indicated that the relative importance of each needed to be better understood if evidence-based practice was to be achieved (Rycroft-Malone et al., 2002).

Research evidence that is considered high is well-conceived, designed and executed research, appropriate to the research question, whereas low evidence is poorly conceived, designed and/or executed research (Rycroft-Malone, 2004b). To be high the evidence must be scientifically robust and match professional consensus and patient preference (Kitson et al., 1998; Rycroft-Malone, 2004a). According to the PARiHS framework the element of evidence refers to health care evidence and includes not only evidence from research literature but also clinical experience and patient experience (Rycroft-Malone, 2004c). Very little of the research reviewed about preparation for childhood hospitalisation met the standard of high evidence. For example, as pointed out in that review, there was an inconsistency of findings in studies that seemed to be similar (Vessey, 2003). Ensuring that all characteristics of evidence are high can be challenging for health care professionals.

The context, the second PARiHS factor, needs to be receptive to change with sympathetic cultures, strong leadership and appropriate monitoring and feedback systems (Rycroft-Malone, 2004c). The context in which the practice of health care takes place can differ dramatically in different settings, communities and cultures. Economic, social, political, fiscal, historical and psychosocial factors influence the settings. The strong support of the Director of Nursing, as a leader within the organisation was of vital importance in allowing access to the context of the present study that is the subject of this thesis. However, partial understanding of some of the characteristics of the

context for the present study of preparation for childhood hospitalisation meant that the culture of the hospital systems needed investigation.

The third element that influences the implementation of practice improvement change is facilitation, according to the PARiHS framework. Facilitation is "the technique by which one person makes things easier for others" (Kitson et al., 1998, p. 152). The three factors considered important in facilitation are the purpose, the role and the skills of facilitation. The facilitator needs to be holistic and enabling on all three of these factors for the facilitation to be high (McCormack, Manley, & Garbett, 2004). Kitson and colleagues (1998) note that when facilitation is ineffective or non-existent successful implementation of change may not occur, even though the other two elements are high.

Table 3-2 summarises a number of studies that have used the PARiHS framework to enable health care practice improvement change in relation to the elements of evidence, context and facilitation that the PARiHS group has developed and refined (Rycroft-Malone, 2004a). Each publication is rated according to the NICE guidelines that indicate levels of evidence from one to five.

Authors and date	Summary	NICE rating
Ellis, Howard, Larson and Robertson (2005)	Pre, post and follow-up of workshop at six sites in Western Australia. Good facilitation is more influential than context in overcoming barriers to the uptake of EBP.	3
Brown and McCormack (2005)	Literature review of post-operative pain management Support of the three elements	3
Wallin, Estabrooks, Midozi and Cummings (2006)	Two surveys of Canadian nurses, in 1996 n=600, in 1998 n= 6526, the better the context the higher the research utilisation score. Examined the three elements of context only, empirical support of context.	3
Kavanagh, Watt-Watson and Stevens (2007)	Pædiatric pain management All three elements affect the uptake of EBP	3
Doran and Sidani (2007)	Outcomes-focused knowledge translation framework utilised the three elements but did not empirically test them.	3
Cummings, Estabrooks, Midozi, Wallin and Hayduk (2007)	Further analysis of Wallin et al., 2006 Showed the influence of organisational factors, that is the context of the change	3
Conklin and Stolee (2008)	Testing of knowledge exchange network in work with seniors Used three elements to develop a useful model	4
Perry, Bellchambers, Howie, Moxey, Parkinson, Capra and Byles (2011)	Used the framework to implement EBP in aged care, three sites (high care low care and dementia care) interviews of all staff, support of pre-intervention planning Support for three elements	3

Table 3-2 Summaries of studies using the PARiHS framework in health care

The research cited about enablers and barriers to practice change indicates that they are very influential in improving practice. The research also indicates the necessity of acknowledging enablers and barriers at the planning stage of any research study. Identifying and addressing enablers and barriers to change can potentially alter the outcome of health care practice change.

3.4.3 Evidence for group work in practice improvement change

The following section outlines two components of group work in practice improvement change. The first component provides a review of the theoretical work about groups. Both Tuckman (1965, 1990; Tuckman & Jensen, 1977) and Lewin (Cartwright, 1952; Lewin, 1997a) have contributed to knowledge about groups and therefore to an understanding of group processes. The second

component is evidence from health care practice change that suggests that working in groups improves the chances of successful practice change. Both these components confirm that group work was the best way to change preparation for childhood hospitalisation practice.

A theory of group development postulated by Tuckman (1965) when he reviewed 50 articles on group development proposed that groups move through specific stages as they work together on issues of shared concern. He labelled these stages "forming, storming, norming and performing" (Tuckman, 1965, p. 396). Later, in collaboration with Jensen a fifth stage "adjourning" (Tuckman & Jensen, 1977, p. 419) was added after reviewing a further 22 articles that had been published in the intervening 10 years. Tuckman claimed that the five stages are sequential and predictable. He hypothesised that groups of people had a way of working together that demonstrated their humanness and that that contributes to understanding how groups work together when the objective is to change the status quo.

Tuckman and Jensen's (1965; 1977) concepts about group work link with the observations of Lewin (Cartwright, 1952), a social psychologist who contended that groups of people are powerful in achieving change through collaboration. Lewin contributed a great deal to knowledge about groups in his work with action research in which he is referred to by many as the father of modern action research (D. J. Greenwood & Levin, 2007). In 1947 he wrote about group dynamics, developing a scientific approach to describing the many permutations of the ways that people interact when in groups (Cartwright, 1952; Lewin, 1997b). After Lewin's death in 1947 all his writing was published in Field theory in social science in 1952, edited by Cartwright (Lindezey, 1952). In 1997, Lewin's work was released again along with some of the writings of his second wife, Gertrude Weiss Lewin.

Importantly, Lewin (Cartwright, 1952) considered that individuals behave differently when in groups than when acting for themselves. He contended that being part of a group, to which the individual wished to belong, resulted in that

person adjusting their ideas and behaviour to conform to that of the group. He provided a number of examples of the phenomenon from his own research. One example was an experiment that he conducted in 1946 in which housewives' group decision making influenced their families' fresh milk consumption. A control group attended a lecture on the topic and the experimental group participated in group discussions leading step by step to the decision to increase their (fresh) milk consumption (Lewin, 1997b). He followed both groups for two and four weeks to map the adherence to the change and found that the change remained constant for the lecture group but for the group decision housewives the rate was greater at two weeks and had increased further at four weeks. Lewin (Cartwright, 1952) contended that sustained change demonstrated the strength of group work.

The significance of a group approach to resolving an issue was found by Warfield and Manley (1990) when they were involved in a project designed to articulate a unit philosophy in an Intensive Care Unit in the UK. The researchers found that until everyone working in the unit contributed to the writing of the unit's philosophy the unit was not truly represented. The researchers initially developed and distributed a questionnaire to nursing staff, however the questionnaire was not completed by everyone. The researchers then initiated group discussions so that all nursing staff were involved in the development of the unit philosophy. A member of the nursing practice group who was not a nurse in the unit provided careful facilitation of the group to enable the discussions. Following many discussions a written collection of common values and beliefs was developed (Warfield & Manley, 1990). The study provides evidence of the tension between ensuring voluntary participation and achieving a defined outcome. Evidently, group work requires careful facilitation to ensure satisfactory outcomes.

Facilitation by university educators of a group of 15 nurses improved their pain management practice and their utilisation of pain management research in a study conducted by Dufault and colleagues (1995). The intervention group were compared to 12 nurses in a control group, pre and post the intervention,

which took place in 6 phases over 28 weeks. The phases of the study involved facilitation in the processes involved in problem identification, evaluation of relevant research, innovation design, innovation testing, the decision to adopt the innovation, and dissemination of findings. The group of nurses worked together to improve practice and simultaneously developed skills in research utilisation in collaboration with the university educators who were their facilitators.

Evidently, group work is a way to optimise individual good will and energy to take advantage of the concept that groups are more than the sum of their parts. Collaborative groups are suited to working together to use evidence to improve practice resulting in evidence-based practice. The literature provides evidence that collaborative groups can change practice. The next sub-section seeks to apply evidence of the effectiveness of collaborative groups to changing preparation for childhood hospitalisation practice.

3.4.4 Collaborative group practice change concepts to improve preparation of children and their families for hospitalisation

Group work has successfully changed practice in many settings including health care. Practice change concepts that use collaborative groups to enact change have created change for the better. It seemed reasonable to anticipate that collaborative group work might be successful in improving the practice of preparation for hospitalisation at this major children's hospital. A small number of studies had used group processes to change practice in areas related to childhood hospitalisation. However, no evidence specifically addressed change to preparation for childhood hospitalisation practice. Therefore, evidence about practice change in similar situations was sought.

A study reported that changes to the practice of hospital discharge preparation for children (Suderman et al., 2000) adopted group processes. A group of five children's nurses in a children's hospital in Canada conducted the study, directing the research. They used an action research methodology to explore

the practice of discharge planning by studying what parents wanted to have included in discharge information. A second group of seven volunteer bedside nurses collected data regarding parents' perspectives about the discharge process. The researchers found that parents wanted different information than nurses were providing. After gathering and analysing the data, the researchers planned to move into the next spiral of action research that was to identify the challenges that nurses face regarding information provision in preparing families for discharge from hospital.

A study by Ely (2001) was discussed in relation to the barriers to change in sub-section 3.4.2. The substance of the study involved group work by children's nurses working in children's unit in a general hospital in the USA. The group of nurses collaborated to improve the practice of pædiatric pain assessment and management in the 12-bed pædiatric inpatient unit at the hospital. The outcome of the nurses' collaboration was identification of barriers to change that enabled the next step to practice change. The group of 16 nurses met every fortnight for 10 weeks to discuss 3 concerns: staff issues in relation to changing pain assessment and management practices, staff commitment to practice change, and clarification of organisational barriers to change. The researchers concluded that consciousness raising through discussion and reflection enhanced communication dynamics (Ely, 2001). The finding underlines the value of collaborative group work to bring together individual commitment to deliver sustainable outcomes for the group and therefore for recipients of health care.

A group of clinicians in a busy pædiatric medical ward in the UK approached the problem of the amount of time taken to accompany children to the X-ray department by working together as a group (Beringer & Julier, 2009). They considered that the task took nurses away from clinical activities with children and that the time taken could be reduced. The clinicians used an action research methodology to improve the process of accompanying children to X-ray and reducing time off the ward for nurses. Data collection before and after the practice changes indicated that time off the ward accompanying children to

X-ray was halved. The action research group acknowledged that other factors might have contributed to the practice improvements. However, the group learnt many new skills including how to collect and analyse data, how to collaborate with one another and other hospital departments, and how to present research findings at the hospital level and at an international conference (Beringer & Julier, 2009). Both practice changes and group collaboration was sustained after the study was completed.

An Australian study examined how a group worked together to improve practice in a Special Care Nursery (V. Wilson, 2005; V. Wilson, Keachie, & Engelsmann, 2003). The group of children's nurses used action learning and action research to achieve a number of related outcomes. Wilson (2005) characterised the outcomes as empowerment of nursing staff, utilisation of staff knowledge and expertise to identify the need for change, encouragement of reflection on and in practice, incorporation of the views of service users in the change process and support of staff to challenge themselves and each other. The achievement for the nurses was that they were able to change the ways in which they worked with patients, families and each other as they developed a more effective environment for care (V. Wilson, 2005). As the study progressed, the nurses required less and less input from the facilitator as they became increasingly independent as a group.

These examples of group work in the pædiatric setting were very persuasive when selecting the best approach to practice change of preparation for childhood hospitalisation. The common thread shows that the context of children's health care is receptive to group work even when the change is of different practices and in different western countries. The evidence supported the concept that group work could improve practice in preparation for childhood hospitalisation.

3.5 Areas of preparation for hospitalisation practice improvement that would benefit Australian children and their families

Australian children and their families are likely to benefit from improvement in the practice of preparation for childhood hospitalisation. The literature review about that practice in Chapter Two identified four areas of complexity to enable analysis for the present study. The first three areas of complexity cover concepts that are common to all preparation for childhood hospitalisation. These are the needs of children and their families for preparation, preparation approaches, and outcomes for participants in preparation and health care professionals. Analysis of the literature suggests that these three areas of complexity have been found throughout western countries.

The fourth theme relates specifically to areas of preparation for childhood hospitalisation practice improvement that would benefit Australian children and their families. The preparation for childhood hospitalisation literature review identified seven issues that were relevant to the practice in the Australian health care setting. These issues were: inconsistency of practice, the three areas of complexity, low levels of evidence, the trend towards shorter stays, financial costs, and lack of evidence-based guidelines or recommendations. These issues are discussed in the following section.

The 2005 AWCH survey (Association for the Welfare of Child Health, 2005) reports that preparation for childhood hospitalisation practice is not consistent in Australia. An opportunity exists to improve the practice through an approach that ensures consistency for all children and their families. Lack of consistency probably relates to the three areas of complexity noted in Chapter Two and also above. The evidence of the effects of the areas of complexity was provided in Chapter Two and findings indicate that children and their families have individual needs for preparation and that no one approach to preparation will meet these needs. The findings also indicate that outcomes of preparation vary and are inconsistently evaluated.

Australian studies, which were a sub-set of publications reviewed in the previous chapter are generally descriptive providing a low level of evidence. However, they provide a rich portrayal of the state of preparation for childhood hospitalisation in Australia. Nevertheless, they do not quantify the situation in the way that the 2005 AWCH survey does (Association for the Welfare of Child Health, 2005). Taken together, the studies and the survey, provide an image of an Australian situation that parallels the situation in other western countries. The image is of a situation in which there is a lack of progress in improvement in preparation practice in other western countries and in Australia.

The last three of the seven issues identified in the preparation for childhood hospitalisation literature review are the same in Australia as they are in other western countries and were discussed in Chapter Two. They are: the trend towards shorter acute care hospital stays, financial costs of providing preparation for childhood hospitalisation and the lack of evidence-based guidelines or recommendations for clinicians.

Each of the seven issues limits the effectiveness of preparation for childhood hospitalisation as discussed in Chapter Two. However, the seven issues also provide guidance regarding the direction that enabling practice change might take. The group of health care professionals had expressed their concern about preparation for childhood hospitalisation at their Australian major children's hospital. The literature reviews of preparation for childhood hospitalisation and of practice change in health care settings informed the action group of possible ways to address the improvement of preparation practice at their hospital.

3.6 Aims of the study

The aims of the study were:

1. To explore the need for changes to local practices for preparing children for the experience of hospitalisation
2. To generate knowledge about existing practice
3. To mobilise collective action for desired change

The potential for gaining insight into how action research could bring about practice change at a hospital-wide level through the collaboration of health care professionals from a number of disciplines underpinned the study. The study investigated the local situation with a view to providing some answers to the universal problem of less than optimum preparation for childhood hospitalisation.

3.7 Summary

Inconsistent implementation of preparation for childhood hospitalisation practice suggested the need for an investigation of how practice may be changed to ensure consistency for all children and their families. The literature review considered the work of leaders in organisational change research and then cited examples of change in organisations. The examples indicate that good outcomes can be achieved. Evidence is compelling that organisational characteristics of health care are amenable to practice change that is realised through group work in which people act together to consider situations and then to change them for the better. A number of examples of group work in children's health care emphasised the utility of the group approach. The literature review examined the evidence for practice change of preparation for childhood hospitalisation. Lack of progress in improving preparation for childhood hospitalisation practice in Australia has paralleled the conditions in other western countries. The success of group work in other areas of children's health care combined with the lack of progress in improving preparation for

childhood hospitalisation practice suggests that a group work approach may successfully effect change.

The next chapter explains the action research methodology that flows from the learning of this chapter. Research paradigms with the potential to meet the study aims are outlined and action methodologies that incorporate group work are explored in relation to critical social theory. Justification for the selection of action research is outlined and the interpretation of action research used for the present study completes the chapter.

Chapter Four – Methodology

The evidence in the literature highlighted the importance of preparation for childhood hospitalisation and the long history of different approaches to improvement of practice. Evidence showed that preparation was complex and resistant to change for improvement. The evidence about changing health care practice was provided in the second literature review that analysed changes, both successful and unsuccessful. The literature review about change drew some conclusions that were very useful because they pointed to approaches to change that might be effective when changing the practice of preparation for childhood hospitalisation.

An opportunity to work with changing practice occurred when health care professionals expressed their concern about the practice of preparation for childhood hospitalisation at their hospital. Preparation practice was an everyday occurrence for these people and they had an ethical and practical interest in the practice. The prospect that we could work together to improve preparation practice and at the same time empower the health care professionals who were concerned about the practice was very persuasive. The motivation for the study was to identify improvements in preparation practice from the evidence and at the same time to identify good outcomes from group processes to enact practice improvement. To achieve improvements, the right approach had to be taken and so careful selection of the methodology used for the proposed study was undertaken.

4.1 Introduction to the study

The focus of the chapter is on the methodology employed in the present study to bring about practice change. Study methods are described in detail in the following chapter, Chapter 5 – Study methods. Consideration of a number of potential research methodologies led to the final selection of action research. Discussion of the potential options including how they evolved and for what purposes, provides a background to the final selection. Following discussion of

research paradigms, there is an outline of the theoretical foundations of action methodologies and their utilisation to effect improvements through change in various real-world situations. The rationale for employing action research was that was well-suited to achieving the study aims and objectives.

4.1.1 Overview of chapter structure and content

The first section of the chapter explores some of the most commonly used approaches to researching improvements in preparation practice of children and their families for hospitalisation. There was a good deal of research undertaken to test predictive models or investigate variables associated with negative or positive outcomes of preparation for childhood hospitalisation. The review in Chapter Two shows that while this has led to some useful knowledge, it largely fails to deal with the complexities involved in preparation for childhood hospitalisation, and has not had the desired impact on day-to-day preparation practice. More interpretive research, involving qualitative methods, has provided some insight into the experiences of children and their families; however, there is little evidence that these insights directly influence practice. Given the desire to bring about local change and understand more fully the factors that enable or prevent change to occur, the next section will explore action-focused methodologies and their unique characteristics that reinforce their suitability when enacting practice improvement with health care professionals.

The second section of the chapter describes the evolutionary journey of action methodologies from their emergence, to the multiple interpretations of the methodology today that shows their flexibility and sustainability. The views of some of the main advocates for the use of action methodologies to enable change through participation and collaboration outlined in this section are very persuasive. However, some action methodologies are not completely congruent with the change sought in the present study and elimination of these methodologies leaves action learning and action research for consideration. These two methodologies reinforce the suitability of action methodologies to

enact practice change in health care, rather than imposing change without the collaboration of those affected by the change. A further exploration of these two methodologies is outlined to identify their characteristics in relation to the change sought in the present study.

The theoretical foundations for action methodologies are the focus of the next section of this chapter, in particular the congruence of critical social theory with action methodologies. Crotty's book "The foundations of social research" published in 1998, informed my initial thinking about the congruence of critical social theory and action methodologies. Critical social theory is a theoretical framework used in many disciplines to enable change. Through action methodologies there is demonstration of a practical way to enact the main thrust of critical social theory that challenges the "status quo" (Crotty, 1998, p. 113) in society and calls on people to make changes for improvement. Critical social theory, employing action methodologies, has achieved change in a range of situations to inform and reform aspects of society and some examples are given. In health care, needed change has occurred over time by changing thinking and behaviour through the influence of critical social theory in improving understanding. The final sub-section of this section analyses some of the changes in health care brought about by using the critical social theory framework.

The next section of this chapter links the improvement sought in the present study with action research as a means of applying critical social theory to a real-world situation. The selection of action research is explained through the use of Raelin's (1999) criteria comparison table that explains the qualitative differences in action research methodologies according to their intervention, ambition and method. The criteria comparison table shows that action research offers a way forward to achieve the study objectives using procedures that maintain congruence with critical social theory.

Finally, there is a review of the study objectives and their relationship to the methodology and theoretical framework of the present study. The action

research methodology approach to improving the practice of preparation of children and their families for childhood hospitalisation is both unique and important. An introduction to the following chapter that describes the study methods in detail concludes this chapter.

4.2 Potential research approaches to meet the study objectives

Review of a number of research paradigms in this section identifies what might be useful in improving the practice of preparation for childhood hospitalisation for quality practice. Some research theorists have identified a vision for research that calls for the realisation of ideals such as improvement, as being fundamental to research activity (Fay, 1987). Using a research paradigm that is congruent with the vision of the improvement sought is essential if that vision is to be realised. There must also be congruence between the research paradigm and the research issue so that the research is most likely to result in the desired improvement.

There are three commonly identified research paradigms: positivist, interpretive and critical (Whitehead, 2007). Each serves a particular purpose and originates in particular theoretical principles (Burns & Grove, 2009). Within the positivist paradigm is research that uses quantitative methods to observe phenomena objectively and several features distinguish the paradigm. Firstly, the research seeks to establish universal rules and generate knowledge that holds true across contexts. Secondly, the researcher does not appear in the data as an actor capable of affecting the conclusions drawn about the data. Thirdly, the researcher is isolated from practitioners, entering the field to gather data and then withdrawing to analyse data and publish findings. These three features contribute to the objectivity of the research and Popper stated that objectivity indicated that scientific knowledge was testable in any circumstance and by anyone (Popper, 1980).

In contrast, the interpretive paradigm uses qualitative methods and describes, explores and generates meaning. The methods used to collect data include

observation and interviewing and result in reporting of multiple constructions of reality (Agostinho, 2005). The research occurs in naturalistic settings that are social and human, and the researcher is an active participant in the setting. The data is usually words that are analysed to provide a holistic interpretation of the experience of the phenomenon of interest (Burns & Grove, 2009; Jackson & Borbasi, 2008; Whitehead, 2007).

A quite different paradigm is critical research which engages in social action to question accepted values and assumptions in order to expose injustice and inequity in society (Crotty, 1998). The critical paradigm proposes that once injustice and inequity are exposed, people are able to participate in activities to make change for improvement. Generally, critical methodologies focus on change, rather than observation or description. Methodologies that are congruent with the critical paradigm involve collaboration with research participants, challenge the status quo, and enable change. The critical paradigm incorporates action methodologies that use both qualitative and quantitative methods to create knowledge that leads to change (Whitehead, 2007).

The early research that dealt with broad issues around the effects of childhood hospitalisation used the positivist paradigm and informed the management of childhood hospitalisation over the past 60 years, for example Vernon, Schulman and Foley (1966). Later research was also positivist and involved the development of preparation interventions that sought to identify and test the effectiveness of specific approaches to preparation in relation to achieving specific outcomes, for example Melamed (1998). The interpretive paradigm has also been applied to preparation for childhood hospitalisation for example Ben-Amitay, Kosov, Reiss, Toren, Yoran-Hegesh, Kotler and Mozes (2006),Thurber, Patterson and Mount (2007), and earlier Gillis (1990) and Ott (1996). However, there is no evidence that either the positivist or the interpretive research paradigms have led to practice change.

The critical paradigm may challenge the status quo to enable practice change to take place. Given that a group of health care professionals had identified their concern, it seemed appropriate to take the opportunity to work with them to improve preparation practice. Working with the group was congruent with critical social theory and with action methodologies. An examination of such action methodologies informs the selection of the research methodology identified as best suited to the present study.

4.3 Action methodology

Researchers engaging in action methodologies use impartial self-observation, critical self-reflection with others, and involvement in intentional real-world action experiments. These unique characteristics distinguish action methodologies from managerial directives and top down approaches and make them suitable for use when enacting practice improvement change processes with health care professionals. Because health care professionals are most familiar with the practice, they are most likely to have knowledge about the practice and commitment to improvement. The unique characteristics of action methodologies also mean that changes made are more likely to be sustained because of the commitment to improvement of the health care professionals and their involvement in making practice changes (Hart & Bond, 1995; Hughes, 2008; Koch & Kralik, 2006; Morton-Cooper, 2000; Stringer & Genat, 2004).

4.3.1 Historical overview of action methodology

The concept of action methodology first arose at a time when organisations were considering how to improve their effectiveness (Denzin & Lincoln, 2005; Raelin, 1999; Revans, 1982). Experts in the field of organisational change nominate Lewin as being the founder of the action methodologies that are a means of conducting systematic inquiry into group phenomenon with an aim of producing knowledge, while acting to improve situations (Raelin, 1997). Lewin was a social psychologist who worked with a wide range of groups of people and first wrote about action methodologies in 1946. He suggested that social

research concerns itself with two things: groups and specific situations (Cartwright, 1952). Lewin and others who followed have used action methodologies to solve real-world problems by both investigating them and working to improve them using a group approach (Bellman et al., 2003; Lewin, 1997b; Moody, Choong, & Greenwood, 2001; Nolan & Grant, 1993; A. Robinson & Street, 2004; Street, 1995; Suderman et al., 2000).

During the subsequent 60 plus years, many others have also examined and refined action methodologies. Raelin, a social scientist with a particular interest in organisational management is one of these. He contends that the common basis for all action studies is that -

1. knowledge is gained through action,
2. the role of personal feelings within the research context is accepted
3. the focus of the project is on re-education and reflection,
4. a skilled facilitator or facilitative participant is required,
5. the projects stem from real life situations, and
6. the researchers and the participants are involved in both the inquiry within the project and its context (Raelin, 1997).

Raelin's identification of action strategies that contribute to change is useful because identification allows a classification that is commonly accepted by experts in action methodology research. In 1999 Raelin developed an action strategy criteria comparison table (Raelin, 1999) that uses 14 criteria to compare elements of 6 action strategies that that he proposes that have evolved from the original conceptualisation of action research by Lewin in 1947 (Cartwright, 1952). The six action strategies are action research, participatory research, action learning, action science, developmental action inquiry and cooperative inquiry (Raelin, 1999). All these strategies are similar and use research techniques to examine and improve practical problems in specific situations. They also utilise a group approach to improvement and so link to Lewin's interpretation of action methodologies that arise from critical social theory.

Four of Raelin's action strategies are not congruent with the present study because they have different purposes, participants, processes and/or outcomes. The purpose of participatory research is community life improvement, rather than improvement of a specific issue. Action science also focuses on the community of participants with the purpose of changing their reasoning and behaviour so that they have an increased capacity for learning and human development. Another action strategy is developmental action inquiry that also directs a focus on the participants' development as a community. Developmental action inquiry bases actions on changes in four territories of experience: outcomes, behaviour, strategy and vision. In cooperative inquiry there is more emphasis on personal change than in other action strategies. Additionally, the strategy lies at the very far end of the facilitation continuum whereby the facilitator initiates the inquiry but then withdraws to enable the participants to direct the process.

The remaining two action strategies that had the potential to meet the study objectives are action learning and action research. In examining the difference between action learning and action research McGill and Beaty (2001) explain that action learning is about reflection on practice and may or may not be directed towards research. Learning, planning new approaches and evaluation follows the reflective phase of the process. The aim of action learning is to advance practice while empowering the participants through what they learn (McGill & Beaty, 2001). Conversely, McGill and Beaty (2001) contend that action research involves investigation and learning that leads to definitive decision-making, actions and evaluation. The evaluation always includes reflection by participants on the research, to enable re-planning if necessary for the next cycle of action. Detailed discussion of these two action strategies follows, whereby the examination of elements of both assists in discovering the one that is most congruent with the objectives of the present study.

Table 4-1 summarises action learning and action research according to four key elements: purpose, participants, processes and outcomes, allowing comparison of the two methodologies.

	Action learning	Action research
Purpose	Understanding and changing of self and/or system through action and reflection on action (Raelin, 1999)	Social change through involvement and improvement (Raelin, 1999)
Participants	Teams or sets generally comprising five to seven people communicate on equal terms about a shared workplace problem	Action groups collaborate on a problem/s that affect them in the workplace
Processes	Participants work on problems where no-one knows the answer through a series of presentations on the problem/s Education of the participants follows regarding the problem Plans are made to apply the knowledge gained to real problems Evaluation of plans by the participants	Continuous cycles of planning, action, evaluation and reflection
Outcomes	Presentation of proposed strategies to the participants' organisation for acceptance and endorsement Further enhancement of the potential value of the learning to the set members	Change/improvement Reduction in the theory/practice gap

Table 4-1 Key elements of action learning and action research

4.3.2 Action learning

Action learning was first associated with Revans, an English educationalist, who developed the method in 1940 while working with the Coal Board and later applied the method to other organisations including hospitals (Revans, 1982). Revans felt that conventional methods of teaching were ineffective and he based action learning on the idea that people learn more effectively when they work on real-time problems in their own work situations. He described action learning as a developmental approach conducted within a group setting. The participants learn by taking the time to reflect with their peers, who offer further insights into workplace problems. The actions which are introduced are subject to inquiry about their effectiveness and are reviewed and applied to theory in practice (Raelin, 1999).

Raelin (1997) maintains that action learning is concerned with behavioural change with a practical, or rational, level of communication between group members. By learning to change their interaction, researchers become more effective while working as a team within the workplace. Assistance of qualified

facilitators, or advisors, is suggested to assist the members and to help them make sense of the study or project experiences (Raelin, 1997). In action learning the role of the facilitator is generally of a passive nature and interventions vary, depending on the comfort level of the facilitator (Raelin, 1997). Most facilitators are content to work at a low level of interference. Although the risk for harm to action learners during action learning projects is generally low, a lack of management support can seriously expose the participants to harm (Raelin, 1997).

During learning sessions, discussion focuses not only on the practical dilemmas from the workplace, but also on the concepts and theories of the actions. The design of action learning challenges the participants by encouraging discovery of alternatives and the creative means to accomplish their objectives, while also considering the constraints of organisational realities. Participatory and collaborative design of the process, while embracing experimental methodology, aims at focusing on re-education and reflection. Participants are committed to improving themselves by interacting, practicing and critically reflecting.

A report of action learning in a Special Care Nursery in Victoria, Australia, shows how useful the methodology can be in improving clinical practice and in improving learning through interaction (V. Wilson et al., 2003). Participants, who were volunteer nurses, met together for a year taking turns to present their issue of concern. Following their presentation, the other members of the action learning set assisted the presenter to re-conceptualise the issue through effective questioning, listening and reflection in a high challenge/high support environment (Rycroft-Malone, 2004b). Tracking of key learning of all group members throughout the process enabled continuous reflection of progress towards practice change. Action learning was a way that the volunteer nurses' group could work together to improve themselves and the workplace problems through action and reflection on action.

4.3.3 Action research

The purpose of action research is social change through involvement and improvement (Raelin, 1999). Action researchers believe the action research process is more robust than other research methodologies because action research does not separate theory from practice and the results of testing demonstrate the interactions of knowledge and action (Reason & Bradbury, 2008). Researchers in projects are both the subject and the object of the research. Raelin (1999) asserted that the two essential aims of action research are the improvement in understanding of practice through reflection and then the improvement of practice that leads to applicability to the real-world of practice. Action research recognises the psychological ownership of the research by the community involved in the project.

Action researchers use a continuous cycle to examine action in order to monitor, analyse and evaluate the action while allowing for reflection about success or the need for modification. Each cycle consists of planning, acting (data collection and analysis), evaluating, and reflecting (Dick, 2005; D. J. Greenwood & Levin, 2007; McNiff & Whitehead, 2002; Reason & Bradbury, 2008; Street, 2003). The cycles of the research provide an advantage because they allow an opportunity to cease action if there are problems. The action can be redesigned and modified to be used in the next cycle (McNiff & Whitehead, 2002; Street, 2003).

With an aim of improving practice in an intelligent and informed way (Street, 2003) the action research process generally begins with an everyday experience which is examined and considered. Any investigation, implementation, evaluation and theorising is linked so that action research has the potential to reduce the theory practice gap. Freire (1972) described the process by explaining that, in action research, the participants become the objects being studied as well as being co-researchers. He contended that action research is a democratic process because of the involvement of everyone at all levels through the process of theorising and action, consistent

with principles of learning by doing. The participants are the ones who make the decisions and therefore, own the outcomes.

The process involves a developmental, inquiry-based form of learning which is also educative, so if change is to be sustainable, there may be need for further education in new knowledge and strategies (Kemmis & McTaggart, 1988; Street, 2003). Action research cannot generalise or predict answers to problems, as Street explains (2003). The value of action research lies within a systematic review of specific concerns through involvement of all stakeholders to discover effective solutions and implement them, with the process owned by all. Consequently, action researchers can employ qualitative and quantitative methods such as surveys, audits, focus group discussions, and in-depth interviews. The important point is that reflection on and analysis of data enables monitoring of actions taken.

The strength of action research is that participants develop and test conceptual models and theories and then transfer these to other similar contexts and issues (Street, 2003). Careful design of action plans includes details of the actions, expected outcomes, methods of data collection and analysis. The common thread is the use of conceptual triangulation of data, which involves data collected by different methods derived from different methodological criteria in order to answer different types of questions. The planned intention is to continue the action, with a predetermined time phase to test the effects of the research.

The chapter section has considered action methodologies, their characteristics and their categorisation into six types according to their differences. The section has also looked more closely at two particular methodologies: action learning and action research. Analysis of these seems to indicate that they may address the objectives of the present study. The next section considers the theoretical foundations of action methodology, illustrating how various action methodologies use the critical social theoretical framework to inform and reform real-world situations. The theoretical foundations demonstrate that the action

research methodology used for the present study is congruent with the objectives of the study.

4.4 Theoretical foundations for action methodology

Critical social theory is the theoretical framework underpinning action methodology in research (Habermas, 1984). Supporters of critical social theory believe that change to oppressive situations occurs through the assistance of people to empower themselves and to take action for change. Researchers using action methodology informed by critical social theory are not interested in controlling, predicting or describing issues - they prefer to change them.

4.4.1 Critical social theory

The critical social theory perspective challenges the givens in society such as power, gender and class. Critical social theory "invites researchers and participants (ideally one and the same) to discard false consciousness, open themselves to new ways of understanding, and take effective action for change" (Crotty, 1998, p. 157). The views of a community of philosophers and social scientists associated with the Institute of Social Research in Frankfurt, Germany in the 1920's and 1930's, in the aftermath of the First World War, informed the development of critical social theory (Burns & Grove, 2009; Crotty, 1998; Kemmis & McTaggart, 1988). The group included Weil, Gerlach, Horkheimer, Fromm, Pollock, Lowenthal, Marcuse, Grossman and Adorno among others. Inspired by the writings of Marx that synthesised philosophy, history and economics, they further developed Marx's foundational ideas that advocated approaches to social existence that are free(er) of domination, power inequities and oppression. People from different disciplines and with different but strongly held views all contributed to the development of critical social theory over the decades (Crotty, 1998). The diversity explains why there is no one critical social theory but a number of interpretations that are all authentic.

After the initial work with critical social theory up until about 1950 there was a period of dormancy that lasted until the late 1960's and into the 1970's when the theory was revised by other German philosophers, the best known being Habermas. He further developed critical social theory, and described seven key concepts that he considered foundational to the theory. One of these concepts is 'Knowledge Constitutive Interests', which describes the perspective and cognitive strategies on which human beings base their knowledge of reality. He linked 'Knowledge Constitutive Interests' to technical, practical, and emancipatory interests (Habermas, 1984; Kemmis, 2001, 2006). Habermas stated that knowledge gives a technical control over the environment and a practical understanding of individuals' experiences. These ideas indicate that knowledge and power relationships are fundamental reasons why people control other people using notions of class, gender and age as discriminators (Habermas, 1984; Kemmis, 2006). The emancipatory interest relates to freedom from the established and accepted power structures in society.

Another of the seven key concepts proposed by Habermas is that of 'Communicative Action', which is action directed towards understanding, and based on definitions regarding situations dependent upon the mutual recognition of ones' perceptions of the environment, social norms and the identities of individuals (Habermas, 1984; Kemmis, 2001, 2006). According to Kemmis, the aspirations of communicative action could be written into or alongside the practices of reflection and discussion characteristic of action research (2001).

Lewin, who was associated with the Institute of Social Research when critical social theory was originally developing, underlined the congruence between critical social theory and action methodology. He worked within the critical social theory framework to develop action methodology and in particular action research strategies. Because during World War 1 and afterwards he, and many others, found themselves persecuted because of their Jewish beliefs, he moved to the USA where he found greater tolerance of diversity. While working in the USA in 1946 he invented the term action research (McNiff & Whitehead, 2002).

Many have followed on from him using action research in their own work such as Gustavsen (2006), Raelin (1999) and Street (1995).

Revans also used action methodologies, specifically action learning, to attempt reform of society by working with people and by enhancing their learning (Revans, 1982). He was involved in projects in industry, education and hospitals in the 1970s and 1980s. He helped people to understand their needs and then supported them to make change through learning and by working together as a group. Action learning as conceptualised by Revans added to the range of action methodologies that are based on the theoretical framework of critical social theory.

Lewin's original concept that critical social theory led to action methodology has evolved in the light of the contributions from sociologists, such as Habermas. The sociologists developed critical social theory and action methodology as a means to understand and improve social situations. In order to accomplish improvement they needed to describe a picture of the prevailing society or community, expose the systems of domination within the society, assess the potential for change, and then empower the individuals and groups of people within the society to promote change.

4.4.2 Employing critical social theory in action research

The critical social theory perspective using action methodologies has analysed situations with a view to understanding them and consequently informing society so that knowledge about the situation can lead to an improvement in the situation. Researchers have worked with people to learn more about their social world and to use the knowledge to improve aspects or sections of society. Early in the history of action methodologies, Lewin undertook a number of projects with a wide range of groups including communities, school systems, single schools, minority organisations, labour, management, and national and state governments (Cartwright, 1952). Lewin's intention was to work with these groups to help them to improve using social action. Group work incorporated

exploring the prevailing situation, generating knowledge about the situation including the potential for change, and empowering the group to promote change for improvement. Group decision(s) and commitment to improvement align with the principles of critical social theory (Kemmis & McTaggart, 1988). Lewin maintained that action research must express theory and that the results of research should feed directly back into the theory (Cartwright, 1952; Street, 2004).

By employing critical social theory in Brazil in the 1960s, Freire worked with oppressed people, helping them to educate themselves. Once these people had changed themselves through education they were able to control their own destinies and to improve their lives (Friere, 1972). He applied the critical theoretical framework to developing the teaching of disadvantaged students in poor communities. Stressing that to achieve freedom, autonomy and responsibility, students who are oppressed must not be liberated by others but rather, by themselves (Friere, 1994). Freire also maintained that by being part of a good educational experience both the teacher and the student learn and grow with the experience.

Critical social theory and action research have become an integral part of educational research all over the world (McNiff & Whitehead, 2002).
In 1949, the value of linking together action and understanding was recognised by Corey at Teachers College, New York, where he employed action research in several teacher-managed research studies (Kemmis & McTaggart, 1988). Action research based on critical social theory was also utilised in the UK in the 1970's in the Ford Teaching project, as a means of helping teachers develop enquiry learning in their classrooms (Kemmis & McTaggart, 1988). There have been many action research projects undertaken in the discipline of education that have applied the principles of critical social theory as articulated by Habermas. Kemmis (2009) refers to these as critical action research, as opposed to technical or practical action research. Although they may use different strategies according to the different problems that they address the aim is to transform the social situation in which they occur.

Action research based on critical social theory has been effective in solving a variety of business problems such as those related to marketing, product development, manufacturing, engineering, operations management, organisational change and transformation, information systems, e-commerce, accounting, small business and management development (Sankaran & Hou, 2003). Managers have engaged in solving business problems using action research methodology that has helped them to identify the business problem and to work collaboratively with others to improve the situation. The managers discussed in Sankaran and Hou's conference paper (2003) also looked at what other action researchers have done and then adapted the methodology used to their own problems. These uses of action research demonstrate that the methodology is a way to achieve improvement through identifying problems and then working collaboratively to solve them.

The sciences have traditionally used positivist paradigm research; however, there is some evidence that the critical paradigm may have a place in the sciences. Swepson, a researcher who uses action research in her work in organisational consultancy in a department of agriculture in Australia, suggests that participation, emancipation and improvement will be outcomes of good research (Swepson, 1998). She argues that the idealistic vision of research is to achieve objective truth and she contends that visions or ideals are necessary as guides for actions. There is no surprise then, that Roberts, an agricultural scientist, was able to involve participants in the research process and so enable them to own and solve their problem. He used action research to facilitate experiential learning with pastoralist farmers in Central West Queensland (G. Roberts, 2000).

Action methodologies enact the principles of critical social theory in many disciplines that relate to people in society. There is evidence that action methodologies have often informed and reformed aspects or sections of society using action methodology based on exploration, knowledge and change. The

next sub-section reviews the evidence for the success of critical social theory in changing thinking and behaviour in health care practice over time.

4.4.3 Influence of critical social theory on health care change

A review of the literature available about the influence of critical social theory in health care reveals that the discipline of nursing has embraced critical social theory. Many nursing researchers and theorists contend that the aim of nursing is to provide holistic health care that is congruent with the objectives of critical social theory (Corbett, Francis, & Chapman, 2007; Yacopetti, 2000). The connection between health care change and the objectives of critical social theory that are empowerment, emancipation and enlightenment (Manias & Street, 2000) is persuasive to nurses.

Manias and Street (2000) took a theoretical approach to comparing and contrasting the benefits of critical social theory and Focault's work for nursing's philosophical development. The nurse researchers pointed out that nursing research has had much to gain from critical social theory perspectives' that facilitate change to health care that lead to improvement. That nursing uses critical social theory to understand and inform health care and therefore health care change follows because nursing concerns itself with issues of equity in health care. Critical social theory provides a mechanism to analyse any oppressive situations such as those sometimes found in health care.

The research of Stevens (1989) illustrates the congruence between nursing and critical social theory. She is a nurse who wrote about re-conceptualising the environment of individuals (patients) as a means of liberating them from oppression. Stevens (1989) identified the oppression experienced by individuals prescribed a particular medication by using research informed by critical social theory. She states that the dominance of the social, political and economic environment is an invitation to action in both nursing practice and research that can be addressed by using a methodology that is informed by critical social theory (Stevens, 1989). Just four years later, Reitman (1993)

critically analysed the financial costs of drugs used to manage pain. She identified the pivotal role that nursing had in advocating for patients by applying the processes and concepts of critical social theory to research that revealed the conditions that contributed to the apparent inequity between quality health care and financial costs.

With increasing emphasis placed on critical thinking, nurses are beginning to address the authority of the power relations that they have previously taken for granted. In many cases critical social theory that incorporates critical thinking has served as the frame of reference for studies into patients' empowerment (Rafael, 1996). For example, Fulton (1997) conducted a study using a critical social theoretical framework to identify nurses' views on empowerment, both of their patients and of themselves. She found that the British nurses she studied manifested signs of oppression and that they strove for liberation. She concluded that various power relationships in British society had a negative effect on people's ability and effectiveness, and that the effects of the power relationships applied to nurses and their patients (Fulton, 1997).

In the 1990s a number of researchers identified the fact that health care perpetuated social inequities and that the inequity could be addressed by taking an approach informed by critical social theory to empower individuals to make changes for improvement (Anderson, 1996; Cody, 1998; Henderson, 1995; McKeever, 1996). The philosophical position of critical social theory was critiqued by Cody (1998) in relation to nursing. He suggested that by using a critical social theory framework in nursing practice, nurses might promote emancipation from oppressive sociocultural systems.

Nurse researchers have used a critical social theory framework to explore oppressive health care systems and their effect on consumers of health care. Dickinson (1999) recognises that adolescents with diabetes displayed oppressed group behaviour because of negative judgements made by health care professionals. She recommends the use of a research method informed by critical social theory with adolescents with diabetes so that they are

empowered to manage their treatment and their lives. When Mohammed (2006) writes about improving clinical practice for adolescents with diabetes she recommends critical social theory as the framework that enables the formation of partnerships with patients. Wittmann-Price (2004), Thrasher (2002) and Drevdahl (1998) also use critical social theory in their research into women's health; highlighting the advocate role of the Nurse Practitioner and the oppression of women who attend a health clinic, respectively. These researchers found that emancipation of individuals from oppressive situations led to an improvement in their participation in health care decisions.

Nursing has been prominent in using critical social theory to improve understanding and informing needed health care change. Other health care disciplines are varied in their use of the theory. Some have repudiated critical social theory because an analysis of political, social and economic perspectives is required. Dickerson and Campbell-Heider (1994) contend that these perspectives are responsible for the existing power structures of society and therefore of health care. Some disciplines, or health care professionals within them, are not interested in challenging the status quo, preferring to retain traditional provider-patient relationships (Dickerson & Brennan, 2002).

Other health care professionals have used action methodologies underpinned by the critical social theory framework (Anderson, 1996). An important example is Hart, a social worker who conducted studies in collaboration with various health care colleagues in the UK (Hart, 1996; Hart & Bond, 1995, 1996; Hart & Fletcher, 1999; Hart, Lymbery, & Gladman, 2005). The action methodology that Hart uses is action research because she recognises action research's "value … in helping practitioners, managers and researchers to make sense of problems in service delivery and in promoting initiatives for change and improvement" (Hart & Bond, 1995, p. 3). In collaboration with Bond, a social anthropologist, Hart wrote a guide to action research practice that describes five case studies in health and social care in which they were involved (Hart & Bond, 1995). The case studies serve to exemplify the various models of action

research in health care that they propose. The case studies were all conducted in the National Health Service in the UK and aimed to:
Case study 1: Improve standards of care in a district general hospital
Case study 2: Develop staff in the same district general hospital
Case study 3: Work with elderly people in the community
Case study 4: Provide services to people with disabilities
Case study 5: Change medication practices in an aged care facility.

The range of situations in which critical social theory in the form of action research has improved understanding and informed needed practice change is noteworthy. In the examples from nursing and other health care disciplines, individuals acquire knowledge to create technical control within certain areas of the health care system. They collaborate, question and challenge power structures in order to understand their individual experiences and those of their colleagues and of consumers of health care.

The power relations existing within the health care system are all that health care professionals and patients have known and are taken for granted, and therefore appear normal to them (Hughes, 2008). Since critical thinking is an essential requirement in professionalism, the degree to which health care professionals challenge the established system of power relations may be dependent on the degree to which they accept and strive for professionalism (Hart & Fletcher, 1999). Critical social theory offers a way forward to achieve change in health care practice that is congruent with critical thinking that leads to challenging existing political, economic and social perspectives and that may result in empowerment, emancipation and enlightenment for the health care professionals.

4.5 Study methodology - action research

Street (2003) suggests that action research is used in health care to critically reflect on issues that affect many people and has the explicit goal of providing practical knowledge, while improving health care in the context-specific

environment in which health care is practiced. The issue of interest and concern that is the focus of this thesis is located in health care, and specifically relates to the practice of preparation of children and their families for hospitalisation. The literature review of preparation for childhood hospitalisation provided evidence that the practice was less than optimal in many centres around the world. Health care professionals at a major children's hospital identified from their own practical experience that the practice was less than optimal at their hospital and this was an issue of concern for them. Their self-identified concern provided me with the opportunity to work with them and facilitate their investigation of a change to their preparation practice. The literature review had revealed a number of methodologies taken to explore the issue of preparation for childhood hospitalisation but none had attempted to change preparation practice through action research.

The selection of action research as the research methodology for the present study occurred after reading and reflecting on the literature about the various methodologies available to change practice that were congruent with critical social theory. Action research seemed an ideal research methodology to achieve the study objectives because it allows facilitation of group process whereby all health care professionals associated with the hospital's preparation for childhood hospitalisation practice as well as the whole hospital community were able to work collaboratively within their own health care setting.

4.5.1 Justification for the selection of action research

In the literature reviewed about change there was evidence that change in health care organisations is more likely to be successful if the change is voluntarily undertaken by people rather than having the change imposed upon them (Greenhalgh et al., 2005). The selection of action research from the range of action methodologies available was influenced by the work of Raelin and the 14 criteria in his action strategy criteria comparison table (Raelin, 1999). The use of action research for the present study is because action research is

undertaken by people to enact change and that involved people are enabled to improve situations.

Using Raelin's (1999) 14 criteria, as a basis for examination of the action strategies, differences were identified, as well as commonalities, to enable selection of the most suitable strategy for the present study. According to the 14 criteria, 4 of the action strategies were not exactly suitable for the present study and thus were eliminated from consideration. These four were participatory research, action science, developmental action inquiry and co-operative inquiry. Elimination of each of these was because of fundamental differences in relation to the objectives of the present study. Participatory research, action science and developmental action inquiry were eliminated because they focus on development of the community to which the action group members belong rather than development of the action group members. Co-operative inquiry was eliminated because it emphasises personal change, and because facilitation only involves initiation of the research, and then participants continue the process without the facilitator, rather than the consistently available facilitation that the present study required. Raelin's criterion related to the time frame for change was especially important to the decision to reject the latter two strategies because these strategies require a much longer time commitment than was available to devote to a PhD thesis.

The elimination process left two action methodologies remaining: these are action learning and action research. There followed an exploration of the principles of both action learning and action research as potential alternatives for the present study because these action methodologies best fitted the aims and objectives of the study. Both involve active participation with a view to developing empowerment for the people involved in the study. Both methodologies are widely used for projects in health care that have similar objectives to the present study: that is to encourage active participation of the concerned health care professionals.

The action learning methodology was ultimately eliminated because the purpose of action learning is understanding and changing of self and/or system through action and reflection on action, whereas the purpose of action research is social change through involvement and improvement (Raelin, 1999). Action learning involves change of those involved in the action learning research whereas action research involves change of a situation for improvement. The methodology that best suits the objectives of the present study is action research because of the focus on practice change. Table 4-3 describes action research in terms of the Raelin's (1999) 14 criteria.

Criteria	Purpose for use
Philosophical basis	Gestalt psychology, pragmatism, democracy
Purpose	Social change through involvement and improvement
Time frame of change	Both short and long term
Depth of change	Intrapersonal through cultural, ranging from shallow to deep
Epistemology	Knowing through doing, making and applying discoveries
Nature of discourse	Collaborative discourse of action and problem-solving; use of data-based, actionable knowledge
Ideology	Focusing on participation, involvement and empowerment of organisational members affected by the problem: re-educative
Methodology	Interactive cycles of problem defining, data collection, taking action or implementing a solution followed by further testing
Facilitator role	Primarily functions as research/process guide
Level of inference	Focussing on data encourages low levels of inference, but re-education process encourages higher level testing
Personal risk	Moderate risk, but ultimately depends upon organisational culture, consequences, visibility, and degree of sanction
Organizational risk	Depends upon strategic importance of the problem chosen, may entail less risk than doing nothing
Assessment	Validity based on appropriateness of method and on the extent to which the original problem is solved
Learning level	Varies based on nature of project, skills and risk-taking of participants

Table 4-2 Action research action strategy criteria from Raelin (1999, pp. 120-121)

4.5.2 Action method adopted for the present study

The work of Hart and Bond (1995) discussed in sub-section 4.4.3 also provided guidance in choosing the best action research methodology for the present study. Hart and Bond (1996) developed a typology in response to a criticism of action research as not being true research. They believed that the view arose

from an imprecise use of terms when using action research, so they defined the terms and related them to the models of action research used in health care. They described four models in their typology and defined them according to their distinguishing criterion (Hart & Bond, 1995). The models and the criteria are summarised here:

1. Experimental - focused on experimental interventions to provide controlled outcomes,
2. Organisational – definition of the problem by management and aimed at achieving definite outcomes,
3. Professional - a reflective and practitioner-based problem arising from practice, in which the group is led and the project is aimed at improvement in practice, and
4. Empowering - allows the problem to develop and be addressed as awareness grows within the group

According to the distinguishing criteria of the models, the present study was the professionalising type because the study developed professional control and improvement of practice. The study enhanced reflection through an educative base that involved reflective practice where the action research cycles incorporated reflection on actions by the group prior to further planning and implementation of plans. In addition, the educative base of this action research study aimed to empower the various health care professionals through reflection on advocacy for children and their families. These factors indicated the practitioner focus of the action research. However, the health care professionals would argue that the focus of the study was on the children and their families, because of an interest in learning what they want and think about preparation that had been an enduring theme.

The next criterion that distinguishes the present study as professionalising action research was its problem focus. The action group members defined the problem following their disquiet about the disparity between best preparation practice and what was currently occurring in the hospital. Additionally, there had been input from children and their families through their demonstrated lack

of preparedness for, and distress during, hospitalisation. Chapter Two outlined the challenges to the implementation of preparation for hospitalisation for children and their families. Evident from that review is the problem that there are many causative factors in the disparity between the knowledge about preparation and the implementation of preparation. These causative factors, or enablers and barriers, include organisational issues and human issues. On the surface the problem of less than optimal preparation for childhood hospitalisation is located in the practice of health care professionals (Hart & Bond, 1996) however, the problem has a number of causes including the context of the hospital, children and their families, and health care professionals who practice preparation.

Another distinguishing criterion of the present study was improvement/involvement, operationalised by the planned outcome to improve preparation for hospitalisation, as defined by the group. Others outside the group may have also defined the improvement required; however, the planned outcome for the group was an improvement to preparation for children and their families, enacted on their behalf by the group. Possibly, and indeed probably, the group members' clinical work is more acceptable to them when they are caring for children and their families who are better prepared. Indeed the hospital may also benefit through improved preparation procedures, if shorter hospital stays, less use of analgesia and lower complication rates for some children are more likely to result (Association for the Welfare of Child Health, 2005).

Therefore, the type of action research described as professionalising by Hart and Bond (1995, 1996) guided the present study. The procedures used to operationalise action research are the focus of the next sub-section. Demonstration of how the study procedures addressed the study aims anticipates the fuller discussion of the study methods in the next chapter.

4.5.3 Action research implementation procedures adopted for the study

The cyclical nature of the action research design was referred to in sub-section 4.3.3, and the present study adopted the action cycles that are pivotal to action research. Action cycles consist of action phases of planning, acting, observing and reflecting, and each is a discrete part of the whole action research methodology (Dick, 2005; D. J. Greenwood & Levin, 2007; McNiff & Whitehead, 2002; Reason & Bradbury, 2008; Street, 2003). Each action cycle is informed by the previous action cycle and informs the next action cycle. The cycles are interlinked although separate.

Implementation of the present study was through three action cycles. The first action cycle was called *mobilisation of engagement of the hospital community in the study*, the second was called *the steps toward practice change,* and the third was called *mobilisation of collective action for change*. The three action cycles were sequential as shown in Figure 4-1. However, within each action cycle planning, acting, observing and reflecting took place with respect to those research activities that were the subject of that cycle. There were many smaller cycles within these three cycles as everyday actions were observed and reflections led to modifications of plans as is expected in action research studies (Dick, 2005). Chapters Six, Seven and Eight provide detailed description and analysis of each of the three action cycles for the present study.

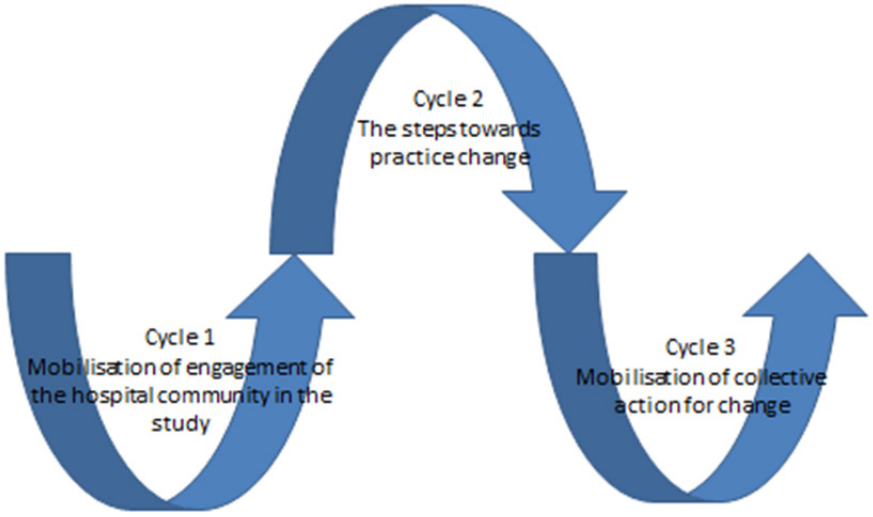

Figure 4-1 Action research cycles for this study

One of the strengths of action research is the characteristic that allows adaptations to research plans as more information becomes available. Although more complex to manage than traditional sequential research the benefit gained from action research is that the research is more responsive to the environment or context of the research (Hart & Bond, 1995; Raelin, 1999). The responsiveness makes the research more relevant to the participants because of their involvement in changing practice that they regard as problematic.

4.6 Summary of the research methodology used in this study

The action research methodology adopted for the present study was chosen because it was congruent with the theoretical framework of critical social theory that challenges the givens of society to bring about change (Crotty, 1998; Kemmis, 2006). The next chapter outlines in detail the study method employed to enact the chosen research methodology of professionalising action research. There is discussion of all aspects of the methodology used in action research.

Discussion includes the study design chosen because action research that included collaborative group work was most likely to ensure preparation practice improvement. The study setting, a major children's hospital, and the study population give a sense of place to the study. Discussion of the ethical considerations for the potential participants in the study is an important consideration given that the present study used the action research methodology in which ethical considerations are challenging but extremely important. Finally, there is discussion of the data collection that led to the study outcomes. Data collection such as measurements, techniques and analysis provide further evidence that this action research study aligned with critical social theory.

Chapter Five – Study methods

The major goal of this chapter is to provide the reader with information required for making sense of the three action cycles undertaken within the study; outlined in Chapters Six, Seven and Eight. There is, thus, a broad overview of the methods that spanned the three cycles, rather than the detailed description that is provided in subsequent chapters.

A description is provided in this chapter of the methods used within this action research study. The study had three aims that were to explore the need for changes to local practices for preparing children for the experience of hospitalisation, to generate knowledge about existing practices and to mobilise collective action for desired change. An action research methodology was chosen as the approach allowed participants to collaborate and take action to improve preparation practices associated with children's admissions to hospital, and the invasive procedures related to their treatments and care. The research collaborators believed that the preparation provided to children and their families was less than optimal and that health care professionals felt relatively powerless, as individuals, to provide the type of preparation they believed necessary and to systematically improve current practice.

5.1 Study design

Action research was conducted in three cycles over four years, using mixed methods in collaboration with health care professionals, and children and their families from a major urban children's hospital in Australia. The study design used action cycles and the fundamental characteristic of action cycles is that they function by permitting modification of plans in response to alterations as the action research evolves. The unknown nature of action cycles must be anticipated and accommodated in the study design.

The first action cycle focused on *mobilisation of engagement of the hospital community in the study*, in which plans were made to act on preparation of

children and their families for hospitalisation at this hospital by providing an opportunity to the hospital community to become involved in practice change. The process employed to bring members of the hospital community together emphasises the value of using action research for the present study.

The second action cycle focused on *the steps towards practice change*, in which the newly formed action group collaborated to explore local practice and to generate knowledge about existing preparation practice at the hospital and therefore be able to identify areas for improvement. The second cycle involved planning to survey children's and their parents' expectations and experiences of hospital preparation, and planning to undertake an audit of hospital staff regarding hospital preparation practices. The cycle also involved planning the reinstatement of a procedure information booklet. The existence of the unused preparation resource was discovered as the group explored existing preparation practice at the hospital.

In the third and final cycle, which focused on *mobilisation of collective action for change*, the action group mobilised collective action to enact plans to change preparation practices in ways that would be accepted by the different hospital departments. The action group analysed these data and then reflected on the major issue of concern that required improvements in service delivery. The procedures and outcomes of the three action cycles will be elaborated upon in Chapters 6, 7 and 8 that detail each cycle are illustrated in Figure 5-1 below.

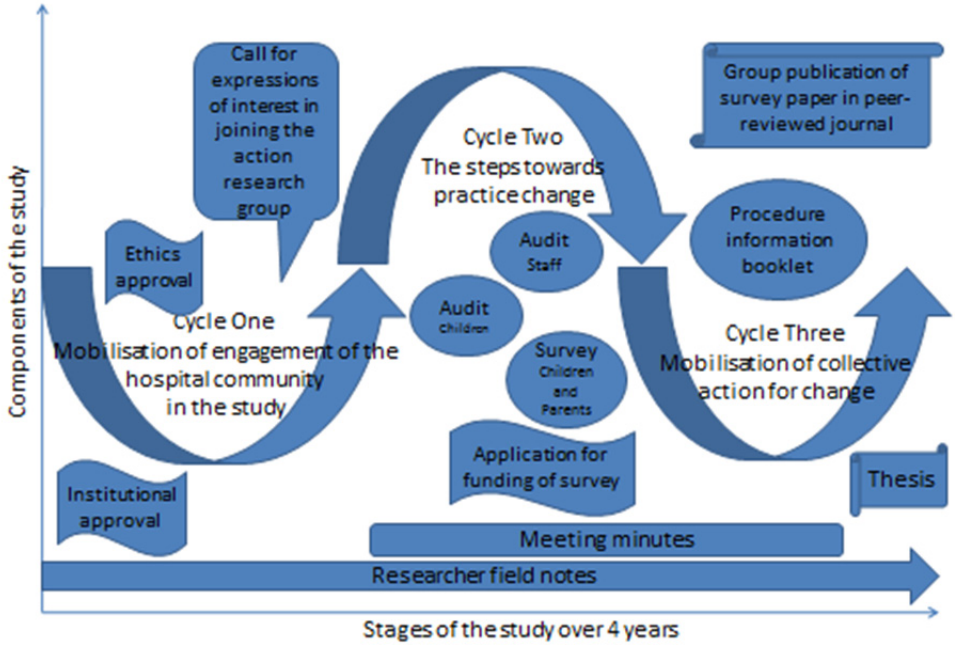

Figure 5-1 Components of the action cycles

5.2 Study setting for the improvement of preparation for childhood hospitalisation

The unique characteristics of the study setting influenced the selection of the research methodology and the use of successive action cycles. The study setting was a major public children's hospital in metropolitan Sydney, Australia, one which was child friendly (hereafter termed kid-friendly due to contextual usage) with large bed numbers. Staff of the hospital termed it kid-friendly because the focus of all hospital activities was on making children feel important to the organisation and therefore that the organisation was friendly towards them. In 2005, when the call for expressions of interest in participating in the study was made, there were 50,000 annual admissions of children to this hospital which is an indication of the size of the hospital. No baseline assessment of the number of children being prepared was undertaken. The study was about the experiences and perceptions that motivated action to change practice of those who responded to the call for expressions of interest and subsequently joined the action group.

The hospital was part of the New South Wales Department of Health, whose vision is … *for everyone in NSW Health to work together to achieve "Healthy People - now and in the future"* (New South Wales Department of Health, 2011). Aligned to NSW Health vision was the hospital's mission statement that the hospital *…aims to improve the health and wellbeing of children and their families through promoting wellness and caring for illness effectively, efficiently, compassionately and equitably...* . The hospital existed to provide health care to children and their families in a way that was associated with the vision of the New South Wales Department of Health. Familiarity with the characteristics of the study setting is relevant in any action research because of the study setting's potential influence on the study's progress and outcomes. Full exploration of the structural, policy and cultural frameworks that shaped the setting was also important in order to work with hospital staff to improve preparation for childhood hospitalisation at this hospital. My close association with the hospital and its staff over many years had enabled me to have an understanding of the preparation of children and their families for hospitalisation at this hospital.

Health care services were provided by this busy hospital to a wide range of children and their families in terms of the variety of illnesses, the degrees of acuity, metropolitan versus rural and remote location, and the number of countries of origin and ethnic backgrounds that they represented. The welcome message on the hospital website noted that the hospital

…is a specialist facility for children's health, a paediatric teaching centre and the hub of a network of professionals caring for children throughout Sydney and New South Wales. We provide a comprehensive range of services from the most urgent and essential to the most complex and technologically advanced…

At the time that the study took place no formal policy was in place at the hospital to prepare children and their families for hospitalisation or for painful procedures. Children underwent a range of procedures at the hospital, all of

which were considered to have the potential to be painful. These included surgical, medical and radiological procedures and they took place in various departments of the hospital. The departments included nursing, allied health, medicine, surgery, radiology, pathology, operating theatres, accident and emergency, outpatient clinics and specialist wards. Although there was no formal preparation policy in place, many health care professionals prepared children for hospitalisation and/or procedures informally. Prior to the action research study health care professionals understood that children were being prepared; however, as there was no specific direction about preparation, what did take place was of variable quality and quantity, and sometimes preparation did not occur at all. The consequences for children and their families were inconsistencies in their experiences and the outcomes of their hospitalisation.

The hospital provided health care services to children and their families through nurses, allied health professionals and doctors. Many of these health care professionals were pædiatric specialists. They often worked in multidisciplinary teams to optimise the health care services that were provided at this hospital. For example, the Pain Management Team pooled the expertise of nurses, psychologists, play therapists and doctors, to review all children receiving health care, on a daily basis. Undergraduate and post-graduate students of nursing, allied health and medicine from a number of universities also participated in health care provision as the hospital was a teaching hospital that provided educational opportunities and gave support to students of various health care professions.

A combination of strategies with the purpose of making the hospital kid-friendly were in place. Wards and departments were designed to be visually appealing and interesting, particularly to children. The use of bright colours in the internal and external design, children's drawings and art work on the walls and in open spaces gave a very non-clinical appearance. For example, the accident and emergency department was colourful and children watched television, or played with toys or played computer games while in the waiting area, awaiting health care treatment. The post-operative recovery room was brightly decorated and

parents were encouraged and supported to be with their children when they were waking up from their operation. Other services provided by the hospital were also very kid-friendly including the services provided by the allied health disciplines including physiotherapy, social work, occupational health and pharmacy. The physiotherapy department, for example, not only provided mobility aides and educated children in their use but also provided the type of mobility aides used by children, such as modified wheelchairs or crutches.

Facilities such as the “Fairy Glen” and the “Starship Café” acknowledged the fact that the health care services provided by the hospital were used by children and their families. The “Fairy Glen” was a garden that had been designed specifically for children and families to get away from the ward environment, and relax. The “Starship Café”, which was located just inside the busy foyer of the hospital, was also a place where children and their families could relax away from the ward or clinic environment and be able to eat and drink in pleasant surroundings. A care by parent unit was part of the service offered by the hospital, in which collaboration between health care professionals and parents enabled the provision of health care to children, particularly those who were admitted for a long period of time or for repeated admissions. There was a hospital school staffed by qualified teachers who taught hospitalised children according to school grade so that their education was minimally disrupted while the children were hospitalised. A Play Therapy Department offered services such as art therapy and music therapy in all departments of the hospital. Play therapists were active in preparing children and their families for hospitalisation and various health care procedures.

All wards included a playroom that was a safe place to play and interact with others. No procedures took place in the ward playrooms. There was also a “Star Room” that provides play opportunities away from the ward environment. In the “Star Room” there was a broad range of activities for all age groups and interests, and all hospital staff encouraged children to participate in these activities. The “Star Room” staff broadcast a radio program to children confined

to bed in the wards so that they could participate in some of the activities provided by the “Star Room”.

Some health care services were provided in collaboration with the hospital for the care of adult patients on the same campus. In particular, the Medical Imaging service was a shared service that delivered specialist radiological procedures for children and adults. Sharing the service across quite different groupings of patients was challenging for the health care professionals and other staff who worked in the shared service. Kid-friendly strategies were used for children in the Medical Imaging Department thus linking the health care services provided by the children’s hospital with the adult hospital.

Benefactors contributed financially to the hospital with a structured process for donations to be made. There was a foundation that accepted and distributed funds that had been donated from a variety of sources, both public and private. The foundation distributed donated funds to various unfunded projects through a transparent process. Members of the hospital staff including management and health care professionals were involved in fund raising activities and various other events to attract funds that were additional to the hospital’s operating budget provided by the New South Wales Department of Health.

5.3 Study population and participant recruitment procedures

Hospital staff and children and their families, who formed a part of the study setting, made up the study population. The hospital staff were from various employment groups including nursing, allied health, medicine, pastoral care, school teachers, and administrative support and provided a kid-friendly health care environment. The key consumers of the health care environment, the children and their families, were provided with a wide range of health care services from the hospital. A culture of caring for children existed at the hospital; the hospital motto was “Children first and foremost”. However, there was no hospital policy that related specifically to the preparation of children and their families for hospitalisation. The lack of a policy was an important reason

why the study took place and why it was able to attract concerned people to work to improve preparation for childhood hospitalisation.

5.3.1 Study population of this major children's hospital community

Potential participants in the study fell into one of two cohorts from the study population described. One cohort was the hospital community members who volunteered to join the action group. The second cohort included two groups. One group were the children and their parents/guardians who completed a hospital preparation survey. The other group in the second cohort were the health care professionals who completed a hospital preparation practice audit. The two groups in this cohort provided the data that the action group cohort sought in addressing the aims of the study.

Health care professionals were either involved in patient care, such as nurses, allied health professionals and doctors, or manage those who were, for instance, the manager of the Social Work Department. Some, such as the psychologist in the Pain Management Team, were involved in research activities into children's health care issues. Some health care professionals had a mixture of patient care and other roles. For instance, the Clinical Nurse Consultants who were appointed to coordinate the specific health care needs of children, such as those with asthma, had administrative responsibilities as well as a patient care role.

Administrative staff were engaged in many different roles; some, such as ward clerks and outpatient clerks, had direct contact with children and their families while others, for instance the personal assistant to the Director of Nursing, did not. Hospital support staff also had a very wide range of responsibilities as caterers, laundry staff, cleaners, clown doctors and "Star Room" staff. Some of the tasks involved in these responsibilities included contact with children and their families; for instance the cleaners interacted with children and their families when cleaning ward areas.

Children and their families were an important part of the study population. Health care treatment of children and their families, was the fundamental reason why the hospital existed and thus why all of these hospital staff were employed. The age range of children who were admitted to, or treated at, the hospital was from 6 weeks of age up to 16 years of age. All children had the opportunity to access all health care services provided by the departments of the hospital. Families were actively encouraged to be present during their children's treatment and to participate appropriately, if they wished. Children attended the hospital and were classified by the hospital organisation as belonging to one of three groupings. Either they were in-patients, children who were admitted into the accommodation of the hospital for health care treatment, or outpatients, children who accessed health care from specialist clinics but who do not stay in the hospital or non in-patients, children who were treated in the shared services of the hospital but who did not stay in the hospital.

5.3.2 Recruitment procedures

One of the crucial aspects of action research is the early identification of potential collaborators and discussions about their voluntary role in the research. Therefore ensuring that all of the hospital community population were aware of the study and its various data collection components was important. The hospital community population were also made aware of the opportunity to participate in various aspects of the study, but also that they could choose not to participate. Only members of the hospital community who freely volunteered to join in the data collection were recruited.

To ensure congruence with action research it was important that participants voluntarily joined the action group. Following ethics approval from the children's hospital division of the Area Health Service Human Research Ethics Committee, see Appendix A (Protocol No. 05/264), and ratification of the approval by the University Human Research Ethics Committee, see Appendix B (Protocol No. 2005-188), a call for expressions of interest in joining the action group was made to all staff members of the hospital community through a

notice shown in Appendix C, during the first action cycle. The notice was emailed to all staff and posted on the noticeboards strategically placed around the hospital, for example at the waiting areas for lifts. The notice included a statement that the study had the support of the hospital's management. The call for expressions of interest was made in November 2005, soon after ethics and institutional applications had been approved by the Area Health Service Human Research Ethics Committee, see Appendix A, and the University of Technology, Sydney, see Appendix B. Potential participants could express interest in knowing more about the study, be provided with information by me (see Appendix D) and be given an opportunity to ask questions and receive answers. If they wished to proceed they could then become voluntary participants in the action group. The recruitment process satisfied the fundamental action research aspects of early identification and voluntary participation of collaborators.

During the second action cycle, the newly formed action group nominated the cohort that could provide the data that was needed to address the study aims. Potential participants for the hospital preparation survey and the hospital preparation practice audit included people impacted by, and agents of, hospital preparation practices. One group was children and their parents/guardians who were in-patients and who had experienced hospitalisation. The action group considered that these people would be able to inform them about existing preparation for hospitalisation practices from direct experience. The other group of people were hospital staff who had direct knowledge of and/or involvement with hospitalisation preparation practices. These people were highly likely to have contemporary knowledge of and experience in children's hospitalisation preparation practices. These two groups of participants were provided with information and explanation prior to giving informed consent to complete a hospital preparation survey or a hospital preparation practice audit. No participant recruitment was required in the third action cycle of the study.

5.4 Ethical considerations in participant recruitment

Action research raises a unique set of ethical challenges, both in the conduct of studies and in the participation of action researchers (Brydon-Miller, 2006b). The ethics approval process that is conventionally undertaken in any research study has been said to regard participants as subjects of research, rather than as human beings (Eikeland, 2006). This is the children's hospital section of the ethics committee which is familiar with the concepts of children's assent and parental consent, the ethics committee provided guidelines and the study adhered to these. Action research is a research methodology that seeks to be inclusive of practitioners, researchers and the researched. The methodology differs from conventional research that conducts experiments on subjects to answer questions. In the present action research study, ethics were addressed when recruiting participants and when fulfilling the requirements of the institutional ethics approval processes. They were also addressed by providing information in the consent form about the ethical challenges regarding the inclusiveness of the action research methodology. Throughout the study the action group were conscious of the imperative to regard practitioners, researchers and the researched as equally part of the study (Brydon-Miller, 2006b; Eikeland, 2006; Fontenla & Rycroft-Malone, 2006; Williamson & Prosser, 2002a, 2002b).

For the action group cohort, there were ethical challenges in maintaining their confidentiality. Because the study was conducted at a relatively small site where most staff knew one another, ensuring the confidentiality of individual action group members was important. Potential action group members were informed, in the consent form, that confidentiality was an issue to be considered by all participants. The process to address this issue was that particular procedures would need to be agreed by all action group members to assure staff confidentiality was maintained for the duration of, and following the study, see Appendix E.

Ethical considerations that related to the hospital preparation survey participants and the hospital preparation practice audit participants similarly included consideration of how to maintain their anonymity and confidentiality in data collection and reporting when ethical approval was sought to conduct the survey and the audit in the second cycle of action research. The children and their parents and the hospital staff who were asked to consider participating in either the hospital preparation survey or the audit of hospitalisation preparation practice at the hospital were informed that their responses would be anonymous and confidential because no data would be matched to any particular respondent. Surveys and audits were allocated numbers and were stored in a locked cupboard. Consent forms, which contained data that identified participants, were stored separately in another locked cupboard.

Some of the hospital preparation survey participants were children between 6 and 10 years of age. Therefore additional ethical considerations were raised and were considered carefully by the action group when developing the survey. Children were legally not able to consent to complete the survey and parents or guardians provided consent on their behalf. However, the action group wanted to acknowledge the children's right to consent on their own behalf and so the consent form included a section to be completed by children that indicated their assent to participate in the data collection, see Appendix L. Ethical considerations in relation to gaining informed consent and in maintaining participants' confidentiality are incorporated into each reported action cycle. There is also acknowledgement of the different emphasis of these ethical issues in an action research study in relation to the participants' direct and ongoing participation in the research.

5.5 Data collection tools and procedures

The data collection procedures used were researcher field notes, a hospital preparation survey for children and their parents, and an audit of hospital preparation practices. In the regular action group meetings, group members worked in a collegial and collaborative way to develop, implement and analyse

data from the survey and the audit. The minutes of the action group meeting discussions and decisions informed the researcher field notes and trace the development of the collaborative processes used by the action group in developing, executing and evaluating successive plans. The action group developed and executed a hospital preparation survey and a hospital preparation practice audit during cycle two, and evaluated them in cycle three. The researcher field notes were collected throughout the study and included data about the reinstatement of the Micturating Cysto-urethrogram (MCU) booklet that was planned and executed in cycle two and maintained in cycle three.

5.5.1 Researcher field notes

The researcher field notes are my reflections on the meeting minutes and other relevant study matters. I started writing the researcher field notes on 3rd August 2005 and stopped on 16th August 2010. Notes made during the research phase of the study when the action group were meeting regularly are a subset of the researcher field notes. The field notes were word processed, in landscape orientation with columns labelled planning, acting, observing and reflecting, and so mirrored the action phases. They included comments on the progress that was made with regard to the aims of the study, observations of and reflections on the ease or difficulty encountered in making group decisions, and a plan of actions that I and/or other members of the action group needed to address prior to the next meeting.

The first group meeting was on 3rd February 2006 and the last was on 31st October 2008, which is a period of two years and nine months. The action group met once each week for four weeks initially, and then met by agreement once per month for more than two years. In the call for expressions of interest notice, I acknowledged my role in undertaking the study was as a doctoral student in the Faculty of Nursing, Midwifery and Health, at the University of Technology, Sydney. Additionally, information about the process to audio record the meetings was given to each of the action group members in the

consent form, see Appendix E, that they signed when they joined the action group. Each meeting of the action group was audio recorded and the recordings were stored on a computer with secure password access. After the meeting I word processed minutes of the recorded discussions and prior to the next meeting all members of the action group checked them for accuracy and completeness. All action group members had an opportunity to make amendments, additions and deletions to the meeting minutes before they were accepted as a record of the meeting.

5.5.2 Hospital preparation surveys for children and their parents

A hospital preparation survey for children and a survey for their parents was developed by the action group to generate knowledge about what preparation they were receiving at the hospital. The surveys collected data from children aged between 6 and 10 years of age, and their parents or guardians. Selection of this age range was for a number of reasons that will be fully described in Chapter Six; however, one of the reasons was that the age range coincided with one of the age ranges used in the analysis of a variety of hospital data by the hospital organisation.

An ethics application to conduct the data collection was submitted to the hospital's Area Health Service Human Research Ethics Committee on 1st December 2006. Notification that the survey was approved was received on 2nd March 2007, see Appendix K (Protocol No. 07/010), and data collection began immediately. The research assistant who collected and entered the data was a volunteer with a psychology degree who was undertaking six months of work experience with the clinical psychologist who was a member of the action group. The research assistant became a member of the action group receiving information about the study and consenting in the same way as the other action group members had done.

The hospital preparation survey is Appendix M of this thesis, and is in two parts; the first was designed to be completed by children and was titled Child's survey.

The second part was to be completed by their parent or guardian, and was titled Parent's survey. The action group developed the surveys ensuring that the language and layout of each item and section was suitable for the potential responder. The action group decided not to pilot test the surveys because members considered that the collaborative development that took place over several months ensured the validity and reliability of the surveys because they were developed for this hospital and to meet the needs of this action group only.

The children's survey includes pictures, space for responding to a question in writing and space for drawing. The survey begins with instructions in language appropriate to the 6 to 10 year age group, and on the first page there are two demographic questions, two questions about previous experience of hospitalisation and three questions about information about the current hospitalisation. On the next page, the question "If your friend had to come to hospital what would you tell them to make it better for them?" is followed by a space on which a response may be written. The final page is in two sections: the top section seeks information about how scared the children felt before hospitalisation and how scared they would be if they had to come to hospital again. Two five-point likert scales using drawings of faces, somewhat like the faces used in pain rating scales, are provided and the children are invited to colour in the face that best represents how they felt/feel. Children are invited to draw whatever they choose in the space for drawing on the lower half of the last page.

The parent's survey uses text, suitable for year nine school reading level, to communicate with the parent, first with instructions for survey completion and then to ask 16 questions. The questions include three demographic questions about the children and a 10-point likert scale that indicates the parents' perception of distress caused by any previous hospitalisation of their children. The survey then seeks information about the children's current admission to hospital and preparatory information received by the children and/or parent/guardian. Spaces are provided for parents/guardians to complete responses, including 3, 10-point likert scales and a table. The final question,

“What general types of questions has your child asked you or your doctor about going to hospital?” has seven lines of space for a written response.

5.5.3 Hospital preparation practice audit

The hospital preparation practice audit, see Appendix N, was developed to generate knowledge about existing practices designed to prepare children and their families for hospitalisation. The audit was pilot tested by members of the action group for validity and reliability prior to releasing the audit for completion. Hospital staff received the preparation practice audit by internal email. Informed consent was assumed from each participant when the audit was completed. The electronic format was completed online, responses saved and returned to the action group by email. Alternatively, the audit could be printed, completed by hand and returned to the action group by internal mail. There were three sections that sought the participants’ opinions about preparation strategies at the following occasions: Pre-admission, On admission/during admission and Pre-discharge/post admission. Each section comprised 13, 5 and 4 items respectively. Each item had five statements to be rated for the utility of the strategy, using a 10-point likert scale. Five check boxes indicated the age of children for whom the strategy was suited. More than one box could be checked, see the audit in Appendix N.

5.6 Data collection procedures

Data were collected from two cohorts of participants, one cohort being the action group and the other cohort being the two groups of data collection participants. Data collected from the action group members provided information about the action process and were the researcher field notes that incorporated the action group meeting minutes. The second cohort of study participants provided data either through a hospital preparation survey for children and their parents, or a hospital preparation practice audit. The data provided information about the existing practice of hospitalisation preparation at the hospital and the outcomes of the practice. Each of the three strategies for

measurement used in the present study employed different procedures to collect data and an outline of these procedures follows.

5.6.1 Recording researcher field notes

Data collected in the researcher field notes was about the action research process as the research unfolded. Essentially the field notes are my reflections of all aspects of the research process that the action group were following, and they were recorded directly into a typed document on a password protected computer. I wrote these field notes at various times, sometimes directly after an action group meeting, when I would record my reflections of the mood of the meeting and whether predicted goals had been achieved. Sometimes I wrote the field notes after some event had taken place, such as when an application for funding of a part of the study had been submitted. I also wrote field notes that recorded other events that took place outside the action group meetings, such as, when action group members emailed their thoughts to me following a stimulating discussion at an action group meeting. At other times, I wrote my reflections about my own progress in acting on plans or changing them in response to the evolving nature of the research.

The minutes of the action group meetings provided the foundational structure for the researcher field notes. The meetings were held weekly from 3rd February 2006 on Friday from 12 midday to 1pm for four weeks, and then monthly at the same time until 31st October 2008. Several steps were involved in the development of the meeting minutes. Firstly, I audio recorded everything that was said by all attendees at each meeting with the consent of each group member, by switching the recorder on at the commencement of the meeting and switching it off again when the meeting ended. These audio recordings formed the basis of the written meeting minutes which were not verbatim transcriptions but rather brief summaries of plans, actions, observations and reflections. I wrote these minutes after each meeting while listening to the audio recording. Each meeting followed an agenda according to the action group's requirements, I attended all 32 meetings throughout the study and

attendance by the other action group members is not relevant here, and will be discussed in Chapter Seven. However, the minutes of each meeting that I wrote had input from the recording of that meeting, the agenda of that meeting and my presence at that meeting.

Each action group member had the opportunity to make amendments, additions and deletions to the meeting minutes during the following week or month, when they received them by email on the weekend following the meeting. The ability to edit the minutes allowed action group members to manage any omissions or inadvertent breaches of confidentiality that may have occurred, and simultaneously allowed them to have control of the written record of meetings. Any amendments, additions or deletions were then recorded by me and then distributed by email to the action group for comment. The final minutes were then emailed to each action group member with the next meeting's agenda, on the Thursday before the next Friday meeting. In the case of the first meeting, I distributed the agenda to the group members one week prior to the first meeting. These minutes and any amendments were stored on a password protected computer and the action group members also stored their own draft and final copies of meeting minutes on password protected computers.

These minutes became a part of my researcher field notes after they had been accepted as accurate by the action group. I included these in the action column of the field notes because the meetings were central to the action of the research, and the approved minutes represented the collaborative intent of the action group. I read these and wrote entries in the other three columns of the field notes, observing, reflecting and planning. These were in terms of: action group decisions made regarding plans and actions, group process observations, individual and combined group member's reactions/responses to issues.

The field notes were fundamentally different to the minutes because they were a written collection of my responses to plans, actions, observations and reflections of the action research process. They were a purely personal record

and a means of managing the complexity of the cycles to ensure that the study addressed its aims.

5.6.2 Surveying children and their parent/guardian

The hospital preparation surveys were completed by children and their parents/guardians who were identified from the hospital admission lists and were approached by a research assistant, after all health care treatments were concluded. Informed consent was sought by the research assistant; see Appendix L for the form that provided the information and the opportunity for parents to consent, and for children to assent to participate in the study. Potential participants had an opportunity to ask any questions that they might have of the research assistant, prior to deciding whether to participate in the data collection. If they consented, the research assistant took the signed consent form and assent form to later be filed in the identified locked cupboard. She then left the survey with the children and their parents to be completed just prior to discharge from hospital. The research assistant provided information about how to return the completed survey to ensure anonymity and confidentiality, by putting the survey in the one-way sealed pizza box at the ward clerk's desk.

Children were not supervised or helped by the research assistant when responding to the survey as the children completed the survey on their own. However, parents sometimes assisted their children; for example if the children had difficulty completing some sections due to an injury which caused their hospitalisation. The research assistant emphasised to the parents the point made in the written instructions for the survey that parents were asked not to answer for their children and parents were to give their children every opportunity to complete the survey accurately from their own point of view.

When complete, the surveys were placed in a pizza box that was attached to the wall of each ward, just near the desk of the ward clerk who completed the discharge formalities. The research assistant collected completed surveys from

the pizza box at least once per day. Data was entered from the survey into a spreadsheet on a password protected computer by the research assistant. The data from the children and the parents were entered separately, although each member of each dyad was allocated the same number but differentiated by the addition of C (children) or P (parent/guardian). Therefore, linking of the responses was possible, if required.

5.6.3 Auditing hospital staff

The hospital preparation practice audit was a tool that collected data about the existing practice of preparation for childhood hospitalisation at the hospital and was provided by the hospital's staff. The action group developed the audit, see Appendix N, and submitted an application to use it to collect data to the Quality Improvement Committee at the hospital on 23rd August 2006, see Appendix O. The application was approved on 30th September 2006 and after several action group meetings to pilot and streamline the data collection process, the audit was emailed to all staff members using the hospital staff email distribution list. Staff members were asked to return the completed audit by replying to the email address from which the audit had come within one month of receipt. The email address had been set up by the Information Technology Department of the hospital to enable secure and anonymous return of electronic audits. Reminders to complete the audit were emailed to all hospital staff, once per month for three months.

If the audit was not completed electronically the recipient could print the audit, complete it and return it to the action group via the hospital internal mail system. If the audit was completed electronically the computer mouse was used to tick the appropriate boxes, if the audit was printed and completed by hand the boxes were ticked by hand. No identifying data was available on either format. The completed electronic audit could be saved and stored on the responder's password protected computer. The hardcopy of the completed audit could be printed and saved by the respondent.

5.7 Analysis of the data collected in the present study

Data analysis procedures suitable for each of the three data sets were undertaken at different stages of the study; these are further explained in the sub-sections of this section, and in each of the three subsequent action cycle chapters. Qualitative analysis techniques were used in relation to the researcher field notes and the responses to the open-ended questions that were in the hospital preparation survey. Quantitative techniques were used to analyse the data collected from the responses to the closed-ended questions in the hospital preparation survey, and the hospital preparation practice audit data. See Figure 5-2 on page 149, for a graphical representation of these processes.

Figure 5-2 Process of data collection and analysis to address the aims of the present study

5.7.1 Qualitative data analysis

Analyses of the qualitative data arising from open-ended survey questions, hospital audits, action group minutes and researcher field notes provided a wealth of information that provided a deeper understanding of preparation for childhood hospitalisation ideals and what was occurring at the hospital during the study period. The Action group meeting minutes informed the development of the researcher field notes and provided an audit trail of activities occurring at the hospital, the plans made and acted on and the action group's evaluation of these. The researcher field notes told the story of the study, describing the plans, actions, observations and reflections that constituted each cycle of action research. Examination of the researcher field notes was continuous throughout the study providing a reflection on the study rather than an analysis of the study. Each plan and action of each action research cycle appears in the field notes in chronological order with accompanying observations and reflections by the researcher. There were reflections on reflections that captured the evolution of the study and enable the study's story to be told. The multi-layered approach captured the richness of the story and demonstrates the complexity of the interaction of the phases of action research.

Information about the preparation for childhood hospitalisation was obtained through analysis of the responses to the open-ended questions in the hospital preparation survey. Analysis of the data collected from this part of the survey used the software program Statistical Package for the Social Sciences (SPSS). SPSS is a software program commonly used in health care research to assist in the analysis of research data. Version 16, SPSS16, software helped to sort the children's and families' textual responses to the survey questions into similar categories. These formed the basis for undertaking a thematic analysis of the data using a standard content analysis technique. The themes derived from these coded data provided a clear understanding of their expectations and experiences of childhood hospitalisation practices at the hospital.

5.7.2 Quantitative data analysis

Descriptive data analyses techniques were used to identify the different preparation practices occurring for childhood hospitalisation from the children and family surveys and the hospital audit. These data were used to inform the action group's decision on the need to further investigate hospital preparation practices. The closed-ended survey questions described the experience of preparation for childhood hospitalisation. They required the respondent to select one response from a range of response choices by children in the Child's survey and by parents/guardians in the Parent's survey. Frequencies of the children's and their parents'/guardians' responses to closed-ended survey questions were analysed using descriptive statistics (Schneider, 2003) using SPSS16 software. Descriptive statistics provided frequency distributions and ranges.

The hospital audit obtained hospital staff responses on strategies they were aware of to prepare children and their families for hospitalisation, including strategies at the hospital and at other hospitals. .The audit required the selection of one response on a five-point likert scale. Both electronically returned audit data and handwritten audit data were entered into the Excel spread sheet. Excel 2007 software used descriptive statistics to identify ordinal measurement of the hospital preparation practice audit data. Descriptive statistics provided frequency distribution and range.

Combining different data analysis techniques enhanced the richness of the data and enabled the telling of a more comprehensive story about preparation for childhood preparation practice (Whitehead, 2007).

5.8 Summary

This chapter provided the information about the context of the study and the study methods required to understand the three cycles of action research outlined in the subsequent three chapters. The context of the study was

dynamic and energetic and demanded a research methodology that captured that complexity and achieved contextualised research outcomes. Participant recruitment, study measurement, and data collection and analysis in the complex setting of the study indicate the congruence of the action research methodology with achievement of the objectives of the study and with telling the story of preparation for childhood hospitalisation at the hospital.

Action research that used three action cycles is outlined in the following three chapters. The next chapter will review the first action cycle – *mobilisation of engagement of the hospital community in the study*. In this cycle, the study was set up and actions such as applying for and receiving ethical approval to conduct the study are described prior to engagement of the hospital community to come together to improve the practice of preparation for childhood hospitalisation. The action cycle shows how the study aims were central to the conduct of the study.

Chapter Six – Action research Cycle One – Mobilisation of engagement of the hospital community in the study – October 2004 to January 2006

The action research study took place because of an opportunity that arose in October 2004 to review the preparation for hospitalisation of children and their families at the specified major children's hospital. A number of health care professionals at the hospital from a variety of disciplines had shared their concern about preparation for childhood hospitalisation. There were 21 people with whom I had preliminary discussions prior to formation of the action group. The health care professionals knew each other professionally as co-workers at the hospital. Preparation for hospitalisation had not been an agenda item at any hospital meetings but when they met, the health care professionals discussed their concern.

6.1 Introduction

As a member of the hospital community, the hospital's Director of Nursing was aware of the health care professionals' concerns about children's hospital preparation and was supportive of the health care professional's resolve to act on these concerns. The Director of Nursing had an interest in the provision of preparation for hospitalisation both as a senior executive of this major children's hospital and as a clinician who had experience of preparation in a number of children's hospitals. The Professor of Child and Adolescent Nursing at the hospital who was my primary research supervisor was aware of my strong and long-standing interest in preparation for childhood hospitalisation and had regularly discussed issues related to nursing practice development with the hospital's Director of Nursing, including my wish to pursue improvements in children's hospital preparation. It was my primary research supervisor who facilitated my collaboration with the hospital health care professionals to implement the study, with the Director of Nursing readily agreeing to become my site supervisor.

Three circumstances were present in support of the study at the hospital. The first was that the health care professionals had spontaneously expressed their concern about preparation practice at the hospital. The Director of Nursing reported that health care professionals were interested in improving hospital preparation practices and were willing to invest their time and energy to achieve these improvements, and the Director of Nursing supported them in improving these practices. Finally, I had the knowledge, experience and desire to work with these health care professionals to achieve this goal. Having each of these circumstances in place is essential when using action research to improve health care practices.

My initial plan was to undertake a randomised controlled trial to assess the effectiveness of a targeted hospital preparation program. Therefore, my decision to use a collaborative approach to achieve improvements in children's hospital preparation practices was a significant methodological shift. It was clear in discussions with the Director of Nursing that employing an action methodology would enable the health care professionals to participate willingly in facilitating change. As noted in Chapter Four, action methods are best able to facilitate practice change when used in the right circumstances such as those described above. Other features of action research that were well suited to the study were the cyclical nature of bringing about planned change through reflection on the process and the outcomes as they occurred. In this process of reflection, the opportunity was taken to revise and adjust plans that were untimely, not accepted by the group and/or proved ineffective in bringing about desired change.

The following three chapters outline the cyclical development of the action research study, arising from a concern about preparation for childhood hospitalisation through to the implementation of the actions agreed by the action group. Each of the following three chapters describes one cycle of the action research and the first is the subject of this chapter. The first cycle in the action research process focuses on the *mobilisation of engagement of the hospital community in the study*, which comprised actions that engaged and mobilised

the hospital community in considering and discussing preparation for childhood hospitalisation. The cycle commenced in October 2004 and was completed by January 2006. The framework of **planning**, **acting**, **observing** and **reflecting**, was used to establish the action research study in its context. The four phases of the framework were embedded in each action cycle. Figure 6-1 illustrates the activities occurring in this first cycle.

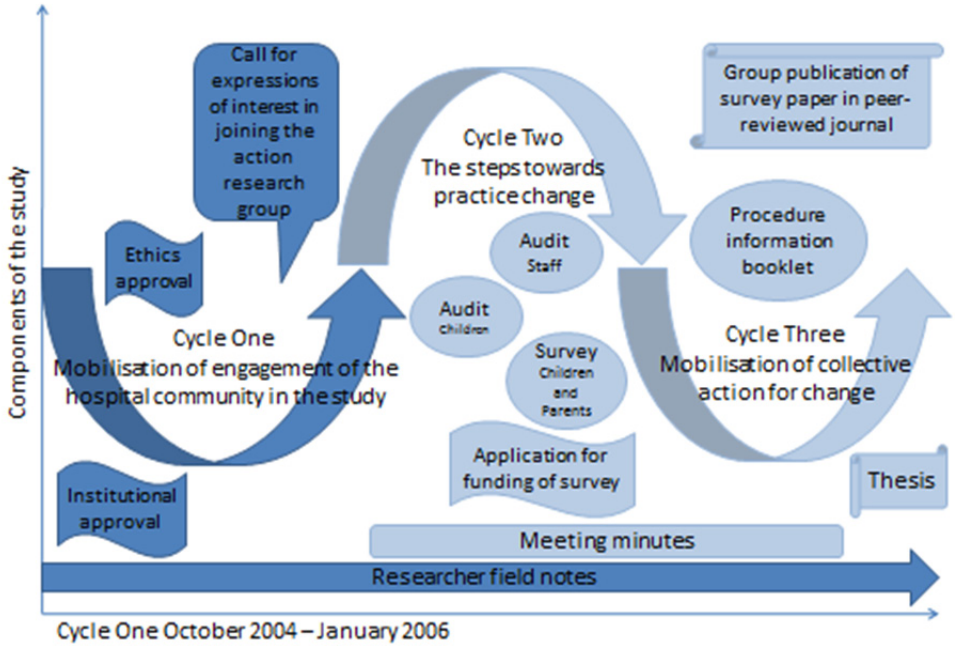

Figure 6-1 Cycle One - Mobilisation of engagement of the hospital community in the study – October 2004 to January 2006

The planning phase of this cycle illustrates how various elements were brought together to enable the action research study to proceed. The phase is described in section 6.2.

The next section of this chapter provides a description of the acting phase in which the study was set-up. Observation of the planning and acting occurring in Cycle One constituted the next phase and prepared the way for the final phase. Reflection on the actions and their outcomes in each cycle is an important feature of action methods and one that distinguishes action research from more traditional methodologies (Waterman, 1995). Reflection on the activities and

outcomes of the first cycle consequently led to the start of the second cycle, *the steps towards practice change,* which is described in Chapter Seven.

6.2 Planning

The first phase of Cycle One focused on planning the action research study. During this phase I made preparations by undertaking all the activities outlined in the study proposal to enable the study to proceed. These included seeking institutional approval to conduct the study and calling for expressions of interest in joining the action research study, and are further covered in the acting phase of this cycle. Several discrete procedures occurred to prepare the ground for the next action phase. The following sub-sections outline the planning phase procedures and the rationales for each of the plans made.

6.2.1 Applying for institutional approval to conduct the study

Between October 2004 and November 2005 planning occurred to prepare for gaining institutional approval to conduct the study. Approval was required from two institutions: the University of Technology Sydney and the Area Health Service. The University required the study to comply with all the ethical and scientific principles for conducting research with humans outlined by the National Health and Medical Research Council (2007), including requirements particular to protecting the rights, safety and confidentiality of vulnerable health populations and health care staff. In consultation with my university research supervisors preparation of the application occurred.

The second application for ethical approval was to the Area Health Service Human Research Ethics Committee. Apart from the usual ethical principles of conducting research with humans including respect for participants and prevention of harm, two aspects of the ethics application were highlighted (Brydon-Miller, 2006a). One was the assurance of confidentiality and the maintenance of privacy of participants. Data collected for the researcher field notes in the meeting minutes may be identifiable as coming from an action

group member. Therefore, planning involved notifying all those who consented to take part in the action research study, as an action group member, of the possibility that they may be identified as a co-researcher. The consent form includes the notification, see Appendix E.

The second issue addressed in the ethics application were the outcomes that participants might receive from participation in the action research study. Potential outcomes proposed included: involvement in developing strategies to improve preparation of children that is evidence based, a voice in practice and policy decisions, development of group cohesion to act on a common issue of concern and development of stronger links across disciplines. Other outcomes were potential indirect benefits to participants such as the possibility of practice change that may result from the action research study, and benefit to the health care staff who agreed to become co-researchers on the study such as through research publications. The application placed emphasis on these ethical considerations (Brydon-Miller, 2006b; Eikeland, 2006; Fontenla & Rycroft-Malone, 2006).

6.2.2 Engaging support for the study from the hospital community

Action research requires the active participation of those involved in the research, with the consequence that members of the hospital community who wished to participate would need to commit to making time available to participate in a range of activities as this was an unfunded project. For example, health consumer interest and support groups are acknowledged for the good work that they do in preparation for childhood hospitalisation, but they could not be included because this would have required payment for their contribution and thus, having to seek research funds to reimburse them. The main focus of the study was on health care professionals and hospital community members at one site who did not expect to receive financial reimbursement for their participation. To ensure that participants were in a position to undertake that commitment, negotiation of various organisational

and logistical arrangements occurred prior to commencement of the planning meetings in preparation for the study.

6.2.2.1 The hospital management committee

The Director of Nursing, who agreed to provide supervision to me during my work with the action group, played a crucial leadership role for the study by engaging the support of the hospital management. Leadership is about knowing how to make visions become a reality (Kitson, 2001). The Director of Nursing enabled the action group's communication with the hospital managers, which helped to engage their support for the study. The management committee comprised managers of the various departments of the hospital, including the Director of Allied Health and the Director of Medical Services. The committee met every week for two hours to discuss many issues related to the day-to-day running of the hospital as well as long term planning issues. The leadership provided by the Director of Nursing was invaluable because it enhanced my understanding of the hospital's management structure and enabled participation with the action group members in ways that were congruent with the context of the hospital organisation.

The Director of Nursing suggested asking the management committee to act as the steering committee for the study as a way of overseeing the activities of the action group. As well, the Director of Nursing suggested that if the management committee agreed to take this role, she would regularly be able to present the committee with study progress reports, either at the request of the committee or the action group. In this way, the Director of Nursing would be able to act as an intermediary between the two and be fully abreast of how the study was progressing. The terms steering committee and working party were in common use at the hospital at that time, so the suggestion that the management committee would be an ideal steering committee was an acceptable concept to the action group. Hospital staff understood that a steering committee is a group of senior managers who advise and oversee the activities of a working party, without taking actions to enable outcomes. Staff

also understood that a working party, or action group in this case, would autonomously take actions to achieve a given goal but with the support and guidance of the steering committee. In consideration of this understanding, the hospital management committee agreed to become the steering committee for the study and plans to form the action group were made, with the Director of Nursing agreeing to maintain communication between the two.

6.2.2.2 Stakeholders in hospital activities

Another logistical arrangement to ensure free participation of health care professionals in the action group was initiating a relationship with stakeholders at the hospital. Stakeholders had either an interest in the action research study or a stake in its work and outcomes, and included hospital staff, including managers and the executive. Guba and Lincoln (1989) discuss stakeholders when describing Fourth Generation Evaluation, an approach that is similar to action research but with a focus on evaluation rather than on the emancipatory intent of critical social theory that is the guiding framework for an action research study. In action research the “claims, concerns and issues” (McCormack, Manley, & Wilson, 2004, p. 93) of the stakeholders guide the evaluation process. The stakeholders in the action research study include everyone with an interest in the work of the study or its outcomes.

The Director of Nursing identified a number of people as stakeholders including clinicians caring directly for children such as nurses, allied health professionals and doctors at all levels. Nurse Unit Managers, who organised the coordination of the care of individual children and their families, as well as the administration of the various units of the hospital had a particular interest in the provision of preparation for childhood hospitalisation and therefore potentially had an interest in the action research study. Staff working in the allied health departments such as Play Therapy, Physiotherapy, Psychology, Social Work and Occupational Therapy were also potential stakeholders. However, stakeholders also included people providing health care services for children and families such as such as pathologists and radiologists.

As well as making me aware of various stakeholders who might wish to be involved in the study, the Director of Nursing helped me to understand the way that hospital departments worked with one another. The suggestions were helpful for me to work with the staff as an outsider (Titchen & Binnie, 1993), although at one time I had been a nurse researcher at the hospital. Some hospital personnel knew me as someone with a children's nursing background who had knowledge, experience and a specific interest in preparation for hospitalisation of children and their families. My background and interest in an issue shared by many staff working at the hospital enabled a relatively smooth transition from outsider status to being a member of the action group.

Other stakeholders included the children admitted to the hospital and their families who, more than any other stakeholder, had an acute interest in the study and its hope of positive outcomes for them. It was decided to maintain an open list of potential stakeholders for people not yet considered but who would be likely to wish to join the study in different capacities. Notification to stakeholders of the plan to set up the action research study was the same as the technique used to recruit participants to the action group: the call for expressions of interest flyer. Health consumers and all hospital staff became aware of the planned research through wide distribution of the flyer throughout the hospital. A description of the plan to distribute the flyer appears in sub-section 6.2.3 below.

6.2.2.3 Potential consultants to the action group

Given that the purpose of action research is social change through involvement and improvement (Raelin, 1999) engaging assistance for the action research study from the whole hospital community was essential. Involvement of everyone affected by the proposed change enabled the opportunity to contribute to the action research study in a variety of ways. There was an enormous amount of expertise regarding children and their health available at the hospital. Therefore, the concept of engaging consultants to the action

research study was established. Potentially, the consultants could advise on aspects of preparation for childhood hospitalisation of which the action group did not have sufficient knowledge or expertise. In addition, consultants may have different points of view and different priorities to the action group and therefore their contribution of these different ideas might be was invaluable to successful implementation of practice change.

The plan was that members of the hospital community would be informed of the action research study through the flyer that called for expressions of interest. Once aware of the study and having the opportunity to express interest in joining the action group they might be responsive to subsequent requests by the action group for assistance in furthering the objectives of the action research study as consultants.

6.2.3 Mobilisation of the action group

Planning was required to enable the involvement of hospital staff who had identified their concerns about hospital preparation occurring at the hospital and to make it possible to include others who had not had the opportunity to express their concern publicly. The technique of calling for expressions of interest in joining the action group through a flyer was chosen because the technique is congruent with critical social theory (Fay, 1987; Kemmis, 2008), which proposes that the people who are affected by the issue of concern should have the opportunity to make change for the better by challenging the status quo (Crotty, 1998; Kincheloe & McLaren, 2005). Calling for expressions of interest throughout the hospital in this way was an attempt to reach as many people within the hospital community as possible. The call was designed to reach everybody and therefore give everybody an opportunity to respond if they were interested.

In a 24-hour day health care system it was recognised that some health care professionals who might be interested in the action research study might work at night or do shift-work that would make participation in research difficult. As

well, I was acutely aware that the many other commitments of hospital staff could prevent their participation in studies despite having an active interest in the issue being researched. Being aware of the study did not necessarily mean that all members of the hospital community would participate.

One reason for non-participation might be that the flyer quite clearly stated that the action research study was part of doctoral studies, indicating that the action research study was an academic research project and therefore the outcome might not necessarily benefit the hospital community. Some members of the hospital community might prefer not to participate in such a study. There are many reasons why staff do not get involved in research into health care practices that have direct application for them.

Nevertheless, by calling for expressions of interest throughout the hospital all staff were provided with information about the study aims, planned action and had the opportunity to join the study. Permission was sought from the hospital administration on 15thNovember 2005 to post the flyer at sites around the hospital where it could be seen by all members of the hospital community and to email it to all hospital employees. The flyer calling for expressions of interest can be found in Appendix C.

6.2.4 The researcher's role in mobilising the action group

A tension existed between the research being doctoral work and participation in the action group to facilitate group activity. One of the characteristics of the action research methodology that is based on philosophical position of critical social theory is that participants are able to affect outcomes because they participate freely and without any external coercion (Crotty, 1998). Because of my own long-standing interest in preparation for childhood hospitalisation and because the study was my doctoral focus, I had already assembled a large number of resources that I could share with the action group in its consideration of best practice in hospital preparation. Part of the planning to address the concern of the health care professionals about preparation for childhood

hospitalisation was to consider resources that might be required when the action group initially formed and met. My contribution to the group's deliberations was the offer of useful sources of literature; however, this created a tension for me as an equal member of the group.

Putting a strategy in place that managed the tension between my doctoral work and free participation of action group members was important. The strategy was that no decisions of the action group were pre-empted or manipulated by presentation of resources chosen by me as the researcher rather than by the action group. Assembled resources might not be called for or required by the action group. However, it was worthwhile to anticipate what the group might find helpful to their thinking and planning for change. If any of these resources was requested I reasoned that if required, one of my contributions to the group's work could be to assemble resources for the group's consideration.

Since it was possible that the action group might want to review material about preparation for childhood hospitalisation before beginning to decide how to act within the local setting the following resources were assembled. The first was a brief synthesis of the literature about preparation for childhood hospitalisation gathered in the preparation of my Master's thesis in 1994 and added to over the intervening time up until 2006. A brief document synthesised the findings of more than three hundred articles (see Appendix I). A synopsis of the action research study was available to the action group and the steering committee and anyone else who was interested in preparation for childhood hospitalisation that the study addressed (see Appendix H). Other resources included samples of preparation strategies used in the Australian context to prepare children and their families for hospitalisation.

Two other aspects of my involvement in the study had to be acknowledged and addressed to manage the tension between my doctoral work and the participatory intent of the action group. The first was that as I planned to call for expressions of interest for hospital staff to engage in the study, my role in the group could be interpreted as the leader, which had the potential to limit full

participation by potential action group members. My role in the action research study was addressed in the second phase of the first action cycle when potential participants asked for more information about the action research study at face-to-face meetings. Once I clarified my role as a member of the action group as being equal with the other members, and like others being able to offer particular expertise that could be utilised to meet the study aims, the group's impression of my role being the group leader dissipated.

The other aspect of my involvement in the action research study related to my role as a nurse and having initiated staff participation in the study, because the multidisciplinary action group might have considered the study as a nursing initiative. Prior to initiating the invitation to hospital staff to join the group I considered that the group was likely to be multidisciplinary because the health care professionals who had expressed their concern about children's hospital preparation represented a number of different health care disciplines. Clarification of my role as a nurse in the action group was given in the face-to-face meetings that took place in the acting phase of the first action cycle. That a nurse should be interested in preparation for childhood hospitalisation is not unreasonable and indeed a number of health care professionals who had expressed concern were nurses. However, I emphasised that my role was as a group member foremost, then as a facilitator of group action, rather than as a leader of the group. I explained to interested staff that as a facilitator the contribution that I would make was to guide where requested, provide support as required and assist with project management (Harvey et al., 2002; Heron, 1999). Undertaking these processes addressed the issues related to the possible tension between my doctoral work and the participatory intent of the action research study.

6.2.5 Initial action group planning meetings

It was important for me to consider the literature about group functioning so that I had greater skills in facilitating group cohesion in planning change. Much of the evidence cited in the literature review about change included reference to

the effectiveness of groups to enable change. In particular, Lewin (Cartwright, 1952) noted that group members conform to group norms to enable optimal outcomes of the group's work. Lewin contended that groups of people are different to individuals in this regard and are more likely to be effective in taking decisive action as necessary to the situation presenting.

Tuckman (1965) identified the different stages of group development that occur and those that tend to influence group cohesion. A reading of this work suggested that the action group were at the stage of "forming" (1965, p. 396), that is coming together with a common purpose, in the first cycle. In the forming stage the group go through specified processes and these include orientation, testing and dependence, when the group members establish relationships that will enable them to work together (Tuckman, 1965). Tuckman's theory of group development revealed the importance of establishing the group structure to optimise the effectiveness of the group to enable a change in practice. The opportunity to meet with staff who had expressed interest in study participation began the establishment of group structure before the first action group meeting.

Staff who had expressed concern about preparation for childhood hospitalisation at the hospital were all very busy health care professionals and therefore it was important that the action research study was not excessively time consuming for them. Attendance at meetings was voluntary and did not involve a sense of obligation. Therefore, it was important that all the action group members negotiated the best time, place and format for meetings. As the outsider group member, I needed to recognise and acknowledge that the other participants would need to determine when, where and how meetings would fit into the functional routines of the hospital and its various departments (Titchen & Binnie, 1993). All group members realised that their individual commitments needed to fit around those of the group as a whole, so flexibility in my own work scheduling was also an important factor in group participation (Morton-Cooper, 2000).

6.2.5.1 Engaging action group participants

The evidence in the literature clearly shows that for group meetings to enable practice change group participants need to be interested in the work of the action group and in establishing group cohesion (Beringer & Julier, 2009; Cartwright, 1952; Hart & Bond, 1995, 1996; Heron, 1999; Suderman et al., 2000; Tuckman, 1965, 1990; Tuckman & Jensen, 1977). The health care professionals had already communicated their interest in the work of the action group; now it was necessary to support them in establishing group cohesion (Cartwright, 1952).

Planning to engage group participation of the health care professionals committed to the study involved planning group activities that would allow participants to feel welcome in the group. The first activity was to provide food and refreshment that the group could share during meetings. Sharing food and refreshments made the meetings more enjoyable, as this contributed to creating a more relaxed atmosphere and satisfied the practical need for the participants to eat their lunch while meeting. The second activity to increase group cohesion was to provide meeting folders that were used only for business related to the action group. Each member's folder contained their name and of the name of the study to emphasise their importance as a member of the action group. These two activities indicated the formal intent of the action group and helped to establish group cohesion.

6.2.5.2 Developing proposed plans and procedures

In keeping with recommendations by action researchers to maintain a clear record of the planning, acting, observing and reflecting that occurs during the study (McNiff & Whitehead, 2002), a plan was developed to make audio recordings of the action group meetings. The purpose of the audio recordings was to augment the meeting notes and my memory of discussions and decisions regarding actions that would enable tracking of the research as it happened. Recording meetings would also free me to facilitate discussion at

times and to participate freely in discussions along with other group members that would have been more difficult if I also had to take detailed meeting minutes.

Undertaking these recordings required planning to gain informed consent of action group participants. They needed to have a clear understanding of the recording procedure so that they could give informed consent to participating in this aspect of the action research study. Information about recording was included in the participant consent form (Appendix E). The procedure planned was that the recording would begin at the start of the meeting and continue until the end. Two audio recorders were to be used to provide backup in case of a failure of technology. I advised the action group members that the recording would be downloaded to a computer and stored securely in the same way as any other confidential data collected throughout the action research study, and as approved by the research ethics committees. Action group members were also advised that when I listened to the recordings this would enable me to reflect on the action group discussions and decisions taken by the group. I planned to inform the group about my reflections on the recordings. In gaining group member's consent, I confirmed they would have control of the recording process by asking to have the recording stopped at any time in the discussions and they could ask to have parts or all of the recording erased if they wished.

6.2.5.3 Field note reflections on the action process

Field notes are a means of recording plans, actions, observations and reflections for review. Kemmis and McTaggart (1988) recommended that the researcher should keep a diary or field notes as a means of keeping track of the complexity of an action research study, particularly given the cyclical nature of action research. Following their recommendation I had started writing field notes of the events associated with the action research study in October 2004 when the opportunity to work with the health care professionals arose.

Congruent with the action research methodology, I divided the field notes into four sections corresponding to the four phases of action research. Columns across a landscape-orientated page enabled me to show the relationships between the different phases of the study. The first column was headed *action* and was a description of an activity. The next two columns were headed *observation* and *reflection* and were written from my point of view observing and reflecting on the activity. The fourth column was headed *plan* and showed the plans of the action group and my plans given reflection on the activity that had taken place. Entries into the field notes took place whenever an activity or event occurred, prior to and during the action research study. Appendix F shows an example of an entry in the field notes demonstrating the cyclical nature of the action research methodology.

During the time between the posting of the call for expressions of interest and the first meeting, for example, I recorded my actions, observations, reflections and plans. Records of the cyclical nature of the first phase of the study include meeting with potential participants to clarify the proposed action research study, noting their responses and planning further approaches to meetings with other potential participants based on my observation and reflection.

6.2.5.4 Documenting the meeting minutes and decisions made

As a group of participants planning to meet regularly, it was considered important to record the minutes of the meetings from summaries of the activities undertaken at each meeting. This process enabled transparency and accountability of the action research process. As already noted, because I had instigated the call for expressions of interest in joining the action group, I had assumed the role of facilitator of the process. Harvey and colleagues' (2002) undertook a concept analysis of what facilitation entailed and while it is not a fully developed or understood concept, it does refer to supporting people to change in some way (Harvey et al., 2002). It seemed that taking on this role would be helpful to the group, especially since the staff who were likely to join the action group were time poor. As well, in taking on the facilitation role, it

seemed reasonable that I take responsibility for documenting the discussions and decisions of each meeting, and the group members agreed to this.

Documenting the meeting minutes was congruent with action research. Undertaking this task required summarising the key discussion points and the decisions taken in planning each stage of the study. The audio recordings of each meeting informed these summaries and the hand-recorded field notes notes following each meeting. The action group decided that distribution of the minutes by email to group members would work most easily and would also enable them to make comments and corrections to the minutes that could be circulated to the group members for further discussion. It was suggested that having the opportunity to clarify and correct the minutes would enable further participation by the action group. The action group made a decision to store the minutes electronically with a unique and secure password, according to ethics approval protocols. This procedure provided action group members with a corrected record of the meetings and ensured the recording of the meetings was open to scrutiny at any time, thereby ensuring transparency and accountability of the process.

The first planning phase of the study dealt with a number of aspects required in preparing for the study. The activities undertaken included planning to apply for institutional approval to conduct the study and this involved applications being prepared for two institutions. Planning also occurred to engage the support of the hospital community. Potential supporters invited to participate in the study in different capacities included the hospital management committee, other key stakeholders and potential consultants who could provide insights and expertise needed to mobilise the study. Plans were made to make a broad invitation to all potential participants to find out more about the study and to consent to join the action group if they wished. Identification and assembling of various resources that might be useful to the work of the action research study occurred. Finally, plans were made to take steps to optimise the action group meeting records.

6.3 Acting to engage the hospital community in the study

The acting phase of the first cycle aimed to instigate the plans made for setting up the action research study. The actions taken paid attention to the principles of critical social theory, such as offering potential participants the freedom to participate without pressure or manipulation on the part of an authority figure or group (Kincheloe & McLaren, 2005). This section outlines how the study plans made by the action group were acted upon to enable the action research study to be undertaken, and follows the planned procedures outlined in the planning phase section above.

6.3.1 Obtaining institutional approval to conduct the study

The University of Technology Sydney approved the action research study proposal and confirmed my PhD candidature on 13th July 2005. This enabled an application to the Area Health Service Human Research Ethics Committee for ethical approval for conduct of the study to proceed and was submitted on 22nd August 2005. The Area Health Service Human Research Ethics Committee approved the ethics application on 17th October 2005, see Appendix A (Protocol No.05/264) and that ethical approval was ratified by the university on 15th November 2005, see Appendix B (Protocol No.2005-188).

The two institutions interrogated the conduct of the action research study prior to satisfying themselves that the study met the respective institution's standards. After presentation of the study proposal to the academic panel and members of the Faculty of Nursing, Midwifery and Health some methodological issues were raised. The focus of discussion was on the feasibility of conducting the study using action research as a way to change practice. Discussion revealed a number of viewpoints from several researchers. I defended the use of action research by citing a number of instances when action research had been used to change practice: including in aged care to change procedures for referring patients between health services (A. Robinson & Street, 2004); in developing a clinical pathway in midwifery practice (Moody et al., 2001); in

pædiatric acute care pain management practice (Ely, 2001) and, in pædiatric acute care discharge planning (Suderman et al., 2000). Following discussion by the academic panel and my defence of the methodology, the academic panel approved the study proposal and an application to Area Health Service Human Research Ethics Committee for ethical approval to conduct the study was submitted on 22nd August 2005.

The Area Health Service Human Research Ethics Committee sought clarification of the outcomes of the action research study and of the data collection techniques at their meeting on 27th September 2005. The outcomes of the action research study relate to the aims of the study and these were re-iterated. In particular the unknown nature of the outcomes of action research (McNiff & Whitehead, 2002) while maintaining the ethical principles of research (Williamson & Prosser, 2002a) were clarified. The application stated that data would be obtained from health care professionals who participated in the action group, hospital staff who completed an audit of preparation practices at the hospital, and children and their parents/guardians who completed a survey regarding their experience of preparation for hospitalisation at the hospital. Informed consent would be required from each of these groups. At the time of applying for ethical approval only the first group was known but the application to the Area Health Service Human Research Ethics Committee included all other potential participants. The unknown nature of involving participants in action research studies was explained to the Area Health Service Human Research Ethics Committee with a reassurance that further applications would be made to the Area Health Service Human Research Ethics Committee if the action group chose to include other participants in the action research study. The Area Health Service Human Research Ethics Committee considered these explanations and approved the action research study regarding its ethical conduct at their meeting on 17th October 2005, see Appendix A (Protocol No.05/264).

6.3.2 Setting up communication with the hospital community

There is an increasing awareness that organisational influences are important in the implementation of practice change (Cummings et al., 2007). Therefore, the elements of the organisational context and culture of this tertiary children's hospital were considered. However it was acknowledged by the action group, and as McCormack and colleagues (2002) note, the term context does little to reflect the complexity of the concept. Setting up communication within the hospital community required attention to the inner context (Kavanagh et al., 2007) of the action research study. In a paper describing their study, Kavanagh and colleagues (2007) write that understanding the culture of the inner context was key to meaningful and lasting change to acute pædiatric pain practices. In preparation for commencing the study the actions required to engage the hospital community, as described in the following sub-sections, were critical to success for the action group in achieving the study aims.

By mid November 2005 a call for expressions of interest in participating in the action research study was made. Planning to distribute a call for expressions of interest flyer began with seeking permission from hospital administration, which was granted immediately with the condition that the executive assistant to the Director of Nursing arranged distribution of the notice. As site supervisor, the Director of Nursing made her executive assistant available to facilitate the process. The flyer was distributed in hardcopy to the notice boards in all the lift waiting areas of the hospital and distributed electronically by email to all hospital employees on 17thNovember 2005.

6.3.2.1 The hospital management committee

One factor in the context is the culture that is created at the level of the individual, the team and the organisation (Rycroft-Malone, 2004b). The management committee influenced the culture of the organisation and therefore their approval of the conduct of the action research study was essential to enable the action research approach to practice change. In her role as site

supervisor the Director of Nursing presented the action research study aims and proposed procedures to the management committee on 24th November 2005, one week after posting of the call for expressions of interest flyer to the hospital community. These study details were provided in a synopsis of the study that I had prepared (Appendix H). The study synopsis provided comprehensive information upon which to make decisions regarding their support for the study. The management committee members read the synopsis and asked no further questions regarding the proposed action research study; they agreed to act as a steering committee and gave their support to the conduct of the action research study. As well, the committee wished the action group well in acting to improve preparation for childhood hospitalisation practice at this hospital.

6.3.2.2 Other stakeholders in hospital activities

A broad range of members of the hospital community were identified as stakeholders during the planning phase of this cycle. They became aware of the action research study when the flyer (Appendix C), calling for expressions of interest was distributed on 17th November 2005. The flyer specified that anyone who was interested in knowing more about, or participating in, the action research study could contact me for further information and clarification.

Only one stakeholder, who was a parent of a hospitalised child, contacted me regarding the action research study in the acting phase of the first study cycle. She said that she had had cause to think about preparation for hospital of children and their parents because of the current admission of one of her children. When she saw the flyer she wanted to know more about the action research study and to contribute in some way. It was considered that this parent's experiences and perspectives of children's preparation for hospitalisation would be useful information for the action group to consider. However, after receiving a description of the action research study aims and processes, she said that she was unable to join the action group because she was unable to attend action group meetings due to other commitments. While this parent was subsequently invited to become a consultant to the action

research study, she declined the invitation and made no further contributions to the study, either as a stakeholder or as a consultant.

6.3.2.3 Potential consultants to the action group

At the outset of the first phase of the study the call for expressions of interest flyer notified potential consultants of the plan to set up the action research study and provided details of the study objectives and procedures. Any person who was interested in the study had an opportunity to offer their services. Members of the hospital community who took the time to read the flyer would have been aware of the action research study. If any individual showed interest by contacting me about the study they were invited to participate as a consultant for the study.

Seven health care professionals responded to the call for expressions of interest on the flyer by registering their interest to participate but not as a member of the action group. They all were allied health professionals or nurses in management positions. When I met with these staff to explain the action research study, they agreed to be available as consultants to the action research study if their knowledge or expertise was required. They stated that they could not commit to the regular meetings and tasks that may be required as a member of the action group. Engagement of consultants was an ongoing process throughout the action research study as the action group found that particular information and expertise was needed at different times to further the work of the group.

6.3.3 Call for expressions of interest in joining the action group

By 2nd December 2005, 21 people had responded by email or phone to the call for expressions of interest to join the action group. The information pack, see Appendix D, was sent to them and I followed up with a phone call to interested individuals. If the individual continued to show further interest, I made an appointment to meet with them in person to clarify the action research study

further and to obtain informed consent. Twenty clarification meeting appointments took place. These meetings were an opportunity for people to obtain detailed information about the action research study aims and methods. Most asked about the action research methodology and what action research meant for them. An explanation was given of the cyclical nature of action research, its collaborative intent and that the research processes were unknown until the action group had met and had made decisions about how to address the concern. There was considerable discussion about preparation for childhood hospitalisation practices, and those who had expressed interest in the action research study expressed a range of views about how to address the practice.

6.3.4 Reaching action group consensus on study objectives

Of the 21 people who responded to the call for expressions of interest, 12 consented to join the action group. They were all health care professionals who worked at the hospital in the following roles:

- Nursing Unit Manager Recovery
- Nurse Educator Recovery
- Senior Nurse Clinician Recovery
- Clinical Psychologist Pain Management Team
- Clinical Nurse Specialist Pain Management Team
- Manager Play Therapy
- Play therapist
- Nurse Educator Emergency Department
- School Projects Officer
- Social Work Manager
- Social Worker
- Occupational Therapist

They agreed to become co-researchers for the study. They also agreed that collaborative group decision-making was perhaps the best way to address the issues of concern, since the problems associated with children's hospital preparation involved almost every department in the hospital, which was represented to some degree by the action group membership. Those who consented to participate in the action research study wanted, and were in a position, to do something tangible to improve the preparation for childhood

hospitalisation practice at this major children's hospital. Therefore, gaining the group members' formal agreement to participate in the study through a collaborative group process was relatively straightforward.

6.3.5 Facilitating action group meetings

Although the members of the action group had consented to become co-researchers in the action research study by December 2005 the first action group meeting was scheduled for 3rdFebruary 2006. Selecting a delayed start date meant that all action group members could attend the first meeting, given that many of them were due to take leave during the approaching holiday season. Hope (1998) emphasises the importance of face-to-face meetings when discussing the complexity of initiating action research in the clinical setting. He states that the first meeting is of utmost importance because it can be influential in the conduct of future meetings. Discussions and decisions about the future action of the action group made during the first meeting needed the input of all members of the action group, and not just those who were not on leave. Enforced delay allowed for a little time for all members of the action group to reflect on potential actions and allowed me to make further preparations to ensure smooth running of the action group meetings. The Director of Nursing was supportive of the action research study to the point of asking her executive assistant to book the room for the first meeting. One of the tasks of that meeting would be to discuss the time and place of future meetings convenient to all action group members.

The format of meetings included their location, and the action group determined that hospital meeting rooms were most convenient. These were formal places in which meeting participants were able to write notes if they wished. Members of the action group had agreed that I would remind group members of the meetings, facilitate and record the minutes of the meetings and distribute them to the group members for their comment and correction. However, in every other way action group members agreed to working collegially to share their

knowledge and expertise to enable a productive working environment for the group.

The first actions taken for the first phase of the first action research cycle were now complete. The following section, observing, provides a description and an analysis of the actions that were taken in phase one. This section pays attention to the hospital's organisational structures and the task of ensuring that an opportunity was provided to all potential participants to join the study. Thus, observation of the practical activities that were required to meet the action research study aims is presented.

6.4 Observing mobilisation of engagement of the hospital community in the study

The third phase of the first action cycle involved the action group, including myself, in analysing activities occurring in the first two phases of the first action cycle, which included planning and acting to mobilise community engagement in the action research study. Many action researchers have acknowledged the observation phase as one that is essential to enable revision of the research when needed. Kemmis and McTaggart (1988) refer to the observation phase as the monitoring phase and recommend the phase as a basis for the reflection phase to come. They recommend that the researchers' field notes should inform the observation phase of the action research. In taking this advice, much of the following detail is derived from what is written in my field notes.

Greenwood (1994) wrote about the use of action research in nursing and stated that this approach to research helped "self-conscious, intentional agents…(to) perform actions that bring about change and observe…with the intention of finding out what is the case" (1994, p. 14). She noted that during the observation phase "practical reasoning skills of practitioners are …potentially enhanced… (and that this) increases the likelihood of effecting lasting change" (1994, p. 17). The observation phase of the first action research cycle is

composed of observations of the plans and actions I had taken to mobilise the interest of the hospital community in the study.

6.4.1 Observing each process of the action

During the first action cycle plans were made for the actions that needed to occur to meet the action research study aims. To make sense of the different procedures, this sub-section discusses the actions taken that enabled the next phase, which is the reflection on the preceding phases. My observation of the plans and actions taken in this first phase, followed by reflection on them, ensured that the aims of the action research study were in process.

6.4.1.1 Observing institutional approval processes

One aspect of the study that I found most difficult was the complex process required to obtain institutional approval and the unexpected length of time that was required in gaining approval. Gaining institutional approval to conduct the study took thirteen months, from October 2004 until November 2005. The applications to the two institutions were prepared during the first eight months and the application submission process began in June 2005. As Burns and Grove (2009) report no matter how enthusiastic the researcher, or how special their research is, the steps required are the same for all applicants and the time taken should be included in the planning. Because final approval was granted on 15thNovember 2005, there was a slight delay in starting meetings because they were predicated upon responses to the call for expressions of interest to join the action group. While this delay affected the pre-prepared plans for the study it did not reduce the enthusiasm of the participants to work together to improve preparation for childhood hospitalisation practice. Observation of the extended time taken to obtain institutional approval indicated that it probably did not negatively affect the action research study.

6.4.1.2 Observing engagement of support for the study

The advice and guidance of the hospital's Director of Nursing, my site supervisor, was fundamental to the success of engaging support for the action research study from members of the hospital community. This process of support was facilitated by introducing hospital executive and members of the management committee to the study and by alerting and enabling me to speak with these people. This type of assistance is valuable in an action research study (Hughes, 2008). Meyer and colleagues (1999) reported in their systematic review of action research projects in the UK, that lack of support was one main theme of action researchers' field notes, and a key barrier to planned change. Therefore, I was appreciative that the Director of Nursing facilitated my efforts to engage support from key hospital personnel.

The call for expressions of interest was also important as it served two purposes: one was the opportunity to notify the hospital community of the proposed action research study, and another was the opportunity to invite people to join the action group or be a consultant to the action group. When discussing the challenges of conducting health care action research from the inside, Coghlan and Casey (2001) acknowledge the importance of formally engaging the hospital community. At the outset of the action research study, when the action group began their meetings, three groups, hospital management, stakeholders and consultants, had been informed of the action research study and had some idea of the planning to move the action research study forward. The management committee had agreed to support the action research study by acting as the steering committee even though, for some, the evolving nature of action research was conceptually challenging.

My field note records of this process indicate that some action group members informed me of the existence of another group of health care professionals at the hospital. They had not responded to the call for expressions of interest in joining the action group and were waiting to see what the activities were before making a commitment to participating. The action group members who knew of

these people were confident that they would be prepared to consult with the action group, if asked. Even though they had not registered themselves as such, they were potentially consultants because they seemed to meet the criteria for the consultancy role

None of the potential stakeholders expressed an interest in joining the action research group in response to the flyer. However, this did not mean that there were no stakeholders who might potentially inform the study, but in the same way that some consultants had not expressed interest, they may have been waiting to see how the action research study unfolded. Therefore, consideration of how to engage stakeholders continued throughout the first and subsequent cycles of the study. As Cummings and colleagues (2007) argue in their report of the influence of context on research utilisation, every aspect of the context must be considered to ensure the integration of practice change.

6.4.1.3 Observing establishment of the action group

I was very pleased that 21 people with different expertise and experiences with children's preparation for hospitalisation expressed interest in knowing more about the action research study. Unfortunately, only seven of these people agreed to become consultants and two decided not to become involved with the action research study.

Prior to the first meeting 12 people had consented to participate in the action group. While the number was smaller than anticipated the action group members included representatives from a range of health care disciplines involved in caring for children. This held hope that the action research objectives were able to be achieved. The health care professionals understood that the action group was established on the premise that the action research study of which the action group was a part, sought practice change and that the action research study aimed towards improvement in practice defined by the professionals and on behalf of the users (Hart & Bond, 1995). That is, the action research study used what Hart and Bond (Hart, 1996; Hart & Bond, 1995,

1996) refer to as a “professionalizing type” (1995, p. 45) of action research to achieve the study aims.

6.4.2 Observing critical social theory in action

Critical social theory guided the action research study. Along with me, all the other action group members expressed a strong desire to improve the circumstances of children and their families through acting to improve preparation for childhood hospitalisation at the hospital. In sharing this common purpose, the group members individually and collectively sought to improve the circumstances of these children and their families (Cody, 1998; Kincheloe & McLaren, 2005). At the same time these health care professionals were likely to experience greater freedom and justice in their respective roles because they resolved to improve preparation practices that had been an issue of concern for them for some time (Hughes, 2008; Kincheloe & McLaren, 2005). The action group were taking action rather than accepting the status quo and were beginning the process of becoming enlightened, empowered and emancipated group members simply by raising consciousness (Henderson, 1995) of the issue of concern.

6.4.3 Observing action group cohesion and coming to consensus

According to my field notes the very early signs of action group cohesion were evident in the meetings I held to clarify the study with the health care professionals. Although the aspirations of the action research study were the subject of the clarification meetings, the meetings also provided an opportunity for like-minded health care professionals to share their concern. Those who had expressed interest in joining the study spoke of their concern with, and commitment to, preparation for childhood hospitalisation and their desire to improve its practice at the hospital. These early meetings included values clarification as Nolan and Grant (1993) recommend. Potential action group members shared their concern and expressed values regarding the health care professionals’ role and the importance potential members placed on preparation

in the health care of children and their families. Values clarification added to the connection and commitment and therefore the cohesion of the action group.

The health care professionals stated that they were satisfied that their expressed concerns about children's hospital preparation had led to the formation of the action group and the potential to collaborate in changing current preparation practices. While these health care professionals had not yet met as members of the action group, when meeting with me to clarify the study objectives and procedures they gained a sense of belonging to a group with a common interest. This sense of commonality of purpose was the seed from which consensus could develop given the right circumstances. Kemmis (2008) writes that members tacit or explicit agreement to continue the conversation is sufficient to enable consensus that will inevitably be situated and provisional. Although the potential action group members happily anticipated working together, there was a risk that reaching consensus would be challenging.

In *the steps towards practice change* cycle that follows this first cycle, a description of the efforts made by the action group to reach consensus is provided and analysed. Coming together as a group of concerned health care professionals indicated a commitment to reaching consensus regarding the practice of preparation for childhood hospitalisation. What is now reported is the reflecting phase of the first cycle, which had been occurring continuously throughout the cycle, but is recorded here as if in sequence.

6.5 Reflecting

The reflecting phase of this cycle is probably the most challenging to report in chronological order, as reflection took place continuously throughout the action research study. However, reflection can also be seen as a discrete phase in which time is taken to step back from the action research study (Stringer & Genat, 2004) and disentangle the tightly linked planning, acting and observing (Hart & Bond, 1996). The type of reflecting that occurred throughout the study was what Schön (1995) refers to as reflection-on-action. Greenwood (1993, p.

1185) refers to this phase as a “cognitive post-mortem” in which understandings are explored in the light of experiences. Learning what you need to learn is the most important outcome of the reflection phase (Kemmis and McTaggart 1988). I reflected at length about the three previous phases of this first cycle and the reflections are captured in the field notes that I wrote in response to the plans, actions and observations of the cycle. The potential action group members reflected on aspects of the cycle in the clarification meetings that were part of the expression of interest process. The section outlines the reflection that took place both by the action group and by me about the first action research cycle with a view to learning from what had happened so far.

6.5.1 Action group reflection

The potential action group members did not come together as an action group during the first action research cycle. We had all met one another, as the health care professionals that eventually formed the action group were all employed at the hospital in various roles and I had been associated with the hospital over several years. Potential members had expressed concern to one another about preparation for childhood hospitalisation at this hospital for some time prior to conceptualising the action research study. The opportunity for individual staff to act on this issue was enabled first by a common desire to collectively identify how the issue could be addressed and secondly to form an action group when this possibility was presented to them. Two issues dominated the reflection of the potential action group participants. One was that these health care professionals had taken the step to work collaboratively (Fay, 1987). The other was that the decision meant that potential participants had decided that collaborative work might result in practice change (Hughes, 2008). Reflection observed in the potential participants constitutes the next sub-section.

6.5.1.1 What does this mean for the group action?

Everyone who expressed interest in joining the action group had a sense that preparation for childhood hospitalisation was an important issue that each

health care professional had tried to act on individually but without success. Description of individual efforts led to the sense that this was an issue too big for individuals to tackle successfully. Lewin (Cartwright, 1952) undertook a number of projects which demonstrated that groups of people, rather than individuals, were effective in addressing issues that impacted on everyone. All potential participants felt that the group approach, the formalising of the action group process, encouraged a belief that together we could make a difference. Action group members, hospital management, stakeholders (including hospital management) and consultants who became involved in the study expressed enthusiasm for the group approach.

6.5.1.2 The decision to work collaboratively in pursuing change

Although the action group members had not yet met as a group, the promise of cohesive group formation was apparent since individuals had expressed a common purpose in response to the call for expressions of interest through the flyer. Prior to the action group having a face-to-face meeting, individual staff who expressed interest in joining, discussed their feelings about membership of the action group and chose to join. Potential members spoke of understanding that their contribution to the activities of the action group including planning, acting, observing and reflecting, as outlined by Kemmis and McTaggart (1988). Potential participants expressed satisfaction at the formation of the action group and enthusiasm for the work that the action group was about to do. Additionally, potential participants expressed pleasure that their previous individual achievements regarding preparing children and their families for hospitalisation had been worthwhile because these strategies might be considered worthy by the action research group.

From my own perspective, the level of concern, commitment, satisfaction and enthusiasm boded well for the likely success of the group. The success might simply be raising of consciousness (Henderson, 1995) about preparation for childhood hospitalisation and of concern about its practice. However, these particular characteristics of the potential action group members, concern,

commitment, satisfaction and enthusiasm, seemed also to indicate a reasonable chance of success to change practice. Potential participants were learning that pooling resources enabled the resultant action group to be greater than the sum of its parts as Lewin had found (Cartwright, 1952).

6.5.2 Personal reflection on the action process

Reflection on the first action cycle to find out what could be learnt from it was very refreshing. Because of the delay between the clarification meetings and the first action group meeting there was an ideal opportunity to reflect before moving into the planning phase of the second cycle. My reflection on the three major tasks of this cycle: obtaining institutional support, engaging the support of the hospital community and then establishing the action group are provided in the sub-section.

6.5.2.1 Obtaining institutional approval

The planning and acting that occurred in gaining institutional support is outlined in the relevant phases of the first action cycle. Using action research methodology did not cause any unnecessary delays in the process of obtaining institutional research ethics approval even though action research was not the usual research approach taken in the Area Health Service. However, five months elapsed between submission of the first application and the final approval by both institutions. Preparation of the applications began over a year prior to receipt of the final approvals. The application and approval processes are a routine part of gaining access to research sites and participants, and are an essential part of the research process, but novice researchers are often unaware of the long lead time required to undertake this process (Burns & Grove, 2009).

I reflected that time could be an issue for me when considering the research plan. My supervisors also advised me that approval to conduct this research was not automatic and so the action research study time-line should allow time

for negotiation of the application and approval process (Morton-Cooper, 2000). However, I also reflected that the longer lead-time would give me an opportunity to refine the plans and set out study procedures that would potentially result in smooth progress of the initial phases of the action research study. For example, several meetings with the Director of Nursing took place in which she provided the leadership required to engage the hospital community in the action research study. Therefore, the learning achieved here was that developing a positive attitude towards unavoidable delay can lead to better outcomes and so should not be regretted or railed against.

The time taken to prepare the applications included time to review the literature related to ethical considerations in action research (Barazangi, 2006; Brydon-Miller, 2006a, 2006b; Eikeland, 2006; Fontenla & Rycroft-Malone, 2006; Hilsen, 2006). Not only did review of ethics literature assist in preparing the applications, the review also prepared me for the different way of working with participants that action research requires. Action research involves a collaborative approach and therefore acknowledgement of participants and negotiation of their points of view was vital. Kemmis and McTaggart (1988) caution action researchers to take care to observe the ethical principles guiding their work. The authors note that not only should confidentiality and respect for study participants be important considerations in research but also that in action research the researcher should define appropriate ways of working with participants in a social organisation.

The ethics application documented my commitment to working with participants in a way that indicated acknowledgement of them for their contribution to the action research study and acknowledgement of opportunities for them to determine the course of the action research study (Dick, 2005; Street, 2004; Stringer & Genat, 2004). For example, action group members were able to control the process of audio recording the meetings by asking for erasure of part or all of the recording if they wished. Learning about the ethical principles of action research led to a deeper commitment to collaborative activity.

6.5.2.2 The process of engaging support

To ensure smooth functioning of the action research study, it was important to identify significant people at the hospital and make them aware of the action research study and its potential impact on them and their work. Grimshaw and colleagues (2006) tested the feasibility of identifying opinion leaders to enable the implementation of research findings in Scottish health care settings. The researchers concluded that opinion leaders tend to be "monomorphic (different leaders for different issues)" (2006, p. 5). This evidence not only emphasised the importance of identifying significant people but also of engaging them in this action research study into preparation for childhood hospitalisation.

I reflected that the support of the Director of Nursing was pivotal to my success in having an opportunity to engage members of the hospital community. The Director of Nursing presented the action research study to hospital management at a weekly management committee meeting using the synopsis of the proposed action research study. The management committee needed to know that the action group would examine the practice of preparation for hospitalisation. Given that there had already been some dissatisfaction expressed by those closely associated with the practice it was likely that the practice would be found to be inadequate. Revealed inadequacy could have implications for the hospital management (Hart & Bond, 1995; Morton-Cooper, 2000) and so it was gratifying and important that committee members agreed to form the steering committee for the study (Rycroft-Malone, 2004b). Their commitment to potential practice change showed the hospital community that the action research study was important and reinforced to the action group that what it was doing was important.

Two other groups in the hospital community that were relevant to the action research study were the stakeholders and the consultants. They, like everyone else in the hospital community, were notified about the action research study through the call for expressions of interest. One concern I held was that while the flyer called for registration of interest it did not guarantee that anyone in the

hospital community would show an interest and agree to participate. However, I realised that given the context of practice at the hospital, no other means of inviting participation was possible to enable free and uncoerced participation (Stringer & Genat, 2004). Stakeholders needed to know that a group of people with a particular interest in improving the practice wanted to make changes that might threaten the status quo. Consultants' needed to know how the action group might require their expertise as the members developed their plans. Some people in the hospital community belonged to more than one of these groups and had more than one perspective of the action research study to consider.

The fact that one parent responded to the call for expressions of interest flyer presents an interesting point. For some reason other parents had not become engaged with the action research study. There is no information available to determine why other parents did not express an interest in the action research study. Parents of hospitalised children are particularly time poor and often emotionally drained by the experience of their children's hospitalisation (Caty et al., 1989; Li et al., 2007b; Tiedeman, 1997; Vulcan & Nikulich-Barrett, 1988; Wray et al., 2011). However, I wonder whether parents felt that the invitation was not directed at them as well as at the rest of the hospital community. It may have been that in their view, this was an issue that hospital staff ought to take leadership of, that they did not feel that they could contribute in a meaningful way to improving preparation for childhood hospitalisation practice, or that they had lost hope that anything useful would result despite putting in an effort to assist. Undoubtedly, there are other possible explanations for the lack of support for the action research study by parents. In the following cycle, the action group decided to survey the views of parents as well as their children about preparation practice at this hospital. Nevertheless, the absence of parents in the first cycle is worthy of reflection.

Although the process of engaging the parents' support failed, it was successful in notifying the hospital community of the action research study. It was significant that leadership was provided willingly by the Director of Nursing in

notifying senior staff and the executive about the study. I believe that this support was a factor in enabling the study to occur. Kemmis and McTaggart (1988) advise on engaging support noting that part of the planning of an action research study includes identifying all interested people so that not only can their cooperation be engaged but also the researcher develops a reputation for creating transparent processes by showing what is being done. My reflection on the notification process resulted in my heightened awareness that the action research study was taking place in the less than perfect real world.

6.5.2.3 Establishing the action group

The action research used to address preparation for childhood hospitalisation meant that the action group was central to the achievement of the action research study aims. The action group comprised individuals who were concerned about and committed to improving the practice of preparation for hospitalisation of children and their families. The task for the next cycle was to effectively harness their concern and commitment in such a way that the group would work together to achieve the goal. Collaboration optimises the context specific nature of action research that enables participants who are locally orientated to change local issues (Hart & Bond, 1995; W. L. Miller & Crabtree, 2005).

Given the centrality of the group to the action research study, the group's development needed close attention. In the first cycle the action group was at the beginning of the forming stage that includes orientation, testing and dependence according to Tuckman's (1965) group development theory. Orientation is establishing a common ground, a common purpose and a reason for working together (Tuckman, 1965). Testing and the development of dependence were to follow at the beginning of the next cycle: *the steps to practice change*. The group development process had inherent personal and professional risks for the health care professionals and these were identified for them to consider before they agreed to participate in the action research study.

The personal risks identified included how participants own views about hospital preparation affected the ethical importance that they placed on the practice of preparation. If they perceived that the outcome did not meet their expectations, they may have felt personal disappointment, even a failure to live up to what they believed in (Stringer & Genat, 2004). It was, therefore, important to me to remind the action group members that as a group we could work together on something that we all believed in but that there were many aspects to the issue and we may not have the ability to control all of them. That the action group members tried to change preparation practice as a collective was as important as it was to change preparation practice.

The action group members also had to face risks to their professional selves, such as the perception that the hospital community might have of them because they were members of the action group (Stringer & Genat, 2004). For example, others might judge individual participants on the outcomes of the activities of the action group, and if these were not substantial and not deemed to be worthwhile, then the health care professionals might experience a sense of professional failure. It was important to stress to the action group members and to the hospital community that the action group's work was to strive as far as possible to improve preparation practice at this hospital, and that improvement was not a guaranteed outcome.

6.6 Summary

The first cycle of the action research study, *mobilisation of engagement of the hospital community in the study,* was conducted in four overlapping phases of planning, acting, observing and reflecting. The cycle shows how a concern for preparation for childhood hospitalisation led to engagement of the hospital community in the action research study to improve the practice of preparation of children and their families for hospitalisation.

The outcomes included receiving institutional approval to conduct the study, informing the whole hospital community of the action research study and inviting

participation by individuals interested to join either the action group or to be a member of a stakeholder or consultancy group. Inevitably, the learning from the cycle informed the next cycle: *the steps towards practice change*. Cycle Two is the subject of the next chapter of the thesis in which the action group comes together to discuss the practice improvement of preparation for childhood hospitalisation.

Chapter Seven – Action research Cycle Two – The steps towards practice change – January 2006 to February 2008

Collaboration was an important characteristic that was prominent throughout all meetings. The action group members had hoped that by collaborating with others who were concerned about preparation for childhood hospitalisation members would optimise the chances of improving preparation practice. Potential participants raised the importance of collaboration during the clarification meetings of the first cycle and collaboration continued to be a characteristic of action group meetings. Individuals took on various activities throughout the study; however, the action group always discussed these activities collaboratively as a group.

7.1 Introduction

Chapter Seven describes and analyses the second cycle of the action research study and the *steps towards practice change* cycle is represented diagrammatically in Figure 7-1. The cycle began in January 2006 and finished in February 2008, taking over two years of monthly action group meetings. A description of the four phases of the cycle, **planning**, **acting**, **observing** and **reflecting**, follows. The planning phase outlines how the group of health care professionals worked together to determine what was the best approach to take to address concerns about preparation for childhood hospitalisation at this hospital. The action group developed a number of actions that were congruent with the study aims, and for each a plan of action was determined. The acting phase describes the actions taken and includes the revisions that resulted from the group's observations and reflections on these actions and their outcomes. These processes occurred during each meeting held by the action group and are reported in the relevantly titled chapter sections. The last sub-section of the chapter provides my reflections on the entire second cycle of action research.

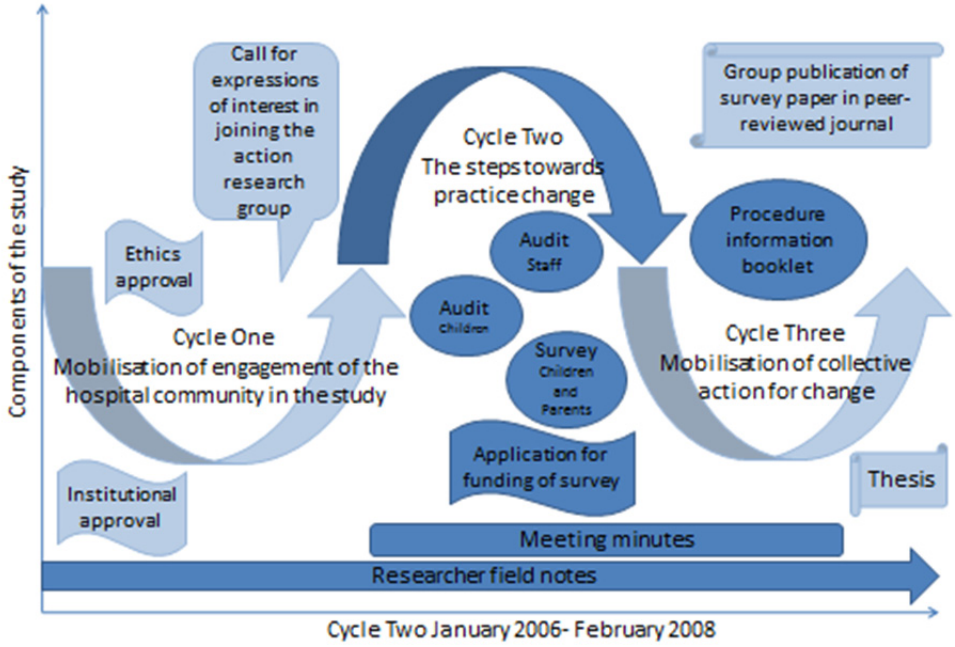

Figure 7-1 Cycle Two - The steps towards practice change – January 2006 to February 2008

7.2 Planning

The first phase of cycle two involved planning for the actions taken by the group. Six sub-sections report the planning process. The first sub-section outlines the development of the action group as it formulated planning procedures for the study. The plans revolved around three projects devised by the action group with sub-sections devoted to each of these. The fifth sub-section outlines the plans the action group made to maintain communication with the steering committee, comprising members of the hospital management executive and other staff. The final sub-section reviews the conservation of the action group both within the hospital and within itself.

7.2.1 Action group planning procedures

On 3rd February 2006 at 12 midday, 13 people met for the first time as the "Preparing children for hospital" action group. Everyone was very enthusiastic

and participated in all discussions; the whole time passed in exchanging ideas and planning, acting, observing and reflecting on the future of the action group. Audio recordings of meetings enabled tracking of the research and provided a resource for meeting summaries. The action group members gave further consent to the use of audio recordings as a resource for my reflections and subsequent recording of the meeting minutes. None of the members asked for changes to the distributed meeting agenda. At the conclusion of the first meeting the agenda was developed by the action group members for the following meeting and this was a process repeated at every subsequent meeting.

At the earlier clarification meetings, all action group members agreed to participate in a collaborative task at the first action group meeting to develop the rules of every meeting, so that members were clear on agreed principles. The decisions made by the members on meeting conduct included ensuring that every group member had opportunities to discuss ideas, offer their opinions and listen to the ideas and opinions of other group members. The meeting rules were documented (see Appendix G) and were tabled at every subsequent action group meeting to remind group members of the agreed meeting rules.

Engagement of the action group members was encouraged to give all members the confidence to know they played an important role in the conduct of meetings and in the decisions taken by the group. The documented meeting rules helped to confirm the group's common purpose and the member's unique contributions. All 13 action group members who were present at the first meeting decided that sharing a platter of sushi should become a feature of every meeting. The action group members brought their individual folders of project documents to the first and subsequent meetings and added further information produced by the group as the meetings progressed. These included the hospital's admission data, preparation for childhood hospitalisation strategies used at this and other hospitals, and sample questions devised by clinicians and asked of children about hospitalisation. Over time, these shared resources helped to enhance

group cohesion as described in sub-section 6.2.5.1 by assisting individual members identify with the group's purpose and role.

The first meeting lasted two hours and involved a reconnaissance as proposed by educational action researchers, Kemmis and McTaggart (1988), where action group members can reflect on the issue of concern before making plans, taking action, observing these and reflecting on the outcomes in light of project goals. When the action group met for the first time, reconnaissance involved the opportunity for each member to say exactly what their concerns were about preparation for childhood hospitalisation practice. Discussing the concerns together meant that the action group could identify common concerns and begin to develop plans to address these. The initial reconnaissance meeting made the way clear for subsequent meetings to follow the format of the four phases of action research.

As the action group members had limited time available to attend the group meetings, the members decided to reduce the meeting time from two hours to one hour for subsequent meetings. The action group agreed after some debate to meet once per week for the first four weeks and to meet monthly thereafter. These first four meetings enabled more discussion and decision making during the planning phase, as well as group development and formation (Tuckman, 1965, p. 396).

The first of a set of actions planned by the group members was to develop a list of the hospital's current and past strategies for preparation for childhood hospitalisation. The list was quite extensive and the action group were satisfied with the range of preparation for childhood hospitalisation strategies that were available. Members decided it was better to concentrate on improving existing strategies rather than to develop new strategies. This became the focus of the action group collaboration. Achieving consensus on the best approaches to improve preparation for hospitalisation strategies required a process of revising plans and taking action simultaneously for many decisions made at subsequent meetings.

Group members needed to find out what children and their families generally want to know about the children's hospitalisation and what the hospital provided to meet their needs. Two of the three projects undertaken by the group were to collect data on children's and their parents' information needs and experiences with hospitalisation. A survey of children and their parents about their experience of preparation for hospitalisation at this hospital and an audit of the hospital staff regarding preparation for childhood hospitalisation strategies were actioned. The third project undertaken was, somewhat unexpectedly, the reinstatement of an information booklet designed to prepare children and their families for a particularly difficult investigative procedure. The action group planning that occurred to set in motion these three projects is detailed in the following three sub-sections.

7.2.2 Survey of children and their parents/guardians

The first project planned to meet the study aims was the development of a hospital preparation survey for children and their parents/guardians. This plan became more fully developed during discussions at subsequent meetings. The action group decided to develop two surveys to capture specific information about children's and parents'/guardians' expectations and experiences of hospital preparation. Members took almost one year to plan and develop the surveys to the group's satisfaction, even though the concept of surveying children was first raised at the second action group meeting on 10thFebruary 2006.

Several factors contributed to the length of time taken between concept initiation and survey development. One was that the action group participated in discussions at several meetings before the whole action group reached consensus about the content and format of the survey. Another was the often lengthy periods for different hospital departments to give assistance to the group, such as the hospital data collection department. Yet, another factor that contributed to the delay in the administration of the survey was the action

group's uncertainty about the best way to distribute the survey. The distribution technique required consultation with several hospital departments before the group determined the final distribution technique.

All action group members participated in obtaining resource materials to use in developing the children and parent/guardian survey. However, at the seventh meeting, on 31st March 2006, the action group decided to start by obtaining information from the staff of various hospital departments about what children ask them about being in hospital. This decision also contributed to the lengthy time taken to develop and distribute the survey.

7.2.2.1 Confirming what children ask about being in hospital

Since the action group members had all worked with children who were admitted to hospital and engaged with the children's families, so they felt confident of the type of questions that children generally asked about this experience. However, group members acknowledged that these assumptions needed to be confirmed and agreed that one of the best ways to gain more accurate information was to record the questions that children asked while they were hospitalised. In particular, the group members believed it was important to identify what children did know about hospitalisation in order to help identify what the children and their families needed to know. To assist with questionnaire development the group referred to Smith and Callery's (2005) journal article about what children ask about their proposed hospital admission. These researchers had collected data related to the questions that 7 to 11 year old children ask about a surgical hospitalisation in the UK (Smith & Callery, 2005) and the group members felt the article findings were relevant to hospitalisation of Australian children. The action group noted that the children's reported questions in the UK study were very similar to those questions asked by children in their care.

The action group designed the semi-structured questionnaire for collecting this information from nurses, allied health professionals and doctors and called it

"The Clinician's Table". The Clinician's Table was used to collect information about the children's age, gender, first admission and reason for admission, when children asked questions about the hospital experience and what questions the children asked (Appendix J). As the action group members worked in, or were associated with, seven clinical areas in the hospital, the distribution of the Clinician's Table commenced in these seven clinical areas, with requests to staff to complete the questionnaire whenever appropriate. The Clinician's Table provided some new information on children's questions about being in hospital to that reported by Smith and Callery (2005), whose focus was on children's questions asked prior to surgery. These data informed the inclusion of survey items and design.

7.2.2.2 Designing the survey

A review of the meeting minutes during this phase of Cycle Two reveals that planning the survey occupied a great deal of time at every meeting between February 2006 and 19th January 2007, the date the action group submitted the survey for approval by the Area Health Human Research Ethics Committee. The survey comprised two parts: one for children and one for their parent/guardian. After much discussion about which children should be surveyed, the action group decided that children of various ages and treatment groups should be invited to participate, so long as they could understand and answer the questions. Initially, the preferred option was to survey children and their parents/guardians on admission to hospital. However, a review of the literature by the action group indicated that children and their family were particularly vulnerable before a planned procedure (Battrick & Glasper, 2004; Bonn, 1994; Caldas et al., 2004; Foley, 2000) and were therefore unlikely to provide useful data (Callery, 2005; Clatworthy, Simon, & Tiedeman, 1999; Lightfoot & Sloper, 2002; Strickland, 2005). The action group consequently agreed to survey dyads of 6 to 10 year old children and one of their parents/guardians prior to their discharge from hospital. During the acting phase of this cycle, survey questions were developed and the process is

described in that section. Completion of the survey was one of the key steps to achieve the first study aim.

7.2.3 The audit of strategies currently used at the hospital

The second study project planned to meet the study aims was to conduct an audit of hospital staff's knowledge of preparation for childhood hospitalisation strategies. The audit asked hospital staff to anonymously identify any preparation for hospitalisation strategies that they were aware of that were currently available at the hospital to children and their families. At the first action group meeting there had been considerable discussion about preparation strategies occurring at the hospital. Interestingly, not all members of the action group were aware of all the preparation strategies currently or previously used at the hospital. Members decided to document the preparation strategies that each was aware of and to collate individual member lists into one consolidated list.

At the third meeting, on 17th February 2006, the hospital's manager of Play Therapy services, also a member of the action group, distributed the collated list of 13 hospital preparation strategies with some analysis of each strategy.

Pre-operative tour ceased 16 yrs ago – despite good feedback
Pre-admission advice from Play Therapist – individualised, requires proactive/ informed parents Includes Dorothy video, pre-op tour, medical equipment kit
Pre-admission clinic – Thurs pm, not offered to all children
Unit prep (ED, Ambicare, POWPH)- individualised, random application Includes Play Therapist consult, procedure specific kit, photo book, dolls
Virtual tour – visual and accurate, non-specific
Hospital explorer tour – well evaluated, non-specific
MCU booklet – specific, not used, why?
Powerpoint presentation to educate clinicians
Booklets on pain management
Case conferences
Spica booklets for parents – after procedure (some seen prior , who decides?)
Parent info on Infant immunisation – well evaluated, still used?
Informal preparation given by interested clinicians when conditions allow

Table 7-1 Thirteen hospital preparation strategies previously or currently used at this hospital

One preparation strategy listed was a pre-operative tour, but this had ceased in 1990. The only explanation for the cessation was that the person who had arranged and presented the tour had resigned from the hospital. The action group decided that there could be more than 13 hospital preparation strategies occurring across the hospital and that other members of hospital staff may have knowledge and opinions about them. Therefore, the action group decided at the eighth action group meeting on 28th April 2006 to develop and conduct an audit of hospital staff's knowledge of any strategies occurring that focussed on preparing children and their families for hospitalisation.

7.2.3.1 Planning the implementation of the audit

The hospital's Quality Improvement Manager advised the action group that it was possible to conduct the audit as a quality improvement initiative, rather than as a research initiative because existing hospital preparation strategies were to be identified, rather than proposed/future strategies. The Quality Improvement Manager advised that applying to the relevant hospital decision-making authority to undertake a procedural audit was less complicated and time-consuming than would be the case with gaining approval to extend the action research project. The advice of the Quality Improvement manager was found to be accurate according to the Australian code for the responsible conduct of research (National Health and Medical Research Council, 2007), therefore a Quality Improvement application was prepared (see Appendix O) by the members of the action group. The action group began to plan implementation of the audit, knowing that approval would be simpler to achieve.

Considerable discussion took place at the eighth action group meeting on 28th April 2006 regarding the best method to reach all hospital staff and to encourage them to complete the audit. The action group considered various distribution and return options. The first option was email distribution and return of a hardcopy of the audit via the hospital internal mail system. The second option for distribution was email of a soft copy of the audit for online completion.

Using both options, return of the audit to the action group could then be electronic or in hardcopy. Both distribution options included an introduction to the audit and advised how the audit data would be used to generate knowledge about the hospital's existing childhood hospitalisation preparation practices.

The action group made the decision to email the audit to all hospital staff with a request to complete the audit online. Completion by staff was anonymous and potential respondents were advised that their consent to participate would be implied through completion of the audit. The plan required the establishment of an email address for the action group and requisition of hospital staff lists from various departments of the hospital. Members of the action group divided these tasks amongst them and committed to completion of the tasks by the next meeting.

7.2.3.2 Engaging the audit respondents

The action group considered that an audit of preparation strategies currently used at the hospital would be useful in generating knowledge about existing practices and thereby achieve the second aim of the study. An informal audit of the action group members' knowledge of preparation practices occurring at the hospital revealed that it would be essential to determine the breadth of these practices in different hospital departments. The audit was a potential source of important information for the action group in determining what was already available and what might augment existing strategies. Engaging hospital staff as effectively as possible in responding to the audit was vital to the success of the data collection.

As previously described, the flyer circulated throughout the hospital calling for expressions of interest to join the action group had already notified all potential hospital staff respondents about the study's focus on preparation for childhood hospitalisation practice. Since the flyer had been circulated to the whole hospital community, in either hard or soft copy or both, the group members anticipated that when hospital staff received the audit by email they would

already have knowledge about the study and its purpose. The group planned to incorporate an introduction to the audit in the emailed audit, in order to reinforce staff's knowledge of the study and why the data they provided would be useful. Consequently, the audit had the dual purpose of providing information about the study and its members and requesting staff to provide information about preparation strategies at the hospital.

7.2.4 Reinstatement of the "MCU" booklet

The third activity of the action group to achieve the third study aim was the reinstatement of the Micturating Cysto-urethrogram (MCU) booklet. This activity also required a great deal of planning by the action group to first determine the usefulness of the MCU booklet in meeting the study aims and then to decide how best to distribute and advise staff how to make use of the information it contained in improving hospital preparation practices.

Some of the action group members were aware of the previous existence of a booklet of information about the MCU procedure which was developed and pilot tested at the hospital two years previously (Salmon & Pereira, 2002). The booklet prepared children and their families for the MCU procedure through information provision. The group members decided to investigate the details of the booklet with a view to reinstating it and contacted the original research team to find out more about the study and the booklet. The action group also wanted to see a copy of the booklet to review it for possible reinstatement at the hospital. Various members of the action group committed to completing these tasks by the next meeting.

Children between 18 months and 6 years of age underwent the diagnostic MCU procedure in the Medical Imaging Department. Discussion of the MCU procedure occurred at every action group meeting and the action group were concerned about children undergoing this procedure because it was invasive, painful and there was no formal preparation provided for it. A member of the action group, in her role as play therapist, had occasionally prepared children

for the procedure and had knowledge about the negative effects of the procedure on children.

The group noted that no staff from the Medical Imaging Department had joined the action group and that the department was not included in the group's plans for distribution of the Clinician's Table. Because of their concern about the lack of preparation for the MCU procedure, the group wanted the Medical Imaging Department staff to complete the Clinician's Table. After investigating the lack of response from this department it transpired that shared services departments, including Medical Imaging, had not received the email with the flyer calling for expressions of interest and therefore staff in the department were unaware of the study.

At the group's request, information on the action groups' plans was provided to Nurse Manager of Medical Imaging, as well as the summaries of the first seven meetings and the consent form to join the action group. The Nurse Manager of Medical Imaging agreed to disseminate the information to the staff in the Medical Imaging Department prior to the next action group meeting. The Clinical Nurse Specialist (CNS) of the Medical Imaging Department enthusiastically joined the action group at the next meeting. She informed the group about the process of the MCU procedure and the physical preparation for it. The group decided to explore whether preparation of this procedure occurred through provision of written information to children and families.

Table 7-1 documents the sequence of events that led to action group's decision to consider reinstating the MCU booklet as part of the hospital preparation strategy.

Date	Event
31st March 2006 7th group meeting	Group decision to collect data of children's questions about hospitalisation using The Clinician's Table to inform survey development The action group noted that children attending the Medical Imaging Department were not included in the data collection
7th April 2006	Contact with the Nurse Manager of Medical Imaging resulted in data collection in the department and an expression of interest in joining the action group from the Clinical Nurse Specialist (CNS) from Medical Imaging
28th April 2006 8th group meeting	The CNS from Medical Imaging voluntarily consented to join the action group and provided background information about the MCU booklet
26th May 2006 9th group meeting	Results of investigation into the MCU preparation strategy development presented by the CNS from Medical Imaging to the action group

Table 7-2 Events leading to consideration of reinstatement of the MCU booklet

7.2.5 Maintaining agreed communication procedures with the steering committee

It was an agreement that the Director of Nursing would report on a regular basis to the steering committee as part of the structural set up for the project. The action research study's steering committee was comprised of hospital management committee members. The management committee was a major element of the context in which the action research study took place. The action group members took note of McCormack and colleagues (2002) observations that context plays a significant role in the effective functioning of research within it. As well, the members noted that Beringer and Julier (2009) found that without consideration of the context of their study into pædiatric transport practice, the study would not have changed practice and streamlined the processes involved in accompanying children to the X-ray department. Action group members were, therefore, aware of the importance of the context of the study and the significance of the steering committee's support to the achieving the study aims. Clear communication with the departmental managers was one of the important elements of the working relationship between the steering committee and the action group.

The Director of Nursing of the hospital, who was my site supervisor, agreed to mediate the communication between the steering committee and the action group. The action group decided that is would be best to report the study's

progress to the steering committee upon reaching significant study milestones. The group planned to prepare reports that summarised plans, outlined activities and described the participants' involvement. Feedback to the action group reports by the steering committee occurred via the Director of Nursing. The reporting and feedback process enabled regular and effective communication between the steering committee and the action group and this served to help the study to progress as planned because it indicated the needed support of the steering committee for the action group and incorporated the element of context into the research (McCormack, Manley, & Garbett, 2004).

7.2.6. Anticipating the stages of group development

Throughout the study the action group developed into a cohesive unit, passing through each of the stages that Tuckman proposed: "forming, storming, norming and performing" (1965, p. 396). By anticipating these stages of group development, it was possible to predict action group development and plan to address challenges as they arose. For example, it was likely that conflict would occur from time to time as members discussed the best way/s to improve preparation for childhood hospitalisation. The documented meeting rules developed by group members at the beginning of the study reminded them that every group member had the opportunity to discuss ideas, offer opinions and to listen to the ideas and opinions of others. Members acknowledged that sometimes group cohesion and consensus could be problematic, or at least it might take time for consensus to occur for some issues and actions. The action group members discussed potential challenges to group dynamics as the group developed and formed as a cohesive unit and came to agreement about the actions that could be taken to resolve any conflict in decision-making. The group also acknowledged that working through conflict in a democratic way could lead to group cohesion and tangible planned outcomes.

7.2.6.1 Maintaining the membership, collaboration and work of the action group

The health care professionals who formed the action group had done so on the basis of their having concerns about preparation for childhood hospitalisation and their resolve to work as a group to help improve them. They consented to join the action group with the express purpose of collaborating to address their concerns. Over the study the members voluntarily collaborated as a group because of their individual and collective commitment to improving preparation practices at the hospital. Since the time taken to act on this collective commitment extended beyond the initial timeframe considered there were many factors that could have challenged the group's cohesion, therefore, it was necessary to anticipate what challenges might arise and to plan strategies to avoid any untoward consequences. This planning process occurred during the planning phase of the second cycle of the action research study.

The strategies employed to avoid some of the potential challenges to study progress included planning regular group meetings and making room bookings for the meetings. Another strategy was planning the meeting schedule in a democratic way at the beginning of the study and holding individual discussions with action group members to determine how the meetings could best meet the groups' needs. As well, meeting agendas were developed to give meetings a structure and to ensure that the group members were able to plan the meeting schedule to allow sufficient time to discuss the tabled agenda items. The summaries that were made of meeting discussions also helped the action group members to have a record of the progress occurring and to identify non-productive activities for further review. Since all action group members were involved in reviewing meeting summaries this gave them the opportunity to amend summaries as required, which in turn enhanced their continuing interest and participation in the study.

7.3 Acting to change practice

To progress from planning to action the action group focused on developing and implementing the children and parent/guardian survey, the staff audit and the MCU booklet, which is the subject of this section of the thesis. In this section there is also a description of how the action group functioned, both as an entity within the hospital's organisational structure and as a cohesive group of health care professionals with a common commitment to children's hospital preparation.

7.3.1 Implementing the survey

There were two elements involved in the implementation of the survey. The first was an analysis of the Clinician's Table data in order to inform the development of the survey intended for the children and their family. The Clinician's Table recorded questions that children asked about hospitalisation when receiving treatment and care in one of seven hospital units. A description of the review process by the action group is included in sub-section 7.3.1.1.

The second element of survey implementation was identifying the questions and the procedures most likely to encourage children and parents/guardians to share their experiences and provide information about preparation for children's hospitalisation. Four procedures were involved in this second element: developing the survey, applying for funding to administer the survey, identifying the best way to administer the survey to children and parents/guardians, and collecting the survey data from them. An outline of the procedures follows the description of the action group's review process of children's questions.

7.3.1.1 Reviewing children's questions about coming to hospital

From March to May 2006 the action group members collected data on questions asked by children during a hospital admission and the group reviewed these data at each monthly meeting. After three months of data

collection, the action group found that no new questions emerged. While data collection continued, development of a spreadsheet of the questions asked by children facilitated their analysis. Spreadsheet classification of questions reflected the information gathered on The Clinician's Table.

Review and analysis of all questions occurred at the tenth group meeting on 30th June 2006. Initially questions were analysed according to the clinical area in which the question was asked and the frequency that the question was asked. Analysis of data according to age, gender, first admission and reason for admission, followed the initial analysis. The data collected by The Clinician's Table confirmed the action groups' beliefs about the question topics/themes that children asked about being in hospital. For example, the majority (66%) of 4-year-old girls asked, "Will it hurt?" prior to having medication administered by injection. The action group relied on these common response themes to develop the survey items.

7.3.1.2 Developing the survey

A survey was developed using the key question themes for children in the 6 to 10-year-old age group and their parent/guardian. The action group chose the 6 to 10-year-old age group because of two factors. One factor considered was that children aged between 6 and 10 years are more likely to be able to articulate with reasonable clarity the questions they have in regard to being in hospital and undergoing procedures. A number of research studies have collected data from this age group because of their communication ability (Carney et al., 2003; Pelander & Leino-Kilpi, 2010; Smith & Callery, 2005; Visintainer & Wolfer, 1975). The other factor considered important was the ability to ensure that aspects of the survey data, for example demographics, would be comparable to routinely collected hospital data for children in the 6 to 10-year-old age group. Consequently, the action group planned to survey all 6 to 10-year-old hospitalised children and their parent/guardian, irrespective of the type or reason for the hospitalisation. The group applied for and received

approval from the Area Health Service Human Research Ethics Committee, see Appendix K, (Protocol 07/010) on 2nd March 2007.

The action group discussed ethical considerations in conducting the survey. Consent to participate was a relatively straightforward process for children's parents/guardians. The group selected one of the consent form templates available from the Area Health Service Human Research Ethics Committee that was most suitable for parents consenting to participate for themselves and their children, see Appendix L. The consent form developed for the parent/guardian provided information about steps that would be taken to assure the confidentiality and use of their responses in reporting the data, and how to find out more about participating in the study. The parent/guardian information and consent form provided details on the process of lodging complaints about the study, and how to revoke their consent, and included contact details of the Area Health Service Human Research Ethics Committee for this purpose.

Consent to participate in the survey was not required from children directly as they were minors and not able to legally consent for themselves. Their parent/guardian was able to give proxy consent for the children by signing the proxy consent form. However, the action group wanted assurance that the children were willing participants and to acknowledge their contribution to the study. Assent, the non-legally binding counterpart to consent for children, exists to decrease the risk of exploitation (V. Miller, Drotar, & Kodish, 2004) and to acknowledge children's developing competencies (Kumpunen, Shipway, Taylor, Aldiss, & Gibson, 2012; Rossi, Reynolds, & Nelson, 2003). Therefore, the standard consent form template was adapted to allow space for the children's signature as an acknowledgement of their assent to participate in data collection. The ethics application submission to the Area Health Service Research Ethics Committee, including the adapted consent form (Appendix L) was on 23rd November 2006 and approval was on 2nd March 2007. All members of the action group contributed in different ways to the survey development and applying for ethical approval to administer the survey to children and their parents/guardians prior to hospital discharge.

7.3.1.3 Applying for funding to administer the survey

The action group recognised the logistical problems of administering the survey without a hospital-endorsed support strategy. No funds were available to employ a project consultant or for time release for any staff who were members of the action group. Since participation in the action research group was an additional role for group members they considered that their continuing involvement in the study would be enabled by employing a research assistant to administer the survey. The members considered this would ensure a timely and efficient recruitment and data collection process. Therefore, the action group decided to apply for funding to pay for a research assistant to assist in this work. Table 7-2 summarises the actions taken by the group to apply for funding for a research assistant.

Date	Event
28th July 2006 11th group meeting	Decision to apply for funding of $50,000 to pay a research assistant for six months to collect and analyse survey data Action group reviewed current funding application information and a successful application made by one action group member
4th August 2006	Three action group members edited a draft application via email
18th August 2006 extraordinary group meeting	Four action group members reviewed the draft application further
25th August 2006 12th group meeting	Nomination of three action group members as co-chief investigators for the application form, however, all action group members indicated their intention to participate in data collection and analysis
28th August 2006	Submission of funding application on due date - rejected because I was not a hospital employee
29th August 2006	Re-submission of funding application with two nominated co-chief investigators – rejected because one had not held her current position at the hospital for a minimum of 12 months
1st September 2006	Submission of funding application for $15,000 from an established investigator
13th September 2006 13th group meeting	The action group acknowledged the limitation on the employment term of a research assistant in the reduced funding application
11th December 2006	Notification that the application for funding to administer the survey was unsuccessful

Table 7-3 Sequence of events in the funding application related to the survey

The action group spent a significant amount of time and effort on the application, which was unsuccessful, because members considered that

funding would advance the improvement of preparation practice at the hospital. Although members were disappointed that the application was unsuccessful they continued to enact plans to explore the need for changes to local practices for preparing children for the experience of hospitalisation and to generate knowledge about existing practice, the first and second aims of the study.

7.3.1.4 Collecting survey data

In consideration of the unsuccessful bid to secure funding to employ a research assistant to recruit children and their parents/guardians and to administer the survey, a new strategy recommended by a group member was to engage a research student who would benefit by involvement in the study. Table 7-3 provides details of her recruitment into the action group and the action group's activities related to data collection.

Date	Event
11th December 2006	Notification that the application for funding to administer the survey was unsuccessful
19th January 2007 16th group meeting	Action group discussion of data collection options Suggestion of one member that a post-graduate psychology student volunteer in the Pain Management Team collect data and enter it in an electronic format for analysis as part of her work experience - accepted
2nd March 2007	Area Health Service Human Research Ethics Committee provision of ethical approval to conduct survey data collection
14th March 2007	Volunteer from the Pain Management Team consented to join the action group
30th March 2007 17th group meeting	Action group plans and actions to collect survey data Introduction of the volunteer to the team leader in each inpatient unit of the hospital, by an email that had a copy of the survey attached The volunteer contacted the team leader, Monday to Friday, to identify potential participants in the survey "Pizza boxes" for return of surveys were installed at the ward clerk's desk in each unit
16th April 2007	Data collection began
31st August 2007	Volunteer completed her term with the Pain Management Team – 50 surveys collected
September 2007 to March 2008	The action group distributed, collected and analysed survey data
14th March 2008 group meeting	Target reached – 102 surveys

Table 7-4 Sequence of actions related to collection of survey data

Hospital admission data indicated to the action group that data collection should take no longer than six months. The action group postulated a number of reasons for the delay in reaching the target number of surveys noted in Table 7.3. One possible reason that so few surveys were completed is that children and their parents/guardians did not complete the survey prior to discharge despite having consented to the data collection. Another was that return of completed surveys was difficult, possibly due to various issues related to the discharge from hospital process. The action group considered that a research assistant dedicated to data collection for the survey may have improved the time taken to achieve the pre-determined response rate.

7.3.2 Developing the staff audit

To achieve the second study aim the action group collaboratively developed the "Preparing children for hospital" strategy audit to provide a fuller insight into what preparation for hospitalisation strategies were occurring at the hospital. During the planning phase of the study the action group was advised by the hospital's Quality Improvement Manager to implement the audit as a hospital quality improvement project. The Quality Improvement Committee approved the audit on 30th September 2006. Included in the approval was permission to send the audit to all hospital staff by email via the hospital staff group email address. The following sections provide details of the audit's development, piloting and distribution.

7.3.2.1 Designing the staff audit

An Information Technology (IT) consultant undertook design of an electronic version of the audit under the direction of the action group. There was no cost as the IT consultant was a private contact of one member of the action group. The audit was in an electronic format that required selection of 1 of 10 likert scale items by clicking on the computer mouse. Construction of the audit incorporated three sections that contained a varying number of questions related to specific times during children's hospitalisation. The three sections of

the audit were Pre-admission, On admission/during admission, and Pre-discharge/post admission. A hardcopy of the audit is located in Appendix N.

7.3.2.2 Piloting the staff audit

The action group piloted the online audit among group members following approval by the hospital Quality Improvement Committee. Piloting the electronic audit took four months, since the action group members were simultaneously spending a great deal of the time they had available for the study in developing the survey for children and their parents/guardians about preparation for childhood hospitalisation. The action group encountered technological issues when piloting the online audit, including having difficulty in accessing the online audit from the link in the email. To overcome the problems related to online completion of the audit the action group decided to attach the audit document to an email message. That distribution method was successful and all action group members printed the audit, completed it and returned it to the action group's internal mail address.

7.3.2.3 Administering the staff audit

After consideration of a range of distribution and return alternatives, the action group decided to email the piloted audit to hospital staff for completion online and be returned to the action group by email or in hardcopy via the hospital internal mail system. These techniques had been approved by the Quality Improvement Committee on 30th September 2006. Identification of potential hospital staff respondents to the audit and email contact occurred through the hospital staff email distribution list. The audit was emailed to hospital staff on 30th March 2007. The action group's decision to include the message "Help us better prepare children for hospital" in the email subject line was a planned technique to engage hospital staff in responding to the audit.

The initial response from hospital staff was poor, with only two completed audits received by the deadline of 30th April 2007. During this period all hospital staff

were taking on extra workload demands by completing a detailed and lengthy hospital quality assurance review, called the “Evaluation and Quality Improvement Program” (EQUIP). The action group decided to encourage further responses to the audit by resending the email to staff as a prompt to complete it, and extending the submission deadline. The action group also included a reminder that not all sections of the audit were relevant to all units of the hospital. This message elicited only one more completed audit return.

In total the email communication process resulted in the completion of only three audits by hospital staff over a period of seven months. Given the very poor staff response to the audit, the action group abandoned further use of the audit. While, initially there had been technological and access issues to overcome, the lack of hospital staff completion of the audit puzzled the action group since members had tried a number of strategies to improve the staff response. Unfortunately, the data provided in the three completed audits were too few to give any advice to the action group about preparation for childhood hospitalisation practices at the hospital. These data were discussed but not analysed to derive themes. Members surmised that “unless children and their families are booked, they are not prepared for hospitalisation, except in an ad hoc way for individual procedures” (excerpt from the 22nd action group meeting on 28th September 2007). Table 7-4 outlines the events involved in designing, piloting and collecting the audit data.

Date	Event
April - July 2006 8th - 11th group meetings	The action group refined the audit and the associated data collection procedures
8th August 2006	Action group members approved the audit and the audit Quality Improvement application via email
23rd August 2006	Application for a Quality Improvement project submitted
30th September 2006	Approval of application by hospital Quality Improvement committee
17th October 2006	Action group email account set up by IT to receive audit responses
19th January 2007 16th group meeting	Action group pilot of the audit Decision made by the action group to email the audit as an attachment
30th March 2007 17th group meeting	Audit attachment emailed to all hospital staff
27th April 2007 18th group meeting	Audit submission date extended from 30th April 2007 to 4th May 2007 by the action group as only two completed audits received
30th April 2007	Original audit submission date
4th May 2007	One more completed audit received
31st August 2007 21st group meeting	Action group planning and acting to improve response rate of the audit Director of Nursing to request steering committee to remind hospital staff to complete the audit Director of Nursing recommended a personal approach to hospital staff – action group gave hospital staff hardcopies of the audit with instructions for submission, including members of the Nurse Unit Manager (NUM) committee of which one action group member was a member
28th September 2007 22nd group meeting	Report from one action group member that the NUMs told her that the audit was not relevant to their unit and therefore they did not need to complete the audit
26th October 2007 23rd group meeting	Abandonment of audit data collection

Table 7-5 Sequence of events related to implementation of the audit

7.3.3 Reinstating the MCU booklet

As previously identified the preparation of children who underwent the MCU procedure in the Medical Imaging Department had been of concern to the action group members since the first study meeting in February 2006. Their concern arose from the fact that the procedure was invasive, painful and it was not clear if any formal preparation of children and their families took place for the procedure. The MCU booklet, see Appendix P, had been successfully piloted (Salmon & Pereira, 2002) in the Medical Imaging Department two years previously. The MCU booklet was an information resource used by children and their families prior to the MCU procedure and included information about

the procedure, photographs of the equipment used and advice about the process of the MCU procedure.

The CNS in Medical Imaging joined the action group at the eighth action group meeting in April 2006, thus enhancing the opportunity for the action group members to use this resource in improving children's preparation for the MCU. Like the other members of the action group, the CNS in Medical Imaging was concerned about all preparation for childhood hospitalisation practices. Throughout her association with the action group, from April 2006 until December 2008, she contributed to discussions and decisions about all the activities of the action group, not just those related to the reinstatement of the MCU booklet.

Since the CNS was a highly regarded clinician in the Medical Imaging Department, she provided a link between the action group and other clinicians in the Medical Imaging Department. The link enabled the Medical Imaging clinicians to be involved in reinstating the MCU booklet. The action group members were encouraged to learn of an action research project that improved pædiatric discharge preparation by acknowledging the contribution of bed-side clinicians in the research (Suderman et al., 2000). The Medical Imaging CNS's involvement in the study enabled the action group to make a collaborative decision about reinstatement of the MCU booklet. She was also instrumental in printing and distributing the booklet after the action group agreed to reinstate the booklet.

7.3.3.1 Investigating successful implementation procedures

At the monthly action group meetings from April 2006 until August 2006, the CNS provided the following background information about the MCU booklet. Successful implementation in the previous pilot study was through collaboration between clinicians in the Medical Imaging Department and clinical psychologists in the School of Psychology at one of the universities associated with the hospital (Salmon, McGuigan, & Pereira, 2006; Salmon, Price, & Pereira, 2002).

Testing of the MCU booklet was part of research into preparation of children for novel events and their memory and management of the events (Salmon, 2006; Salmon et al., 2002; von Baeyer et al., 2004). These researchers had not conducted evaluation of the MCU booklet so the booklet was not available for distribution to children undergoing the MCU procedure. However, discussions by members of the action group identified that the information contained in the MCU booklet would augment the usual care practices for the procedure that were occurring at the hospital.

The CNS brought a copy of the MCU booklet to the 12th group meeting on 25th August 2006. The action group approved of the booklet as a preparation strategy because it conveyed ideas clearly and simply, and the messages were realistic and age appropriate. In coming to this conclusion, the action group reviewed the literature on the characteristics of quality written hospital preparation strategies for children and their families (Clough, 2005; Nelson & Allen, 1999; Stone & Glasper, 1997; Wallace, 1983; White & John, 1997; C. J. Wilson, 1987). At the following meeting, the action group decided to offer to address practical issues such as obtaining approval for the MCU booklet reinstatement and applying for funding to print and distribute the booklet as one action to improve preparation for childhood hospitalisation. The CNS made the offer on behalf of the action group to the Medical Director of the Medical Imaging Department who had been a member of the original research team and who readily accepted the offer. Table 7-5 outlines the sequence of events involved in obtaining approval, printing and distributing the MCU booklet to enable its reinstatement.

Date	Event
30th March 2007 17th group meeting	Approval from the Medical Director of Medical Imaging to print the original MCU booklet using Medical Imaging Department funds Data collection - 200 MCU procedures annually Decision to distribute the MCU booklet through the outpatient clinic at the hospital
15th March 2007	Withdrawal of approval from the Medical Director of Medical Imaging to print the original MCU booklet using Medical Imaging Department funds
20th April 2007	Commercial printer quotes - $5 and $9 – too expensive Explore other options
27th April 2007 18th group meeting	Seek approval from the original lead researcher to reduce the size of the MCU booklet from A4 to A5 Inquire if a $400 donation from graduating nursing students can be used to print the first 70 booklets Re-use booklets so fewer are required thus reducing printing costs
25th May 2007 19th group meeting	Approval to reduce size received, photographs unchanged Donation will be used to buy coloured ink required for printing Medical Director of Medical Imaging agreed to print the booklet in the department using donated ink
31st August 2007	Submission of MCU booklet to the hospital Publication Committee Application by CNS to supplier of medical imaging equipment for funding of printing
28th September 2007 22nd group meeting	Funding application to supplier of equipment repeated, no response Action group abandoned application for commercial funding
25th October 2007	Approval of the MCU booklet by the Medical Director and Nurse Manager of Medical Imaging as the action group found that the Publication Committee no longer existed
26th October 2007	50 MCU booklets printed Piloting – distributed by the secretary of the one urologist who performed the majority of MCU procedures in the Medical Imaging Department
30th October 2007	CNS reported to the other members of the action group that the first copies of the booklet had been received by children and their parents who would be admitted for the MCU procedure in February 2008
15th February 2008 25th group meeting	Supplies of the booklet were exhausted and the action group planned to have 50 more booklets printed in the Medical Imaging Department

Table 7-6 Events related to the reinstatement of the MCU booklet

7.3.3.2 Obtaining approval to reinstate the booklet

Implementation of the MCU booklet in the previous research project (Salmon & Pereira, 2002) followed the Area Health Service Human Research Ethics Committee's approval of its use. Several of the health care professionals working in the Medical Imaging Department had been part of the previous project team and had provided access to children undergoing the procedure to gain proxy informed consent from their parents/guardians to use the MCU booklet. Given these health care professionals' previous satisfaction with the use of the MCU booklet for children undergoing this procedure, the Medical

Director and the Nurse Manager of the Medical Imaging department approved the reinstatement of the MCU booklet for the action research study.

7.3.3.3 Printing and distributing the booklet

Planning to print the MCU booklet began at the same time as investigation of the approval process in April 2007. The major issue related to the printing of the MCU booklet was the cost that made reinstating the booklet extremely difficult. The action group negotiated a reduction in the size of the booklet, used donated funds to print the booklet and arranged re-use of the booklets. Optimisation of printing costs enabled the first print of the MCU booklet in October 2007. Negotiation with various hospital departments optimised distribution of the booklet.

The action group decided to assess the effectiveness of the reinstatement procedures through one distribution point prior to distributing the booklet to all urologists who performed the MCU procedure at the hospital. Consequently, the Medical Imaging CNS approached the secretary of one urologist who performed the majority of MCU procedures in the hospital's Medical Imaging Department and asked her to include the MCU booklet with other paperwork that was used in the MCU booking procedure. Delivery of the first print run of MCU booklets to the urologist's consulting room followed agreement of the secretary to this process. After almost two years planning and acting, the action group had reinstated the MCU booklet as one step in the process to improve hospital preparation practices for children and their families.

7.3.4 Communicating with the steering committee

As outlined in the planning phase of Cycle Two, communicating with the steering committee enhanced the action research study because it incorporated the element of the study context into the research (McCormack, Manley, & Garbett, 2004). The action group planned to report the study activities undertaken by the action group to the steering committee on reaching

significant study milestones. The Director of Nursing presented the reports at appropriate weekly management committee meetings throughout the study. The reports provided to the steering committee took the form of one-page summaries in point form, arranged according to the activities of the action group to meet the study aims. In total, the action group wrote, approved and submitted five reports to the steering committee with three reports in Cycle Two. Table 7-6 identifies the time periods of these reports and their content in the second action research cycle.

Report	Time period	Content
1	3rd February 2006 to 31st March 2006 (after 7 meetings)	Seven meetings Members of action group Values clarification Gathered admission data Group audit of preparation strategies Planning of hospital staff audit Planning survey development Consideration of reinstatement of the MCU booklet
2	1st April 2006 to 30th September 2006 (after 13 meetings)	Six meetings Quality Improvement Committee approval of audit Gathering data of questions children ask Survey development continues Ethics application for survey in preparation Research funding application for survey submitted Investigating approval to reinstate the MCU booklet Investigating printing and distribution processes for the MCU booklet
3	1st October 2006 to 31st December 2007 (after 24 meetings)	11 meetings Survey – 74 collected since 2nd March 2007, target is 100 Termination of audit on 30th November 2007 Reinstatement of the MCU booklet achieved

Table 7-7 Action group reports to the steering committee in cycle two

The Director of Nursing provided feedback from the steering committee to the action group as the mediator of communication between the two groups. The steering committee was interested in the action group's reports. They stated that they felt very well informed about the action research project and the action group's activities. The steering committee did not advise the action group, but they did provide assistance when the action group was having difficulty gathering data for the audit of preparation strategies at the hospital, the steering committee members asked hospital staff in their departments to respond to the audit email. Therefore, while the steering committee's request of hospital staff

was unable to improve audit completion, their assistance was an asset to the action group by making the study context easier to negotiate than it might otherwise have been.

7.3.5 Maintaining cohesion and commitment in the action group

During the second action cycle, the action group maintained cohesion as a group and its commitment to preparing children and their families for hospitalisation. When the CNS from Medical Imaging came to her first action group meeting, the seventh, it was obvious that the action group had become a functioning, sharing group. However, whether the group could also be effective in changing hospital preparation practice was unknown. Despite a range of difficulties encountered when attempting to initiate improvements to practice, the action group persisted and became more determined to change practice throughout this cycle.

While the action research group was cohesive, meeting attendance by members was inconsistent and from time to time membership changed. For example, the postgraduate student joined the action group in March 2007 and left in August 2007 at the end of her work experience with the Pain Management Team. Other members changed their status in the study such as the School Projects Officer. She no longer worked on Fridays from September 2006 and she decided to become a consultant to the action group. At the end of Cycle Two in February 2008, there were eight members of the action group remaining from the original 13. In the third report to the steering committee, the action group concluded by stating that members intended to continue working together to improve preparation for childhood hospitalisation at the hospital.

7.3.5.1 Action group development processes

In the second action research cycle considerable group development occurred, as anticipated by the action group during the planning phase of the cycle. The development of the group is outlined in this sub-section. As recorded in the

researcher field notes the group members had a shared commitment to preparation for childhood hospitalisation. Tuckman characterised the initial stage of group development as the forming (1965) stage. Much of this group forming stage had occurred prior to and during the first action group meeting. Before the first group meeting, some health care professionals had expressed their concerns about preparation for childhood hospitalisation at this hospital. Then, an opportunity arose to share these concerns at the clarification meetings for the study. When the action group first came together as a group at the first action group meeting the final consolidation of the forming stage took place. Members began to plan actions that would address individual and group concerns. Bellman and colleagues (2003) refer to this phenomenon as values clarification in their project designed to implement three patient-focussed initiatives in a National Health Service hospital, in the UK. Kemmis and McTaggart (1988) refer to the phenomenon as reconnaissance and emphasise its significance in establishing group cohesion.

During the second to fourth meetings, the action group discussed their own perspectives on preparation for children's hospitalisation. Heated discussion took place as some members were determined to tell other members about the implications that poor preparation for childhood hospitalisation had for their own practice. Members had moved into the next stage of group development and Tuckman (1965) refers to this as the storming stage. The action group members learnt from sharing their individual knowledge about issues related to preparation for hospitalisation and were able to collectively reflect about the importance of optimum preparation for hospitalisation. Storming has been evident in other action research studies, for example Bellman and colleagues (2003) noticed group storming in their previously mentioned study about the implementation of patient-focussed initiatives and they characterise the group as a safe environment that enabled collective critical thinking and reflection, sharing of knowledge and identification of knowledge gaps. Safety is an important aspect of the storming stage of group development in which resistance to group influence is overcome (Tuckman, 1965).

From the fifth meeting the action group began to acknowledge other points of view which Tuckman (1965) refers to as norming. Action group members were able to view the problem from a number of perspectives simultaneously. Ely (2001) noted group norming in an action research study in which groups of nurses met regularly to investigate and improve pædiatric pain management practices. The nurses were able to jointly identify themes that they referred to as barriers and solutions to clinical practice change (Ely, 2001). One premise of action research is that when groups work together on shared concerns changes are more likely to occur. Thus, the action group members in the present study came to the fifth group meeting having shared their concerns and aired their differences, and now were ready to work together as an action group, not as individuals.

Relatively early in the life of the action study, by the seventh meeting, Tuckman's (1965) final performing stage was reached by the action group which helped considerably in meeting the aims of the action research study. However, just because the action group had reached the final stage of group development, does not indicate that action group meetings were calm and action group members were always in agreement. Action group members were outspoken and vigorous debate of issues took place in deciding on the best strategies to improve preparation practices. However, the action group worked effectively by devising plans and actions that would potentially enable improvement in the practice of preparation for childhood hospitalisation. The performing stage lasted throughout the second action research cycle.

7.3.5.2 Responding to the stages of group development

The group members acknowledged the stages of group development proposed by Tuckman (1965), accomplishing each stage as a group of health care professionals. Although other theories have been postulated about group development, Tuckman's theory appears to be congruent with action research in health care as Lindeman and colleagues (2003) found in their study. The researchers reviewed four group development or team learning theories in order

to identify the crucial aspects of each theory and their relevance to research in health care. The researchers referred to an action research study conducted by Bond about making changes to health care practice in an aged care facility in the UK (Hart & Bond, 1995). Lindeman and colleagues' (2003) reported that Bond compared Duchet and colleagues' team learning theory with Tuckman's group development theory. Bond concluded that "forming, storming, norming and performing" (Tuckman, 1965, p. 396) exemplified the development of group cohesion that enabled planned changes in health care practice (Lindeman et al., 2003).

Change in preparation for childhood hospitalisation practice was fundamental to establishing the action research group. Group development was an essential element that allowed the group to be functional and then to move forward to change practice. Conceptualising action group development in stages enabled members to distinguish the cumulative aspect of the group's development.

7.4 Observing

The planning and acting phases in Cycle Two led to the observation phase of the cycle. As noted in Chapter Six, the observation phase is an essential part of action research that results in health care practice change. The observation phase focussed on the concepts explored by the action group that enabled development of the next cycle of action research as Kemmis and McTaggart suggested (1988). The sub-section outlines the plans and actions of the second cycle and observes them from the perspective of their effectiveness to begin the change process.

Observation of the three projects of the action group led to building on, and learning from, the successes and failures of the plans and actions for the projects. Given that the activities took place in the context of a major children's hospital, the observation phase considered the concept of collaboration of health care professionals in forming into an action group to achieve health care practice change. Similar studies reported in the literature, for example Bellman,

Bywood and Dale (2003), clarify the processes involved in achieving group work and provide contrast to the achievements of the present study. Finally, comparison of the present study's effectiveness with the effectiveness of previous studies enables exploration of the concept of the use of critical social theory to change in health care practice. These observations inform the reflective phase of the second cycle of action research.

7.4.1 Observing influential concepts when taking action on action group decisions

The action group's activities were congruent with the members' desire to improve the practice of preparation for childhood hospitalisation at the hospital. The concepts that influenced the groups' evaluation of the usefulness of the activities that were undertaken were the time taken for their completion, the funding and other support for planned actions and the mixed success of the projects that the group was able to undertake. There was a considerable overlap of plans and actions involved in these three projects, many occurring simultaneously. For clarity, the following sub-sections provide a description of the observation phase in relation to the three projects that were conducted in the second action research cycle.

7.4.1.1 Observing the survey

The survey design provided data about the experience of preparation for childhood hospitalisation at the hospital. Development of the survey continued for almost a year because the action group were determined to ensure that the survey provided the data required for future planning. Beringer, Hagan and Goodman (2009) experienced similar time issues when they used an action research approach to change practice regarding pædiatric surgical waiting times in a children's hospital in the UK. Action researchers met 15 times every three to four weeks to gather data to identify the stages in the process of care for children with orthopaedic trauma (Beringer et al., 2009). The action researchers planned to develop a care pathway leaflet from the data they

collected. The action group in the study reported here observed that it takes time to gather data using the action research methodology. Beringer, Hagan and Goodman (2009) confirmed that patience and persistence are required to ensure that data is collected and analysed in order to inform the next steps of the overall plan.

The failure to obtain funding support to distribute the survey influenced data collection and extended the time taken to collect these data. McKinley (2003) noted that successful applications for funding have particular features, including that the chief investigators have received previous (often pilot) funding for work related to the proposed study and published the results in peer reviewed journals. No members of the action group were able to satisfy these features, thus lessening the chance that the funding application was successful. Additionally, Worrall-Carter and Snell (2004) observed that nurses have difficulty in obtaining research funding due to their lack of expertise in this process. The authors suggested that applications to local funding bodies were more likely to be successful than to national bodies because they were less competitive (Worrall-Carter & Snell, 2004) and the action group heeded this advice. The action group members' lack of research experience is likely to have contributed to an unsuccessful research grant application and consequently to the extra time required to complete data collection.

Preliminary analysis of the survey data confirmed the action group's beliefs about the hospital preparation needs of children and their parents. The data also indicated that while formal and concerted approaches to hospital preparation was occurring generally at the hospital, most children and their parents/guardians were satisfied with their preparation for hospitalisation. This finding indicated that individual clinicians were preparing individual children and their families adequately, despite the original concerns of the members of the action group about preparation delivery at the hospital.

Beringer, Hagan and Goodman (2009) made a similar finding in their action research study into waiting times for orthopaedic surgery. The researchers

compiled a log over a two-month period and found that fewer children than they had expected experienced surgical delay. Despite the finding, the researchers continued with their study, initiating an up-to-date list of children waiting for orthopaedic surgery and a flowchart of the stages of hospitalisation for these children. The intention of both strategies was to improve communication between health care professionals with a view to decreasing surgical waiting times. The action group in the present study decided to continue with the research despite the survey finding that children and their parents/guardians who completed the survey were generally satisfied with their preparation for a hospital admission. The survey, however, provided information that the action group could use to plan further actions in determining what hospital preparation practices were occurring across the hospital.

7.4.1.2 Observing the audit

Members of the action group decided to audit all hospital staff about preparation for childhood hospitalisation strategies before attempting to change preparation practice at the hospital, if warranted. Group members were initially confident that the combination of the call for expressions of interest flyer and the introduction to the audit in the email message would invite an audit response from hospital staff. As previously identified, this initial confidence was ill founded and eventual abandonment of the audit due to a negligible response transpired. In an Australian study of implementation of a community-based health care program, Stubbs and Achat (2011) also found that health care professionals did not respond to data collection, stating that client needs were more important than the research. Members of the action group accepted that the context in which research is being conducted can operate against the research procedures that are required in practice improvement strategies.

Development of the final audit took 19 months and incorporated designing the format and identifying the content of the items, undergoing approval procedures, piloting the draft audit, ensuring the audit was able to obtain the intended information and administering it across the hospital. A significant

amount of time was taken during action group meetings to streamline the distribution of the audit in a way that would take as little time as possible. Reaching consensus was time-consuming; however, the final strategies were ineffective in engaging hospital staff. Not only had the development of the audit taken a considerable amount of time, it did not achieve its aim of gaining details of the hospital preparation practices occurring across the hospital because only three staff completed it. Action research is time-consuming as Beringer and colleagues (2009) found when collecting data to inform the development of a care pathway leaflet. The research inexperience of some health care professionals (Worrall-Carter & Snell, 2004) means that time may not have been well spent when designing data collection tools. On the other hand, the lack of interest shown by hospital staff might have signified their uncertainty about the hospital preparation occurring in their department, their failure to undertake this role and thus no knowledge of what is required, or their belief that hospital preparation occurs routinely and their insights are not required.

7.4.1.3 Observing the MCU booklet

Although the reinstatement of the MCU booklet took twenty months, the action group were very pleased with the effectiveness of the plans and actions associated with the project. Members had started sharing concerns about preparation for the procedure at the first action group meeting. The group had investigated the preparation strategy, then planned and acted to obtain approval to print and distribute the booklet. The action group was cohesive throughout this process, demonstrating persistence in the face of distractions as Gelling, a nurse researcher, had recommended when interviewed by Deaton (Deaton, 2012). The distractions that occurred for the group were the simultaneous plans and actions required to develop the survey and the audit. The processes undertaken by the action group to reinstate the MCU booklet demonstrated their achievement of the three aims of the study.

Like the action research projects in children's nursing coordinated by Fletcher and Beringer (2009), in which groups of clinicians researched and acted on issues of concern in order to improve them, the action group in the present study comprised mainly clinicians and myself as a pædiatric academic. In Fletcher's and Beringer's (2009) work, the coordinators were the academics, not the clinicians, unlike the present action group where the achievement of reinstating the MCU booklet arose mainly through the coordination efforts of clinicians.

7.4.2 Observing the outcomes of collegial action

At the end of the second cycle, the action group observed that a number of changes had occurred through working together. Through collaboration, the reinstatement of the MCU booklet changed preparation for childhood hospitalisation practice. Collaboration involved health care professionals working together to achieve a mutually satisfactory outcome that addressed the concerns of individuals about preparation for the MCU procedure. Action researchers, Reason and Bradbury (2008) state that action research seeks to bring about "the flourishing of individual persons" (2008, p. 1). Working together enabled the action research group to achieve change and therefore to address individual concerns about preparation for childhood hospitalisation.

By working together a change in one area of hospital preparation practice occurred because the action group proved to be more powerful than the individual action of one clinician. For example, the action group shared knowledge and expertise about the questions that children ask about hospital and devised a data collection technique to confirm this. Jointly, members were able to confirm the questions systematically and use that data collection to inform the development of the survey. The group was then able to implement a survey that met the need to know more about the experience of preparation for childhood hospitalisation for children and their families. Two aspects of working together proved to be beneficial. The first was that the individual group members confirmed for themselves and for each other, that the action group's

understanding of the questions that children ask was accurate. Secondly, group momentum enabled persistence in the face of difficulty in collecting data, not only for the survey but also for the audit.

Deaton (2012) conducted an interview with Gelling, a cardiology nurse researcher. Gelling asserted that multidisciplinary approaches to health concerns enhance the likelihood of success and that groups working together with persistence can achieve more than individuals working in isolation from each other (Deaton, 2012). The persistence of the study's multidisciplinary action group in pursuing a collaborative approach to improve hospital preparation practices was a factor in the achievement of this aim.

7.4.3 Observing group cohesion and coming to consensus

The time required to achieve group actions is a challenge to group cohesion in action research studies that seek practice change. Hughes (2008) summarised the organisational factors that influence health care practice change that Meyer, Spilsbury and Prieto (1999) found when systematically reviewing 75 action research reports in health care. A key barrier proposed to effective action research is lack of time, energy and resources (Hughes, 2008). In action research studies establishment of cohesion of the research group must occur prior to taking effective action. Action group members recognised that development as a cohesive group relied on the ability to form, storm and norm before performing. Members met in a progressively more collaborative and collegial fashion over the study period. Professional boundaries diminished as it became increasingly obvious that a genuine desire to improve the practice of preparation for childhood hospitalisation was fundamental to the continued work of the action group.

The ability of the action group to come to consensus contributed to the time taken for the second cycle to be completed. Coming to consensus is evident in the performing stage of group development. The action group came together because of a shared concern (forming), aired differences (storming), realised

that there were a number of perspectives to the issue of concern (norming) and then were able to work together as a group of concerned health care professionals to improve the practice of preparation for childhood hospitalisation (performing). Consensus was vital to all the activities of the action group, as opposed to compromise. Compromise, which is a feature of some managerial approaches to changing practice (Greenhalgh et al., 2005; Hart & Bond, 1995; Reason & Bradbury, 2008), was not a feature of the action research used in the present study.

The action group had eight members remaining by the end of cycle two, whereas there had been 13 members at the beginning of the cycle. All members of the action group observed the reduction in numbers, but realised that taking on such a commitment might have been too onerous for retiring members. Indeed, the stated reason for people leaving the action group was having both a heavy workload and other commitments. The remaining members of the action group accepted this reason and continued to work together as enthusiastically as ever. In the literature related to group membership, changes in peoples' circumstances leading to changes in group membership is accepted as normal (Duffield, Roche, O'Brien-Pallas, & Catling-Paull, 2009; Tuckman & Jensen, 1977). The context in which the action group existed was dynamic, the action group needed to be dynamic to function within the context and the group anticipated and accepted changes in group membership over time.

7.4.4 Observing critical social theory in action

The basis of critical social theory is that people can change the status quo through collaborative group action (Crotty, 1998; Friere, 1994). During the second cycle, the members of the action group observed that they were able to affect outcomes when they used a critical social theory framework to work together for change. Initially the health care professionals were unsure of critical social theory and the action research methodology. At the clarification meetings prior to the study commencing, the health care professionals who

expressed an interest in working to improve preparation for childhood hospitalisation asked for an explanation of critical social theory and action research. In particular they wanted to know what this type of research meant for them. The study by Dickinson (1999) was cited to advise them of the process usually occurring in an action research study, because it related critical social theory and the health care of adolescents, a group with which the health care professionals were familiar. The effectiveness of involving those affected by a practice in changing the practice persuaded potential participants to try this approach to improve preparation practice.

As the second cycle progressed, the action group worked together using the critical social theory framework to improve practice. Crotty (1998) interpreted critical social theory as "invit(ing) researchers and participants (ideally one and the same) to discard false consciousness, open themselves to new ways of understanding, and take effective action for change" (Crotty, 1998, p. 157). The action group observed that this was precisely what members were doing and they were encouraged and energised to continue working together to change practice. Members of the action group were able to relate to the health care professionals involved in Dickinson's (1999) study, that was identified in the clarification meetings, with their use of critical social theory in the action research methodology.

Critical social theory has informed a number of research studies in health care that aim to improve working conditions and support for health care professionals, facilitate greater opportunity for them to provide quality health care services and improve health outcomes for the person receiving health care services. Some studies have employed the framework of critical social theory to understand the ways that health systems can constrain the delivery of evidence based practice and/or dis-empower health care professionals and health care recipients.

Such studies have conceptualised the health care system as an oppressive one from which patients and health care professionals should be liberated (Corbett

et al., 2007; Thrasher, 2002; Wittmann-Price, 2004). Mohammed (2006) argued that critical social theory can be used to assess how socially derived power structures filter into healthcare practices in her study into the health care of adolescents with diabetes mellitus. The action group in the present study put aside professional and personal differences to participate in achieving mutually acceptable outcomes designed to improve the practice of preparation for childhood hospitalisation. By participating together, the action group were able to perceive that action research procedures enabled demonstration of critical social theory in action.

7.5 Reflecting

Reflection was continuous throughout the second cycle of action research and both influenced and was influenced by the dynamic events and outcomes of the action research group's participation in the study. Reflection was also influenced by the support provided by the hospital's Director of Nursing and the steering committee, and the engagement of the hospital community with different aspects of the study. Stringer and Genat (2004) comment that the reflective phase in action research allows time for the participants to step back from the plans, actions and observations that they are making in order to disentangle the phases.

During the second action cycle there were three projects occurring almost simultaneously, with the planning, acting and observation phases overlapping for each of these. At times it felt as if the plans and actions of these three projects were 'tangled' and the action group needed clarity of purpose to cope with complex nature of the various factors and events in progressing practice change. By reflecting on the interrelationships between the various project requirements the action group was able to evaluate more clearly the influence of the study context on project success.

Reflection focuses on the outcomes of the actions taken and why they worked, or did not work, in the way that the action group planned. The reflective phase

involves reflection on the theoretical assumptions that influenced the study and the processes undertaken to change practice. Interrogation of the usefulness of the theoretical assumptions to progress the study was part of the reflective phase. Reflections made by the action group, and myself as a member of the group, during the second cycle of the study reveal how reflection enabled the action group to optimise efforts to pursue the study objectives and to move forward despite the difficulties that occurred at different times. At the end of this section, I reflect on the action research processes that occurred in the second cycle and on the effectiveness of group work to achieve desired change in hospital preparation practices.

7.5.1 Action group reflection

The reflections presented in this sub-section represent those of the whole action group rather than the independent reflections of the individual members. Kemmis (2008) identified that group reflection enhances the cohesiveness of the group and Lee (2009) used the concept of group reflection in her action group study into nurse-led care in a community hospital to advance the study objectives. The whole group, as a functional entity, participated fully in reflection on the second cycle.

7.5.1.1 What does this mean for group action?

The reflections of the action group indicated that a cohesive group with a common purpose can be an effective vehicle for changing out dated, unpopular, unworkable or poor quality health care practices. Initially, the health care professionals who comprised the action group came together because of a shared desire to improve children's preparation for hospitalisation, as each had concerns that these practices needed improving. Therefore, while the phases of action research that ensued proved to be challenging for the action group from time to time, small successes along the way and the support provided by the Director of Nursing, the steering committee and the Medical Imaging Department encouraged the action group to pursue their goals.

Ultimately, some of the goals were achieved because the action group harnessed the power of the group to effect change in at least one area of hospital preparation practice, with the support of powerful hospital personnel. Reinstatement of the MCU booklet was a validation of a group approach to changing practice. Achievement of the reinstatement was through action group persistence continuously reinforced by various members of the action group. Members reflected on the groups' persistence in this journey and felt satisfied that at least one positive outcome had resulted. While only one change in practice was achieved, the action group was able to generate information about the children's and families' experiences of hospital preparation that was of interest to the wider hospital community and which could ultimately assist with identifying and addressing gaps in hospital preparation practice when the time was ripe for change.

The action group also achieved something they had not anticipated, that was the confirmation of group strength in acting on a common issue of concern. The action group reflected on the satisfaction and achievements that were possible when collaborating with others who were not only concerned, but also passionate about changing an aspect of practice that had implications for the health and well-being of children and their families, as well as consequences for the health care professionals who cared for the children and their families during hospitalisation. As Greenwood and Levin (2007) identified, the group members recognised that participation in an action research group can be an effective way to act on issues of concern.

7.5.1.2 What was found and deciding to continue

The action group reflected on the effectiveness of group work. Members observed the development of the group and reflected on the action group's effectiveness in achieving planned goals by the end of the second cycle. However, achieving these goals had taken nearly twice as long as planned for each of the three projects. Even so, the group reflected with some satisfaction

about the group members' persistence in continuing to pursue these goals while having to negotiate the funding application, dealing with the prolonged data collection for the survey and the disappointment of the lack of hospital staff's response to the audit despite many attempts to engage them (Deaton, 2012). Perhaps the most positive outcome of the group's work was the empowerment they achieved throughout the process and their resolve to continue as a group to work on practice change of preparation for childhood hospitalisation into the future.

Another aspect of the reflections by the action group was their realisation that the number of action group members had decreased from 13 to 8 over time. Up to this point, changes in the composition of the action group and in the numbers of action group members had not interfered to any great extent with the effective collaboration of the group in progressing their research agenda (Aranda & Street, 2001). However, the eight remaining action group members were progressively taking on more of the action group work as they became more empowered and passionate about acting on what they believed were needed practice changes. Since heavy workloads and conflicting priorities meant that some action group members missed some of the meetings from time to time, remaining members pondered on the sustainability of the work the group had set itself. To counter the risk of diminished sustainability members reflected about attempting to increase the number of participants of the action group during the third cycle of the study.

When considering the sustainability of the action group work, members decided that if the number of participants in the action group did not increase then the third cycle would need to be the final cycle, since the workload of the remaining members was already very high. If this was the case members decided to bring the activities of the action group to a conclusion that benefitted all members. Action group members had effectively learned what needed to be learnt as Kemmis and McTaggart suggest (1988) and identified the limitations of the research. Members decided to plan to optimise achievements for the action group's benefit, as well as for the benefit of children and their families.

7.5.2 Personal reflection

My personal reflection is on the processes and achievements of Cycle Two and focuses on the challenges and successes of the actions taken by the group. Challenges that I encountered in the second cycle were shortage of time and negotiation with some hospital staff in pursuing the action groups' goals. Time was a challenge to group work because action group members were time poor since they were all working full time in health care professional roles. Time was also a challenge when group members tried to negotiate with various hospital departments at different stages in Cycle Two. The processes required to gain approvals to pursue the three different projects from various decision-makers and departments was also complex and time consuming. This presented many challenges for the action group, despite the strong support and assistance of the Director of Nursing, the steering committee and the CNS from Medical Imaging. Successes came about through the cohesive working relationship between members of the action group and these support persons, as occurred in the survey distribution to children and families and the reinstatement of the MCU booklet.

Since my interest in working as a member of the action group centred on my doctoral studies, my own reflections about the achievements of the group are unique and differ to some degree from those of the action group reflections. My doctoral studies had time-defined limitations that affected my ability to commit to the action research for a longer period, and so time was a critical influence on my reflections during the second action research cycle. Concern about not being able to achieve the group's goals during the time available to me was always on my mind. The challenges and successes of the action research study influenced my reflections about the cycle and the following sub-sections outline these.

7.5.2.1 Reflection on the activities occurring in cycle two

The action group decided upon pursuing three major projects quite early on in the action meetings. Each of the projects required much more time to complete than the action group had anticipated. In fact, the second action research cycle that incorporated the three projects lasted for two years, rather than the one year originally anticipated. Neither I nor the other group members considered concluding the research after one year, as the action group had not yet achieved all the goals considered important to bringing about desired change in preparation for childhood hospitalisation practices. I think that this point emphasises the commitment that the action group had to pursuing this research agenda.

7.5.2.1.1 The survey

Development of the survey was a collaborative effort: discussions about collective concerns led to plans that led to actions to address these concerns (Reason & Bradbury, 2008). Information, advice and reflection came from all members of the action group and this created an accumulation of expertise in various aspects of the design and implementation of the survey. For example, the action group deliberated during several meetings about an appropriate face scale that children used while completing the survey. When I reflected on this, the commitment of the action group to design the best possible survey impressed me. However, I also reflected on the lengthy time taken to reach consensus about the face scale, and whether the action group would be able to progress as planned.

On reflection, it is possible that the longer than anticipated time it took to achieve each of the three projects decided by the action group could have occurred because of my style in facilitating the action research study (Heron, 1999). If facilitation of the group in pursuing action research is characterised as being along a continuum, then I consider that my facilitation style would be located at the most non-interventionist end of the continuum. In other words,

the action group took as long as it needed to reach consensus and I did not interfere with that process as the facilitator. Researchers, such as Ellis and colleagues (2005), have found that good facilitation is more influential than context in the uptake of evidence based practice and practice change. Good facilitation is a balance between allowing participants to have time to consider options and ensuring timely outcomes of group activities (Harvey et al., 2002; Heron, 1999). In that respect, I consider that I might have attempted to get the members to make faster decisions about each of the projects. However, as a member of the group I also knew how important it was to work with the group at a pace that was possible for the members, given their heavy work commitments, and to allow sufficient time for the group to reflect on the processes of change. With hindsight my facilitation style might change in future research projects of this kind, since the whole context and purpose will possibly be different.

The reflection phase of action research permits the opportunity to change planning for the next action research cycle (Kemmis & McTaggart, 1988) and my reflection made me aware that I might consider becoming more directive in my facilitation of the action group. My facilitation of the action group focussed on assuring the health care professionals that I was not their leader, but indeed a facilitator of plans and actions (Ellis et al., 2005; Heron, 1999). A conscious decision not to lead the action group drove my approach to facilitation. However, the result of that decision was that the action group took much longer to reach consensus on every issue, than it may have done if I had been more directive. There was a tension between consensus and facilitation. I believe that my approach to facilitation was appropriate for this action research study in order for this action group to reach consensus. Therefore, my reflection did not lead me to change my facilitation style.

7.5.2.1.2 The disappointment of the audit

My reflections about the unsuccessful attempt to audit the hospital staff's experiences with and views on children's hospital preparation practices are both

positive and negative. There were useful and less useful aspects to developing and distributing the audit. These aspects influenced my learning about change processes and my application of that learning to the next cycle of action research. A useful aspect of the audit was that its design met the requirements of a data collection tool. The audit document, developed in collaboration with an IT consultant, also met the needs of the action group to identify staff experiences and views about preparation for childhood hospitalisation. The action group piloted the audit and found it to be user friendly. When reflecting about designing a data collection tool I think that it is useful to engage experts in the particular design technology used, as consultants to the study. In that way, the expert can incorporate specific functions into the design that ensures that the tool meets the requirements of accurate data collection (Frank-Stromberg & Olsen, 2004). This reflection helped the action group to consider how a consultant could help in analysing the survey data in the third action research cycle.

My reflections about the lack of interest by hospital staff to complete the audit also helped me to consider the issues associated with research data collection, the process that can be used to engage audit respondents and the audit distribution method. Despite using several strategies, the action group did not successfully engage the audit respondents. This failure was a limitation of the audit and made me realise that assumptions about hospital staff notification and clarification of the audit's purpose and use were erroneous. While on reflection the notification and distribution processes seemed satisfactory, there might have been two reasons why hospital staff were not engaged in audit completion.

The first reason is that hospital staff were busy and the other is that they did not believe that they had anything to contribute by completing the audit. Both of these limitations relate to the context of the action research study. It was a busy children's hospital and it makes sense that the hospital staff working within it were busy. The "hamster-wheel of busyness" referred to by McCormack, Manley and Wilson (2004, p. 88) is a fundamental element of the context of

health care that McCormack and his colleagues characterise as being taken for granted by hospital staff.

It is less clear why the hospital staff did not believe that they had anything to contribute, or did not feel obliged to contribute any information. As Greenhalgh and colleagues (2004) note in their systematic review of health care practice change, the context into which innovation is diffused must be receptive to innovation. Part of the receptivity is that health care professionals within the organisation are valued for their input into how the organisation progresses. It is possible that the hospital staff did not believe that their experiences and ideas were of value, or perhaps they did not believe their input was relevant despite the audit introduction that indicated that the action research group valued the contributions of hospital staff.

I also reflected on whether the method of distribution of the audit was optimal. The action group spent a lot of time trying various distribution methods. My reflections about this were paramount in my mind during these failed attempts. Minimising the time it took to distribute the audit and obtain the data the group needed to plan change strategies was critical to me as a doctoral student. However, I also reflected that sufficient time was necessary to enable negotiation about the audit distribution and data collection with the context of the study. A review of the literature of practice change does not specifically mention the factor of time but rather incorporates time into issues related to the context of research studies (Meyer et al., 1999). During Cycle Two of the study I learnt that time is a powerful element of the context that can conspire against the realisation of practice change.

7.5.2.1.3 The MCU booklet

My reflections about the reinstatement of the MCU booklet, which was successfully developed and distributed to children and their families who consulted with the main MCU urologist at the hospital, are about time but also about persistence. What was a simple process took twenty months to complete

within the contextual constraints of a large tertiary hospital. If the action group had not persisted in their desire to improve preparation for hospitalisation, reinstatement of the booklet might not have occurred. The action group has the satisfaction of knowing that one group of children and their families continue to benefit from using the MCU booklet as a preparation strategy. This process reminded the action group that persistence is required in attempting to bring about desired change through action research (Deaton, 2012) because the context of the research is likely to produce delays in the implementation of change (Hughes, 2008).

The combination of allowing sufficient time and persistence in pursuing change overcame the influence of the hospital context to some extent. The context was not malevolent to the objectives of the study, but rather the context was not open to the novel concepts that the action group proposed. To some extent, the group acknowledged the constraining influence of the study context by engaging the Director of Nursing as the liaison between the group and the steering committee and gaining the agreement of the Director of Nursing to be the site supervisor for the doctoral study. However, the context was far more complex than any of the action group had anticipated, as Cummings and colleagues (2007) observed in their study to bring about health care practice change generally. Being part of the action research group helped me to realise the complexity of the context and gave me insight that enabled a better understanding of the context that others have identified (McCormack et al., 2002). Understanding this constraint to the pursuit of change in the health setting enabled the action group to consider a new approach to addressing issues of context in the third cycle. This new initiative involved education of the hospital staff as a means of improving preparation for childhood hospitalisation.

7.5.2.2 Group work to achieve change

I reflected in the first action research cycle and into the second cycle on being surprised that the action group moved through the stages of group development relatively quickly, taking only seven meetings over eight weeks to reach the final

stage described by Tuckman as performing (1965). Given the heavy workload of the action group members and the many other priorities they had in their various work roles I was even more surprised that the group became firmly fixed in the final stage of group development throughout the following two years. Tuckman predicted that in the performing stage "roles become flexible and functional and group energy is channelled into the task" (1965, p. 396) and so it was with the action group. The result of group development was that the group was cohesive and focussed on improving preparation for childhood hospitalisation. The action group member who joined the group at the fifth meeting moved through the stages even more quickly and became a functional member of the group by the seventh meeting, possibly because of the cohesion of the group and its shared purpose.

As the action group worked together, I reflected on group cohesion and on the process of coming to consensus. Members put aside their personal and professional differences in the interests of achieving the action group's work as Lewin predicted (Cartwright, 1952). Individuals demonstrated a determination to work collaboratively to improve children's preparation for hospitalisation at this hospital. The determination to stay together and to achieve this common goal was evidence of a belief in the group approach to change, rather than the individual approach that some group members had previously used. Despite the determination of the group members to be cohesive, it was coming to consensus that often took many meetings and discussions (Cartwright, 1952).

Action group members consciously put aside their differences to enable group cohesion, however, the unconscious differences amongst members meant that coming to consensus was more time consuming than anticipated (Hughes, 2008). The most notable example of the impact of individual differences on consensus was the design of the survey of children and their parents/guardians. There was a lot of expertise in the action group regarding hospitalised children. However, rather than speeding up the process of survey design it slowed it down. A review of meeting audio recordings indicates lengthy debate of most design issues. Individual action group members were reluctant to accept the

ideas of others, from their own and other disciplines, resulting in many discussions before reaching consensus.

Consensus was not as much of an issue in the reinstatement of the MCU booklet. It is possible that the success and relative speed of implementation of the MCU booklet was a result of the fact that it already existed, it was accepted by the department head and other senior staff and it was already in a form that could easily be reinstated (Salmon, 2006). Contextual issues, such as obtaining approval to reinstate it from the hospital, caused delay in the implementation of the MCU booklet, but this was an accepted feature of making changes to information for patients and their families at the hospital. Reinstatement of the MCU booklet was not delayed by gaining group consensus to do so.

7.6 Summary

The second cycle of the action research study continued to pursue the necessary steps towards achieving practice change. The steps taken by the action group in this cycle show how a concern for preparation for childhood hospitalisation led the action group to collaborate and work towards practice change of preparation for childhood hospitalisation practices for children and their families at this hospital. The functional element of this second cycle was the action group meetings through which the action group became central to the action research. Initially the action group made plans to undertake the three projects that occurred in the action research study, to maintain communication with the steering committee through the Director of Nursing, and to conserve the action group members. The acting phase saw the implementation of the detailed plans made through consensus to systematically achieve practice change through the survey of children and their parent/guardian, the audit of hospital staff and the reinstatement of the MCU booklet. These three projects met with varying degrees of success in Cycle Two. The hospital context both enhanced and constrained progress. However, it was the action group

cohesion, commitment and joint pursuit of change that enabled the achievement of most of the group goals.

By the end of the second action cycle in February 2008 the status of the three projects was as follows: data collection for the survey was complete and initial analysis had begun, the idea of further data collection with the audit was abandoned, and children and their families who attended one of the hospital's urologist's rooms were issued with the reinstated MCU booklet preparation strategy. The Director of Nursing and the steering committee had received three reports of the achievements of the action group during the two years of the second action cycle. Support of the work of the action group was in the form of feedback to members from the steering committee by the Director of Nursing. Finally, the action group, although reduced in number from 13 to 8, continued to maintain cohesion and commitment to improving preparation for childhood hospitalisation with enthusiasm.

In this chapter, I indicated that the second cycle's third phase, observing, followed the phases of planning and acting. However, observation was an intrinsic phase of the first two phases that informed decisions of the action group in the second cycle. The action group meeting minutes became much more influential than the researcher field notes in the observation phase of the second action research cycle because they outlined the plans and activities occurring from the point of view of all members of the action group.

The observing phase informed the reflecting phase, but as previously discussed reflection occurred through a continuous process that enabled all action group members to step back from the actions occurring (Stringer & Genat, 2004) and evaluate the factors that had contributed to and hindered achievement of the action group goals and activities in Cycle Two. This process of evaluation of factors and reflection on them helped the group members to work out optimal efforts in moving towards the third study cycle. The main outcome of these reflections on progress was the learning acquired about how action research can help to bring about change, and how difficult this process can be within the

constraints of a busy hospital environment. The action group also reflected on how group work can be an effective way to change health care practices that are less than optimal in the circumstances in which they are occurring. The action group decided to continue working together despite some challenges. However, members decided that the third cycle of action research would be the last one they would be able to participate in, so they determined that they would finalise their efforts to improve preparation for childhood hospitalisation at the hospital.

The second research cycle was confirmation of action group formation as a means of bringing together people from various disciplines to enable practice change. Only one change to preparation practice took place at this hospital during the study period, however, the action group had also found out what children and their parents thought about the experience of preparation for hospitalisation at this hospital. The action group reasoned that the knowledge obtained from the survey could potentially inform further plans and actions in the next action research cycle. That cycle will be the subject of the next chapter of the thesis. In the third cycle, the action group worked together to finalise the projects that members instigated in the second action cycle to improve children's preparation for hospitalisation.

Chapter Eight – Action research Cycle Three – Mobilisation of collective action for change – March 2008 to December 2008

Two action research cycles were complete and the action group were ready to embark on the third and final action research cycle. The third action cycle lasted ten months. Once again, the action group meetings were the functional component of the study and members met seven times in the third cycle. After the last meeting, communication continued by email until the end of the cycle. The four phases that characterised the first two cycles were also evident in the third cycle. Although, the phases overlapped, this chapter reports them as if they were discrete phases. The action group discussed plans to use the findings of the second cycle to inform the third cycle and then acted to enable the action research plans. Simultaneously, members observed the plans and actions, making changes to ensure maximum effectiveness of the work together to improve the practice of preparation for childhood hospitalisation at this hospital. Finally, the action group and I reflected on learning during the third action research cycle.

8.1 Introduction to the third action research cycle

To optimise the previous achievements of the action group the third action research cycle focused on finalising the activities begun in the second action research cycle. Therefore, cycle three provided an opportunity to reflect on what the action group had already achieved and what the future held for improving preparation practice. As previously identified over the course of the study the action group had reduced in number from the first meeting in February 2006. The number of action group members had progressively reduced from 13 to 8 by the end of the second action research cycle. Most of the members had left the action group for work-related reasons. The remaining action group members felt the need to persevere in their goals despite many challenges, and at times this had the effect of diminishing the remaining members' enthusiasm for making a change in hospitals preparation practices.

During the third cycle, the number of action group members present at meetings continued to fluctuate. Two members took leave from their employment at the hospital and one resigned; however, a new member from an associated hospital joined the action group. Between six and seven action group members were able to participate in the activities of the third action research cycle. While action groups can be effective when there are only six to eight members (New South Wales Health Department, 2002), their effectiveness requires the full participation of all members. This was an issue in the third action cycle since the members were unable to attend every meeting and this delayed some of the decision-making processes. Meetings were the functional element of the action research study, and so non-attendance of some members at different times affected the pace of activities determined by the group, including the members' decision to finalise the activities of the action group.

8.1.1 Overview of chapter structure and content

Chapter Eight describes and analyses the third *mobilisation of collective action for change* cycle. Figure 8-1 shows a diagrammatic representation of the third cycle. The cycle began in March 2008 with formal analysis of the survey of children and their parent and finished in December 2008 with the final action group report to the steering committee. The final action group meeting was held on 31st October 2008. The chapter is organised around the four phases of action research: **planning**, **acting**, **observing** and **reflecting** in relation to the third cycle of the study to mobilise collective action for desired change. The planning phase outlines the action group's plans to mobilise collective action on improving preparation for childhood hospitalisation practices. There were five aspects to this planning phase and they related directly to the second action cycle that was described in the previous chapter. The acting phase of the third and final action cycle aligned with the five planning phase aspects.

Incorporation of the observing phase of the action research cycle occurred at the action group meetings as a way of optimising group collaboration. During meetings, members observed how the plans and actions would benefit from

revision. Many of the observations made in the final cycle related to group cohesion and consensus that was challenged because the action group was reduced in size and only met seven times face-to-face during the third action cycle. Some communication occurred between action group members following the last meeting to observe the plans and actions of the third action cycle. Members of the action group met by email to discuss the publication plans for a journal article about the results of the children and parent/guardian survey, the action group's final report to the steering committee reporting the study progress and results, and the document that tabled the action group's beliefs about hospital preparation practices.

The reflecting phase of cycle three focused on the process of changing practice. These processes are presented in two sub-sections. The first sub-section reports the action group member reflections on the impact of group work for each member. The second sub-section outlines my personal reflections as a group member on the group actions and the process of using group work to change health care practice.

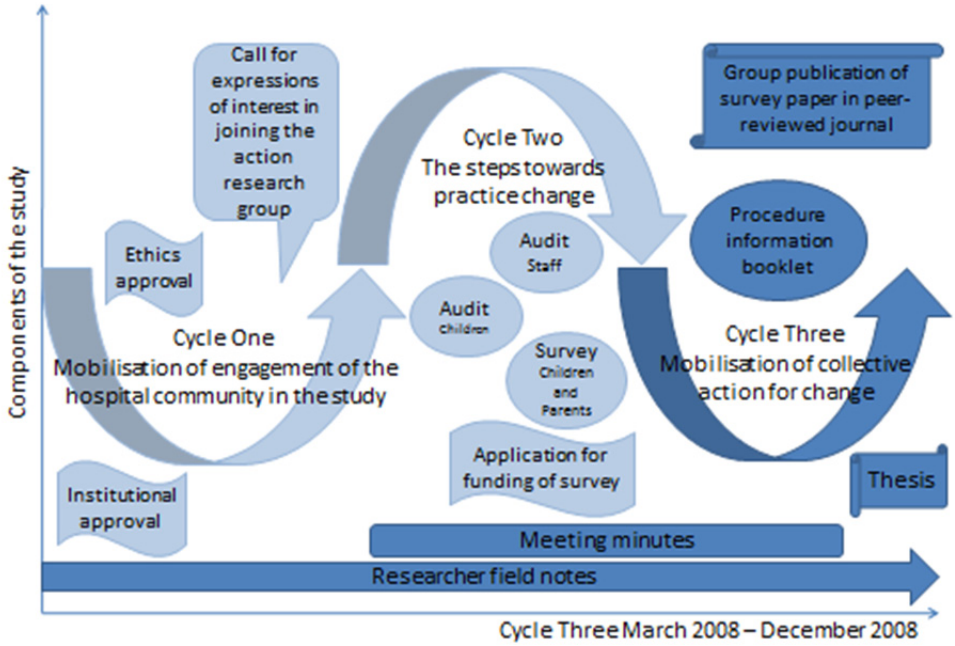

Figure 8-1 Cycle Three - Mobilisation of collective action for change – March 2008 to December 2008

8.2 Planning to mobilise collective action to improve practice

The planning phase of the third action research cycle focused on optimising the three projects that were implemented in the second action cycle. These projects included the children and parent/guardian survey of the experience of preparation for childhood hospitalisation, the audit of hospital staff regarding preparation strategies and the re-instatement of the MCU booklet. The action group also planned closure of the relationship with the study's steering committee, now that the final stage of the study had been achieved. Finally, action group members also planned the future of the group while considering achievements and limitations in changing the practice of preparation for childhood hospitalisation.

8.2.1 Planning analysis of the children and parent/guardian survey and dissemination of the survey findings

As was the case in previous cycles, planning involved identifying the expertise of different action group members to move forward with group action. The action group was multidisciplinary and members had various educational and professional experiences and took advantage of this diversity to work together in a supportive and collegial fashion. For example, the clinical psychologist who worked in the Pain Management Team had significant knowledge and experience with the statistical tool known as the Statistical Package for the Social Sciences (SPSS) that was used to enter and analyse the survey data. The action group planned that she would lead the analysis of the survey data, with her agreement, and that she would teach other action group members how to use the software for data analyses and to prepare a report of the findings for the action group. The analysis included action group review and analysis of the open-ended response "advice to a friend" section of the Child's survey. The action group planned to undertake the review at the meeting on 25th July 2008 and to include the analysis in dissemination of survey findings.

The action group planned to write a paper that would enable dissemination of the survey findings to the wider health care professional community. At the first meeting of the third cycle, allocation of responsibility for one section of the paper to each of the five present action group members occurred. For example, the plan was that the action group member who led analysis of the survey data would take responsibility for writing the "Results" section of the paper, while other members would take the lead of other sections of the paper. At several group meetings members discussed the most appropriate journals for submission of the paper for publication. Action group members also planned to notify the hospital community about the results of the survey by reporting a summary of the findings in the hospital newsletter.

8.2.2 Planning the use of the audit response

As there had been minimal response of hospital staff to the audit in Cycle Two, the action group reluctantly decided to abandon the audit as a data collection tool. In Cycle Three, the action group discussed options for using this activity to enhance the learning of the group. The action group planned a review of the design and the distribution of the audit with the intention of increasing members' ability to gather data more effectively in their own areas of practice. In particular, members wanted to improve their ability to gather data to inform the second aim of the action research study, which was to generate knowledge about existing practice.

8.2.3 Planning continued use of the MCU booklet

Distribution of the MCU booklet began in October 2007 with the first users of the preparation strategy due to come to hospital for their procedure in February 2008. Just before the third cycle commenced the booklets needed replenishing. Fifty more booklets were printed for distribution by the secretary of the urologist who performed the majority of MCU procedures in the Medical Imaging Department. The action group was very pleased about the success in reinstating the MCU booklet in that hospital department. Members planned to

continue to support the printing and distribution of the booklet to all children booked in for the MCU procedure at this hospital.

Broadening of the distribution processes was required so that the booklet reached all appropriate children and their families. At the 17th action group meeting on 30th March 2007, during the second cycle, the action group had decided to distribute the booklet through the hospital outpatient clinics following piloting of the distribution method. As the distribution process during the pilot had proved successful, the action group decided to distribute the booklet as originally planned, a year later, at the first action group meeting of the third cycle. The action group sought approval to continue to distribute the MCU booklet from the three urologists who consulted with urology clinic patients and the clerical staff in the outpatient urology clinic. When approved on 30th May 2008, 100 booklets were printed and distributed to the outpatient clinics. The action group planned to seek agreement to print subsequent batches of the booklet from the managers of the two hospitals located on the health campus that shared the Medical Imaging service.

8.2.4 Planning closure of the relationship with the steering committee

The principle form of communication with the steering committee had been the reports submitted to the steering committee via the Director of Nursing. Members planned to submit one report in the middle of 2008 summarising the group's activities in the final part of the second action cycle and the activities of the third action cycle. In a report submitted to the steering committee the group members also planned to notify the steering committee of the intention to repeat the call for expressions of interest in joining the action group. Planning the activities of the third action research cycle included a plan to the close the formal relationship between the action group and the study's steering committee at the study's conclusion. The action group planned for this to occur at the first meeting of the third cycle. The hospital's Director of Nursing facilitated this communication to the steering committee. At the final meeting on 31st October 2008, members planned to submit a final report to the steering committee that

included the groups' beliefs about preparation for childhood hospitalisation practices that drew on the information provided by the children and parent/guardian respondents to the survey. Details of the final two reports of the action group to the steering committee are in sub-section 8.3.4.

8.2.5 Anticipating the future actions of the action group

At the beginning of the third action research cycle the action group decided not to plan any new activities and to finalise the activities undertaken, since remaining members believed that at that particular point of time they could make no further progress with improving hospital preparation for children and families at the hospital. Members of the action group had worked together for more than two years to progress preparation practices at the hospital. However, the members decided to plan a second call for expressions of interest in joining the action group at the meeting on 29th August 2008 as a final attempt to increase the group membership and potentially undertake more improvements to preparation for hospitalisation practice. At that meeting, members decided to cease meeting if the second call was not successful in recruiting new members to the action group. One member of the action group went on maternity leave in March 2008 but continued her association with the group by email, in particular regarding development of the paper for publication. Therefore, the action group identified that email communication could be an alternative to face-to-face meetings to maintain the group's momentum. Members concluded that the action group had developed an identity and was an entity that did not necessarily need to meet face-to-face to continue its work.

8.3 Acting on plans to implement improved hospital preparation practices

The actions taken by the group in cycle three aligned with the five aspects of the planning phase described, with three of them designed to improve the practice of preparation for childhood hospitalisation at this hospital. Members thought it likely that the action group would conclude work together when the activities were complete, so a major task of the third cycle was finalising the

activities begun. The fourth aspect of the planning phase related to reporting to the study's steering committee. A description of the action group's communication with the steering committee with the purpose of closing the formal the relationship with the committee follows the description of the finalisation of action group activities. Dissolution of the action group after the finalisation of all of activities was the fifth aspect of the planning phase of this cycle. A description of the dissolution concludes this section of the chapter.

8.3.1 Analysing the survey data for children and their parent/guardian

The children and parent/guardian survey on their experiences of preparation for hospitalisation at the hospital occurred between April 2007 and February 2008. One hundred and two children/parent/guardian dyads responded to the survey just prior to their discharge. In each dyad, children completed a Child's survey and one parent/guardian completed a Parent survey of their preparation experiences and information received about preparation prior to and during hospitalisation. Children respondents were in the 6 to 10 year old age group. Of the 102 admissions, there were 73.5% planned admissions and 26.5% unplanned admissions.

One member of the action group, a clinical psychologist in the Pain Management Team, presented early analysis of the survey data at the first meeting of the third cycle. A psychology student who was a member of the action group for six months had entered data into the SPSS software under the supervision of the clinical psychologist action group member. The clinical psychologist group member then entered the second six months of data into the SPSS software and analysed all the data. These analyses showed that the respondents, children and their parents/guardians, were generally satisfied with preparation for hospitalisation at this hospital, as identified in the summary of survey results in Table 8-1.

Survey results	
Information provided to children	All children reported that they had been informed about their admission: by one or both parents - 46.7% by a doctor - 41.3% by parents and a doctor - 12% Children reported that they: were happy with the amount of information (would be less scared on a repeat admission P<0.05) - 85% would have liked more information - 12% would have liked less information - 2.7% According to parental report children received information about the admission: via a letter - 26.7% verbally - 66.7% According to parental report information was received by children: from doctor only - 42.9% from one or both parents - 32.7% from parent and doctor - 24.5%
Planned versus unplanned admission	According to parental report: unplanned admission was significantly more distressing for children- P<0.01
Questions asked by children	According to parental report: children asked at least one question about hospitalisation - 63.7%
Children's advice to a friend	Themes: 1. Reassurance not to be scared 2. Reassurance that doctors and nurses are nice and will look after you 3. Fun activities while in hospital
Information received by parents	According to parental report: procedural information -95.8% about anaesthesia - 91.9% about their child's condition - 92.6% about the hospital environment - 75.3% about how their child might feel - 78.4% options for parental presence - 86.6%

Table 8-1 Summary of the results of a survey of children and their parent/guardian regarding preparation for hospitalisation at a major children's hospital

The action group discussed the preliminary analysis of the survey data and its implications for preparation practice at the hospital. Although preparation was not formalised at the hospital, the findings of the survey showed that children and their parents/guardians surveyed were satisfied that they had been adequately prepared. The action group concluded that it was likely that the hospital staff were individually preparing children and their families for the events, procedures and possible experiences of hospitalisation. So, despite the ad hoc nature of preparation delivery, there was a high level of satisfaction of

the surveyed children and their parents/guardians. Therefore, the action group concluded that the current situation regarding preparation was not as concerning as members had originally thought. The action group discussed these findings and decided that it was more appropriate to place emphasis on improving children's preparation for hospitalisation through consistent education of health care staff, particularly for those whose role included preparing children and their families for hospitalisation.

The action group agreed that producing a publication of the survey findings would benefit the group members and the rest of the hospital staff by stimulating an awareness of the issues and the need to continue improving education for health staff on childhood hospitalisation preparation. The group members hoped that a journal publication of the survey findings would also encourage hospital staff, particularly those involved with preparing children and their families for hospitalisation, to seek out opportunities for improved education, given the direct relevance of the study findings for hospital staff. Through consensus, group members agreed to take responsibility for instigating different sections of the manuscript according to their experiences and levels of confidence with this task.

As the action group was multidisciplinary, considerable discussion took place about the range of multidisciplinary health care journals available for submission of the manuscript. Ultimately, the action group decided on one journal and formatted the paper according to the journal's requirements (Appendix Q). Members drafted their allocated section between meetings and collation of the manuscript draft occurred at the final action meeting on 31st October 2008. The whole action group contributed to preparing the manuscript for submission, which required significant collaborative effort before the approved version was submitted to the chosen journal on 17th December 2009, more than a year after the action group ceased meeting face-to-face.

In the meantime, at the fifth action group meeting of the third action cycle, the group members reviewed the results of the children's "advice to a friend"

section of the survey. The children's survey responses indicated that the hospital provided a "kid friendly" environment, and this was very reassuring to the action group members. Discussion took place about reporting these particular survey findings in the monthly hospital newsletter. However, since the number of action group members was by now quite reduced, the group decided to report the findings in an oral presentation to health care professionals who attended the hospital staff communication forum that was held several times a year. The communication forum provided an opportunity for managers and clinical staff to discuss important issues from across the organisation, so this was considered an ideal venue for presenting these findings. Preparing the presentation occurred during the action group meeting on 26th September 2008. The presentation was very well received at the communication forum and the health care professionals who attended were very pleased to hear the findings from the survey. The action group were pleased that they had publicly informed the hospital community of the survey findings through the communication forum. The group members meanwhile continued to develop the journal article to inform a broader audience of the study results.

8.3.2 Applying the lessons learned from conducting the audit

The lessons learned from conducting the hospital staff audit of hospital preparation practices alerted the action group to the challenges that can be encountered using some data collection techniques. Multiple attempts were made to improve the staff's completion of the audit. This involved reviewing the audit design and the distribution techniques in an effort to identify problems that may have led to the poor staff response. Despite the multiple cycles of planning, acting, observing and reflecting (Reason & Bradbury, 2008) to improve staff's participation in the staff audit this activity proved futile, an outcome that has been reported by others who have attempted to gain potential participant engagement in research that will impact on their practice (Stubbs & Achat, 2011).

Lack of engagement of potential participants was a perplexing issue for the action group since the audit design was congruent with the communication techniques most commonly used by hospital staff and included either electronic or paper-based formats. In addition, the group members considered that they had tried a number of the most appropriate forms of distribution suitable for electronic and paper return of responses. However, following the first call for audit completion the action group became aware that the audit had asked for a response at a time when the hospital was particularly busy with other work. For that reason, the action group re-distributed the audit at a later date and devoted a significant amount of time to distributing the audit. However, this proved fruitless and eventually group members used the experience to learn more about the difficulties associated with data collection and the procedures required to gain staff participation.

The lessons learned about the data collection process were how to improve staff's awareness of the audit and how to use additional strategies to encourage audit response. The action group decided that in future invitations to participate in research that notification about the data collection tool and the procedures for collecting the data ought to be very specific and closely aligned with the distribution of the data collection tool. Engagement of staff champions or facilitators to encourage staff responses to surveys/audits seemed another useful strategy for the future. Williams and colleagues (2008) conducted an action research exploration of the feasibility and effect of a coordinated approach to the provision of emotional care to hospitalised patents in a hospital in Western Australia. The researchers found that the involvement of a staff champion resulted in 90% of hospital ward staff attending educational workshops that were a precursor to practice change. Therefore, the action group concluded that combining the services of a staff champion with improved advice and timing of staff audits or surveys would possibly improve future data collection from hospital staff.

8.3.3 Evaluating the utility of the MCU booklet

There was considerable overlap between the planning and acting phases of the third action research cycle with regard to the MCU booklet. Printing and distributing the MCU booklet dominated action group activity in the third action cycle. However, two unplanned actions also occurred. The first was that at the first meeting of the third cycle, the CNS from Medical Imaging reported to the action group that Nurse Manager of Medical Imaging had applied for funding to print and distribute the MCU booklet. This funding application was submitted by the Nurse Manager of the Medical Imaging Department to the hospital's Director of Medical Services who was a member of the study's steering committee. Unfortunately, the funding application was unsuccessful.

The other unplanned action that occurred was in relation to sharing the MCU booklet with a colleague from another hospital in the Area Health Service who joined the action group on 20th June 2008. The new member of the action group had written a similar booklet to prepare 6 to 10 year olds for eye surgery. Comparison of the content and style of these two preparation booklets led the action group to discuss formal evaluation of the MCU booklet. At the action group meeting on 30th May 2008, the fifth of the third cycle, the Play Therapy manager suggested assessing if children and their families were using the MCU booklet as a first step towards evaluating it. At the time the Play Therapy manager was working with children who were undergoing the MCU procedure. According to the action group's understanding of the booklet distribution, at least some of those children had received the MCU preparation booklet. The action group decided at the next meeting, one month later, to quantify distribution of the MCU booklet by asking the nursing staff in the Medical Imaging Department to survey children and their family regarding receipt of the booklet. After each MCU procedure, the nurse caring for the children and their family asked, "Did you receive the MCU booklet?" and recorded their responses.

The Medical Imaging CNS tabled an email from the lead researcher of the original MCU booklet research project at the final meeting of the action group on 31st October 2008. The email congratulated the action group for reinstating the MCU booklet and offered funding to have the booklet evaluated. While this offer was considered by the action group it was not taken up since by this time the action group had decided to disband and had held its final group meeting. However, the MCU preparation booklet continues to be printed and distributed to prepare children and their family for the MCU procedure.

8.3.4 Communicating with the steering committee and closing the formal relationship

At the beginning of the third action cycle the action group made several plans related to communication with the steering committee. Members reasoned that if the action group ceased to exist so the formal relationship with the steering committee would cease as well. Therefore, the action group wanted to inform the committee of group activities and to acknowledge their support of the study and the action group's work. As planned, members wrote two reports of these activities for the steering committee. The Director of Nursing presented the reports to the steering committee and fed back to the action group that the steering committee received the reports with pleasure and commended the action group for its persistence in pursuing the study aims. Table 8-2 summarises the content of the fourth and fifth reports to the steering committee.

Report	Time period	Content
4	1st January 2008 to 31st July 2008 (after 29 meetings)	Five meetings MCU booklet is being printed and distributed Analysis of survey data continues with a view to publishing the results Peri-operative nursing educator of associated hospital is collaborating with the action research group Acceptance of conference paper about re-instatement of MCU booklet Repeat call for expressions of interest in joining the action group due to significantly reduced numbers Proposal of a rotating chair of the action research group to be discussed at the next meeting
5	1st August 2008 to 31st December 2008 (after 32 meetings)	Three meetings Preparation of a manuscript for publication to continue via email Nil response to repeat call for expressions of interest to join action group Cessation of action group meetings, last meeting 31st October 2008 See attached comments of the action research group Offer of research funds to evaluate the MCU booklet not accepted by the action research group

Table 8-2 Action group reports to the steering committee in cycle three

As noted in the fifth report to the steering committee on 31st December 2008, the action group submitted a list of comments (Table 8-3) based on the survey of children and their parents/guardians about the experience of preparation for childhood hospitalisation at this hospital.

- There is little information about what children and their parents would like to know about a forthcoming hospitalisation
- Children and their parents can provide this information by age appropriate surveys
- Children have many questions about forthcoming hospitalisations, regardless of the reason for their admission
- Parents play a significant role in information provision to their children
- Further research is needed to assess how competent parents are to accurately address their child's information needs

Table 8-3 Action group comments regarding surveying children and their parents about the experience of preparation for hospitalisation at this hospital

Presentation of the last report to the steering committee was two months after the last action group meeting. Members no longer sought the advice or the support of the steering committee as the work of action group had concluded. Because the action group no longer met as a functional working party, there was no longer a relationship with the steering committee to maintain. The steering committee was aware, however, that the remaining six action group members planned to work together through email communication to prepare the survey results manuscript. In August 2010, a copy of the published survey results paper (Appendix Q) was emailed to the Director of Nursing who tabled it at the next hospital management committee meeting, which comprised members of the former study steering committee. The management committee, through the Director of Nursing, congratulated the action group on the publication of the paper and on the quality of its writing. The management committee did not take any immediate action regarding the documented comments that the action group derived from the survey findings. It is unknown if the committee used this information to pursue future improvements in hospital preparation practices.

8.3.5 Terminating the action group activities

The logistics of terminating the action group's activities were part of the acting phase of the third cycle. The action group activities coincide with the five aspects of the planning phase. Details of the first four of these, the conclusion of the three activities of the action group and of the relationship with the steering committee are in the previous sub-sections. The final sub-section of the acting phase details the termination of the action research group as a functional working party.

As previously identified, the action group decided during the planning phase of the third cycle not to continue the action research meetings. The action group suspected that their call for expressions of interest in joining the action group might not be successful. If this was the case then the action group agreed that members could not continue to work together under such difficult

circumstances. Any planned activity of the action group would inevitably require a greater number of members than the six currently in the action group. However, as noted in the planning phase the action group were also aware that email could be an effective communication technique for busy health care professionals, including the group members.

Reluctantly, the remaining members of the action group subsequently terminated the face-to-face meetings and all activities to improve preparation children and their families for hospitalisation. The action group chose to optimise the work undertaken thus far by reporting on the two successes, and by learning from the failure of poor staff response to the staff audit. The remaining action group members reported the findings of the survey to the hospital community, and then planned to continue communication through email to develop a research paper publishing the findings of the survey to the broader community of health care professionals involved with preparation for childhood hospitalisation. Group members also established processes to print and distribute the MCU booklet to children and families through relevant hospital departments.

Part of the reluctance by the action group to terminate its work related to awareness that there were many other potential actions that could be implemented to improve preparation for childhood hospitalisation at the hospital. During the seven meetings of the third cycle, various members of the action group spoke reflectively about potential worthwhile actions. For example, at the fourth meeting of the third cycle, the action group considered collaboration with a colleague from an associated hospital. She wanted to administer the survey to the children and their parents admitted to the children's unit in the adult hospital in which she worked as a Clinical Nurse Educator. At the next meeting, the action group agreed to the administration of the survey at the associated hospital, providing that the same inclusion and exclusion criteria applied and there was appropriate ethics approval provided by the hospital. The action group did not participate in the administration of the survey despite recognising

the value of the process for the benefit of children and families admitted to the other hospital.

Since there were no expressions of interest in joining the action group when the call occurred on 29th August 2008 at the sixth meeting of the third cycle, the action group proceeded to develop the presentation of the survey to the hospital community. Members decided at the meeting on 31st October 2008 to terminate face-to-face meetings and to meet via email regarding development of the survey results manuscript and the final report to the steering committee.

8.4 Observing planned action on hospital preparation

Members of the action group maintained continuous observation of the planning and acting phases of the third action cycle, which was made easier by the groups' familiarity with the phases of action research and the small number of action group members facilitating the process. However, simultaneously the presence of a new member of the action research group in cycle three obliged members to make explicit the observation phase, or the process of "monitoring" (Kemmis & McTaggart, 1988, p. 77) which may not have otherwise occurred. Although the main aim of the action group during the cycle was to finalise activities, the main observations of the cycle were about group work in action, group cohesion and consensus in decision-making, and understanding the group's appreciation of critical social theory as a framework for practice change.

8.4.1 Analysis of what working together had achieved

As planned at the outset of the study, the action group collaborated with one another in the third action cycle to address the improvement of hospital preparation practice. As a group, members observed that much more was achieved than individuals could have done, although they were not able to continue with all of the practice improvements they desired. One of Raelin's (1999) 14 criteria of action research indicates that a fundamental aspect of action research is that its purpose is social change through involvement and

improvement. Groups of people involved in real world situations undertake change. The action group observed that the effectiveness of their actions increased because of the group approach, and that planned actions were achieved because all group members contributed in a collegial way to the process.

Other action researchers have reported the effectiveness of group collaboration. For example, Gerhardt and colleagues (2007) maintained that without the collaboration of a multidisciplinary group they would not have implemented clinical guidelines at a pædiatric hospital. The challenge of Gerhardt and colleagues' (2007) group had been to implement more effective and efficient patient care and this was achieved through group processes. In the present study the group rose to the challenge of implementing some processes that would likely improve preparation of children and their families for the experience of hospitalisation. It was the groups' common commitment, willingness to work on the issue collaboratively and group cohesion that saw achievement of the main group goals. For example, reinstatement of the MCU booklet potentially led to the provision of more effective and efficient care for children undergoing the MCU procedure.

Professionalising action research as conceptualised by Hart and Bond (1996; 1995), involves improvement in practice undertaken by a group of health care professionals. Because the action group defined the improvement that members strove for, they were able to plan and act on their shared concern as a group. Through working as a group, the health care professionals were able to identify that the hospital context was one of a number of barriers to improvement of hospital preparation practices (Meyer et al., 1999). One of the most noticeable contextual barriers to achieving group objectives was the lack of available time that members had to lead preparation improvements. All group members interpreted lack of time as a contextual barrier, yet this common recognition and experience seemed to enhance group cohesion and consensus in the decision-making process.

8.4.2 Consideration of group cohesion and coming to consensus

By the third action cycle in 2008, the action group had continued to be operating at the group development stage named as performing (Tuckman, 1965) since April 2006. The group had thus been performing as a group for two years by Cycle Three. As Cycle Three progressed, members were acutely aware that the group had reduced in number and as a result had less capacity to implement the actions that were planned in the previous cycle (New South Wales Health Department, 2002). Nevertheless, the remaining action group members were committed to improving preparation for childhood hospitalisation at the hospital and members were pleased with the achievements of Cycle Three, despite their smaller number. The reduction in numbers did not threaten group cohesion and consensus, however, the success of the action group's plans varied since only some of the plans were achieved Members partially achieved two of the aims of the study, *exploring the need for practice change* and *generating knowledge about existing practice*, through analysis of the survey data. The action group ensured the continued distribution of the MCU booklet, thus achieving the study aim of *mobilising collective action for change*. However, because the staff audit was not successful, the action group members were disappointed that the study aims were not fully met.

Mixed success has been encountered by other action researchers, such as O'Shea and colleagues (2010) who set up pre-admission visits for children undergoing day surgery in a hospital in the Republic of Ireland. The group of multidisciplinary health professionals planned to develop a visit that included a tour of the children's ward and the operating theatre as well as an information session, a video and a booklet. All elements of the pre-admission visit were ultimately completed. However, the final video was quite different to the planned video. An outbreak of an infectious disease at the hospital meant that the video had to be filmed in the clinical skills laboratory at the local university's School of Nursing. The sound quality of the recording was very poor and narration replaced the original actor's voices. Although the video was not completely abandoned, the final product bore little resemblance to the original

intention of the group and thus demonstrated the mixed success that is inherent in group work in the real world of health care. An outbreak of an infectious disease changed the plans of the group who set up the pre-admission visits. Similarly, in the present study the hospital staffs' sense of busyness and possibly their perception that they had nothing to contribute to preparation for childhood hospitalisation practices, changed the action group plans to generate knowledge about existing preparation practice via the staff audit.

Group cohesion and consensus are extremely important for group development and for group maintenance (Tuckman, 1965, 1990; Tuckman & Jensen, 1977). The action group felt that members had developed cohesion and that through discussion at meetings the action group had been able to reach consensus on all issues. Members knew that cohesion and consensus had maintained the action group as a group despite the challenges encountered over the life of the action research study. However, members recognised that the reduction in the size of the group meant that the action group was no longer viable as a means of changing practice. Group cohesion enabled consensus regarding termination of the action group, the final stage of Tuckman and Jensen's revised model that they called "adjourning" (Tuckman & Jensen, 1977, p. 426). Reluctantly members made the decision to disband despite their ongoing concern about the practice of preparation for childhood hospitalisation at this hospital.

8.4.3 Relevance of critical social theory in taking collective action to improve hospital preparation

The action group took collective action to improve preparation for childhood hospitalisation in the third action cycle. A concern for preparation at this hospital was the motivation of the remaining members, as it always had been. Members recognised that their motivation and actions were congruent with the objectives of critical social theory to provide holistic health care for vulnerable health groups, such as children and their families (Corbett et al., 2007; Yacopetti, 2000). Individual members of the action group achieved this

realisation at different times throughout the action research study. For some, the collaborative intent of the action group's work was the most important aspect of it at the beginning. Other members developed an appreciation of the effectiveness of group collaboration during the course of the three action cycles. Over time, the group came to appreciate the usefulness of using the principles of critical social theory to understand how to work collaboratively in addressing an issue of concern that was held by individual members and also by the group as a collective of committed health professionals (Lincoln, Lynham, & Guba, 2011).

Many other studies have shown the relevance of framing research on critical social theory principles in order to change health care practice. For example, Dickinson (1999) and Mohammed (2006) used the critical theory framework to improve the health care of adolescents. Examining disparities in the health care of adolescents with diabetes mellitus through critical social theory revealed the oppression that these people endure that is taken for granted (Maggs-Rapport, 2001) by society but not by the health care professionals who work with them. Dickinson (1999) and Mohammed (2006) found, as the action group did, that the structures of society "are not natural and fixed, but ...historically created and alterable" (Mohammed, 2006, p. 68).

Recognition of the inequities that exist in society (Habermas, 1984; Maggs-Rapport, 2001) assisted the action group to collectively influence the health care system that was (potentially) marginalising children and families by not adequately preparing them for the hospital experience. Concern about preparation for hospitalisation was a concern identified by the action group, especially for some hospitalisation events. While wanting to improve preparation the action group simultaneously acknowledged the members' role as analysts and critics of the underlying conditions of the social environment of the hospital (Maggs-Rapport, 2001). Understanding the contextual features of a potentially frightening, or oppressive, experience for children and families was important as a first step in the action group's exploration of the status quo (Crotty, 1998) of preparation for childhood hospitalisation. Having undertaken

this first step, the action group was in a better position to identify changes that could possibly be made to improve hospital preparation practices and plan to take action to implement desirable changes.

8.5 Reflection on the process of changing practice

While presented as the reflective phase of the third action cycle, to provide clarity on the process, reflection on all aspects of the cycle by the action group members occurred continuously throughout. The reflections occurring throughout Cycle Three include the action group reflections and my personal reflections. As reported in Chapter Seven, the second action cycle, the reflective phase allowed the group members time to step back from the activities of the study (Stringer & Genat, 2004) to critically evaluate the plans, actions and observations occurring. These reflections did not inform the processes involved in undertaking a fourth action cycle: rather they informed the members' understanding of the processes of changing practice. The significance of reflections was, as suggested by Habermas' (1984) theory of 'Communicative Action', that the group members gained an appreciation of the value of employing action research, underpinned by critical social theory, in facilitating desired changes in health care practice.

8.5.1 Action group reflection

The first group of reflections discussed were those of the action group members. Although each group member bought different expertise and experience to the action study, and each contributed to the progress of the group activities through their reflections and insights, the group reflections discussed in this chapter refer to the reflections of the group as a whole. The members reflected on three aspects of the process of changing practice that collaboration had taught the group. The first was what working together to develop new understandings meant for members as individuals and as a group. The second aspect that members reflected on related to examining the advantages and disadvantages of group work and taking collective action on a

common issue of concern. Finally, members reflected on the achievements of the group, both in improving preparation for childhood hospitalisation and in changing practice in the health care setting.

8.5.1.1 Working together to develop new understandings

Throughout the third cycle, the action group collaborated in working on the study goals and processes required to achieve these goals using similar processes as in the second cycle. Members met monthly, meetings were audio recorded and I drafted meeting minutes that the action group read and approved as a record of the meeting. The main task during this cycle was to finalise the actions begun in the second action cycle. At meetings members discussed several issues associated with these goals and made plans to carry out the actions proposed. However, as Raelin (1999) identified there are generally two objectives of action research. One objective is to act on an issue of common concern, which follows from reflection on the issue, the factors that give rise to the issue and the potential approaches/strategies that can be applied to address the issue. In the present study the group members' joint issue of concern was the hospital preparation practices for children and families.

The other objective of action research proposed by Raelin (1999) is to develop new understanding of the issue and all the contextual factors that give rise to the issue through the group members' reflection on the issue itself, the impact of this issue on those affected by it and the potential ways of addressing the issue. In the third cycle members reflected about the development of a new or deeper understanding of the issue and its contextual features.

Despite having a common concern with hospital preparation practices each member had a different educational background and workplace experience that they brought to the work of the action group. Additionally, each member had unique personality characteristics that influenced the way that they functioned within the action group and in acting on the decisions taken by the group. As

individuals, each action group member developed a new set of understanding/knowledge about the various dynamics of the group and individual group member perspectives on the issue, its impact for the children, families, themselves and their workplace colleagues, and the potential actions that the group might decide upon to act on the common issue of concern. Essentially, individual group members developed a deeper understanding of the members' unique perspectives, informed by discipline and personality differences. There was a deeper appreciation of the value of having these different characteristics among the group (Hart et al., 2005).

Sharing personal perspectives on the issue and its impact on hospital preparation practices enabled the breakdown of any disciplinary barriers that might have previously been in place among the action group members. Members shared their knowledge and experience of preparation for childhood hospitalisation in an open way and worked collegially to come to group consensus on group decisions. Although members knew each other through professional roles, it was working together in a group that helped members to develop new understanding of the range of professional perspectives, roles and responsibilities for hospital preparation practices. Undoubtedly, the benefits of gaining a new understanding of one another would have influenced their continuing communication and interactions with other group members after the study finished. Both Freire (1972) and Kemmis and McTaggart (1988) emphasise the sustained educative aspects of action methodologies for participants. Action group members learnt about the action research process and about one another, developing an appreciation of varied perspectives on the issue of concern.

During the third cycle of action research the members were more effective in carrying through planned actions, pooling their expertise and allocating tasks according to the individual strengths of members. For example, the group decided to take advantage of the clinical psychologist member's expertise in using SPSS for the survey data entry and analyses procedures and her expertise in teaching the rest of the group about data analysis. This decision is

an example of the way that the action group members had developed a mutual recognition of the environment, social norms and the identities of the individual group members (Habermas, 1984; Kemmis, 2006) through working together in a collaborative and democratic way.

8.5.1.2 What does this mean for group action?

The action group reflected that the development of the members' new or extended understanding of the factors associated with issue of concern, and the contribution that each group member was able to make in acting on the issue, gave endorsement of the group approach to action. As Lewin (Cartwright, 1952) found when conducting community projects in the USA, action research group commitment to improvement enables research results to be fed back to the group. Each progressive phase of the study depends upon effective interaction among group members and this tends to enable a better understanding and/or improvement of the contextual factors that give rise to and perpetuate the issue of concern (Cartwright, 1952).

The new appreciation of the issue of concern and the group members' potential and actual contributions were characterised by action group persistence in the face of a range of challenges to achieving the study goals. Nevertheless, this process was not straightforward or easy, and the members took a lot more time to achieve improvements in preparation practice than originally planned. Although, the number of members of the action group gradually decreased the remaining members were still ready to work together at the beginning of the third action cycle. However, the group identified what it needed to learn to progress their plans for action (Kemmis & McTaggart, 1988) and were generally satisfied with the achievements of the actions taken. The action members also reflected that without the support of new group members, they were unable to continue to progress change in the ways they had decided.

Members of the action group reflected more broadly on how the group's collaboration was able to achieve some of the desired changes in the hospital's

preparation practices. Group members recognised that some fundamental aspects of group work were potentially transferable to other group work in health care practice change (Hart & Bond, 1995). Sharing the concern for preparation for childhood hospitalisation at the hospital prior to formation of the action group was an important preliminary task that united the action group before it met. Taking time to develop group cohesion and consensus was also fundamental to success as a group. Members reflected that the action group had moved through Tuckman's (1965) described stages of group development relatively quickly. Recognition of development as a group with an interest in a common issue of concern probably enabled the existing group members to include new members so readily into the group at different times. By the third action cycle the remaining action group members worked very well together, having previously worked through all the group formation stages, and were able to achieve a clear focus on how to act on planned changes.

8.5.1.3 Achievements

By the end of the third action cycle the group members realised that changing practice is complex and difficult to achieve. Members reflected about the achievements but acknowledged that a number of factors conspired against timely and complete accomplishment of the action research aims. The action group knew it was not the first group to make this discovery as they reflected that many experts have written at length about the challenges of health care practice change. For example Baker and colleagues (2010), Greenhalgh and colleagues (2005) and Cork (2005).. Initially the members had been very optimistic that the action group could make changes because members were taking a collaborative approach driven by a common concern about preparation for childhood hospitalisation. However, the group reflected that simply collaborating to act on a common issue of concern is not sufficient to change established health care practice.

The group reflected on their achievements but it was the successful reinstatement of the MCU booklet that was prominent in their reflections in

Cycle Three. Members had persevered for nearly two years to reinstate this preparation strategy and its reinstatement at the hospital demonstrated the members' extraordinary persistence and patience in achieving this goal; persistence and patience are both common characteristics of action researchers (Deaton, 2012). Overall, members reflected positively on the successful reinstatement of the MCU booklet and continued its distribution.

The group members learnt more about the experience of hospital preparation for children and their families from analysing the survey data (Gordon et al., 2011). The action group were pleased to find that most children and their parents/guardians felt satisfied with their hospitalisation preparation experiences at the hospital. However, the action group were challenged by the apparent dissonance between the children's and parents'/guardians' views about hospitalisation preparation and the action group's concerns about preparation. This reflects the issue for health care professionals in coming to terms with "real and the ideal" health care practices (Crotty, 1998, p. 158). By undertaking research to explore and act on this practice concern, the action group had identified that the problem was not a lack of preparation but a need to educate health care professionals at the hospital about ideal hospital preparation practice.

Analysis of the survey data provided the information that the action group needed to notify the hospital staff of the quality of hospital preparation practices from the perspective of the children and families admitted to the hospital, and to advise the hospital staff through the staff forum that children and parents/guardians perceived that staff were meeting their hospital preparation needs. The action group considered that the presentation of these results raised the hospital staff's consciousness (Henderson, 1995) of the practice and that this provided an important first step towards educating hospital staff of ideal preparation practice. In the same way, group members reflected with satisfaction on the journal publication of the survey findings that would have been accessible to health care professionals from a number of disciplines and others with an interest in the issue. The manuscript had taken quite some time

to write after the action group ceased meeting face-to-face. However, members had persisted and had the pleasure of seeing the article in print and of receiving praise for it from the Director of Nursing and the hospital management committee.

Members reflected on the achievements in changing practice of the whole action research study with mixed feelings. The action group had been successful in achieving one planned change, the reinstatement of the MCU booklet, in achieving one improvement in staff knowledge through publishing the results of survey data, and in gaining one opportunity to learn more about collecting data from hospital staff. However, the action group needed to stop the work together and reflect individually (Reason & Bradbury, 2008) before members could re-group to make any further changes to preparation practice.

8.5.2 Personal reflection

The main success of the third action cycle was finalisation of the activities of the action research through effective group work. The success demonstrated itself in group work to maintain change, group work to improve knowledge about preparation for childhood hospitalisation and group work to disseminate the knowledge gained. The main challenge encountered in the third cycle was maintaining group cohesion to enable outcomes from the research when the group only had six members. Another challenge was dealing with the temptation to continue the work of the action group by collaborating with a colleague from an associated hospital. Lack of time continued to be a challenge as it had been in the second cycle.

8.5.2.1 The activities

The planning and acting phases of the third action cycle describe the five aspects of the cycle that incorporated the five activities that members had decided upon in the early meetings of the second action cycle to meet the aims of the study. The focus of the third cycle was finalisation of activities to ensure

positive outcomes for everyone involved in the action research study. Action group members encountered many challenges to finalisation that had resonated throughout the study.

Maintaining group cohesion in the third cycle was its major challenge. The action group had reached the group development stage of performing that Tuckman (1965) proposed, which implied its cohesion. In the third cycle, the smaller and more cohesive group moved to a higher level of functioning. Efficiency and persistence learnt in the prolonged second cycle enhanced the group's ability to apply that learning to the activities of the third cycle. Meeting the challenge of maintaining group cohesion was through using professionalising action research in which the group of health care professionals had reflected on their learning and enabled practice change to take place (Hart & Bond, 1995).

The focus of the third action cycle was on finalisation of activities, however, members were open to the opportunity to act to improve preparation further, presented by a colleague from an associated hospital. She joined the action group at the third meeting of the cycle and was eager to participate in efforts to improve preparation for childhood hospitalisation practice. She was particularly interested in using the survey findings to facilitate changes at her hospital. Other commitments prevented her from attending three of the last four meetings of the action group.

Her limited meeting attendance indicates the difficulty of balancing the multiple tasks of a health care professional and of being a researcher. Many of the action group members who had left the action group experienced similar conflicts that led to reduced attendance at meetings and possibly to their withdrawal from the action group. Hughes (2008) reports that organisational factors can be facilitators or barriers to action research. Coghlan and Casey (2001) note, when they explore the nature of the challenges which face nurse action researchers, that the "role duality (of action researchers) can create the potential for role ambiguity and conflict" (Coghlan & Casey, 2001, p. 674).

Atwal (2002), a British occupational therapist observes the challenges of organisational factors in her action research study of changing discharge practice. The study describes the unsuccessful implementation of an interprofessional discharge model with fractured neck of femur patients. She notes that the demands of the organisation for clinical work of health care professionals can prevent them from changing practice in their role as researchers.

Another aspect of the colleague from the associated hospital's association with the action group was her suggestion that it may be possible to make a combined application to the Area Health Service for funding (McKinley, 2003; Worrall-Carter & Snell, 2004) of replication of the survey. The action group had applied unsuccessfully for funding at a local level. Members had been disappointed that funding was not available to pay for a dedicated research assistant to collect data for the survey. It was possible that the lost opportunity to collect data efficiently had probably led to some members leaving the action group. Given the challenges that I have already acknowledged for health care professionals to participate in changing practice, it is not surprising that some members felt obliged to leave the group when data collection took so long. It was also not surprising that the remaining action group members rejected the suggestion of applying for Area Health Service funding. The original application had taken a lot of time and effort to submit and had not resulted in efficient collection of survey data.

8.5.2.2 The process

Reflections on group work are fundamental to my reflections on the process of the third action cycle. I observed that it was through working as a collaborative group that members had been able to meet the three aims of the action research study. The process of action research, chosen to enable concerned health care professionals to work together (Hart & Bond, 1995), allowed the group to meet the study aims. Members successfully worked together and I reflected that group work is an effective means to improve health care practice

providing that a number of challenges are considered. Challenges encountered in the present study include challenges to group cohesion, time challenges and challenges related to the level of knowledge of the context.

The action group had developed (Tuckman, 1965) to the point where plans and actions were discussed and decisions made with a minimum of disagreement. Members were cohesive and coming to consensus was much easier than it had been when the action group was newer and larger. The remaining members were what I considered the core members of the action group. They were the ones who had attended most meetings in the second and third cycles. Members seemed to be more committed to improving preparation for childhood hospitalisation practice at this hospital. Reinforcement of the impression of commitment was by persistence in the face of the challenges that the action group encountered and determination to improve preparation despite the challenges. I reflected on the efficiency and persistence to finalise the activities as thoroughly and quickly as possible.

The six remaining members of the action group were very familiar with the process of action research in the third cycle. They were a cohesive group, focussed on achieving the goal of finalising the activities of the action research as effectively as possible. Finalisation involved ensuring continued distribution of the MCU booklet and the two methods of disseminating the results of the survey, the journal article and the staff forum. However, members were challenged to find the time required to put plans into action (Hughes, 2008). The challenge of available time to be both clinician and researcher relates to the context of the research study (Atwal, 2002; Coghlan & Casey, 2001).

8.6 Summary

Chapter Eight described and analysed the third and final cycle of action research called *mobilisation of collective action for change*. The activities of Cycle Three involved the completion and to some extent the achievement of the study's goals. This cycle comprised five aspects that were planned and

actioned at the seven action group meetings between March and October 2008. The willing collaboration of the remaining action group members continued to be pivotal to enabling the achievement of planned actions. The fundamental elements of action research, the four phases of planning, acting, observing, and reflecting, were the basis of the organisation of the five aspects that occurred through the seven meetings held in cycle three.

During the planning phase of the cycle the action group acknowledged that the study would need to be finalised, since some of the key study goals had been achieved and the momentum to continue further change had waned. The action group subsequently developed actions that enabled the finalisation of study activities that would be most advantageous to the hospital and to the group. Optimising the actions that would achieve the most advantage arose from the group's observation in the second action cycle that survey results revealed that preparation for childhood hospitalisation was not as concerning for children and their families as the group members had originally thought. Rather, it was the need for hospitals staff's education about preparation for childhood hospitalisation that was considered to be of prime importance in improving its practice.

For this reason, the action group planned to provide information about their activities as a first step towards improving education to the health care professionals working at the hospital. The action group felt that improved education would result in improved practice of preparation for childhood hospitalisation in other health settings as well. Members disseminated the results of their work together in a number of ways. Actions developed included reporting the findings of the survey to hospital staff at the forum and submitting a paper to a journal that targeted multidisciplinary, children's health care professionals (Appendix Q).

The other planned actions occurring in the third action cycle included the continued distribution of the MCU booklet, closing the relationship with the study's steering committee and terminating the direct face-to-face work of the

action group. These actions occurred smoothly and as planned by the group. Although the action group officially ceased to exist in December 2008, the six remaining members continued to communicate by email until the manuscript based on the findings of the analysis of the survey, was accepted for publication in August 2010.

Throughout the remainder of the third cycle the action group members continued to observe and reflect on the journal publication and the study report to the steering committee. Observation of the plans and actions indicated that the group was cohesive and were able to change practice. Change was particularly notable when the MCU booklet was reinstated and continued to be used to prepare children and their families for an invasive and potentially painful procedure. However, observation of the other activities of the cycle showed the achievements of the cohesive group.

The action group observed that they had had a role as analysts and critics of the underlying conditions of the social context of the hospital (Maggs-Rapport, 2001). They had encountered various challenges to changing practice that were taken for granted in the existing culture and structure of the hospital. Members had reflected on how they might use critical social theory as a framework for addressing their concern about preparation for childhood hospitalisation. The action group found that this was a useful framework to understand how health care practices can become established and go unchallenged once accepted within the culture of the workplace. The critical social theory framework also helped the group members to identify how they might set about to challenge the status quo regarding hospital preparation practices, by first investigating what children and their families thought about these practices and then giving health care professionals the opportunity to identify what they perceived was happening and ought to be happening regarding these practices.

Finally, reflection about the third cycle focussed on the process of changing practice. Reflections did not inform another cycle of action research but

informed the learning of the action group members. The action group reflected that their opportunity to change hospital preparation practice was possible through collegial and collaborative action research underpinned by a well-tested theoretical framework. The learning that resulted from this reflection indicated that the action group had developed many new understandings about group work and how group action could be used to improve an area of health care practice that was a concern for members. My reflections about the activities of the third cycle and the action research process were that the process enabled these activities to be realised.

The achievements of the third and final action cycle confirmed that collaborative group action can facilitate improvements in health care practice in a supportive workplace environment. Although aspects of the workplace environment and the context in which the study occurred impacted on the action group's ability to facilitate all the practice improvements that they intended, some important changes were able to occur in hospital preparation practice. The next chapter outlines my discussion of the action research study as a whole. The processes involved in conducting the study are analysed and recommendations for further research in the area are suggested.

Chapter Nine - Discussion

9.1 Introduction to discussion of the findings and implications of this study

This final chapter reflects on and discusses the way that the action research process set out to achieve the aim of improving hospital preparation practices for children and their families, and considers the enablers and barriers to achieving this aim. Reflection on the actions and outcomes of the study are examined in light of the existing literature and critical social theory which provided the guiding framework for the study. This framework was fundamental in facilitating the change process, because it offered the action group members an opportunity to apply the critical paradigm to a real world situation that was of concern to them individually as health care professionals and collectively as a health care team. Critical social theory provided a framework for challenging the accepted values and assumptions about children's hospital preparation requirements and experiences, gave the group members a process for investigating these practices within their workplace, and helped to uncover and address some practices that resulted in injustice and inequity for some groups of children and their families. In achieving the study aim three study projects occurred simultaneously over three years, during which time group membership changed. However, it was the collective force of the action group working within the critical social theory paradigm which realised desired changes in hospital preparation practices for children and their families.

Applying critical social theory as a model of change helped the action group to understand how to negotiate the bureaucratic structures that can inhibit but also enable change in a hospital setting. The action group learnt to interpret the project findings in light of the factors associated with gender and class imbalances, power inequities and domination of hegemonic social groups when seeking to reform health care practices. Consequently, the action group's success in shaping aspects of hospital preparation practices for children and their families laid the foundation for a reconceptualisation of the hospital workplace culture and established work practices. The implications of this

process of change include the use of group work as an effective means of achieving a proactive approach to hospital preparation for children and their families, and the application of multidisciplinary perspectives to identify and act on areas requiring practice improvement. A further implication of the process of reconceptualising workplace culture was the potential to identify and address relative power imbalances in health care service operations and thus, the opportunity to uncover unseen or unknown barriers to staff collaboration in leading practice change.

Reform of accepted hospital preparation practices involved challenging the hospital's status quo in respect of the fundamental organisational structures that enabled these practices to continue without review for some years. Once the action group gained insight into the tenets of critical social theory, members recognised that the main construct shaping hospital preparation practices was the 'power' exerted by hegemonic groups among hospital staff, both administrative and clinical. Delving further into the relative positions of power that enabled these particular groups to exert undue pressure to retain the status quo, it became apparent that power was associated with gender, expert knowledge, class, and social domination. The effect of these dominating forces was the establishment and maintenance of injustice and inequity for some individuals and groups, mainly the children being admitted to the hospital and their families.

In considering the established culture of the hospital, which has traditionally been shaped by the medical profession and the 'organ system' model, and more recently by government regulations and administrative forces that seek above all else organisational efficiencies, the action group were more able to harness this knowledge as a collective to bring about change. Gaining an appreciation of critical social theory also helped the members to critically evaluate the hospital's purported mission to be "kid friendly", and to recognise that this occurred only when children and their families conformed to the way in which health care services were provided. It was the guiding framework of

critical social theory which enabled the group members to embrace the action research process in spearheading practice change.

9.2 Study findings

Action methods that derive from the critical social theory paradigm address both the theoretical and practical issues of change in complex situations because the change originates from local concerns and is implemented by the people themselves. People engage in critical social theory processes to challenge existing power relationships and accepted cultural circumstances and to address them by changing them. Critical social theory processes are enlightenment, empowerment and emancipation. In this study enlightenment resulted from the pooling of knowledge and expertise by a group of people so that all members of the group benefited from increased knowledge about preparation for childhood hospitalisation practice at this hospital. Empowerment came from the increased knowledge combined with the collective force of the action group to enable practice change. Finally, the processes of enlightenment and empowerment, and the appetite for collaborative engagement experienced within the group, may have formed a foundation for the ongoing emancipation of individual members. That is, harnessing and sharing knowledge about practice change techniques, as well as quality hospital preparation practices, not only empowered the members of the action group, these knowledge sets provided the catalyst for taking collective action to improve preparation for childhood hospitalisation practice.

As the study proceeded, the action group came to fully appreciate the value of engaging in a collaborative approach given the complex health care setting and the many different hospital preparation needs of different children and their families. The group's experiences confirmed the relevance of reviewing the organisational change literature, which highlighted both the challenges encountered in achieving practice change in a bureaucratic health care system and the ways in which research work situated within the critical social theory paradigm is more likely to bring about sustainable change (Cartwright, 1952;

Crotty, 1998; Dufault et al., 1995; Friere, 1972; Warfield & Manley, 1990). The processes of enlightenment, empowerment and emancipation aligned with drawing on the critical social theory concepts of power and culture, and this resulted in sustained change within the hospital rather than the transient change that may have resulted from working within other research paradigms.

9.2.1 Summary of key study findings

The key findings from this study include both what the action group set out to do and what happened serendipitously through the critical social theory processes of enlightenment, empowerment and emancipation. Key findings and other findings were both positive and negative and some can be explained by critical social theory. The key findings were:

- the usefulness of collaborative group work as a means of engaging health care professionals in improving health care practice

A hallmark of critical social theory is that change to unacceptable situations results from collaboration by groups of people who are affected by the situation. In this study the action group that formed to address preparation for childhood hospitalisation practice engaged with one another in a group to be far more effective than they had been as individuals in addressing the practice. The members of the action group became engaged with one another because they shared a goal of improving preparation practice and therefore were able show that their collective action was much greater than the sum of the actions of individual members. The action group found that this collaborative approach enhanced learning around group processes (Kemmis, 2008), and that the collective knowledge, planning and action of their collaboration were all aspects of critical social theory.

- the benefit of multidisciplinary perspectives on practice issues

Knowledge was generated through the multidisciplinary nature of the action group that was able to contribute a number of disciplinary perspectives to the issue of preparation for childhood hospitalisation practice. The various

members of the action group became enlightened when they saw the issue from the perspective of different health care professionals. Critical social theory acknowledges the power of various perspectives because they uncover previously unknown truths about unacceptable practices and enable them to be challenged.

- the impact of relative power in health care contexts

Power is a fundamental construct of critical social theory and it emerged in this study as the action group interacted with the hospital organisation. Members of the action group were aware of the power within the hospital setting that was made manifest through the hierarchical structure and supported by hegemony, gender, class and social domination. The resulting workplace climate was one of compliance with policies and practices established by powerful groups within the hospital hierarchy, and which resulted in injustice and inequity for different groups of children and their families.

The action group accepted the powerful position of the hospital's hierarchical structure and agreed to negotiate with executive staff in positions of power to achieve the study goals. In this way the group harnessed the power of the hospital organisation to enable the achievement of its goals, rather than working against the organisational bureaucracy. Gaining the support of the Director of Nursing for the study was a key plank in the group's platform for action, since her position of power was recognised and accepted, and staff at all levels in the organisation were responsive to her requests to support the study. Therefore, the action group not only acknowledged that the critical social theory construct of organisational power as being a major influence on established hospital preparation practices, they also accessed the position power of the Director of Nursing and the management executive committee to promote and lead the change in these practices.

- the place of responsive and flexible facilitation in research

Fundamental to critical social theory are collective processes that enable groups of people to work together to challenge and address a situation. Part of

the collective processes in this study was the group facilitation processes that were adjusted as conditions and group needs changed. Modified facilitation approaches occurred as the study requirements changed, but this process never lost sight of the main aim of assisting the group to focus on strategies to consider and enable better preparation for childhood hospitalisation practice. Facilitation of the group processes supported the continuation of the research despite challenges to making improvements to preparation for childhood hospitalisation practice. Responsive and flexible facilitation justified the use of critical social theory as the underpinning theoretical framework of the study.

- the importance of health care research that is valued by the organisation and by the staff of the organisation

The pivotal point of collective action in this study originated as an issue of mutual concern to health care professionals regarding preparation for childhood hospitalisation. Health care professionals, as members of the organisation, valued the issue as deserving of research. The research approach took advantage of the collective concern, and challenged the power and culture of the values and assumptions of the organisation to engage in social action to improve preparation practices. It was important that the research was generated from within the organisation because it enabled challenges to be addressed that were ultimately valuable to the organisation and its most vulnerable consumers, the children. Challenging the organisational preparation practices in an approved and collective way began the process required to realign power inequities among the multidisciplinary health care teams working across the hospital. This process of challenge to hegemonic power influences is a hallmark of the critical social theoretical approach to address social issues.

9.3 Link between study aims and findings

The study aimed to:

1. explore the need for changes to local practices for preparing children for the experience of hospitalisation
2. generate knowledge about existing practice
3. mobilise collective action for desired change

Action research methods proved effective in empowering the health care professionals to identify the need for practice change and to work collaboratively to implement actions that best suit the context and the situation to address issues requiring change (Hughes, 2008; Kemmis, 2009; Reason & Bradbury, 2008). In an action research study the process of reflecting on the issues of concern, making plans and acting on them and then evaluating the outcomes of the actions taken and the effectiveness of the process employed to enable planned change, are all essential components in evaluating the study findings.

The form of action research used in specific studies can vary, however, the four key elements of action research as outlined in Chapter Four were successfully mobilised in this study. The first key element was the purpose of the study, which was social change within the hospital through involvement and improvement in hospital preparation practices (Raelin, 1999). The next element was the nature of the hospital staff's participation in the study. In this study the action group members collaborated to identify and address an issue that they were concerned about but that also affected them in their workplace and the patients and families for whom they cared. Action research processes of continuous cycles of planning, action, evaluation (observation) and reflection occurred throughout the study and are the third key element of an action research study. The outcomes of action research are the final key element and in this study the outcomes involved a change and improvements in hospital preparation knowledge and practices. This whole process enabled a reduction in the theory/practice gap of hospital preparation practices for children and

families. All four key elements linked to the processes of critical social theory: enlightenment, empowerment and emancipation. The following discussion provides a comprehensive evaluation of critical social theory processes against the study aims and in light of the extant literature on practice change.

Initially, the action group decided to explore local practices to determine whether there was a need for practice change. The action group decided that exploring the need for changes required the generation of knowledge about existing practice. The survey and the audit achieved this and informed the group about the current situation at the hospital, because the survey outlined the experience of preparation from the recipients' point of view and the audit described preparation from the providers' point of view. This meant that the first two aims of the study were met which enabled the action group to address the third aim of mobilising collective action for desired change. Serendipitously, exploring needed change and generating knowledge provided the opportunity to reinstate an MCU booklet to better inform children and their families about the MCU procedure. The group decision to reinstate the MCU booklet meant that all three study aims were achieved. However, as the group reflected, none of these achievements were straightforward or easy to accomplish.

9.3.1 Findings that were not anticipated or different to those expected

To the surprise of the action group, the data from the survey showed that children and their parents/guardians were satisfied with the process of hospital preparation. This is similar to the unexpected findings in Beringer's, Hagan's and Goodman's study (2009) where waiting times for pædiatric orthopædic surgery were not as long as the researchers had anticipated and believed. Similarly, in this study the survey findings revealed that both children and their families were satisfied with the preparation they had received and did not identify a need for change. The action group reflected on the findings and decided to report the survey findings and comment on issues of preparation to the steering committee. As well, the group decided to proceed with other agreed activities related to the audit and the reinstatement of the MCU booklet.

The decision to continue with planned change also occurred in the Beringer, Hagan and Goodman (2009) study.

Reinstatement of the MCU booklet was an important decision and achievement for the action group, for children and their families undergoing MCU procedures and for the clinicians caring for them. While the action group members expressed concern for children who underwent the MCU diagnostic radiological procedure, they did not originally plan to act on that concern. However, the process of sharing these concerns as Kemmis and McTaggart recommended (1988), led the action group to identify that the MCU was a common concern for all members and thus, an issue that was worthy of group action.

An event that influenced the reinstatement of the MCU booklet was the inadvertent discovery that the Medical Imaging Department staff did not know about the action research study. This shared service was not included in the hospital staff email list and the department was located in the adjacent adult hospital where the study flyers had not been posted. The action group reflected that a call for expressions of interest should have been made to all staff at all hospitals co-located on the hospital campus to ensure that all parties were aware of the study and had the opportunity to find out more about it and/or join it. By reconsidering the opportunity presented through the interest and support of the Medical Imaging Department, the action group was able to further recognise the powerful influence of some of the hospital's health professionals in achieving their aims to improve children's hospital preparation experiences.

9.4 Study findings compared with and contrasted to research of others in the area of preparation for childhood hospitalisation

The extensive literature review undertaken throughout the study failed to locate any study that used critical social theory principles to bring about change in preparation for childhood hospitalisation practice. Nevertheless, the use of critical social theory principles through action research methods in this study, and other studies located in the pædiatric and adult hospital settings, indicates

that it is an effective approach to changing health care practice (Beringer & Fletcher, 2011; Hughes, 2008; Stringer & Genat, 2004).

The major reason that the study was conducted was the desire to find out more about preparation for childhood hospitalisation practice at the hospital and the potential need for change to this practice. One of the main rationales for choosing to engage in action research methodology was that it can help action group members explore and address a collective issue of concern. This was the case in Beringer and Fletcher (2011) programme that aimed to improve care coordination at a children's hospital in the UK. The staff of seven wards met with varying degrees of success in addressing their different care coordination issues through an action research process (Beringer et al., 2009; Beringer & Julier, 2009; Fletcher & Beringer, 2009; Higby & Pye, 2009).

Although, the staff of all seven wards were given the same opportunity to select the issues that they wanted to improve, a number of non-staff factors influenced variation in engagement in the process of change and achievement of planned outcomes (Beringer & Fletcher, 2011). Factors impacting on project success included having proactive leadership, stable management and a trusting relationship with the action group facilitator (2011). Other healthcare researchers have identified these three factors in the context in which action research is undertaken (Hughes, 2008; McCormack et al., 2002; Rycroft-Malone, 2004b).

The context of this action research study was a busy children's hospital and the three factors identified by Beringer and Fletcher (2011) applied to the hospital wide context as much as they applied to individual children's wards. It became clear that the proactive leadership of the Director of Nursing was a crucial strength of the present study since her support for the study and her active involvement in the plans and actions were pivotal to the conduct of the study. In an ethnographic research study which examined nursing leadership, Antrobus (1999) observed that both health policy and nursing practice can be influenced and shaped by nurse leaders. The findings of Antrobus (1999) suggest that the

support of the Director of Nursing, a major influence of power within the health care setting, was key to the realisation of the outcomes of the study.

The second influential factor in the context identified by Beringer and Fletcher (2011) to support action research was stable management and throughout the study period the management of the hospital remained stable with no personnel changes in any of the key management positions. Therefore, in this action research study the ability of the action group to continue to pursue change though action methods included the two contextual factors of proactive leadership and stable management.

The third contextual factor that Beringer and Fletcher (2011) identify as influential in successful engagement and achievement of outcomes in action research studies is a trusting relationship between the action group and the group's facilitator. There are many ways to interpret facilitation of an action group (Heron, 1999); however, when the present study was set up, I very clearly articulated to the action group that my facilitation role would be supportive and not directive. I worked consistently to encourage the group to accept and be comfortable with this facilitation style, particularly when the action group was initially forming. Mackewn (2008) describes facilitation as action research in the moment by being responsive to the needs of the group as it progresses towards achieving its aims. As group facilitator, I initiated various activities through group consensus (Harvey et al., 2002) from recording the meetings of the action group to conducting some data collection for the survey, while at the same time adapting my facilitation style to suit what was needed at the time.

Action group facilitation can vary from being an insider to the issue to being an outsider who works with the group to assist in addressing common issues of concern, often by the group's invitation. The facilitator's insider or outsider status can change the nature of the action group's collaboration. In Beringer and Fletcher's (2011) suite of action research projects, Beringer was a researcher from a local university and was the facilitator involved in the day-to-

day running of the research projects, while Fletcher acted as an academic mentor to Beringer. In the present study I was both an insider and an outsider (Coghlan & Casey, 2001; Titchen & Binnie, 1993) having previously worked at the hospital and currently undertaking doctoral studies on the issue of concern. I, therefore, focussed on providing the kind of facilitation that was likely to support group ownership and commitment to improvement of preparation practice. This facilitation style contributed to the group's development as action researchers and helped the group to achieve the study aims.

9.5 Consideration of possible reasons for the study findings and exceptions, in relation to the findings of other studies

It is important to bring a critical eye to research processes and outcomes when discussing findings. Recommendations for future work can be made based not only on the findings of this study but of the body of literature that has informed it. In the present study, a timeframe was planned to achieve the study aims and realise planned outcomes. Time delays associated with group members' busy professional roles led to challenges around keeping the group focussed on their original concerns and on acting to improve practice and thereby address their concerns (Hughes, 2008). Five action group members were no longer able to sustain their commitment to group action after many months of engagement, so were forced to rescind membership of the action group during the second action cycle. There are challenges in maintaining group membership and cohesion in research studies in the context of work-related responsibilities within a health care organisation. Group cohesion is fundamental to group effectiveness and challenges to it can disturb group integrity (Tuckman, 1965) and therefore reduce group achievement as Lewin suggests (Cartwright, 1952). However, in this study it was not the interactions between the group members that had an impact on the ability of the action group to facilitate all the changes to practice that they set out to achieve (Rycroft-Malone, 2004b). Rather, it was the professional responsibilities of their roles that played the major part in some members' decisions to hand over the membership to colleagues.

9.5.1 Context/ Culture

It is not surprising that the health care professionals forming the action group interacted with the hospital culture in their pursuit of practice change. Munn-Giddings and colleagues (2008) identified that the setting for analysis of the action research processes in health care is likely to be hospitals. The tension between the action research methodology and the hospital context, including the hospital culture, is reported in other action research studies (Hughes, 2008; McCormack et al., 2002; Rycroft-Malone et al., 2004; Stringer & Genat, 2004). Meyer and colleagues (1999) reviewed 131 action research studies in health care and found that the context was more influential in achieving change than was the topic under study. Various action researchers have addressed the context of studies in various ways. Either directly or indirectly, the context is acknowledged and incorporated into the research to enable action researchers to work within it. For example, in the action research studies coordinated by Fletcher and Beringer (2009) into pædiatric care coordination at one children's hospital, the context of each of the seven wards was influential in the degree of change achieved (Beringer & Fletcher, 2011). The context of the hospital in this study was composed of a variety of hospital departments, the steering committee and the hospital staff. Discussion of each of these hospital contextual/ cultural elements in relation to the interactions of the action group with them provided a contextual setting for the study.

9.5.2 Hospital departments

The culture of the hospital challenged the action group to consider and try various alternatives to enable realisation of the study aims. This process has been reported by McCormack and colleagues (2002). The interaction of the action group with the hospital culture meant that more time was required to achieve outcomes than the group members had anticipated, and some elements of the planned changes were not able to be achieved. For example, analysis of survey data occurred two years after initiation of the survey rather than the one year as the action group had predicted. Reinstatement of the

MCU booklet took twenty months to complete, despite it being a straightforward process. Although, the action group learnt a great deal about data collection from involvement in the audit of hospital staff, the action group were unable to collect useful data to inform actions.

The action group collaborated to discuss and debate issues on which they ultimately took decisions. Critical social theory operationalised by action research guided the ways in which action group members worked with each other. The action group extended these ways of working into working with the culture of the hospital including the group's interactions with various hospital departments, the steering committee and the hospital staff. A tension existed for the action group members in realising that the somewhat unfamiliar action research methodology needed to employ group collaboration in decision-making, was at odds with the top down approach usually taken at the hospital to achieve planned outcomes.

Waterman (1995) compared and contrasted the collaborative approach used in action research and the top down or traditional approach to research that tend to involve the collection of quantitative data and mathematical manipulation of variables. She concluded that there were similarities and differences but that the main difference was that action research was cyclical, iterative and dynamic, whereas in traditional research there is one complete movement from theory to observations of practice, and to research findings that further develop theory. In a review of action research studies, Waterman and colleagues (2001) found that the cyclical processes related to change and the collaboration among members in creating that change, were among the primary reasons why action research was the methodology chosen by health care researchers. In this study, the action group discussed the use of the collaborative approach when interacting with the culture of the hospital and decided to employ this technique because members were comfortable with collaboration as one way to achieve positive outcomes. However, the collaborative approach agreed by the group members complicated the group's interactions with the culture of the

hospital because of the unfamiliarity of the research approach to the hospital context.

Nevertheless, it was this member collaboration that facilitated members' development and enabled the action group to make the changes that they desired. Marois (2006) explored the concept of collaboration in community health partnerships between community members and health care organisations. She concluded that effectiveness is only achieved when both parties learn to share power. The implication of her finding for this action group study is that a revision of relative power (Angrosino & Rosenberg, 2011) was required to enable effective interaction between the action group and hospital departments, the steering committee and the hospital staff. Action researchers need to learn how to rise above the oppression of being dominated by accepted power relationships and find ways of working with people in positions of power, in order to receive acceptance by co-workers and the approval of influential persons within the context of the organisational hierarchy.

In order to achieve tacit support from senior hospital personnel, the action group interacted with the staff who worked in departments that included the Area Health Service Human Research Ethics Committee, the Information Technology Department, the Graphics Department, the Medical Imaging Department, the Quality Improvement Department and the funding committee. Each department head showed their openness to the action group's requests and were helpful in responding to them. However, delays in responses equated to delays in the plans and actions of the action group. Decision making related to the action group's activities involved a range of departments and that contributed to delays in achieving outcomes for the study projects. One positive aspect of the action group methodology was that often various action group members knew which department personnel to approach for assistance. However, the necessity of interacting with hospital department staff, and therefore working within the established framework of the hospital culture, caused delays in the realisation of the plans and actions planned.

Two reports of action research studies about pædiatric care coordination demonstrate the importance of working with other departments of the hospital to enable practice change. Beringer and Julier (2009) interacted with the X-ray department and Beringer, Hagan and Goodman (2009) interacted with the admission department, the surgical department and six inpatient pædiatric units. The interactions resulted in improved care coordination practice at the hospital; however, both studies took time and commitment to the action research process by the action researchers. Coghlan and Casey (2001) observed that change in health care involving other departments can be challenging and time consuming. Perhaps, the complexity of the problems associated with preparation for childhood hospitalisation practice that required interactions with staff of several hospital departments resulted in the study taking longer to produce outcomes than was originally anticipated.

9.5.3 Steering committee

The action group submitted five written reports to the steering committee over two years through the mediation of the Director of Nursing. After each report, the group received verbal, positive feedback about the action group's research from the steering committee. However, the action research steering committee, which was the hospital management committee, only contributed to the work of the action group on one occasion. This was when the steering committee encouraged staff in their departments to complete the audit of preparation for childhood hospitalisation strategies at the suggestion of the Director of Nursing who was aware of the difficulty the action group were having in collecting data from the audit.

In Suderman and colleagues (2000) action research study to improve pædiatric discharge preparation, the steering committee played a pivotal role in organising the research. Bedside nurses interacted with the steering committee and both groups were action researchers, identifying the problem and collecting data to inform the next cycle of action research. In the present study the steering committee, who were the management committee, received reports of

the activities of the action group and gave verbal feedback. In comparison with Suderman and colleagues' (2000) study, the steering committee of this study played a limited role in advancing the activities of the group.

The hospital senior managers readily agreed to become the steering committee for the action research group working party, and were responsive to communication from the action group in the form of receiving and commenting on the action group reports. An aspect of the hospital culture was the gate keeping role of the steering committee. The action group took a passive role in relation to accessing the services of the steering committee members, who were somewhat unclear about assistance required of them to negotiate the study plans with hospital departments. Neither the action group nor the steering committee were proactive in communicating with one another about assistance with acting on planned study goals, and it is unclear why this occurred.

Senior managers of the hospital may have been perceived by the action group to be very powerful within the context of the hospital and therefore action group members may have been reluctant to enlist assistance from the steering committee in achieving the outcomes of the study. However, Coghlan and Casey (2001) observe that managing organisational politics is part of the role of action researchers in health care, suggesting that skills of negotiating with key personnel is fundamental to successful actions. Given that the brief of a steering committee was to advise as requested and oversee the activities the working party but not take actions, it may be that the steering committee conformed to its expected role and did not exceed it. A future review of the potential interaction between a steering committee and a working party that uses the action research methodology may improve this less useful aspect of the present study.

The action group did not identify the potential role of the steering committee in achieving the study outcomes, seeing the senior managers as gatekeepers rather than colleagues. Only through my reflection on the whole study am I able to perceive that the action group could have shifted their power relationship with

the steering committee, mobilised action with regard to changing this imbalance, and then been able to engage in a more active and supportive relationship with them. I think that this is evidence that empowerment of the action group was limited, although the action group were willing to engage with the person who had immense organisational power, the Director of Nursing, to pursue their goals. Members were certainly empowered by working on behalf of children and their families but their empowerment did not extend to addressing the power dynamic that existed between the action group and the steering committee.

9.5.4 Hospital staff

The reluctance of hospital staff to participate in data collection for the audit of preparation strategies was a less useful aspect of the interaction of the collaborative action group within the hospital culture. Staff busyness, the inability to consider that their opinion would lead to a change in practice and the low priority of research relative to patient care have been postulated as reasons that health care professionals do not participate in research (McCormack et al., 2002; Parahoo, 2000; Stubbs & Achat, 2011) and may be why the hospital staff did not complete the audit. A minimal number of hospital staff responded to the audit of preparation strategies, however such a finding is not unheard of in health care (Stubbs & Achat, 2011).

Dickinson and colleagues (2009) reported on the collaborative implementation of an oral health best practice guideline and educational sessions for nurses in a New Zealand pædiatric hospital. Pre and post-surveys mailed out to nurses working at the hospital received a 21% and 26% response rate respectively. The research team were disappointed with the low response rate. Although they contended that the sample was representative of nurses at the hospital in relation to the area they worked in and their level of nursing education (A. Dickinson et al., 2009). The survey results showed no significant change in practice following implementation of the best practice guideline (A. Dickinson et al., 2009). The finding appears to indicate inadequacy of the staff response to

the survey rather than inadequacy of the guideline implementation. Dickinson and colleagues (2009), concluded that practice change must be supported at all levels of the organisation, both at hospital management level and at unit level.

In this study, lack of encouragement for completion of the audit at unit level by unit managers may have contributed to the poor response to the audit. In a paper first published in 1982 and republished in 2004, Kanter (2004) extolled the virtue of informing managers about proposed activities because she contended that managers are pivotal to the implementation of change.

Broad issues around the culture of the context of the hospital appear to explain the issues associated with interactions with hospital departments, the steering committee, and hospital staff. Initial failure to negotiate with the existing culture of the hospital setting partially explains why the study took longer than anticipated, possibly leading to the loss of some action group members. Identification of workplace culture issues was not addressed at the beginning of the study; although, those that were identified during the course of the study were incorporated into the changes of plans and actions of the action research group, which was a strength of the action research methodology (Reason & Bradbury, 2008). However, the effect of not addressing power relationships within and between the action group and the hospital context limited the achievement of study aims.

9.6 Link of study findings with critical social theory framework concepts

Using critical social theory processes enlightens, empowers and emancipates people to change situations through taking action for change; therefore, the link between critical social theory and change is relevant when discussing practice change. The study sought collaboration of a group of health care professionals in a way that helped them to challenge their own thinking and the practice of preparation for childhood hospitalisation at the hospital. The action group challenged the practice by attempting to improve it through exploration, knowledge generation and mobilisation of action for change. The challenges

that the action group faced relate to critical social theory that encourages practitioners to explore situations openly, think about practices differently and use the new perspectives gained in this way to do something to improve the practices (Crotty, 1998).

Technical, practical and emancipatory interests (Habermas, 1984; Kemmis, 2001, 2006) comprised the work of the action group, because the knowledge generated by their work led to enlightenment within the hospital. Members used the knowledge gained to exert technical control over changing the practice of preparation for childhood hospitalisation. The knowledge generated by the survey delivered a practical understanding of the experience of preparation for hospitalisation of children and their families. The action group began the process of using the knowledge generated to empower them to consider the role of power within the professional, practice and structural realities of the hospital environment.

The reinstatement of the MCU booklet was evidence of the group's emerging empowerment and emancipation. Members worked together despite many challenges to reinstate the booklet so that one group of children and their families had the potential to be prepared for hospitalisation. Action group members were able to stand outside their prescribed roles and observe the situation that had concerned them and it was then that they started to make sustainable changes. Together the action group explored the environment in which preparation practice took place and used action research processes of observation and reflection to consider the possibility of practice change (Habermas, 1984; Kemmis, 2001).

Critical social theory, which was operationalised by action research, enabled the action group to review, evaluate and make recommendations on best-practice preparation for childhood hospitalisation practice. Both Lewin (Cartwright, 1952) and Freire (1972) employed action research to apply critical social theory principles to situations in order to improve them. The basic principle is that generating knowledge about a situation can lead to an improvement in the

situation. This occurred through the knowledge generated by the children and their parent/guardian surveys, in which their experience of preparation for hospitalisation led the action group to inform the hospital community and health care professionals about these experiences. This knowledge also helped the action group to address preparation for the MCU.

An aspect of critical social theory is the mutual recognition of individuals' perceptions of the environment (Habermas, 1984). The group activities leading up to the reinstatement of the MCU booklet was an example of this critical social theory principle. When the action group came together one of the issues that members discussed was concern for children undergoing the MCU procedure. The mutual expression of this concern ultimately led to a change in practice that was observed by the hospital community. Certainly, serendipity and persistence played their parts but the opportunity afforded by communicative action that arose from the knowledge generation from group work and the shared concern was extremely influential in the reinstatement of the preparation strategy.

The audit of hospital staff did not generate knowledge about preparation strategies but it did provide an opportunity for members of the action group to enhance their knowledge and skills about data collection thus leading to their enlightenment, empowerment and emancipation. The intention of the action group was to inform practice improvement and the project to audit hospital staff was successful because it increased the action group's knowledge about the context of the hospital into which members intended to bring practice change. The action group tried several techniques to obtain responses to the audit making revisions when plans and actions did not result in data collection.

Members acknowledged the status quo (Crotty, 1998) of the hospital organisation that made plain to the group the challenges of practice change in the health care environment. Members learnt from conducting the audit that there was a range of reasons that hospital staff might not be able to respond to the audit, including busyness, not believing that their opinion could enable

practice change and giving research a low priority (McCormack, Manley, & Wilson, 2004; Parahoo, 2000; Stubbs & Achat, 2011). Consideration that changing practice involved challenging the existing political, economic and social structures in which the action group worked resulted from action research underpinned by critical social theory.

Reflections on the main study outcomes indicate that framing the study through critical social theory helped to achieve positive outcomes for the action group in terms of their enlightenment, empowerment and emancipation. The action group did not necessarily achieve all that members hoped from the study but the process of working together ensured that the individual members gained knowledge that led to personal and action group development.

9.7 Link of study findings with the literature that has used critical approaches to set about making change that the group/ community considers is needed

In this study, both the multidisciplinary group membership and the processes employed in coming to consensus on key decisions and actions through continuing cycles of planning, acting, observing and reflecting, used similar processes to the action research study conducted by Moody and colleagues (2001) in which allied health colleagues collaborated to develop a clinical pathway for women requiring Caesarean section. The clinical pathway action group comprised a multidisciplinary team who used iterative review processes during the reflective phase of clinical pathway development to simplify the processes and expectations at each stage. Like Moody and colleagues' (2001) study other action researchers have found the planning, acting, observing and reflecting phases helpful in guiding the continuous cycles of practice change (Dick, 2005; Moody et al., 2001; Stringer & Genat, 2004).

Three successful action research studies in aged care used the same four action research phases to improve practices in aged care. The first took place in a USA senior citizen community centre, while the other two were in Australian aged care facilities. By using the four phases of action research Gallagher and

colleagues (2009) in the USA, were able to identify a lack of understanding in the general community about the support needs of older members of the community. In Australia, Robinson and Street (2004) described their use of the phases of action research in one action cycle in a study that comprised six action cycles. The phases enabled modification of plans to improve networks between aged care nurses and the aged care assessment team. Also in Australia, Lindeman and colleagues (2003) undertook an action research project that involved improving practice in five residential aged care facilities with a focus on the processes used in one facility. Observation and reflection on plans and actions led to development and modification of the plans and actions to enable improved nutritional standards for the elderly residents of the facility.

In this study the planning involved in the first action research cycle meant that the busy health care professionals who volunteered to join the action group were not involved in the organisational tasks required to initiate the study. This was seen as an advantage for me as the outsider action group member because it allowed me the time to familiarise myself with the current situation and the hospital setting while undertaking the organisational tasks. A number of action researchers have found it advantageous to organise the research prior to the direct involvement of the action group. For example, in the suite of projects undertaken by Beringer and Fletcher (2011) the facilitators' agreed role was to help set up the projects in light of the clinicians' identified concerns and then the clinicians formed an action group which then took ownership of the agreed projects.

The same processes occurred in this study, whereby I volunteered to commence the groundwork, such as holding meetings with the Director of Nursing, in preparation for the second action research cycle. Having helped to establish executive permission and advice on how to proceed with the study in the first cycle meant that action group members were able to begin their work together immediately in cycle two. Since the other members of the action group were very familiar with the hospital setting and the preparation practices

occurring in their discrete areas of work, this preparatory work helped the group to mobilise their energies for the decisions and activities that occurred in cycle two. In a similar vein Beringer and Fletcher (2011) prepared their suite of action research studies prior to the full involvement of clinicians on the seven selected wards (Beringer, Fletcher, & Taket, 2006; Beringer et al., 2009; Beringer & Julier, 2009; Fletcher & Beringer, 2009; Higby & Pye, 2009). Preliminary preparation by Beringer and Fletcher (2011) parallels the process used effectively in this study.

9.8 Strengths and limitations of the study

9.8.1 Strengths

Reinstatement of the MCU booklet was an important outcome for the action group, for children and their families undergoing MCU procedures and for the clinicians caring for them. While the action group members expressed concern for children who underwent the MCU diagnostic radiological procedure, they did not originally plan to act on that concern. However, the process of sharing these concerns as Kemmis and McTaggart recommended (1988), led the action group to identify that preparation of children and families for the MCU procedure was a common concern for all members and thus, was an issue that was worthy of group action. At the same time, the action group also reflected that a call for expressions of interest in becoming involved in reviewing and working with the action group to improve hospital preparation should have been made to all staff at all hospitals co-located on the hospital campus. The rationale for this approach was to ensure that all health staff were aware of the study and its purpose, and had the opportunity to find out more about it and/or join it.

Group members focused on the use of evidence based interventions that enhanced their professional status among the group, and possibly among other colleagues. The strength of the group approach was influential in the success of the group to undertake evidence based research and to achieve change in

practice. The finding of this study that working in a group enhances research on many levels was an important finding.

The action group recognised that determining the actions associated with the three projects occurring during the study is a characteristic of professionalising action research (Hart & Bond, 1995). The change interventions in the study were neither determined by hospital management, the 'top down' approach (A. Dickinson et al., 2009; Fletcher & Beringer, 2009; Pearcey & Draper, 1996), nor were they undetermined, which can occur from the 'bottom up' approach (Hart & Bond, 1995). The change interventions arose from the determination of the action group alone.

The action group worked progressively towards achieving the aims of the study; however, the processes of group work sometimes threatened the sustainability of the group. Vigorous debate on some issues was necessary to enable ultimate consensus that was an integral part of group decisions. The democratic intent of group work (Friere, 1972; D. J. Greenwood & Levin, 2007) influenced the practical issues related to conducting the survey and the audit because the action group debated design and other issues for a considerable time during many action group meetings. For example, there was the debate that took place during many group meetings when designing the survey of children and their parent/guardian about preparation for hospitalisation. The democratic need of the action group members to reach consensus on some issues, and the planning approaches and actions to be taken limited study progress in some respects.

Although making limited progress can be frustrating for some action group members, undertaking a democratic process to come to consensus during the different stages of the action study is fundamental to critical social theory and therefore, to action research that incorporates group collaboration. Greenwood and Levin (2007), who are experienced action researchers, propose that the essence of democratic processes is the cogeneration of knowledge that informs the action research methodology. Democratic principles should inform each

decision in the development of research projects, from identifying the problem to developing solutions and evaluating outcomes (Brydon-Miller, 2008; D. J. Greenwood & Levin, 2007). One of the most important elements of the democratic process identified by Brydon-Miller (2008) and Greenwood and Levin (2007) is giving respect to group members' knowledge and experience.

The desire of the action group to collaborate with one another in a democratic way was both invited and needed to progress the study. The group resolved to demonstrate democratic principles in their interactions with one another and in their decision making processes. At the same time, the group needed to demonstrate democratic principles because members were using an action research methodology that required collaboration to enable improvement (D. J. Greenwood & Levin, 2007). A tension existed between the democratic intent of group work and the practical intent of the research that required group consensus. The tension was a necessary part of the group's work together that resulted in robust debate among the action group members. Paradoxically, although a necessary part of group work, at times employing democratic principles in decision making hindered progress because of the need to reach consensus before agreeing to a decision and subsequently taking action on that decision.

9.8.2 Limitations

The three aspects of group work that hindered group progress at times included the individual member's acceptance of the democratic framework of the action group, the members' ability to reach consensus on shared values and beliefs regarding children's hospital preparation practices, and the reduction in the size of the action group over the study period. Each or these factors limited the time available to achieve the original study aims and objectives. Hughes (2008) acknowledged that one of the most important barriers to achieving outcomes in action research projects is the time taken in the context of busy health care settings (Meyer et al., 1999; Rycroft-Malone, 2004b). The action group were challenged by the tension between the members' desire to collaborate in

achieving group aims and objectives as set out in the initial action cycle, and the reality of doing so amid the busy health care setting and demanding work roles. This tension challenged the group's ability to investigate, evaluate and were needed, to improve preparation for childhood hospitalisation in a timely manner.

In the complex area of health care, reaching consensus where many views are deemed legitimate, is challenging (Greenhalgh, Robert, Bate et al., 2004). Researchers report that whether the action group is multidisciplinary (Jeffs et al., 2011) or it is a group of health care professionals from one discipline (Atwal, 2002; A. Dickinson et al., 2009), the same issues around reaching consensus arise. Two issues related to reaching consensus were particularly evident in the study and involved first getting all members to agree to the action group's values about childhood preparation practices and secondly, the necessity for the group members to give respect to the different beliefs expressed by one another.

Reaching consensus on the group's values and beliefs in order to progress the study aims and objectives, involved listening to and discussing the values of individual group members, and then agreeing to accept the values and beliefs that would be pursued as a group, while also remaining committed to their individual values (Nolan & Grant, 1993). Time was needed by the members of the action group to discuss their personal and professional values in order to agree on the fundamental values that would drive the study (Nolan & Grant, 1993). Only when this occurred could the group begin to influence practice change through a carefully laid-out approach (Lewin, 1997b).

The multidisciplinary action group acknowledged the important place of values clarification in action research (Manley, 2004). In the same way, early on the action group in Nolan and Grant's (1993) study identified the need to reach consensus centred around the integration of personal values and group values to progress the study aims and objectives. In Nolan and Grant's (1993) study the target group were frail elderly people but the action group focused their research on the nurses because their previous study had identified that the

nurses' values influenced their provision of care to frail elderly people. A checklist was developed by the researchers to assist the nurses to identify their espoused values and the theories they employed to focus care activities (Bolton, 2010). Identifying individual values enabled the nurses to consider the next step of developing group values that would influence the care of the frail elderly.

Identification of the group members' unique beliefs about the culture of the hospital, possibly informed by different disciplinary perspectives, and the integration of these beliefs into the action group's beliefs, presented another challenge to reaching consensus and thus, was another hindrance to progress. Coghlan and Casey (2001) characterise the knowledge, insights and experience of individuals as health care professionals' pre-understanding of organisational dynamics that each participant in the research brings with them. Except for me, the members of the action group were employees of the hospital, and members became aware of the strengths and limits of pre-understanding gained through their employment at the hospital as the study progressed. At the outset, the group members were clear about changing the practice of preparation for childhood hospitalisation because collectively, the members believed that preparation practices were a concern in a number of areas. However, coming together as a group exposed their different pre-understandings and as a group, rather than as individuals, members had to recognise the limits of their pre-understanding (Coghlan & Casey, 2001) before they could reach consensus about the best way to achieve the aims of the study. Given how influential reaching consensus is to group work (Greenhalgh, Robert, Bate et al., 2004), pre-understanding is a challenge to the action research process and proved to limit the study progress.

The time taken to reach consensus may have contributed to the reduction in the number of group members over the life of the study. Reduction in the number of members of the action group from 13 to 8 in the second cycle and then from 8 to 6 in the third cycle limited the ability of the action group to achieve outcomes more quickly (New South Wales Health Department, 2002). It is

difficult to determine if one or more reasons explain the reduction in the size of the action group because no formal evaluation of the reasons for drop-out occurred, other than work pressures. Some possible reasons why it took time to reach consensus relate to the democratic intent of the action group (Friere, 1972) and to the need of group members to establish group values and beliefs that were congruent with individual values and beliefs (Nolan & Grant, 1993) discussed above.

All of the aspects of group work that hindered progress in achieving outcomes were also essential aspects to improving the achievement of outcomes using action research underpinned by critical social theory. The important point is that group work in action research requires more time if the challenges to group work are to be brought to the surface of people's minds and kept there.

9.8.3 Extension of findings reported in the literature by this study

The primary positive aspect of this group's work was the combination of knowledge, expertise and experience of individuals, so that the action group was greater than the sum of its parts (Lewin, 1997b; Raelin, 1997; Revans, 1982). Individual group members were very quickly aware of this phenomenon when they shared their perspectives on preparation for childhood hospitalisation. The combination of these elements was a real strength of the action group's work in improving preparation for childhood hospitalisation.

Individual health care staff can benefit personally and professionally from effective group membership, as well benefit the group through its collaborative efforts in bringing about positive practice change (McCormack et.al, 2002). Nurses in three of the seven wards involved in Beringer and Fletcher's (2011) suite of action research projects, found that they were able to combine their individual knowledge, experience and expertise to discover inconsistencies and to uncover poor practices. In one of the projects, conducted by Higby and Pye (2009), the shared care of children with cancer in Bristol, UK, was improved because nurses in different services collaborated to develop a pre-discharge

checklist that allowed communication between services. Previously, the services had operated autonomously, but the action research project enabled individuals to share information and therefore, to improve quality and continuity of care for children with cancer. The nurses recommended that a multidisciplinary group be formed to consider wider issues in the discharge of children with cancer. The actions of the group showed one of the positive aspects of enabling practice change had occurred by combining their knowledge, experience and expertise, as had occurred in this study.

Another strength of group work in this study was the positive energy that was created when the action group worked together to enable improvement. The group of health care professionals had already expressed their concern about preparation for childhood hospitalisation; therefore, it was not surprising that they were attracted to work with other like-minded people. When like-minded people work together it does not really matter what area of clinical practice they what to change but simply that they care enough about the issue to be prepared to work on changing it together. Ely (2001), Jeffs and colleagues (2011) and Moody and colleagues (2001), working in quite different areas of health care, were able to harness like-minded health care professionals commitment to improve practice. Creation of positive energy was one of the study's strengths and a reason why the action group members persisted to pursue the study aims and objectives, despite various challenges to achieving them.

Different disciplinary perspectives impact on how health care professionals view their provision of health care (Atwal, 2002; Jeffs et al., 2011; Moody et al., 2001) and the multidisciplinary nature of the action group took advantage of the diversity of perspectives. The process worked in two ways: first, health care professionals saw preparation for childhood hospitalisation practice from different points of view. Second, members were able to use knowledge of different perspectives to change practice because they had a more holistic view of the situation that they wished to change.

Multidisciplinary approaches to clinical problems can be very effective because problems are de-constructed and re-constructed in light of the range of perspectives on the problem (Jeffs et al., 2011; Moody et al., 2001). A multidisciplinary team of nurses, child life specialists (play therapists), physicians and pharmacists collaborated to improve the management of pain associated with the administration of medication to children by needle in a Quality Improvement study conducted by Jeffs and colleagues (2011). The team became empowered by sharing their disciplinary perspectives, seeing the problem from other perspectives and then working together to improve pain management and therefore health care for children and their families. The multidisciplinary group exemplified what can be achieved through collaboration between disciplines. The multidisciplinary nature of the action group in the study reported here allowed a range of perspectives on the practice of preparation for childhood hospitalisation to enable consideration of practice changes.

Another study (Moody et al., 2001) revealed the advantage of employing action research to change aspects of midwifery practice through optimising different disciplinary perspectives. Moody and colleagues (2001) worked with midwives, nurses, obstetricians, doctors, physiotherapists and social workers to change practice. The multidisciplinary health care professionals used spirals of phases of action research to develop a clinical pathway that met the needs of women requiring Caesarean section and enabled clear communication between disciplinary groups. Communication ensures that all disciplinary groups are recognised for their unique contribution to health care practices. In Moody and colleagues' (2001) study, as in this study, optimising different disciplinary perspectives led to improved multidisciplinary communication that led to practice change and the potential for further changes.

9.9 Important findings and their implications

The aims of this research study were to explore, generate knowledge and mobilise action to improve the practice of preparation for childhood

hospitalisation at one major children's hospital. Overall, the use of action research underpinned by critical social theory proved to be a useful approach to improving preparation practice at this hospital. Challenges and opportunities became evident as the study unfolded and these inform my recommendations that may encourage others to make changes that lead to the provision of improved health care. These recommendations provide insight into potential means of enabling health care practice change that is both achievable and sustainable.

The most important findings of this study fall into three broad areas: a. the need for inclusive models of collaboration, especially when practices and contexts are complex and dynamic; b. the need for transformational approaches to leadership that consistently and explicitly support the engagement of staff in collaborative processes of ongoing practice improvement; and, c. the need for transformational approaches to facilitation, which enable person-centred ways of working together and shared professional power and responsibility.

9.9.1 The need for inclusive models of collaboration

The study findings support the need to find ways for meaningful collaborations and processes for including the perspectives of all stakeholders – health care professionals, and children and their families – in ongoing practice improvement and evaluation. The collaborative approach used provided opportunities for a group of health care professionals with a shared interest in preparation for childhood hospitalisation – a complex and dynamic undertaking (Association for the Wellbeing of Children in Healthcare, 2009) – to learn from and support each other in the generation of knowledge through the use of research evidence.

One of the strengths of the action research approach taken in this study is the concept of collaborative group work to achieve outcomes (Reason & Bradbury, 2008). The health care professionals who joined the action group benefitted from being involved as a group to identify and solve practice challenges as well as from engaging in systematic practice evaluation and research. Within the

current study the action group members worked together over a two year period and supported each other to identify activities that enhanced their shared understanding of what was happening around preparation within the organisation. The group surveyed children and their families admitted to the hospital, audited hospital staff, and reinstated a strategy for preparing children for a radiological procedure.

Collaborative group work was, however, challenging due to contextual issues that the action group had to deal with throughout the study. These related to problematic interactions with some departments within the hospital, issues relating to the support of and communication with the steering committee, and buy-in of individuals and groups within the hospital. Similar challenges have been found by researchers who use inclusive models of collaboration such as in the PARiHS (Rycroft-Malone, 2004a) studies described by McCormack, Manley and Garbett (2004), and the action research studies described by Hart and Bond (1995). In these studies and others contextual issues emanating from the hierarchical and accepted power within the setting as well as the practical issues of health care staff finding time and energy to meet to collaborate confounded the ability to succeed in everything that the study had set out to achieve.

The likelihood that collaborative models evolve within health care teams is enhanced within what Manley (2004) describes as an effective workplace culture. The five essential attributes of such a culture include shared values in the workplace such as person-centredness, a shared vision and individual and collective responsibility, the existence of adaptability, innovation and creativity within the workplace, change driven by the needs of patients/ users/ communities and evaluation of learning, performance and shared governance (Manley, Sanders, Cardiff, & Webster, 2011). The resources required to adapt the context include support for and education about inclusive models of collaboration. Manley (2004) argued for a transformational culture in health care that would provide the resources for quality patient care through adapting the context of health care to enable a culture of effectiveness. Health care

contexts benefit from adaptation to a culture of effectiveness for which Manley (2004) argued. A culture of effectiveness might lead to a less challenging environment to undertake collaborative group work and enable an action group to be more likely to successfully change practice.

Health care professionals benefit from inclusive models of collaboration that include all heath care disciplines (Ely, 2001; Jeffs et al., 2011; Moody et al., 2001). The reported finding in Ely's (2001) study was that barriers to multidisciplinary collaboration such as health care staff time constraints were exposed which then enabled change to the clinical practice of pain management in a pædiatric unit (Ely, 2001). Similarly, Jeffs and colleagues (2011) identified that multidisciplinary collaboration was the key to the success of improving the management of pain associated with the administration of medication to children by needle. The researchers found that the multidisciplinary approach enabled all perspectives on the issue to be considered so that practices could be established that satisfied the needs of all relevant health care disciplines and children and their families. Moody and colleagues (2001) reported that their study had resulted in staff development, improved outcomes for women (undergoing caesarean sections) and enhanced multidisciplinary communication. The researchers found that the enhanced communication between disciplines provided an opportunity to address other issues that had been a source of ongoing frustration within the unit.

Inclusion of a range of stakeholders increases the opportunity to provide a health care service that meets the needs of consumers (Tritter & McCallum, 2006) and increases the influence and motivation of health care providers (J. K. Dickinson, 1999; Marois, 2006; Mohammed, 2006). Tritter and McCallum (2006) found that consumers provided different forms of relevant knowledge and expertise to efforts to change practice. Consumers of health care have been shown to benefit from collaborative approaches to practice change as Dickinson (1999) and Mohammed (2006) both found in their studies into the health care of adolescents with diabetes. Both researchers found improvements when adolescents collaborated with an inclusive group of health

care professionals in making decisions about the provision of their own health care. Marois (2006) found that effectiveness is only achieved in community health centres when health care professionals and community members collaborate and share power in decision making.

Action-based research methods are valuable because they bring collaboration into knowledge generation and utilisation that is locally relevant. The three studies described by Beringer and Fletcher (2011) identify how collaboration of groups of people can have the effect of uncovering knowledge and utilising that knowledge to improve practice. The action methodology enabled capacity building of the health care staff so that they were able to develop existing research findings to generate new knowledge. Similarly, in this study health care professionals in the action group worked collaboratively in a process that engaged them in systematic, action-based research that led to increases in the capacity of each member of the action group to participate in the generation and use of new knowledge through research.

The ability to be involved in inclusive models of collaboration requires support and education that builds the capacity of individuals and groups to work together effectively. Inclusive models of collaboration require active participation of all collaborators with their contribution of knowledge of processes that encourage all voices to be heard. Support for collaboration and education in relation to systematic processes should be provided within the health care setting to enable health care staff to participate in practice improvement that benefits the recipients of health care as well as the providers. The findings from this study indicate that building collaborative capacity through support and education enables health care staff to engage in systematic, action-based collaborative processes that lead to local practice improvement. The capacity to make local practice changes can occur through supporting group collaboration, education for active participation in change initiatives, and proactive leadership that encourages inclusive models of collaboration (Bamford-Wade & Moss, 2010).

As well as the essential characteristics of an effective workplace, Manley and colleagues (2011) identified a number of individual and organisational enabling factors for an effective workplace culture that will directly and positively impact on patients, users and staff. Transformational leadership and skilled facilitation are proposed as two of the enabling factors (Manley et al., 2011). It follows then that this study found the concepts of leadership and facilitation to be of fundamental importance to the transformational collaboration and engagement of the health care professionals who formed the action group.

9.9.2 Transformational leadership to support staff engagement and collaboration

In this study an effective leader who provided the pathway to planned change through a culture of practice improvement was an essential ingredient in progressing the study aims. The leader was the Director of Nursing, who was a powerful member of the hospital organisation, and it was her ongoing support for the study that enabled the action group to mobilise collective action for change. While the Director of Nursing's support took a number of forms, it was her close association and communication with the management (steering) committee that provided the authority needed to progress the study and to maintain progress until its conclusion.

Support for the work of the action group by the Director of Nursing exemplified the four components of transformational leadership – idealised influence, inspirational motivation, intellectual stimulation and individual consideration (Doody & Doody, 2012). In Bamford-Wade and Moss's (2010) study, transformational leadership and the values of the nursing model of shared governance enabled the emergence of a confident, competent and committed nursing workforce engaged in collaborative processes of ongoing practice improvement who expressed a professional respect for one another. The descriptive and exploratory study sought to identify the elements of the incremental breakthroughs associated with culture change in nursing and found that transformational leadership is essential for practice change to occur.

The importance of nursing leaders in influencing health care practice and policy is acknowledged (Antrobus, 1999; Hill, 2011). Kanter (2004) found middle managers are influential in a complimentary way that relates to stability of the nursing workforce. In an Australian survey of nurses' job satisfaction Duffield and colleagues (2009) found that the experience of good unit leadership was strongly correlated to the intention to stay in the job. In the present study nursing unit managers as unit leaders had an opportunity to contribute to practice change by encouraging completion of the audit of preparation practices. As the audit was the one part of the study that did not provide useful data it can be concluded that Kanter's (2004) assertion that middle managers are influential in fostering practice improvement was found to be the case in this study. For transformational leaders to support practice change they must be supported by environments of shared responsibility (Doody & Doody, 2012) that enable a culture of effectiveness (Manley et al., 2011).

Transformational leadership that encourages practice improvement can be enabled when power relationships within hospital organisations are exposed and openly addressed. A fundamental construct of critical social theory is that by identifying the power brokers and the way that power relations occur within the health care organisation members of the organisation can locate the sources and incidences of injustice and inequity that occur to constrain a culture of openness, person-centredness and member collaboration in pursuing collective goals (Kemmis, 2008; Manley et al., 2011; McCormack, 2009). Addressing injustice and inequity created by dominating power forces is a fundamental characteristic of transformational leaders who encourage and actively support an inclusive workplace culture.

There is a need to address the relative power (Angrosino & Rosenberg, 2011) roles of steering committees and working parties in research projects so that the two groups are more responsive to one another which may enhance the potential for research groups to improve clinical practice in health care settings. The collaboration, processes and outcomes achieved within the current study

may well have been enhanced if the relationship with the steering committee had been addressed and clarified at the outset of the study. Transformational leadership and organisational support of action-based research projects that address the relative power of steering committees and working parties (or action groups) should enhance the effectiveness of the research and may lead to increased acceptance of action-based collaborative research as worthy of consideration by health care professionals who are concerned about making practice improvements.

9.9.3 Transformational facilitation which enables person-centred collaboration and shared professional power and responsibility

Innovation uptake and sustainable change are dependent on effective facilitation that transforms health care cultures to cultures of effectiveness (Harvey et al., 2002; Manley, 2004; Manley et al., 2011; Rycroft-Malone et al., 2004). One intention of the research described here was to facilitate a group of health care professionals who sought to improve their own practice and that of their colleagues so that they helped to create a culture of effectiveness. For research knowledge to be used to create a culture of effectiveness when pursuing the aim of improving health care practice, action-based methodologies can be helpful. However, these methods require the type of group facilitation that supports critical dialogue and enables the transformation of both individuals and practice (Heron, 1999; Manley & McCormack, 2003; McCormack, Manley, & Wilson, 2004; V. Wilson, Hardy, & Brown, 2008).

Inclusive models of collaborative research require effective facilitation that seeks to help individuals and groups to understand what they need to change and how they need to change it in order to apply evidence to practice. Effective facilitation provides person-centred ways of working together and shared professional power and responsibility (McCormack, 2009). Transformational facilitation seeks to explore and release the inherent potential of individuals, supporting them to change their practice, thus transforming practice and workplace culture (Crisp & Wilson, 2011). The fundamental place of responsive

and flexible facilitation emphasises the need for an environment that challenges all evolving ideas and their meaning but that also provides support for the people who are thus challenged.

In facilitating the action group I strove to support a critical dialogue primarily between members of the action group and secondarily between the action group and the hospital organisation – hospital departments, the steering committee and hospital staff. This form of facilitation is difficult to achieve however it can lead to an effective workplace culture (Manley et al., 2011) through the development of individuals, groups and the organisation. Facilitation that supports a critical dialogue leads to a better understanding of what is going on (enlightenment), to the generation of ideas by all involved to improve practice (empowerment) and to the taking of responsibility and the positive rewards of taking responsibility and owning practice (emancipation).

Support of critical dialogue required facilitation that continuously strove to adapt throughout the study. Heron (1999) proposed a model of facilitation that had three modes of facilitation - hierarchical, co-operative and autonomous - and he suggested that at various times in every project there was a place for each mode of facilitation. Heron's (1999) model of facilitation confirms the challenges associated with effective facilitation describing each mode of facilitation in terms of a range of interventions that may be used in each mode that make each qualitatively different. For example, the supportive intervention aims to ensure that members always feel valued and honoured; however how this is achieved in each mode of facilitation differs considerably. In the hierarchical mode, it is achieved through the facilitator deciding the ground rules that support valuing and honouring members and by having a positive regard for people. Whereas, in the co-operative mode the achievement of the supportive intervention is through the facilitator collaborating with the group to create a favourable climate that values and honours all members.

The development of critical dialogue occurs when health care environments are supportive of facilitation that seeks to develop practice (Titchen, 2004). Wilson

and colleagues (2006) described a framework that provides high challenge and high support to the wide range of strategies that are used to develop facilitation skills. Discussing the concept of the development of facilitation expertise further Crisp and Wilson (2011) proposed that different strategies are suited to the different stages of development of the expertise of the facilitator. Crisp and Wilson (2011) used critical creativity to generate a framework that identified three stages of development of facilitators from preliminary, to progressive, to propositional.

The stages track the transformation of facilitators as they gain the required expertise to develop practice within various workplace cultures. The first stage, the preliminary stage, was demonstrated in cycle one of this study when although enthusiastic I was focussing on getting the facilitation 'perfect' and consequently was less aware than I needed to be of how my engagement with the aims of the study may be experienced by others. Heron (1999) describes this mode of facilitation as hierarchical, when the facilitator uses a prescriptive (planning) intervention to develop the programme for the rest of the group. However, as the study developed the co-operative mode of facilitation (Heron, 1999) was most suited to working with these health care professionals as their level of functioning in the study was somewhat impaired by their busy professional roles but they needed and wanted to share power over the learning process. Being able to move from one mode of facilitation to another is an important characteristic of an effective facilitator (Heron, 1999). During cycle one I alternated between the co-operative and hierarchical modes of facilitation to set up the study, however, it was not until the action group members became involved in the study on a daily basis in cycle two that I learnt to work with my fellow collaborators to achieve the aims of the practice change that we sought, in a co-operative way.

The processes of this study continued to be rules driven and activity-based as was the facilitation at the next, progressive stage, of facilitator development. There were a number of reasons for the concrete application of rules at this stage that related to the characteristics of the workplace culture and to my own

development as an effective facilitator. One reason that lends itself to modification was organisational constraints, for example interactions with various hospital departments, which resulted in inadequate organisational support to enable practice improvement. Another modifiable reason was inadequate access to forms of experience that support ongoing facilitation development. An organisational environment that supports these modifications might enable the development of facilitation that sees the third and final, propositional, stage of facilitator development that Crisp and Wilson (2011) identify. The propositional stage is characterised as moving away from rules and towards more flexible ways of working that incorporate transformational thinking and reasoning to solve practice problems.

Combining knowledge of Heron's (1999) model of facilitation and Crisp and Wilson's (2011) framework of facilitation development in health care settings may lead to the utilisation of knowledge generated through research to improve practice that will transform practice and workplace cultures. Transformational facilitation will encourage a critical dialogue that leads to shared professional power and responsibility that will assist in the realignment of power relationships within the hospital context. Realignment of power relationships is a fundamental objective of critical social theory that seeks to address injustice and inequity as occurred when one preparation practice was transformed by the reinstatement of the preparation booklet for the MCU procedure that benefitted both children and their families, and clinicians.

Health care practice and workplace culture require transformational facilitation that is promoted and supported by the organisation so that evidence developed by research can be applied to practice. A workplace culture that shares power and responsibility between all members of the organisation and where trust is expected between them will lead to a culture of effectiveness in which evidence and knowledge are developed from research. The existence and acceptance of transformational processes including encouragement and support of inclusive models of collaboration, transformational leadership and transformational facilitation must be promoted by all members of health care settings at

corporate, organisational and workplace levels if needed health care practice change is to occur as a result of the creation of a culture of effectiveness within the hospital context.

9.10 Conclusion

While preparation for childhood hospitalisation was the focus of this study, the most important study outcome was locating an effective and facilitative way of applying research findings into practice. Critical social theory was the theoretical framework that enabled this achievement through its liberating insights into the powerful influence of the organisational hierarchy on hospital preparation practices. Action research provided the vehicle for planning, acting, observing and reflecting on practice change considered necessary to transform aspects of these hospital services. Undertaking the study through collaborative group work allowed the contribution of multiple perspectives on the issue of concern and ultimately was instrumental in achieving group goals and increased the professional development of the action group members.

The key message of the study described and analysed here relate to the recommendations made in this thesis; that is, for achievable and sustainable change three features of health care settings need to be in place. These are inclusive models of collaboration, transformational leadership and transformational facilitation. The ongoing engagement of staff in critical reflection on practice and collaboration in order to bring about sustainable and evidence-based change demands cultures that explicitly support such collaboration. Collaborative cultures can only evolve and be sustained if the leadership, at all levels of the organisation, explicitly support and role model transformation of individuals and of practice. The availability of facilitation is a critical factor in this process that is of vital importance to the transformation of health care settings to cultures of effectiveness.

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Appendices:

SOUTH EAST HEALTH
South Eastern Sydney Area Health Service

HUMAN RESEARCH ETHICS COMMITTEE - Eastern Section

Room G71, EBB
Cnr High & Avoca Strs
RANDWICK NSW 2031
Tel: 9382 3587
Fax: 9382 2813

18 October 2005

Ms Bronwyn Gordon
Nursing Practice Development Unit
Level 2
Sydney Children's Hospital

Dear Ms Gordon

RE: An action research approach to preparation for children admitted to a major children's hospital. Ref: 05/264

The Human Research Ethics Committee is in receipt of your e-mail dated 14 October 2005 in relation to the above study.

Following consideration Ethics Approval was given on 17 October 2005 for:

- **Subject information sheet and consent form Version dated July 2005.**
- **Advertisement**

This interim decision will be placed before the full Committee for Ratification at the next meeting on 22nd November 2005.

Approval has been granted for this study to commence with the understanding that if there is to be any approach or material sent to parents and children prior approval must be obtained from the Human Research Ethics Committee. This approval is valid for 5 years.

This study must be conducted in accordance with the National Health and Medical Research Council of Australia and Good Clinical Research Practice. It is the responsibility of the Chief Investigator to furnish the Human Research Ethics Committee with a progress report every 12 months for the duration of the study and a final report on completion of the study. Any advertising or media articles must be submitted for ethics approval prior to media release. The Committee must be notified of any Serious Adverse Events or Unexpected Events that occur in relation to this study.

Production Note:
Signature removed prior to publication.

Suzy Naumovska
Research Ethics Coordinator
Human Research Ethics Committee - Eastern Section

Appendix B

UNIVERSITY OF TECHNOLOGY SYDNEY

OFFICE USE:

RATIFICATION OF EXTERNAL ETHICS APPROVAL
UTS HUMAN RESEARCH ETHICS COMMITTEE

PROJECT TITLE: An action research approach to preparation for children admitted to a major children's hospital.

Supervisor: Professor Jackie Crisp	
Faculty: Faculty of Nursing Midwifery and Health	Address: Professor of Child and Adolescent Nursing Nursing Practice Development Unit Level 2, Sydney Children's Hospital (SCH) High St Randwick
Email: Jackie.Crisp@uts.edu.au	Phone No: : 9382 1797
Qualifications: **(REF NS 1.15)** RN, RM, Paed Cert, M/craft Cert, BA (H1), PhD, FCN (NSW)	
Experience relevant to this application: Research areas: Preparing children for invasive procedures Children, Adolescents and their families adherence to treatment regimes Evidence-based practice in general Quantitative design and analysis in general – particularly clinical research Major teaching areas: Evidence-based practice Quantitative research methods The psychosocial needs of children and adolescents	

Co-supervisor: Professor Lynn Chenoweth	
Faculty: Faculty of Nursing Midwifery and Health	Address: Professor of Aged & Extended Care Nursing War Memorial Hospital 125 Birrell Street Waverley NSW 2024
Email: Lynnette.Chenoweth@uts.edu.au	Phone No: 02 9369 0288/02 9369 0304
Qualifications: RN, Cert Burns/Plastic Surgery, Dip Rec/Leis, BA, MA(Hons), M Ad Ed, PhD	
Experience relevant to this application: Action Research methods in nursing and health practice, community capacity-building, and client and family well-being Research approaches: Quantitative and Qualitative research methods in a number of areas of inquiry, including Case study, Interview, Focus group discussion, Observation, Delphi technique, Document review and Questionnaire development and testing. Major teaching areas: Health systems for the aged, aged and dementia care nursing, policy and politics in health systems, qualitative research methods	

Field supervisor: Ms. Phyllis Moran	
Faculty/School: Faculty of Nursing Midwifery and Health	Address: Nursing Administration Level 4, Sydney Children's Hospital High St Randwick
Email: moranp@sesahs.nsw.gov.au	Phone No:
Qualifications: RN MN	
Experience relevant to this application: Director of Nursing, Sydney Children's Hospital	

Student: Bronwyn Gordon	
Faculty/School: Faculty of Nursing Midwifery and Health	Address: 7 Orlando Ave, Mosman NSW 2088
Email: Bronwyn.K.Gordon@student.uts.edu.au	Phone No: 0408 461 924
Qualifications: RN, MN, CM, Paed Cert	
Degree being undertaken (attach letter of candidature): PhD	
Has doctoral/masters assessment been obtained? If not, when will it be sought? Yes	
Experience relevant to this application: Honourary Research Fellow, Faculty of Nursing, Midwifery and Health, UTS. Research Nurse in the Child and Adolescent Nursing Professorial Unit at Sydney Children's Hospital, Randwick and the University of Technology, Sydney 2001 and 2002 Project manager of "A randomised control trial of a debriefing intervention for hospitalised children". Co-investigator for the above project 2003 and 2004 Masters Nursing major project entitled "Children's experience of hospital: some implications for preparation."	

Professor Jackie Crisp

DETAILS OF APPROVING EXTERNAL HUMAN RESEARCH ETHICS COMMITTEE (HREC)

HREC name: **South Eastern Sydney and Illawarra Area Health Service – Human Research Ethics Committee – Eastern Section**	
Approval number: **Ref: 05/264**	
Period of approval: **5 years**	
HREC Contact: **Ms K Breheny, Executive Officer, SEAIAHS – ES, HREC**	
Address: Room G71, EBB Corner High and Avoca Sts Randwick NSW 2031	
Email: brehenyk@SESAHS.nsw.gov.au	Phone No: 9382 2813

RESEARCH SUMMARY

There is a perceived need for enhancement of preparation for hospitalisation for children admitted to Sydney Children's Hospital (SCH). Clinicians working at the hospital such as nurses, play therapists, occupational therapists, physiotherapists and doctors, have identified this as a concern and wish to set up a process to change this situation. The researcher will work with this multidisciplinary group, using Action Research to develop, implement and evaluate a range of preparation programs, for the children who are admitted to SCH. The research group will comprise clinicians who have an interest in improving preparation for hospitalisation at SCH, that is people who are involved in the care of these children at some point along the hospitalisation trajectory.

Explain the involvement of UTS, including details of any access to UTS staff or students.

The involvement of UTS relates to the enrolment of Bronwyn Gordon as a PhD student only. My student number is 91024644.

Does your original application contain information relating to any of the following? If yes, please submit copies of any relevant information with your UTS application, and/or indicate the page number of your external application form on which the information can be located.

	Yes	N/A	Page No
Funding	☐	☒	_____
Contracts/confidentiality agreements/IP/ other constraints	☐	☒	_____
Is this a clinical trial (CTN or CTX?)	☐	☒	_____
Literature Review	☐	☒	_____
Research involving children	☐	☒	_____
Research involving another language/culture, offshore research	☐	☒	_____
Risk assessment	☐	☒	_____
Access to medical or government records	☐	☒	_____

FINAL CHECKLIST

To ensure minimum delay in the consideration of your application, please indicate by ticking the appropriate boxes below that you have supplied the following:

I have attached the following supporting documents:	Y	N/A
• Four copies of external application form, including:	☒	
• external approval letter	☒	
• consent form/information letter(s)*	☒	☐
• surveys/questionnaires/outline of questions	☐	☒
• translation of forms/information letter(s)/instruments	☐	☒
• approval from external institution/community group	☒	☐
• signature from Dean/Head of School to access students	☐	☒
• budget page from funding application	☐	☒
• explanations of any technical terms used	☐	☒
• signed declaration	☒	

- I have emailed my application to Research.Ethics@uts.edu.au ☐
  (note: all attachments should, where possible, be consolidated into one electronic document before being emailed)

For students:	Y	N	N/A
I have successfully completed my doctoral assessment	☒	☐	☐

DECLARATION

I declare that the information I have given above is true and that my research does not contravene the *National Statement on Ethical Conduct in Research Involving Humans* and the UTS policy and guidelines relating to the ethical conduct of research.

I also declare that I will respect the personality, rights, wishes, beliefs, consent and freedom of the individual subject in the conduct of my research and that I will notify the UTS Human Research Ethics Committee of any ethically relevant variation in this research.

In signing this declaration, I guarantee that this form has been distributed to each member of the research team, and they have agreed to abide by the principles and processes of the research as outlined in this application.

Production Note:
Signature removed prior to publication.

Date: 25/10/2005

Chief Investigator/Supervisor

Production Note:
Signature removed prior to publication.

Date: 25/10/2005

Student (if applicable)

UTS
University of Technology, Sydney

SYDNEY CHILDREN'S HOSPITAL RANDWICK

Preparing children for hospital: An action research study

We are forming an action group of health professionals who are interested in developing, implementing and evaluating preparation for hospital at Sydney Children's Hospital. The group will work together to develop the best preparation for children admitted here. It will be led by a PhD student. The project has the support of hospital management.

Are you interested??

If so, contact Bronwyn Gordon to find out more.

Email to Bronwyn.K.Gordon@student.uts.edu.au

Written information and further discussion of the project will be provided.

Preparing children for hospital: An action research study

Broad Aim

To improve preparation of children for hospitalisation, through an action research process.

Study Objectives

1. To develop practices associated with preparing children for hospitalisation at one major children's hospital.
2. To contribute to knowledge in the area of preparing children for hospital, that will be a logical consequence of the strategy development and evaluation processes.
3. To achieve insights into the functioning of a practice-based action research group in bringing about practice change.

Background

Preparation of children

The literature provides evidence that preparation of children for a hospital experience is very complex (Mitchell, Johnston & Keppell, 2004; Wright, 1995). This has contributed to inconsistencies in recommendations concerning the form of preparation that is most likely to be effective. Also there are inconsistencies across pædiatric hospitals in the extent to which preparation is provided and the form that it takes (Association for the welfare of child health, 2005). The majority of the theoretical and empirical work shows that preparation for hospitalisation and associated procedures is needed and beneficial (Mitchell, Johnston & Keppell, 2004; Whelan & Kirby, 1998; Wilson, 1991; Caty, Ritchie and Ellerton, 1989; Kennedy and Riddle, 1989; Wolfer, Gaynard, Goldberger, Laidley and Thompson, 1988; LaMontagne, 1987; Lambert, 1984; Ferguson, 1979; Wolfer and Visintainer, 1979; Visintainer and Wolfer, 1975). People with an interest in the area agree that it is an important issue and worthy of further exploration that clarifies and distinguishes optimum preparation.

Action research

This research approach has been used widely to create change. In health care, there is evidence that if change is to be sustained over time then it must be developed and owned locally (Robinson & Street, 2004; Bellman, Bywood & Dale, 2003; Bellman, 1996; Suderman, Deatrich, Johnson & Sawatzky-Dickson, 2000; Waterman, 1995; Webb, 1989). Greenwood (1994) described action research as situational, participatory and self-evaluative. The proposed study is situational in that it addresses preparation at this hospital where it has been identified by clinicians working in a number of disciplines as an issue of concern. It is participatory in that the clinicians will work together to bring about change for the children. Finally, it is self-evaluative in that those bringing about the change will implement and evaluate it and the processes by which it is brought about.

An action research study typically develops in a spiral fashion from the starting point of the identification of the issue of concern. This is explored thoroughly in order to create an initial plan of action which is developed by the group (Street, 2003; Kemmis & McTaggart, 1988). The group then moves through the phases of action research. The researcher, who is both participant and observer, records the process as it is happening using a research diary (McNiff, Lomax & Whitehead, 2003) so that the process is available for evaluation all the time. Members of the group contribute to the study by activities such as planning action, that is, preparation strategies, implementation of the action, collection of data regarding the action and analysis of the data. The analysis enables evaluation of the effectiveness of the strategies that have been developed and implemented. The group then reflect on the findings and develop a revised plan. It may involve further implementation, data collection, analysis, evaluation and reflection. This

spiral continues until the issue of concern has been improved (Street, 2003). Although plans may change the original aims and objectives of the study will be met.

Study design

An action research group will be formed to review, develop and evaluate preparation for hospitalisation and associated procedures at this hospital. The basis of the analysis of the data collected through this action research process is reflection in practice by the group. A steering committee will be formed at the outset of the study and will include managers of all the departments of the hospital who have an interest in the processes, decisions and outcomes of the study. I will negotiate with the Director of Nursing, who is my site supervisor, to meet with these managers and outline the study. This group will not be directly involved in the study but will provide support and assist in minimising any barriers to the progress of the study.

Research setting

The research will take place at Sydney Children's Hospital. Admissions to the hospital are either planned or unplanned and may be through the emergency department from the community, general practitioners or specialists or as booked surgical and/or medical admissions. Any of these admissions may be from local, metropolitan, rural or remote settings.

Participant recruitment and selection process

The action group will comprise people prepared to make a commitment to improving preparation at this hospital. It will be a multidisciplinary group, known as the 'working party'. A flyer will be distributed by internal mail and email calling for expressions of interest in being involved in the study, from all clinicians working at the hospital. Interested people will contact me to receive further information about the study, such as the action research approach, requirements of involvement and the potential outcomes. Information will be provided about participants' involvement in meetings to plan, implement and evaluate preparation strategies. They will be made aware that meetings will be audio tape recorded and that the data will not identify individuals. The importance of the continual reflection by the group as part of action research will be outlined.

Gaining informed consent

Potential participants may then choose to give written informed consent to participate and thus become co-researchers, that is, collaborators in the study. All group members who have consented to participate will be free to withdraw at any time without prejudice.

Other ethical matters

The preliminary information will outline the risks and benefits of involvement in the study. Risks such as those to privacy and confidentiality will be explained. Potential participants will need to consider these because this is a site specific study at a relatively small site and it will be possible for them to be identified. The action research group will agree on the management of privacy and confidentiality by identifying data from group meetings which is in the public domain and that which is private.

The benefits to the participants will be the improvement to the preparation of children for hospitalisation that they have identified as a matter of concern, through Action Research. Needed change will be facilitated by this collaborative process and will have other associated benefits. These will include giving clinicians a voice in practice and policy decisions, the development of group cohesion to act on a common issue of concern and the enhancement of stronger links across disciplines.

Research plan

When Ethics Committee approval is received the steering committee and working party will be formed. Next an introductory session/s of the working party will set up the processes that the group will use to achieve the aims and objectives of the study. It may require weekly meetings of up to one hour initially. To plan and act on specific issues,

smaller working parties may form and these may schedule shorter meetings. The purpose of all meetings will develop as the action research process unfolds. The group will reflect on preparation practices, identify the thematic concern/s, develop, implement and revise the action plan/s, and evaluate the change in practice. Further Ethics Committee approval will be sought for the activities of these plans. The study may take 18 months to 2 years to complete.

Data collection

The information that will be gathered may include thoughts, discussions, articles about preparation, surveys or interviews with children, parents or clinicians, preparation strategies implemented, evaluations of these and reflective journals kept by the action group members. This data will be considered and reflected upon by the group during meetings. To ensure an audit trail of the progress of the research, the meetings will be audio-tape recorded. I will record my own field notes during and after meetings of any pertinent issues that may affect the progress of the research.

Following evaluation of preparation strategies implemented, for efficacy and satisfaction of all participants, the action research spiral will continue. This will provide further opportunities for reflection on preparation strategies and outcomes for children and families at this hospital.

Data analysis

Some data will be coded and classified and the content analysed to identify common themes, using a technique that is able to be used and understood by the participants (Kelly & Sime, 1990). As facilitator of the group I will provide training, if required, in this analysis. I will encourage the group to use collaborative analysis (Morton-Cooper, 2000) to optimize individuals' strengths within the group and to enhance effective reflection in constructing themes. Other forms of analysis will be used according to the type of data, for example, using descriptive statistics for a questionnaire.

For the recordings of meetings and my field notes I will use content analysis to reveal the processes by which decisions are made by the group about the direction that the study should take.

Data management

Data from recordings of group meetings will originate from the group and will not identify individual participants. Data will be stored in a locked filing cabinet or on a computer with password protection, in the Nursing Practice Development Unit at SCH. Materials will be retained for seven years after the completion of the study. Any files will be shredded, electronic files will be purged and any audiotapes will be erased at that time.

Communication strategies

Activities of the action group will be shared with the hospital staff and the steering committee through a regular newsletter. I will provide a synthesis of meetings to co-researchers for checking and comment, if necessary.

University of Technology, Sydney

SYDNEY CHILDREN'S HOSPITAL RANDWICK

SOUTH EASTERN SYDNEY & ILLAWARRA AREA HEALTH SERVICE - EASTERN SECTION
SYDNEY CHILDREN'S HOSPITAL

SUBJECT INFORMATION STATEMENT AND CONSENT FORM

Preparing children for hospital: An action research study. Ref: 05/264

Dear Colleague

You are invited to participate in an action group of health professionals involved in the care of children at Sydney Children's Hospital. We hope to learn what is the best preparation for children and families admitted to the hospital by working together on preparation strategies. The group will develop, implement and evaluate strategies to prepare children for hospitalisation and the associated procedures.

Action groups work collaboratively to change things for the better. The group will meet regularly to plan our action and to evaluate our plans and make changes as necessary. Then we will implement our preparation strategy plans and evaluate them. An important part of this kind of research is reflection, and the group will reflect on each phase of the research so that we can be confident that we are working together to improve the situation as we see it.

Meetings will be held as often as we decide we need to meet, and will not necessarily be at regular intervals. Usually meetings will last for an hour and be located at the hospital. The group meetings will be audio-tape recorded for further analysis, however this will only take place with the permission of the group and "rules" regarding this will be established when we first meet. When sensitive issues are discussed the group may wish to stop the recording and we will do this immediately. Also, if someone requests that parts of the tape be erased this will be done to their satisfaction. You will have a voice in everything that we decide to do.

If this study is successful we hope that we will have developed optimum preparation for hospitalisation and associated procedures for children admitted to Sydney Children's Hospital. We cannot guarantee that you will receive any benefits from this study.

Any information about you that is obtained in connection with this study will remain confidential and will be disclosed only with your written permission. However, the results of the study may be published or disclosed to other people in a way that will not identify you. The data from this study will be stored in the Nursing Practice Development Unit of Sydney Children's Hospital, on audiotape and file for 7 years and then disposed of by shredding or erasure.

Whether you take part in this study or not, it will not make any difference to your employment at Sydney Children's Hospital. If you decide to take part in the study, you can still withdraw at any time and this will not make any difference to your employment, either.

The study has the support of the Director of Nursing and the activities of the group will be facilitated by Bronwyn Gordon, who is a UTS PhD student and a pædiatric nurse. If you would like more detailed information, please contact Bronwyn on 0408 461 924 or Bronwyn.K.Gordon@student.uts.edu.au or Professor Jackie Crisp (UTS PhD supervisor) on 9382 1784 or Jackie.Crisp@SESIAHS.HEALTH.NSW.GOV.AU or Jackie.Crisp@uts.edu.au You will be given a copy of this form to keep.

Complaints may be directed to the Research Ethics Secretariat, South Eastern Sydney & Illawarra Area Health Service – Eastern Section, Prince of Wales Hospital, RANDWICK NSW 2031 AUSTRALIA (phone 9382 3587, fax 9382 2813, and email Kim.Breheny@SESIAHS.HEALTH.NSW.GOV.AU).

University of Technology, Sydney

SOUTH EASTERN SYDNEY & ILLAWARRA AREA HEALTH SERVICE - EASTERN SECTION
SYDNEY CHILDREN'S HOSPITAL

SUBJECT INFORMATION STATEMENT AND CONSENT FORM (continued)

Preparing children for hospital: An action research study. Ref: 05/ 264

You are making a decision to voluntarily participate in this research project. Your signature indicates that you have read and understood the information statement provided, have been verbally informed about the study, have had a chance to ask questions, and consent to participate in the action research group that will develop, implement and evaluate strategies to prepare children for hospitalisation and the associated procedures at Sydney Children's Hospital, described above. A copy of this informed consent will be given to you.

Signature of subject

Signature of witness

Please PRINT name

Please PRINT name

Date

Date

Signature(s) of investigator(s)

Date

Please PRINT Name

REVOCATION OF CONSENT

I hereby wish to **WITHDRAW** my consent to participate in the research proposal described above and understand that such withdrawal **WILL NOT** make any difference to my medical care or my relationship with the Hospital or my medical attendants.

Signature

Date

Please PRINT Name

Date

The section for Revocation of Consent should be forwarded to Professor Jackie Crisp, Nursing Practice Development Unit, Level 2, Sydney Children's Hospital, Randwick.

Actions	Reflections	Plans
3.2.06 First group meeting 1. Introductions: 2. Apologies: 3. Decisions about group processes a. Meetings Format – agreed by participants Attendance – punctual Be prepared – readings, complete allocated tasks Not too long – reduced to 1 hour Stick to the agenda – everyone to monitor Good chairperson / facilitator Task list – agreed and written in minutes Sushi – bring lunch and mug if desired , BG will bring slice (entirely fat and sugar free) Equal say of all participants – free to say unpopular things Listening to each other Pagers – group acknowledges that if pagers sound there is an acceptable reason Schedule – weekly for 4 weeks at 12md to 1pm in ED tut room, then probably monthly Minutes – Bronwyn will circulate by following Monday for comment at next meeting 4. Timeline for study – 12 months 5. Time commitment – part of participants' job with some extra time according to circumstances 6. Confidentiality of participants – outside the group use the term "the group" rather than individual names in discussions of group activities and decisions. Part of the effectiveness of the group activities will be disseminating findings and outcomes throughout the hospital – "letting people know that something is happening". 7. Ownership of outcomes by participants – the group will be responsible for outcomes. Ownership of publications by participants – decide as papers are planned and written to include all contributors not necessarily all group members. 8. Action Research – cyclical = issue of concern – initial plan – data collection – analysis – reflection – revised plan – data collection… 9. Discussion of preparation generally and at SCH a. Tours for well children – well evaluated, non-	This has been coming for a long time – lots of reading and discussing – seeing things differently than before- more clarity understanding AR. So this is what I did. After introductions I stepped through the agenda. I probably spoke too much but wanted to show the group that I was a strong facilitator and that I had thought issues through. I stated that I was prepared to do the housekeeping but wanted everyone to talk about content and make decisions. Once group "rules" were established – and I think by the nods that everyone agreed. Once they see them in writing they may make more comment. I think they wanted to know what I would do and what I expected of them before they truly threw their weight behind the project. I had to show that I had commitment ie the preparation that I have been doing, and that I knew what I was talking about. At the same time I must show openness to other ideas – their ideas. The local situation for example seems very complex as every participant has a different perspective. It will be challenging to ensure that we all listen – really listen- to how preparation is and the place it holds in each other's practice. In the meeting I perceived a very generous attitude of sharing and listening. Because there was some coming and going, unfortunately, I am not sure if this feeling was shared by everyone. I hope that my summaries of each meeting will clarify this. Perhaps I need to clarify this at the beginning of the next meeting???? I hope that at the next meeting the group will start taking over Recording: task list Very democratic 12 month time line AR described as cyclical, consider the participatory aspect Explorer program expansion limited by funding Use Virtual tour for Year 1s "Doing good"	We will meet weekly for the next 4 weeks Participants will do volunteered tasks Mention the Virtual tour to X (2009)

threatening, limited numbers and capacity, metropolitan, community liaison but not pre-hospital preparation, does fit into the curriculum b. "Hospital in a box"- for booked admissions, play therapy has some procedure specific ones, not available out of hours, when they were stored on wards they disappeared. c. Web resources – all school children have access to the internet at school, fact sheets on web site, "virtual tour" being developed currently will be available to all with access to the internet. d. Bed-side packs – pamphlets e. Photo books – in some departments only f. Dorothy video – parents/ child request is value added with individual information from play therapist prior to posting out. 10. Discussion of what change we want to achieve a. Which group i. ? booked admissions ii. ? pre-op preparation iii. ? age group iv. ? frequent admissions – working with changes over time v. ? unexpected admissions ie ED waiting room vi. ? medical imaging, especially about needles b. Is the information that is being given what the recipients want? i. Questionnaires to both parents and children ii. Literature shows children can articulate what they want to know **Tasks:** Everyone – informal audit of what currently exists and what has existed and why did it stop, was it successful? Group member– email to group - article re children's questions Group member– set up group email at SCH Group member- book meeting room for next 4 weeks Group member– bring photocopies of brochure about "hospital in a box" from Perth Group member– will speak to the Patients' friend	We need to discuss this further – what about the hospitals' ownership as the management group is supporting us? how to reach pre-schoolers? However, parents and children who don't request get neither, increasing inequity.	

Group member– email to group - parents questionnaire article - provide copies of Raeleen's worksheets for group **Potential resource people identified** CNCs to gain access to teams One clinician– interested and may have useful input One clinician– (child protection fellow) interested and may have useful input DON and management committee– supportive and enthusiastic Others when people hear about what we are doing – Patients' friend, Ambi care etc.	Everyone contributing To confirm to the group that this is public and supported.	

Meeting Format – agreed by participants

Attendance – punctual

Be prepared – readings, complete allocated tasks

Not too long – reduced to 1 hour

Stick to the agenda – everyone to monitor

Good chairperson / facilitator

Task list – agreed and written in minutes

Sushi – bring lunch and mug if desired , BG will bring slice (entirely fat and sugar free)

Equal say of all participants – free to say unpopular things

Listening to each other

Pagers – group acknowledges that if pagers sound there is an acceptable reason

Preparing children for hospital: An action research study

Objectives

1. To develop practices associated with preparing children for hospitalisation at one major children's hospital.
2. To contribute to knowledge in the area of preparing children for hospital, that will be a logical consequence of the strategy development and evaluation processes.
3. To achieve insights into the functioning of a practice-based action research group in bringing about practice change.

Study design

An action research group will be formed to review, develop and evaluate preparation for hospitalisation and associated procedures at this hospital. A steering committee will be formed at the outset of the study and will include managers of all the departments of the hospital who have an interest in the processes, decisions and outcomes of the study. This group will not be directly involved in the study but will provide support and assist in minimising any barriers to the progress of the study.

Brief literature review of preparation for hospitalisation

- ambiguity about what is best for whom and under what circumstances.
- a complex issue and that there is no simple answer (Mitchell, Johnston & Keppell, 2004).

-Haslum (1988) 1970 birth cohort in U.K. 13,900 children in the cohort and 2,900 hospitalised between 2 & 6. At both 5 & 10 children who had been hospitalised had lower attainment in mathematics and reading, and higher levels of anxious and anti-social behaviour. Not as relevant today. Separation, restricted visiting, longer hospital stays, different attitudes to children's perception and experience of pain

-Hospital involves separation, hospital environment = unfamiliar, changes to daily routines, strangers, both child and adult, developmental level may limit their ability to understand illness and its causes, their ability to accept procedures that seem incongruent to their health problem is limited (Crisp, Ungerer & Goodnow, 1996).

-Platt Report in the U.K. in 1959. Many recommendations have influenced contemporary pædiatric services. Recommendation was that preparation should be provided for both parents and children

-Hospitalisation and associated procedures cause distress for children and their families (Bentley, 2004) 1965, Vernon, Foley, Sipowicz and Schulman (1965) Visintainer and Wolfer (1975)

-1970's and 80's preparation interventions.

-1990's reviews = many unresolved issues around preparation (Mitchell et al., 2004; LeRoy et al., 2003; Vessey, 2003; Keller, 2001; Shields, 2001; Melnyk, 2000; O'Connor-Von, 2000; Whelan & Kirby, 1998; Sheldon, 1997; Wright, 1995; Vernon & Thompson, 1993) context will determine the aims and objectives, content, implementation and evaluation of preparation programmes.

-preparation for the experience of pain (von Baeyer, Marche, Rocha & Salmon, 2004; Simons, Franck & Roberson, 2001; Fanurik, Koh & Schmitz, 2000; Kleiber & Harper, 1999; Nagy, 1998; Bennett Humphrey, Boon, Chiquit van Linden van den Heuvell & van de Weil, 1992).

- opportunity for enhanced cognitive development (Vernon & Thompson, 1993; Eiser, 1988; Vernon & Schulman, 1964).
-Elder (1998) childhood hospitalisation can have an impact on future interactions with health care. affect this positively (Taylor, 1983).
-prepared children far less distressed than unprepared children (Wilson, 1991; Caty, Ritchie and Ellerton, 1989; Kennedy and Riddle, 1989; Wolfer, Gaynard, Goldberger, Laidley and Thompson, 1988; LaMontagne, 1987; Lambert, 1984; Ferguson, 1979; Wolfer and Visintainer, 1979; Visintainer and Wolfer, 1975).
- model of key concepts (maturational / cognitive factors, ecological factors and biological factors maturational / cognitive factors, ecological factors and biological factors by Vessey (2003) with coping as an overarching framework
- effectiveness of preparation strategies has varied according to (Gordon, 1993). age, developmental ability, previous experience, parental response, timing and nursing care (Mansson & Dykes, 2004; Mitchell et al., 2004; Keller, 2001; O'Connor-Von, 2000; Wright, 1995; Melamed, Meyer, Gee, & Soule, 1993; Bates & Broome, 1986).
-multicomponent preparation programmes found variables interact and confound prediction (LeRoy et al., 2003; Vessey, 2003; Melamed, 1998; Whelan & Kirkby, 1998; Peterson, Harbeck, Chaney, Farmer & Muir-Thomas 1990; Thompson, 1985; Visintainer & Wolfer, 1975; Vernon et al., 1965).
-Strategies - provision of information (to child and/ or parent) (Azarnoff, 1985), hospital tours (Avigne & Phillips, 1991; Holt & Maxwell, 1991), peer modelling (Melamed, 1982), coping skills training (LaMontagne, 1987), play (Gaynard, Goldberger & Laidley, 1991), and procedural information and support (Visintainer & Wolfer, 1975).
-sustained change has not occurred (Board & Ryan-Wenger, 2002; Foley, 2000; Whelan & Kirkby, 1998; LaMontagne, Hepworth, Byington & Chang, 1997; Sheldon, 1997; Wright, 1995).
Is there another way that research about preparation can be carried out that will improve the chances of it being implemented effectively? Action research

What do children ask about being in hospital?

We are trying to find out what children want to know about being in hospital. Please write down any / all questions a child asked you while you were caring for them. Please write their exact words. Write all questions even if they have been written before.
Use this key to indicate when the child asked the question/s (in demographic data box)
O = on admission (as soon as they arrive)
B = before procedure (the time between admission and transfer)
P = during procedure
A = after procedure
D = prior to discharge (the time between confirmation of discharge and leaving)

Department: tick box
Ambulatory care □
Recovery □
Admissions □
Medical Imaging □
Emergency □
Other _____

Demographic data	What the child asked you, don't change your normal practice
Age: years___months___boy □ girl □ 1st admission yes □ no □ Reason for admission_____ When O B P A D (please circle)	What's this? (cannula) For example: When can I go home? Where's mummy?
Age: years___months___boy □ girl □ 1st admission yes □ no □ Reason for admission_____ When O B P A D (please circle)	
Age: years___months___boy □ girl □ 1st admission yes □ no □ Reason for admission_____ When O B P A D (please circle)	
Age: years___months___boy □ girl □ 1st admission yes □ no □ Reason for admission_____ When O B P A D (please circle)	
Age: years___months___boy □ girl □ 1st admission yes □ no □ Reason for admission_____ When O B P A D (please circle)	

SOUTH EAST HEALTH
South Eastern Sydney Area Health Service

HUMAN RESEARCH ETHICS COMMITTEE - Northern Network

Room G71, EBB
Cnr High & Avoca Strs
RANDWICK NSW 2031
Tel: 9382 3587

2nd March 2007

Ms. Bronwyn Gordon & Ms. Phyllis Moran
Practice Development Unit
Level 2 Sydney Children's Hospital
Randwick

Dear Ms. Gordon and Ms. Moran

Re: Information Provision to children and parents before Hospitalisation at Sydney Children's Hospital. What do children and parents want to know? Ref: 67/010

The Human Research Ethics Committee at its meeting of 27th February 2007 considered the Ethics Executive Approval given on 14 February 2007 for the following, for the above study and this decision was **ratified.**

In accordance with the National Health and Medical Research Council Guidelines, the Committee requires you to furnish it with a progress report every 12 months until and on completion of the study.

The Committee wishes you well with the continuation of your study.

Yours sincerely

Production Note:
Signature removed prior to publication.

Angela Sutton
Assistant Administrator
Human Research Ethics Committee - Northern Network

SOUTH EASTERN SYDNEY & ILLAWARRA AREA HEALTH SERVICE - EASTERN SECTION
SYDNEY CHILDREN'S HOSPITAL

SUBJECT INFORMATION STATEMENT AND CONSENT FORM

Title of project: Information provision to children and parents before hospitalisation at Sydney Children's Hospital. What do children and parents want to know?

> "You and your child are invited to participate in a study of information provision before hospitalisation at Sydney Children's Hospital. We hope to learn what children and parents want to know prior to hospitalisation at this hospital. You were selected as a possible participant in this study because your child have just experienced hospitalisation at Sydney Children's Hospital."

If you and your child decide to participate, we, the Preparation for Hospital working party, will ask your child to complete an age appropriate survey of their experience of and their preferences for information provision for hospitalisation at Sydney Children's Hospital. Completion of the survey will occur just before your child leaves the hospital. It may take up to half an hour for your child to complete the survey.

At the same time you will complete a survey of your experience of and preferences for information provision for hospitalisation at Sydney Children's Hospital. Completion of the survey will occur just before discharge from the hospital. It may take up to half an hour for you to complete the survey.

No risks can reasonably be expected from completion of the survey by your child. Nor will there be any direct benefits for your child, although the information collected may inform improvements to information provision for hospitalisation at this hospital.

We cannot guarantee that you or your child will receive any benefits from this study.

Any information about you that is obtained in connection with this study will remain confidential and will be disclosed only with your written permission. However, the results of the study may be published or disclosed to other people in a way that will not identify you. The data from this study will be stored in a locked filing cabinet in the Practice Development Unit of Sydney Children's Hospital and on a password protected PC for 7 years and then disposed of by either shredding or purging of the PC files.

Whether you take part in this study or not, it will not make any difference to the medical care your child will receive in/from Sydney Children's Hospital. If you decide to take part in the study, you can still withdraw at any time and this will not make any difference to your child's medical care either. If you have any questions at any time Bronwyn Gordon, Telephone Number: 0408 461 924 will be happy to answer them. You will be given a copy of this form to keep.

Complaints may be directed to the Human Research Ethics Secretariat, South Eastern Sydney & Illawarra Area Health Service – Eastern Section, Prince of Wales Hospital, RANDWICK NSW 2031 AUSTRALIA (phone 9382 3587, fax 9382 2813, email Kim.Breheny@sesiahs.health.nsw.gov.au).

SOUTH EASTERN SYDNEY & ILLAWARRA AREA HEALTH SERVICE - EASTERN SECTION
SYDNEY CHILDREN'S HOSPITAL

SUBJECT INFORMATION STATEMENT AND CONSENT FORM (continued)

Title of project: Information provision to children and parents before hospitalisation at Sydney Children's Hospital. What do children and parents want to know?

You are making a decision to voluntarily participate in this research project. Your signature indicates that you have read and understood the information statement provided, have been verbally informed about the study, have had a chance to ask questions, and consent to the procedures or treatment described above. A copy of this informed consent will be given to you.

Signature of parent	Please PRINT child's name	Signature of witness
_____	_____	_____
Please PRINT name		Please PRINT name
_____		_____
Date:-		Date:-

Signature(s) of investigator(s)

_____ Date:-

Please PRINT Name

_____

tear here----------

Title of project: Information provision to children and parents before hospitalisation at Sydney Children's Hospital. What do children and parents want to know?

REVOCATION OF CONSENT

I hereby wish to **WITHDRAW** my consent to participate in the research proposal described above and understand that such withdrawal **WILL NOT** make any difference to my child's medical care or my child's relationship with the Hospital or my child's medical attendants.

Signature

_____ Date:-

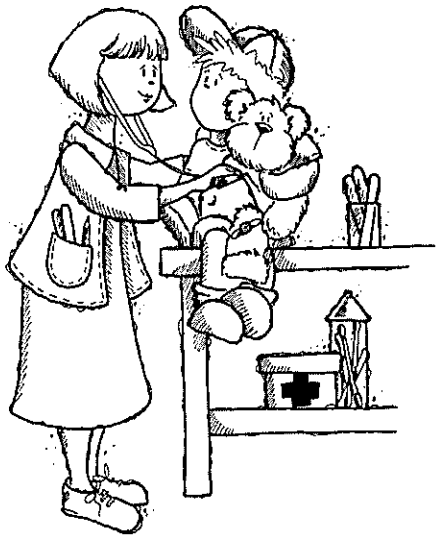
Please PRINT Name

_____

The section for Revocation of Consent should be forwarded to Adjunct Professor Phyllis Moran, Director of Nursing, Sydney Children's Hospital, Randwick, NSW 2031.

Coming to hospital – Child's Answers

Dear Parents - this survey is for your Child's responses. Please let them write their own answers, or if necessary, please record their answers as accurately as possible. Thank you for helping us learn what children would like to know about going to hospital.



We would like to know what kids like you want to know about coming to hospital.

Please write your answers yourself. If you need help, you can ask an adult to write down what YOU would like to tell us.

For some questions you will need to draw a circle ◯ around your answer.

1. How old are you? **6** **7** **8** **9** **10**

2. Are you a boy or a girl? **boy** **girl**

3. Have you ever **visited** someone in hospital before? **yes** **no**

4. Have you ever **stayed** in hospital before? **yes** **no**

5. When did you find out that you needed to go to hospital?

___today or____ days ago or _____ weeks ago or ____months ago

6. Who told you?

Mum **Dad** **Doctor** **_____Somebody else**

7. Before coming to the hospital (please tick):

☐ I would have liked more information than I got

☐ I would have liked less information than I got

☐ I was happy with the amount of information I got

SYDNEY CHILDREN'S HOSPITAL RANDWICK

Coming to hospital – Child's Answers

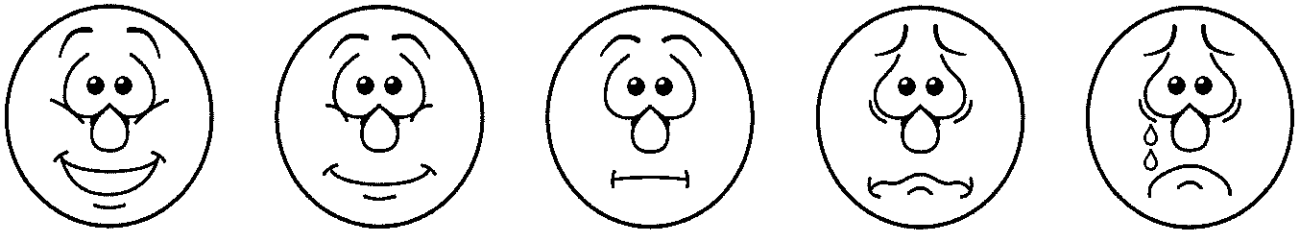
If your friend had to come to hospital what would you tell them to make it better for them?

If you need more space you can write on the back of this page.

Coming to hospital – Child's Answers

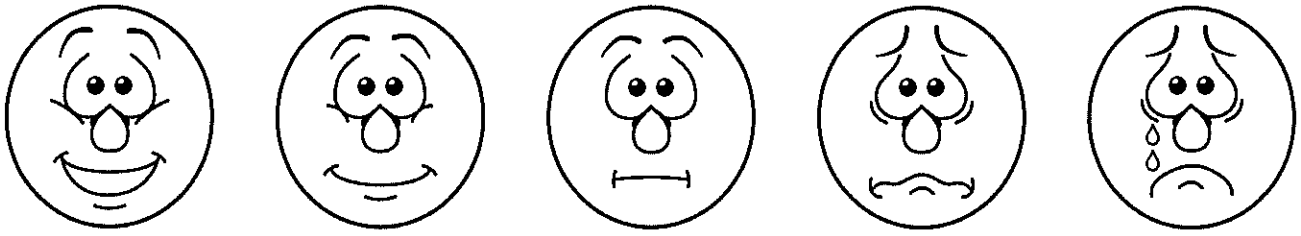
Think about before you came to the hospital and colour in the face that shows how you felt about coming to hospital **before** you got here.

Not at all scared.....Very scared



If you ever had to come to hospital **again**, how would you feel? Colour in the face that shows how you would feel.

Not at all scared.....Very scared



If you want to, draw a picture about yourself and hospital

My drawing…

SYDNEY CHILDREN'S HOSPITAL RANDWICK

Coming to hospital – Parent's answers

Dear Parents,
Thank you for helping us to learn more about what children would like to know about coming to hospital. To help us fully understand your child's responses, please answer the following anonymous questions about your child, by filling in the answer or circling or ticking the correct response.
To have any specific questions about your child's hospitalisation answered please ask your doctor directly or the health care professional caring for your child.

1. Person completing the survey: Mother □ Father □ Other_____ □

2. Child's age: _____ years_____ months 2. Child's gender: boy □ girl □

3. How many times has your child been a patient in hospital? _____times

4. If your child has been admitted to hospital before, how distressing was that experience for your child?
Not at all distressing 0 1 2 3 4 5 6 7 8 9 10 Extremely distressing

This admission:
5. What is the reason for your child's current admission?

_____

6. How much notice did your child's health professional give you that your child needed to be admitted to hospital?

No notice _____days _____ weeks _____ months

7. How much notice was your child given that he/she needed to be admitted to hospital?

No notice _____ days _____ weeks _____ months

9. What form was the information you received about your child's stay in hospital?

Verbal (by whom? _____) Letter Brochure

Factsheet specific to reason for admission None

10. What form would you prefer the information to be in?

Verbal (by whom? _____) Letter Brochure

Factsheet specific to reason for admission None Other
_____

11. What form was the information your child received about their stay in hospital?

Verbal (by whom? _____) Letter Brochure

Factsheet specific to reason for admission None

SYDNEY CHILDREN'S HOSPITAL RANDWICK

Coming to hospital – Parent's answers

12. How satisfied were you with the information that you were provided?

Not at all satisfied 0 1 2 3 4 5 6 7 8 9 10 Extremely satisfied

13. How satisfied were you with the information that your child was provided?

Not at all satisfied 0 1 2 3 4 5 6 7 8 9 10 Extremely satisfied

14. How distressing has this admission been for your child?

Not at all distressing 0 1 2 3 4 5 6 7 8 9 10 Extremely distressing

15. Did anyone tell you and/ or your child the following?

Type of information	Received yes/no	If received, how helpful? Use scale 0-10 above
How to get information		
What is involved in the procedure		
About the anaesthesia		
The possible time schedule		
About the hospital environment		
Options for parental presence		
How your child might feel		
About the condition		
Answers to any concerns		

16. What general types of questions has your child asked you or your doctor about going to hospital?

SYDNEY CHILDREN'S HOSPITAL RANDWICK

Preparing children for hospital at SCH

SYDNEY CHILDREN'S HOSPITAL RANDWICK

Instructions:

This survey may take up to 15 minutes to complete.

Save the Survey to your desktop from the email; you can re-save it at any time and return later to finish.

There are questions about 3 phases - Pre-admission, On admission, Post admisssion.

Use your mouse to

- ***click on boxes (which give instructions) and enter your answer,***
- ***slide the sliders to choose a score between 0 and 10***
- ***click on one or more checkboxes to enter a tick (click again to remove the tick)***

When you have finished save the Survey one more time. E-mail it to us by attaching it to a new email to schprepwp@sesiahs.health.nsw.gov.au

Approximate number of children seen per month in your department / unit / rooms (if known) ☐

Approximate number of planned admissions / visits (if known) ☐

Approximate number of unplanned admissions / visits (if known) ☐

Age range mainly seen in your department / unit / rooms ☑ 0-2 ☑ 3-5 ☑ 6-10 ☑ 11-14 ☑ 15+

Pre-admission

Mail out of information prior to booked admission eg. Ambulatory care	*none/not at all*				*total/extemely*	
Current use of this strategy in your setting	◂				▸	5
Your familiarity with this strategy	◂				▸	5
Your belief that this strategy is effective	◂				▸	5
Satisfaction with this strategy if in use	◂				▸	5
Interest in using this strategy in the future	◂				▸	5

Age range for which this strategy is effective ☑ 0-2 ☑ 3-5 ☑ 6-10 ☑ 11-14 ☑ 15+

Preparation Videos
eg. A Wiggle tale - Dorothy the dinosaur goes to hospital.

	none/not at all			*total/extemely*	
Current use of this strategy in your setting					5
Your familiarity with this strategy					5
Your belief that this strategy is effective					5
Satisfaction with this strategy if in use					5
Interest in using this strategy in the future					5
Age range for which this strategy is effective	☐ 0-2	☐ 3-5	☐ 6-10	☐ 11-14	☐ 15+

Pre-admission clinic

	none/not at all			*total/extemely*	
Current use of this strategy in your setting					5
Your familiarity with this strategy					5
Your belief that this strategy is effective					5
Satisfaction with this strategy if in use					5
Interest in using this strategy in the future					5
Age range for which this strategy is effective	☐ 0-2	☐ 3-5	☐ 6-10	☐ 11-14	☐ 15+

Advice from a Play therapist via phone pre-admission

	none/not at all			*total/extemely*	
Current use of this strategy in your setting					5
Your familiarity with this strategy					5
Your belief that this strategy is effective					5
Satisfaction with this strategy if in use					5
Interest in using this strategy in the future					5
Age range for which this strategy is effective	☐ 0-2	☐ 3-5	☐ 6-10	☐ 11-14	☐ 15+

Advice from a Play therapist with a pre-admission visit

	none/not at all			*total/extemely*	
Current use of this strategy in your setting					5
Your familiarity with this strategy					5
Your belief that this strategy is effective					5
Satisfaction with this strategy if in use					5
Interest in using this strategy in the future					5
Age range for which this strategy is effective	☐ 0-2	☐ 3-5	☐ 6-10	☐ 11-14	☐ 15+

Appendix N cont.

Pre-admission advice from another clinician <<click here for list>>

	none/not at all				*total/extemely*	
Current use of this strategy in your setting	1	2	3	4	5	
Your familiarity with this strategy	1	2	3	4	5	
Your belief that this strategy is effective	1	2	3	4	5	
Satisfaction with this strategy if in use	1	2	3	4	5	
Interest in using this strategy in the future	1	2	3	4	5	

Age range for which this strategy is effective ☑ 0-2 ☑ 3-5 ☑ 6-10 ☑ 11-14 ☑ 15+

Pre-admission tour eg Pre-operative tour

	none/not at all				*total/extemely*	
Current use of this strategy in your setting	1	2	3	4	5	
Your familiarity with this strategy	1	2	3	4	5	
Your belief that this strategy is effective	1	2	3	4	5	
Satisfaction with this strategy if in use	1	2	3	4	5	
Interest in using this strategy in the future	1	2	3	4	5	

Age range for which this strategy is effective ☑ 0-2 ☑ 3-5 ☑ 6-10 ☑ 11-14 ☑ 15+

Fact sheets from SCH website

	none/not at all				*total/extemely*	
Current use of this strategy in your setting	1	2	3	4	5	
Your familiarity with this strategy	1	2	3	4	5	
Your belief that this strategy is effective	1	2	3	4	5	
Satisfaction with this strategy if in use	1	2	3	4	5	
Interest in using this strategy in the future	1	2	3	4	5	

Age range for which this strategy is effective ☑ 0-2 ☑ 3-5 ☑ 6-10 ☑ 11-14 ☑ 15+

Virtual tour via internet (currently being developed at SCH)

Current use of this strategy in your setting	1	2	3	4	5	
Your familiarity with this strategy	1	2	3	4	5	
Your belief that this strategy is effective	1	2	3	4	5	
Satisfaction with this strategy if in use	1	2	3	4	5	
Interest in using this strategy in the future	1	2	3	4	5	

Age range for which this strategy is effective ☑ 0-2 ☑ 3-5 ☑ 6-10 ☑ 11-14 ☑ 15+

Hospital explorer tour for school children

Current use of this strategy in your setting	◂				▸	5
Your familiarity with this strategy	◂				▸	5
Your belief that this strategy is effective	◂				▸	5
Satisfaction with this strategy if in use	◂				▸	5
Interest in using this strategy in the future	◂				▸	5

Age range for which this strategy is effective ☑ 0-2 ☑ 3-5 ☑ 6-10 ☑ 11-14 ☑ 15+

Other *none/not at all* *total/extemely*

Current use of this strategy in your setting	◂				▸	5
Your familiarity with this strategy	◂				▸	5
Your belief that this strategy is effective	◂				▸	5
Satisfaction with this strategy if in use	◂				▸	5
Interest in using this strategy in the future	◂				▸	5

Age range for which this strategy is effective ☑ 0-2 ☑ 3-5 ☑ 6-10 ☑ 11-14 ☑ 15+

Any suggestions?

On admission/ during admission

Advice from a play therapist *none/not at all* *total/extemely*

Current use of this strategy in your setting	◂				▸	5
Your familiarity with this strategy	◂				▸	5
Your belief that this strategy is effective	◂				▸	5
Satisfaction with this strategy if in use	◂				▸	5
Interest in using this strategy in the future	◂				▸	5

Age range for which this strategy is effective ☑ 0-2 ☑ 3-5 ☑ 6-10 ☑ 11-14 ☑ 15+

Procedure specific written material eg MCU booklet — *none/not at all* — *total/extemely*

Current use of this strategy in your setting	1	2	3	4	5	
Your familiarity with this strategy	1	2	3	4	5	
Your belief that this strategy is effective	1	2	3	4	5	
Satisfaction with this strategy if in use	1	2	3	4	5	
Interest in using this strategy in the future	1	2	3	4	5	

Age range for which this strategy is effective ☐ 0-2 ☐ 3-5 ☐ 6-10 ☐ 11-14 ☐ 15+

Informal preparation by clinicians — *none/not at all* — *total/extemely*

Current use of this strategy in your setting	1	2	3	4	5	
Your familiarity with this strategy	1	2	3	4	5	
Your belief that this strategy is effective	1	2	3	4	5	
Satisfaction with this strategy if in use	1	2	3	4	5	
Interest in using this strategy in the future	1	2	3	4	5	

Age range for which this strategy is effective ☐ 0-2 ☐ 3-5 ☐ 6-10 ☐ 11-14 ☐ 15+

Other _____ — *none/not at all* — *total/extemely*

Current use of this strategy in your setting	1	2	3	4	5	
Your familiarity with this strategy	1	2	3	4	5	
Your belief that this strategy is effective	1	2	3	4	5	
Satisfaction with this strategy if in use	1	2	3	4	5	
Interest in using this strategy in the future	1	2	3	4	5	

Age range for which this strategy is effective ☐ 0-2 ☐ 3-5 ☐ 6-10 ☐ 11-14 ☐ 15+

Any suggestions?

_____

Pre-discharge/ post admission

Fact sheets from SCH website	*none/not at all*				*total/extemely*	
Current use of this strategy in your setting	◂				▸	5
Your familiarity with this strategy	◂				▸	5
Your belief that this strategy is effective	◂				▸	5
Satisfaction with this strategy if in use	◂				▸	5
Interest in using this strategy in the future	◂				▸	5
Age range for which this strategy is effective	☐ 0-2	☐ 3-5	☐ 6-10	☐ 11-14	☐ 15+	
Procedure specific written material	*none/not at all*				*total/extemely*	
Current use of this strategy in your setting	◂				▸	5
Your familiarity with this strategy	◂				▸	5
Your belief that this strategy is effective	◂				▸	5
Satisfaction with this strategy if in use	◂				▸	5
Interest in using this strategy in the future	◂				▸	5
Age range for which this strategy is effective	☐ 0-2	☐ 3-5	☐ 6-10	☐ 11-14	☐ 15+	
Other _____	*none/not at all*				*total/extemely*	
Current use of this strategy in your setting	◂				▸	5
Your familiarity with this strategy	◂				▸	5
Your belief that this strategy is effective	◂				▸	5
Satisfaction with this strategy if in use	◂				▸	5
Interest in using this strategy in the future	◂				▸	5
Age range for which this strategy is effective	☐ 0-2	☐ 3-5	☐ 6-10	☐ 11-14	☐ 15+	

Any suggestions?

THANK YOU

Quality Improvement Project Form

HOSPITAL & Department:
Sydney Children's Hospital – Nursing and Allied Health

Project Title:
Strategies for preparing children for hospitalisation at Sydney Children's Hospital.

Proposed Commencement Date:	**Proposed Completion Date:**
1.9.06	30.9.06 (data collection) 31.12.06 (analysis and dissemination)

Contact Person:	**Title:**
Bronwyn Gordon	Ms
Address:	
Practice Development Unit Level 2, Sydney Children's Hospital High St., Randwick, NSW, 2031	
Phone:	**E-mail:** Bronwyn.K.Gordon@student.uts.edu.au

Problem:
It is not known what strategies are being used to prepare children for hospitalisation at Sydney Children's Hospital (SCH).
A multidisciplinary working party has formed to investigate and improve preparation for hospitalisation at SCH using the methods of action research (Morton-Cooper, 2000; Hart & Bond, 1995). The working party has conducted an informal audit of strategies that are currently being used. This has been done by word of mouth by the members of the working party. The results of the informal audit were that there were many strategies, which were inconsistently applied and that many had not been evaluated. The working party recognised the limitations of the informal audit and has developed a survey to enable an accurate audit of strategies currently being used to prepare children for hospitalisation at SCH.

Objective:
To develop a database of preparation strategies being used by all units, departments, shared departments and referring doctors to prepare children for hospitalisation at SCH.

1. To describe the range of strategies that are being used and by whom.
2. To evaluate levels of satisfaction with the current strategies.
3. To assess interest in using the range of existing strategies.
4. To obtain staff's ideas concerning the need for additional strategies and their evaluation.

Methodology:

Clinicians from a number of disciplines, including nursing, play therapy, psychology, teaching, social work and occupational therapy are members of the working party. We would like to learn more about what strategies are being used currently within the hospital to prepare children for hospitalisation. This information will be a starting point for improving the availability and effectiveness of preparation strategies.

Participants:

The working party has developed a survey that will be administered to all units, departments, shared departments and referring doctors. A list of potential participants will be drawn up by the working party and submitted to the SCH Management committee for confirmation of completeness.

Measures:

The survey (see attached) will enable the objective of this project to be met, that is to develop a database of preparation strategies being used by all units, departments, shared departments and referring doctors to prepare children for hospitalisation at SCH. Information related to the four aims designed to meet this objective will be elicited by the survey.

1. To describe the range of strategies that are being used and by whom.

A list of the known strategies will be provided in the survey. Respondents will be asked to rate their current use, familiarity, belief in effectiveness and age range for this effectiveness using the scale provided in the survey.

2. To evaluate levels of satisfaction with the current strategies.

Respondents will be asked to rate their satisfaction with current strategies using the same scale.

3. To assess interest in using the range of existing strategies.

Respondents will rate their interest in each strategy whether they are currently using it or not.

4. To obtain staff's ideas concerning the need for additional strategies and their evaluation.

Space is provided in the survey for respondents to name other strategies that they are aware of and any suggestions for strategies and to rate them using the same scale.

Procedure:

The survey, with an explanatory letter (attached), will be distributed by internal and external mail. Completion and return of the survey will constitute consent. Surveys distributed by internal mail will be returned by internal mail to the Practice Development Unit. Those distributed by external mail will include a stamped return envelope to the same address. The surveys will be distributed on 1.9.06 with a request for return by 30.9.06. The working party will send a reminder to all potential participants on 25.9.06, including the statement "you may have returned your survey and if you have please disregards this reminder". Confidentiality of data will be maintained at all stages of the collection, analysis and publication of the data.

Analyses:

The working party will code, collate and enter the data gathered by the survey into a database. Analyses will primarily be descriptive (eg means and standard deviations). Some correlational analyses may be conducted to examine potential relationships among some of the variables, for example, between interest in using preparation and the forms of preparation preferred. If there is less than a 100% response rate, the analysis will acknowledge this shortcoming of any findings.

The findings of this survey will guide the subsequent steps in the action research process, such as the development of preparation strategies tailored to the needs of children and families cared for within SCH.

Does the project potentially infringe the rights, privacy or professional reputation of carers, health professionals or institutions?
No. This project seeks to gather data from all units, departments, shared departments and referring doctors at SCH.

Likely Risks and Benefits of project:
Is there any risk involved for subjects (patients, staff, students or volunteers)?
No. The data collection is by completion of a survey by all units, departments, shared departments and referring doctors at SCH. Members of the working party will distribute and collect the surveys. The confidentiality of participating and non-participating units, departments, shared departments and referring doctors will be maintained. The response rate to the survey will be reported as a percentage without identifying non-participants.
The benefit of the project is that it will provide information about the preparation for hospitalisation strategies currently being used at SCH, in the following areas:

1. To describe the range of strategies that are being used and by whom.
2. To evaluate levels of satisfaction with the current strategies.
3. To assess interest in using the range of existing strategies.
4. To obtain staff's ideas concerning the need for additional strategies and their evaluation.

This information will facilitate the development and implementation of strategies to prepare children and their families for hospitalisation at SCH.

Ethical Issues:
Are there any ethical considerations associated with the project? For example, protecting confidentiality/anonymity, protection from coercion/discomfort/harm etc.
No identifying data will be included on the survey form. Survey forms will be coded to enable identification of unreturned surveys; however, this code will be stored separately to the survey data. Confidentiality of data will be maintained at all stages of the collection, analysis and publication of the data.

Consent:
Will there be any direct contact with the patients and/or their relatives/carers?
This is a survey of all units, departments, shared departments and referring doctors at SCH. No data will be collected from patients/ families at this stage of our project.

If so will written consent be required? (If yes, please attach draft consent form)
Completion and return of the survey will constitute consent.

Will access to personal information extend beyond those who are members of the clinical care team or others who would normally have access to the patient's record?
No. There will be no personal information collected.

Study Data:

Will the project involve any form of electronic or hard copy record storage (database, tape, video etc)? If so please describe storage & disposal of study data here.

Yes. Data will be stored in a locked filing cabinet in the Practice Development Unit at SCH for seven years. Hard copy data will then be shredded and destroyed and electronic data will be purged.

Is there a process for the de-identification of study data? If so please describe this here.

Surveys will not have identification data on them at any time. Surveys will be coded and the key to the codes will be stored separately to the survey data.

Do you intend to publish?

Yes. The data collected will be part of the larger project "An action research approach to preparation for children admitted to a major children's hospital" ref 05/264 SESIAHS HREC Eastern Section. This larger project will form part of the PhD thesis written by Bronwyn Gordon. It is anticipated that papers will be published from this project which may include the findings of the project that is the subject of this Quality Improvement application.

Will there be any questionnaires/surveys used in this project?

Yes, see attachment.

SIGNATURE PAGE

Sign off:

- Completed form to be forwarded to the Department Head or Manager for their signature. You with then need to forward the completed form to the HREC. for tabling at the next Executive Ethics Committee Meeting.
  (The Executive meets weekly. To contact the HREC phone: 93823587.)
- Email a copy of the completed form to Paul Tyne, Quality Improvement Manager, SCH

Department Head Manager's Name (Print)	Phyllis Moran	Date:
Title	Ms.	
Signature :		
Email Address	Phyllis.Moran@SESIAHS.HEALTH.NSW.GOV.AU	
Phone number	9382 1892	

Department Head Manager's Name (Print)	Virginia Binns	Date:
Title	Ms.	
Signature :		
Email Address	Virginia.Binns@SESIAHS.HEALTH.NSW.GOV.AU	
Phone number	9382 1050	

Applicants Name (Print)	Bronwyn Gordon	Date:
Signature:		

Sign off HREC Chairperson/Delegate

Name:

Signature

Date

Medical Imaging Department,

SYDNEY CHILDREN'S HOSPITAL RANDWICK

and

School of Psychology,

UNSW

The University of New South Wales, Kensington

Preparing Your Child For the MCU

Preparing Your Child And How Preparation Can Help

Preparation can help your child to cope with the medical procedure, which might be unknown and somewhat scary for them.

Preparing your child can help them deal with future medical procedures and visits to the doctor and the hospital.

What Does This Booklet Contain?

1. Information for parents about the MCU procedure.

2. Information for you to discuss with your child prior to the MCU.

3. Ways To Prepare Your Child Before The MCU.

Donna Pellarini, MPsychol (Clinical) and
Dr Karen Salmon, School of Psychology,
University of New South Wales
Dr John Pereira and Margaret Allen,
Sydney Children's Hospital.
The development of this booklet was funded by the
Sydney Children's Hospital Research Foundation.

Any queries please contact the play therapist on 9382 6984 or the Medical Imaging Sister on 9382 0350

Information for Parents about the MCU Procedure

1. What is the MCU?

The MCU (micturating cysto-urethrogram) is an x-ray of the kidneys, which is conducted to investigate urinary problems.

2. What can you expect during the MCU?

- Under most circumstances, parents may remain with their child. A nurse will also stay with you.
- The nurse has children's videos for your child to watch during the MCU. Distraction can increase your child's coping and reduce distress.
- You can help your child change into a gown.
- The nurse will help your child onto a bed. You can stand behind the bed and hold your child's hands.
- The nurse will ask your child to lie still. The doctor will wash their bottom. Your child's lower body will be covered with a green sheet with a hole in it.
- The doctor will insert a small tube into your child's urethra and then into the bladder. He or she will use a lubricating gel so the tube will slide in easily. The tube will remain in for a short time. Your child can watch the video.
- Your child's bladder will be filled with fluid. The x-ray camera will come close to your child, but will not touch.
- The doctor will ask your child to urinate into a bedpan while lying on the bed. Your child will have lots of fluid in their bladder and will feel more comfortable once urination has occurred.
- During urination, x-rays will be taken and after that, the catheter is removed. The procedure is then complete.

Information for You to Discuss with Your Child Prior to the MCU

First you will meet the nurse in the photo room. The nurse will be with you the whole time and so will Mummy/Daddy. Here is a picture of the photo room.

The nurse has lots of children's videos for you to watch. You can pick which video you would like to watch, and watch it the whole time. Here is the TV with a children's video.

What is Likely to be Unhelpful Before and During the MCU?

Excessive reassurance: That is, giving your child frequent reassurance, and speaking in a very worried tone. For example:

> "You'll be fine, Mummy will be there".

Minimising: This is problematic if your child feels more discomfort and believes that you have not been direct with him or her.

> "This is just a little tickle that won't hurt you"

We hope that the information and guidelines that we have provided have been helpful for you and your child.

This camera will come close to you, but it won't touch you.

Then the doctor will put a tiny tube into the hole where the wee* (*insert your child's word for "wee") comes out. The tube will slide in easily. The tube will only be in a little while.

The doctor will ask you to wee* on the bed. The bed is a special bed for children to wee* on.

You will feel better once you have done a wee* and then we can go home.

Ways To Prepare Your Child Before The MCU

- Before the MCU we encourage you to read pages 4 to 6 of this booklet with your child. Look at the photographs with your child and discuss them in a calm and matter of fact way.

- Discuss going to the hospital and the MCU in advance. There is a balance between informing your child about what will happen and focusing on it too much, and you will know this for your child.

- Try to engage your child's interest in the procedure by talking and asking 1 or 2 questions.

- Encourage your child to ask questions.

- We will phone you to see how your preparation is going and to answer any questions you might have.

Helpful Comments To Say To Your Child During The MCU

- **Prompt your child's attention to the video.**

"Watch the TV with me- what's happening in the cartoon now?"

"What's going on in the cartoon? Do you think that's funny? I do".

"Look at the cartoon, what's happening now?"

- **Speak in a calm and matter of fact manner and praise coping:**

"I really like the way you are lying so still".

"I really like the way you are doing froggy legs".

"You're doing well".

"I really like the way you are watching TV".

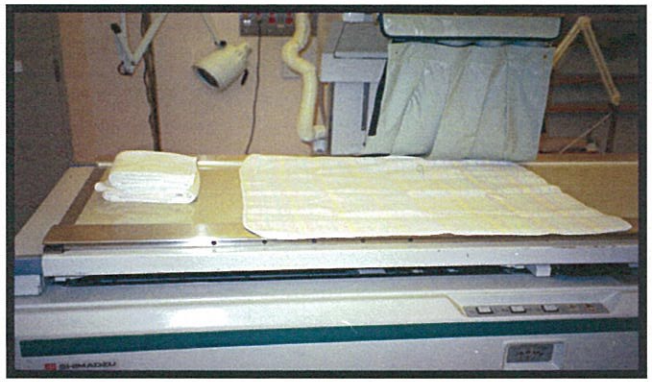
"I really like the way you're trying to wee".

"You've done so well. I am so proud of you".

You may find yourself becoming distracted, but we encourage you to continue to prompt your child's attention towards the video and speak in a calm and matter of fact way throughout.

The nurse will give you a special gown to put on.
Mummy/Daddy will help you put the special gown on.
Mummy/Daddy will put on a special gown too, see
here they are.

The nurse will help you onto this special bed.
Mummy/Daddy will stand right behind you and hold
your hands. The doctor will wash you.



Child: care, health and development
Appendix Q
Original Article
doi:10.1111/j.1365-2214.2010.01190.x

Child and parental surveys about pre-hospitalization information provision

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Abstract

Background There is little available information about what children and parents would like to know about a forthcoming hospitalization and what they currently receive.

Methods The current study was a survey of 102 children between the ages of 6 and 10 years and their parents recruited either from the Recovery Unit following day surgery or from the wards following overnight admissions at Sydney Children's Hospital, Australia. Information was obtained about each child's experience in hospital, the nature and format of information that they had received prior to the admission, and what information the child/parent thought would be helpful to receive.

Results Parents recorded a total of 163 questions asked by children prior to their admission. Questions related to timing (e.g. duration of admission, length of procedure), pain, procedural information, anaesthesia, needles, whether parents can be present, activities to do in hospital, seeking explanations ('Why' questions), hospital environment, seeking reassurance and miscellaneous questions. Children who were satisfied with the amount of information they received before coming to hospital subsequently reported that they would be significantly less scared should they need to come back to hospital for a future procedure. A total of 46.7% of children received information about their hospitalization from their parent(s) and a further 12% from a doctor and parent.

Conclusions Children were found to have many questions about a forthcoming hospitalization. Parents were found to have a major role as information providers. Further research is needed to assess parental confidence and competence to meet their child's information needs.

Keywords
child, hospitalization, information, parent, survey

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Introduction

Hospitalization is a significant, potentially stressful event in the life of a child and his/her parents. Providing a child with appropriate information about a forthcoming hospitalization is recognized to be an important factor in minimizing distress and helping him/her generate accurate expectations (Jaaniste *et al.* 2007). However, little is known about what information children and their parents want to receive prior to going to hospital and what they currently find helpful.

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Hospitalization involves the separation of children from their home, familiar objects, routines and, in some cases, family members (although increasingly parents can be present during a child's hospitalization). The hospital environment and routine may be quite unfamiliar to children. Strangers in the hospital may do things to the child that the child does not understand and that he/she may not be able to comprehend as being a prerequisite for getting better (B.K. Gordon, unpublished). Consequently, hospitalization may have significant psychological and/or behavioural consequences that may be quite negative and enduring for children (Haslum 1988; Wright 1995; Foley 2000; Ben-Amitay *et al.* 2006; MacLaren & Kain 2008).

In line with the self-regulation model of information provision (Leventhal & Johnson 1983; Johnson 1999), providing children with preparatory information about a forthcoming hospitalization may help them to generate more accurate expectations, thus enabling them to develop a more adaptive coping response (Johnson 1999). Unless given accurate information about a forthcoming medical experience, children's expectations may be considerably worse than the reality (Mahajan *et al.* 1998). Accurate preparatory information may help reduce a child's uncertainty, enhance belief in his/her ability to cope with the experience, minimize distress, and optimize treatment outcomes and recovery times [for a review, see Jaaniste *et al.* (2007)]. Previous studies have found that children who are better informed about a forthcoming procedure generally have better outcomes (e.g. lower distress and better adjustment) during and after the procedure (Schmidt 1990; Margolis *et al.* 1998; Claar *et al.* 2002). Moreover, if preparatory information is found to be consistent with the actual hospital experience, children are likely to develop greater trust of the information provider and the health professionals involved.

Descriptive and interventional studies have shown that parents want and appreciate detailed and comprehensive information about their child's hospitalization (Kain *et al.* 1997; Chapados *et al.* 2002; Franck & Spencer 2005; Spencer & Franck 2005). Melnyk (1994) showed that parents who were informed about their child's expected behaviour and their own optimal role were significantly more supportive during their child's intrusive health-care procedures.

Parental satisfaction with their child's medical care has been found to be closely associated with their perception of the adequacy of information provided (Kvaerner *et al.* 2000; Magaret *et al.* 2002). Parents reported high levels of anxiety prior to their child's anaesthesia (Thompson *et al.* 1996), which the parents felt could have been allayed by more explanation from doctors and nurses. As many as 40% of parents with a child having elective surgery reported that their own stress levels could have been reduced if they had received more information preoperatively (Shirley *et al.* 1998).

It is not well understood what information children and parents typically receive and what else they would like to know prior to a child's hospitalization. In a small-scale study, Smith and Callery (2005) interviewed nine children (aged 7–11 years) about their forthcoming planned admission and documented a total of 61 questions that children asked about going to hospital. These questions were grouped into nine categories: getting information, procedures, anaesthesia, timing, hospital environment, family support, feelings/pain, their condition and concerns. The aims of the current study were to survey a larger group of children and their parents and to document what information children and their parents received prior to a child's hospitalization, how satisfied they were with the information received, and what the children would have liked to know.

Methods

Participants

A total of 102 child–parent dyads were recruited from Sydney Children's Hospital, which is a tertiary, teaching hospital in Australia. The hospital provides health-care services to children who live in the local metropolitan area or who come from rural and remote areas of New South Wales. Patients are able to access information about the hospital and various health conditions from the hospital's website. No information was available regarding the uptake of preparation-specific information. The hospital does not have a general pre-admission clinic; however, various departments and various doctors within departments provide specific pre-hospital preparatory information.

Children who participated were aged 6 to 10 years (M = 7.72 years, SD = 1.43 years) and were recruited either from the Paediatric Recovery Unit following day surgery (n = 68, 66.7%) or from the wards following overnight admissions (n = 34, 33.3%). The following exclusion criterion was applied: (i) parent/child with insufficient English ability to complete the surveys; (ii) children with cognitive impairments that would hinder survey completion; and (iii) children with life-threatening conditions. A total of 172 child–parent surveys were given out prior to a child's discharge from hospital and 102 completed child–parent surveys were returned. It was not possible to obtain reasons for non-completion.

Measures

A separate child and parent survey was developed to obtain information about the child's experience in hospital, the nature

of information that they had received prior to the admission and what information the child/parent thought would be helpful to receive. The survey was developed collaboratively by a group of health-care professionals through discussion and consensus. However, beyond establishing the face validity of the questions through peer review, other aspects of survey validity (e.g. construct validity) and reliability (e.g. test–retest reliability) were not formally addressed. It was not possible to assess validity by comparing parent and child responses given that different information was requested from each.

The children's survey was a 9-item survey consisting of both open-ended questions (e.g. 'If your friend had to come to hospital what would you tell them to make it better for them?') and closed-end questions (e.g. 'Have you ever stayed in hospital before Yes/No'). Children were asked to indicate whether Mum, Dad, a doctor or somebody else provided the information.

A 16-item parent survey consisted of five main sections: (1) demographic information (e.g. child's age); (2) this admission (e.g. 'What is the reason for your child's current admission?'); (3) the amount and type of notice (e.g. 'How much notice did your child's health-care professional give you that your child needed to be admitted to hospital?'); (4) the parent's own perspective (e.g. 'How satisfied were you with the information that your child was provided?'); and (5) the types of questions that the child asked about going to hospital. Surveys are available from the first author on request.

Procedure

The current study was part of a larger action research project (Reason & Bradbury 2008) aimed at better understanding and, where necessary, improving the preparation that children receive prior to hospitalization. Ethical approval was obtained from the South East Sydney Area Health Service Research Ethics Committee. Informed parental consent and child assent was obtained.

Data collection was carried out over a 12-month period of time (March 2007–March 2008). Parent and child surveys were distributed to the parents of day-surgery patients in the Paediatric Recovery Unit and collected prior to their discharge from hospital. Patients in the overnight wards were given questionnaires once they were scheduled for discharge. All surveys were completed and collected prior to the child's discharge from hospital. Parents were advised to complete their surveys independently to their child. Parent and child surveys were coded so that parent–child dyads could be matched. However, all surveys were anonymous.

Results

Participant characteristics

The sample included 102 children (aged 6–10 years, M = 7.72, SD = 1.43), with 58 boys and 44 girls. A total of 82 (80.4%) parent surveys were completed by mothers, 17 (16.7%) by fathers, and 1 (1%) by a guardian.[1] The majority of children completing the survey (94.1%) reported that they had previously visited someone in hospital, and 61.8% reported that they had stayed in hospital before. About a quarter of children (24%) who participated in the study had had three or more prior admissions. Children with previous experience of hospitalization did not differ from inexperienced children in their responses to questions regarding satisfaction with the preparatory information provided. Those children whose parent rated the previous experience as being more distressing were more likely to have a more distressing current hospital experience ($r = 0.39$, $P < 0.01$).

The reasons for children's hospital admissions were as follows: general surgery (most commonly hernias, circumcisions, appendicectomies (n = 21; 20.6%), gastroenterological surgery (n = 25; 24.5%), orthopaedic surgery (n = 12; 11.8%), ear, nose and throat surgery (n = 9; 8.8%), plastic surgery (n = 1; 1%), respiratory conditions (n = 7; 6.9%), dermatological conditions (n = 6; 5.9%) and general medical conditions (n = 11; 10.8%). A total of 75 (73.5%) admissions were planned, in that parents had more than 1 day's notice, whereas 27 admissions (26.5%) were unplanned (e.g. due to asthma attack, abdominal pain, injury).

Information provided to children

All children who had planned admissions reported that they had been informed about needing to go to hospital. A total of 35 (46.7%) children reported that they had been informed by one or both parents, 31 (41.3%) children reported they had been informed by a doctor, and 9 (12%) reported they had been informed by a doctor and parent(s). The amount of notice that children having planned procedures received about their admission ranged from no notice to more than 1 year's notice. Nine (12%) children learnt about their impending hospitalization within 24 h of their admission. Seven (9.5%) children received 2 to 6 days' notice, 10 (14%) children received 7 to 14 days notice, 19 (26%) children received 2 to 4 weeks' notice, and 29 children (39%) received more than 1 month's notice of their hospital-

[1] Two other respondents did not identify their relationship with the child.

ization. The amount of notice provided was not significantly correlated with the age of the child ($r = -0.06$, $P = 0.53$). Nor was the amount of notice significantly correlated with ratings of child distress ($r = 0.10$, $P = 0.34$).

Most children reported feeling happy with the amount of information that they received prior to their admission (n = 63, 85%), some stated they would have liked more information (n = 9, 12%) and two individuals (2.7%) stated they would have liked less information. Children who were satisfied with the amount of information they received before coming to hospital subsequently reported that they would be less scared if they ever needed come to hospital again in the future ($P < 0.05$).

According to parental report, 66.7% of children booked in for planned procedures received verbal information about the forthcoming hospitalization and approximately a quarter (26.7%) received information via a letter (typically the same letter that was addressed to parents). For the children who received preparatory verbal information, in 16 cases (32.7%) this was provided by the parent(s) alone, in 12 (24.5%) cases by the parent(s) and doctor, and in 21 (42.9%) cases by a health professional (typically a doctor).

Planned versus unplanned admissions

According to parental report, children who came to hospital for an unplanned admission found the experience significantly more distressing than children who came for a planned admission ($P < 0.01$).

Questions asked by children

Of the 102 parents/guardians who completed the parent survey, 65 identified one or more question(s) that their child had asked about going to hospital. A total of 163 questions that children had asked prior to their hospitalization were documented. Questions related to timing (e.g. duration of admission, length of procedure), pain, procedural information, anaesthesia, needles, whether parents can be present, activities to do in hospital, seeking explanations ('Why' questions), hospital environment, seeking reassurance and miscellaneous questions. See Table 1 for the number of questions asked in each category and examples of questions asked.

Children's advice to a friend

The most common themes to emerge from advice that children would give to a friend coming to hospital were: (i) reassurance not to be scared and that it would be OK (e.g. 'Don't be scared', 'You will be fine – it's not that bad'); (ii) reassurance that the doctors and nurses are nice and will look after them (e.g. 'The doctors and nurses are friendly', 'Trust the people who work there'); and (iii) information about fun activities they can do while in hospital (e.g. 'There are really fun games', 'You get to watch TV in bed').

Information received by parents

Most parents reported that they received information about any procedure that their child was required to have (95.8%), anaesthesia (if required) (91.9%) and about their child's condition (92.6%) (see Table 2). Somewhat fewer parents reported receiving information about the hospital environment (75.3%) and about how their child might feel (78.4%). A total of 86.6% of parents reported being advised about options for parental presence during the admission and any procedures. If received, parents rated this information as very helpful.

Discussion

The current study provides insight into the nature of information about a child's hospitalization received by children and their parents. Moreover, the study also sheds light on the sort of information that children would like to receive prior to coming to hospital. Children who were satisfied with the amount of information they received prior to coming to hospital rated themselves as less scared should they need to come to hospital on a future occasion. This is consistent with other studies that have found children who are better informed about a forthcoming procedure generally had lower distress and better adjustment during and after the procedure (Schmidt 1990; Margolis *et al.* 1998; Claar *et al.* 2002). The current study also found that children who had had more distressing past hospital experiences were likely to have a more distressing current hospital experience. This highlights the potential value of identifying children who have had negative previous hospital experiences and for greater resources to be devoted to helping these children and their families develop and implement helpful coping strategies.

Parents were found to have a major role in providing their child with information about the forthcoming hospitalization. Almost half (46.7%) of the children scheduled for a planned admission were informed about the hospitalization by one or both parents. A further 12% of children received information from both a doctor and their parent(s). Moreover, parents

Table 1. Parental report of questions asked by children about going to hospital

Category of questions	Number of questions asked	Examples of questions asked
Timing	43	How long do I have to stay?
(a) Duration of stay	(31)	How long will the procedure take?
(b)Timing of procedure	(9)	When can I eat?
(c)Timing – other	(6)	When can I get out of bed?
Pain	28	Will it hurt?
Procedure	22	How will it be done?
		Are they going to open my tummy?
		Will they use the same camera for the top and bottom?
Anaesthesia	13	What if the anaesthesia doesn't work?
		How will I go to sleep?
Parents	12	Will mum stay with me?
		Can Mum or Dad be in surgery?
Seeking explanations ('Why' questions)	10	Why do I have to have it done?
		Why do I need to go to hospital?
		Why can't I eat?
Hospital activities	8	Will there be a play station?
		Will they have things for me to do?
Needles	9	Will I have a needle?
		Will they do blood tests again?
Hospital environment	7	Where will I sleep?
		What will I get to eat?
		Can I go out of my ward?
Seeking reassurance	6	Will everything be OK?
		Will it make me better?
		Am I going to die?
Miscellaneous questions	5	What do I take (to hospital)?
		Do I get a day off school?
Total	163	

Table 2. Information received by parents and ratings of helpfulness

Type of information	% of parents who received	If received, helpfulness rating (Mean, SD) (0 = not at all helpful, 10 = extremely helpful)
What is involved in the procedure (if applicable)	95.8	8.46 (1.81)
About the condition	92.6	8.42 (1.81)
About the anaesthesia (if applicable)	91.9	8.51 (1.93)
Answers to any concerns	91.3	8.82 (1.87)
Possible time schedule	87.4	8.01 (2.41)
Options for parental presence	86.6	8.85 (1.62)
How your child might feel	78.4	8.52 (1.74)
About hospital environment	75.3	8.28 (1.86)
How to get information	59.4	8.10 (2.03)

recorded a large number of questions that their child had wanted to know prior to the hospitalization. In light of the significant role that parents play as information providers to their child, attention needs to be directed to equipping parents to carry out this role most effectively. It is not known how confident parents felt in providing their child with the relevant information. Given that one of the categories of questions that children asked parents about related to the hospital environment, it is worth noting that one quarter of parents in the study sample reported that they themselves had not received information about the hospital environment. Hence they are likely to have felt ill equipped to provide their child with accurate and helpful information.

Not surprisingly, children who had an unplanned admission rated the hospitalization experience as more distressing than children who had planned admissions. There are many factors

that may have contributed to this result, most of which stem from the fact that the children who came for unplanned admissions did not have time to prepare themselves for coming to hospital and may not have understood the physical symptoms they were experiencing. These results highlight the importance of forwards planning and scheduling procedures where appropriate to avoid unplanned emergency admissions.

Children who participated in the survey were asked about what they would tell a friend who needed to come in to hospital to make the experience better for them. A common type of response was that children indicated that they would reassure their friend with comments such as 'Don't be scared', 'You will be fine – it's not that bad'. It is likely that children made these comments because they themselves would have liked to have *felt* reassured.

It was surprising that the amount of notice that children received prior to their hospitalization was not associated with distress levels. Previous research has found that children older than 6 years of age responded to preparatory information presented within 24 h prior to surgery with heightened anxiety (Kain *et al.* 1996). Spencer and Franck (2005) found that parents had a 10% increase in knowledge when they received a written information leaflet at the presurgical assessment clinic rather than by post. However, parents who received the information leaflet within 2 weeks of their child's surgery also had a 10% increase in knowledge. The relationship between the timing of information and child and/or parent distress may have been less clear in the current study given the broad range of patients in the sample, including planned and unplanned admissions. Moreover, among the planned admissions, the reasons for the admission varied widely from major orthopaedic surgery to management of chronic conditions such as eczema and obesity. The sample size of the current study was not sufficient to run subgroup analyses for specific patient groups. It should be acknowledged that the data obtained in the current study were from one particular tertiary children's hospital, collected over a 12-month period. Hence, generalizability of results is not known.

In summary, the current study found that children had many questions about a forthcoming hospitalization. Parents played a significant role as information providers to their child. Given that we know that accurate preparatory information helps children cope with a medical experience (Schmidt 1990; Margolis *et al.* 1998; Claar *et al.* 2002), further research seems warranted to assess how competent parents are to accurately address their child's information needs.

Key messages

- There is little information about what children and their parents would like to know about a forthcoming hospitalization.
- Children and their parents can provide this information by age-appropriate surveys.
- Children have many questions about forthcoming hospitalizations, regardless of the reason for their admission.
- Parents play a significant role in information provision to their children.
- Further research is needed to assess how competent parents are to accurately address their child's information needs.

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