

Practice and knowledge: an approach to action research

How can health visitors begin to understand and explain their knowledge and skills to inform improvements in practice? In the first of two papers, the authors explain how action research and a very personal approach allowed them to try to develop a model for understanding

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Action research is a method of developing critically reflexive practice in which theories are integrated and new theories of practice emerge.¹ McNiff *et al*² suggest that action research can lead to:

- practitioners' own personal development
- improved professional practice
- improvements in the organisation
- a contribution to the good order of society.

Collaborative action research also provides a forum for exploring ideas.

One of us, Robyn, was looking for a forum for exploring ideas coming from her own research about putting new parenting theories into practice in health visiting. Realising there were many concerns about health visiting beyond her own, she suggested using collaborative action research to investigate areas of common interest to herself and her colleagues.^{1,3} Six colleagues expressed interest in forming a group to explore current topics of debate in health visiting.

At that time – 1997 – some of our concerns centred on the threat GP fundholding held for health visiting. We were aware of a general unhappiness about threats to good practice arising in part because we could not explain to policy makers what we were doing.

In the group our intention was to be as democratic as possible, so everyone would have equal voice and gain from the experience. Glennie and Cosier⁴ suggest that such groups succeed initially if they have someone to suggest a subject area and a process. Ownership of the content and the process is then transferred to the group as soon as possible.

A structure for the group and ground rules emerged in the early meetings. In summary,

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these were:

- a closed group initially, to enable progress
- monthly meetings for two hours at lunch time
- meetings tape-recorded to capture moments of insight
- personal comments to remain anonymous in meeting notes
- work towards having something useful to say within 18 months
- commitment towards respecting each others' opinions.

Using McNiff *et al* suggestions² for planning research we decided to:

- identify a concern
- imagine possible solutions
- implement solutions
- gather evidence
- evaluate evidence
- write a report.

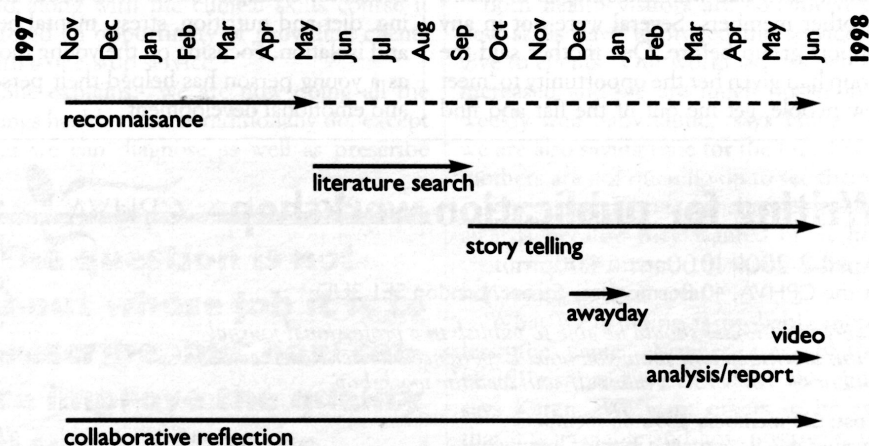
McNiff and others^{1,2,5} suggest that when the concern is a practical one, several cycles of implementation and evaluation may be needed. In our case the process of seeking to understand remained largely within the group and felt more linear. Using the headings listed above, we now describe the reflective phases we identify as reconnaissance, literature review, story telling and analysis for report writing.

Identifying concern

The first reflective phase took five months as we clarified our purpose. We called this a reconnaissance phase, although reconnaissance continued to some degree throughout as we remained open to new themes and influences on our understanding.

We began talking about our current concerns for health visiting. Some of us felt that

Figure 1: Action - reflection phases



Robyn Pound
Mandy Dams
Kate Gammon
Jennie Martindale
Caroline Page
Jan Stapleton
 health visitors
Bath and West Community NHS Trust

although we know we are helping our clients, and our clients appear appreciative of their contact with us, we find it hard to explain what we are doing, how we do it and what difference it makes. It was as if we knew a little about lots of things but were not recognised as experts in any one.

For example, when preparing evidence for court, Mandy was told: 'You can't say there is an emotional bond between that mother and that child, you haven't got a psychology degree. Your professional background will be questioned.'

There was also a feeling of insecurity because of the threat to health visiting from the pressure to balance resources. We are expected to show outcomes from our work and felt a need to demonstrate that we are, to some extent, research-based.

Kate expressed her dissatisfaction with the ways that the role of health visitors are described; 'just listing the tasks we carry out does not adequately explain how we do the job and why the process is so important for clients.'

Health visiting is difficult to research using traditional methods, so we wanted to find a way to show how we work and explore the ways in which our practice can be effective.

As Mandy said: 'I want to be able to describe what goes on while I am doing it and how important that is in terms of supporting people. I want to know how you can

evaluate it and prove that it is good.'

Similarly, hunches and a 'sixth sense' about our work can mean we get to the point quickly and act effectively in helping people, but how can we explain this? We recognised that much of our professional knowledge belongs to each of us individually and privately. It appears that experiences on the job are internalised as intuition.

Robyn believes that her knowledge came from years of on-the-job experience, discussion and reading around the subject; in other words, her best knowledge to date.⁶ She needed to ask herself whether her intentions were founded on a desire to do her best for her client or assumption based on prejudice. How much does being a product of society influence our attitudes?⁷ We felt we drew constantly on different types of knowledge and wanted to understand more thoroughly how we acquired and used this.

We began to formulate sub-questions:

- what are the skills and knowledge we employ as health visitors?
- which qualities in our relationships with our clients make our work effective?
- how can we evaluate, improve and explain what we are doing?

Imagining a possible solution

Phase two consisted of three areas of activity: on-going discussions, best described as collaborative reflection; a literature search and story telling as we worked towards our aim of creating an explanation of how we 'know' and 'do' as health visitors.

From a literature review of the thoughts of others, a tentative model was produced for describing the different ways of knowing health visitors might use.

This model (which will be described in our second paper) formed the basis for the next phase of our reflections. We decided to focus on telling stories of incidents in our practice to try to make sense of, and find evidence for, the types of knowledge we were using.

Benner⁸ defines an incident as 'critical' if it made a difference to a patient outcome, or if it went unusually well or did not go well. Experiences that we notice, especially those that were particularly demanding or ordinary and typical, can help nurses reflect on their actions.

We wanted to try and capture some of the quintessence of health visiting in our stories. Johns' work⁹ encouraged us to think about the importance of our own and our clients' feelings about the work. He offers questions to ask of stories to help explore their significance.

We felt able to present our emerging ideas to colleagues at an awayday. This made us think about the changing dynamics within our group. We videotaped a meeting during the writing up phase so that we could see ourselves in action.

Implementing solutions

In the first two phases we thought about our skills and the types of knowledge we draw from, which we felt were particular to health visiting. As we shared ideas, the strength of our commitment to what we do shone out. Some of us recognised, and were shy about, our passion for the work because to others it might appear irrational, emotional and unscientific.

We asked how could we understand the specific knowledge we have acquired through doing the job? How can we claim that it is valid? Talking about experiences which stand out as important proved a useful way of capturing significant elements in the work.

Each story acted as a trigger for other stories. Box 1 contains an edited example of one of our conversations, providing some indication of the living, evolving nature of our professional knowledge and the value of shared reflection.¹⁰

We tried to notice how we have come to know new things and to enhance what we know in the light of new experiences. Together, through critical collaborative reflection, we began to identify and confront contradictions between our intentions for desirable practice and what we were actually doing.

Effective practice appeared to demand certain qualities from the health visitors' style, but the problem of how to understand and explain how we knew how to work still hung over us. Where does our knowledge come from?

The literature review helped us clarify what has already been written on the subject of nurses' knowledge and developing expertise, notably Fox,¹² Carper,¹¹ Benner,⁸ Johns,¹³ Watson¹⁴ and White.¹⁵ It seems that professional knowledge evolves for each practitioner through an integration of personal characteristics, experiences and information to form attitudes and perceptions which affect how future experiences are understood.

Personal professional knowledge described in this way implies a 'total' available knowledge which includes aesthetic, empirical, ethical and spiritual patterns of knowing, as well the unique influence of the personal self, on how to do things and what is known.^{11,13,14} The socio-political context provides the setting for what we know.¹⁵ All knowledge, it appears, is subject to revision and change over time, and is thus 'living' knowledge.¹⁰ The nature of this knowledge will be discussed in greater depth in the second paper.

We began by telling each other more detailed stories about our work. By asking questions about the stories and what made them critical we tried to identify the meld of knowledge and skills we were using. Each of us called on our own experiences to probe ►

Box 1: An edited example from a conversation

C: 'Someone said the other day: "Oh, I don't like health visitors, they're so nosy." I went away and reflected quite a bit and now I think when I'm going into a house: "Do I need to know this?"'

M: 'That's why I have problems with the models some areas use. One I saw is a 10-page assessment and they ask specific questions about every single aspect of the family's functioning and I think: "Do I need to know this?" Some people say: "Well, I would never have said anything if you hadn't asked me" and other times you get the complete opposite.'

R: 'Also, it doesn't give any credit to your professional skill in being able to allow the conversation to flow on to what is really important for the client at that time.'

J: 'Someone once said to me: "Because you asked questions, I feel I have to think of something." I was quite shocked by that.'

K: 'You might get it wrong because it's your agenda.'

C: 'The skill is knowing when to ask questions and when to listen.'

R: 'We are talking about an "art of health visiting".'

K: 'You can't get it right every time. Picasso didn't do a fantastic picture every time.'

Box 2: A health visitor's story

Her partner went out to get the older children from school and when I'd finished the check I turned my attention to her. On reflection I think it was probably a combination of those circumstances that made her chat: he'd gone, I was about to go but hadn't put on my coat. I said something like: "What about you?" She began telling me she had been suffering from aching joints and couldn't sleep. She had been to the doctor who said, "it's stress".

Before her partner came back I asked how I could help. She said: "Can you help me explain to him how I am feeling?" It was amazing how sympathetic he was once she got talking about how she felt. The children bounced in and she lost her flow, so I left with an appointment to go again.

When I thought about it, her story had brought back feelings about my own mother. I felt drained.'

Here, too, storytelling in small groups helped make more obvious a unity of purpose. We offered our model of health visitors' knowledge for discussion and asked colleagues to consider contradictions arising from it (this will be discussed in paper two).

Gathering evidence

Some clients were asked for their perceptions of some events we talked about. A videotape made of the group while we constructed this report reflects the respect we show for the contributions each of us makes.

Evaluating evidence

The importance of our intuitive knowledge learned through experience, and qualities such as empathy, authentic personal involvement and certain communication skills were found in so many of our stories. By being open to challenge from each other, a wider audience, such as colleagues at the awayday and you in this journal, we are finding a way of validating our ideas. We welcome your comments.

We recognised that respect for each other, and value accorded to each point of view, supported personal and professional growth for each of us. No one has left the group. The result has been thoughtfulness in our practice. Jan's words spoke for us all, 'I've become much more aware of what I'm doing, how I'm doing it, and how the other person is reacting to me.' Within the city

Report writing

No one story explained the range of skills, personal attributes and knowledge which we felt fully described the 'what' and 'how' of our work. For this, and for reasons of client confidentiality, our story is a composite one to include common themes occurring in many of our stories. We wanted to show that only some professional knowledge will be research based. We believe our personal and professional knowledge is presented with a style and pace which experience has modified to be appropriate to the circumstances.

Like Cowley,¹⁰ we were struck by the number of ordinary routine visits, such as those for developmental checks, which led to unexpectedly valuable work. Themes from several accounts have been combined to demonstrate some of the skills we identified, Box 2.

'A health visitor's story' shows how the skilled health visitor is able to shift gear from the policy defined developmental examination of a child, and negotiated problem solving, to an accepting, listening ear which allows the parent to voice anxieties safely, make sense of them and begin to plan her own solutions. The context of the family and the health visitor's previous knowledge are important in her understanding of the whole picture.

Here the health visitor moves beyond her research-based knowledge of child development to use personal attributes of empathy, experience-tuned intuition, communication skills and caring. Jennie showed her intuition: 'Something said to me, don't keep asking questions, let it come out.' An environment is created in which the woman can begin to understand her situation by voicing it, state her needs and recover.

Conclusion

Action research offers a method for practitioners to identify concerns, find possible solutions and evaluate and improve practice. Collaborative reflection describes a process in which all research members have as equal a stake as possible in the safe exploration of ideas.

Implicit in this is an atmosphere of respect and regard for each other. Sharing stories of our health visiting experiences offered a forum for exploring what we do. Each story invited similar stories to be told while our ideas gained credibility in the group. Looking for common threads, the purpose and style of how each of us works, began to be

identifiable among the diversity and similarity of the accounts. There is evidence in the meeting notes of our coming to recognise new aspects to our work.

We have been able to identify qualities within our styles which make the work effective. Some of these qualities are to be found in the composite story. Listening skills, empathy and respect for the other seem central to effective work if we are to concentrate on concerns most meaningful to clients. Some of our stories showed we give a great deal of ourselves to the process.

We use more ways of knowing than can be captured in the concept 'research-based'. In the continuing research process we intend to involve clients more while we focus on evaluating and improving what we are doing. The search for methods of explanation continues.

In paper two we will examine our different ways of knowing more closely and begin to

explore a contradiction which exists between our roles as professional experts who know and our ability to foster client self-growth.¹² We will also explore how experienced health visitors are able to create a professionalism which embraces both of these contrasting approaches.

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