'The Challenge of Embedding Action Research Projects in Clinical Settings - Comparisons from three Projects Addressing Palliative Care for Chronic Life Limiting Diseases'

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CONTEXT

Many health care professionals, patients and relatives perceive palliative care as a speciality that is concerned with cancer and dying patients – the challenge of the three action research projects is to seek to embed palliative care principles into the disease management of heart failure, advanced respiratory disease and dementia, all of which are chronic life limiting diseases.

The establishment of the action research projects was based on the HSE and Irish Hospice Foundation Extending Access Study which explored in an Irish and International context how palliative care is considered for people with diseases other than cancer with a specific focus on heart failure, chronic obstructive airway disease and dementia. Although there was overwhelming literature to support the need for palliative care for people with these disease, there was a dearth of service models to demonstrate how this could be achieved. Key recommendations in the report of this Study – Palliative Care for All Implementing: Palliative Care into Disease Management Frameworks [1] required clarification of how palliative care interventions could be included within these disease management settings

Funding for three research projects was obtained which would allow for the employment of 3 part time project officers over two years, using action research methodology, to introduce palliative interventions in the following clinical settings: heart failure, dementia and advanced respiratory disease. Applications were invited and all projects required collaboration between the disease specialists, primary care and specialist palliative care.

Although the three projects have the same objectives, because they are taking place in different sites, with different personnel, the outcomes are already very different. This presentation will examine the implementation of each project outlining the challenges and developments.

IMPLEMENTATION

Key to the three projects was the need to build individual relationships and develop opportunities for consensus and collaboration amongst the key stakeholders. The extent to which this has been achieved has varied in each of the sites, and is consistent with those outlined by Coghlan and Brannick [2], including the existing culture, whether the researcher is 'insider' or 'outsider' and strength of relationships prior to project commencing.

The size and scale of sites has also influenced the rate of progress as well as the different skill sets that the each of the project officers brings. Enabling meaningful engagement, consensus and collaboration at steering group meetings where it is difficult to get optimum attendance has proven to be one of the most significant challenges associated with the projects [3].

Extra efforts to build relationships with key participants outside of these meetings have taken inordinate amount of time from the project officer's working week. The power and hierarchy in relationships also deserves attention, especially as the projects take place within a health care setting and cannot be isolated from the cultural norms of nursing and medical hierarchies [4].

In the project sites that involve more than one base, the difference in approach to care has resulted in different priorities being set, which has proven to be challenging from a time management and feasibility perspective. This observation has resulted in reducing the scale of one of the projects. The bureaucracy involved in seeking ethical approval from several committees for one project also caused some frustrations [4].

The use of reflection and action learning sets has been a key foundation to the work of the project officers. The reflective diaries have provided opportunities for research officers to critically think about the issues that have presented, although these have not been fully shared[5]. The monthly meetings for the three the project officers were formally established as learning sets a third of the way through the project, and subsequently provided a safe space for discussing critical and confidential issues that are posing for individual project officers [6]. The use of similar methods of data collection, and sharing results, has been another tangible benefit of the co-operation and harmonisation of the three projects.

Although one of the key tasks of the action researcher is to reduce the isolation that can exist between health care professionals, they themselves have valued the peer support that they have offered each other to date, as they seek to build relationships and consensus in their project sites and deal with their role duality. The role of the Irish Hospice Foundation as a key stakeholder in each of the projects has facilitated such harmonisation, although the role of Irish Hospice Foundation in observing and monitoring process and progress was another duality relationship to overcome [2].

Of particular note are the barriers, inhibitors and ladders of inference [2] that deflect from the planned progress of the work of the projects. Common amongst all projects is the time it takes to build relationships with people who, although are motivated to participate on the project, have competing priorities and do not have research protected time. One project officer observed that there has been a visible increase in the workload of all of the staff related to the project since the work commenced. Predictably staff turn-over has also interfered with progress. Challenging the existing organisational culture and anticipated resistance to change is another common thread, alongside the ability of staff to use reflection to challenge their culture and beliefs. However although previous use of practice development and use of internal facilitators was seen to be an advantage in ne project [7, 8], as well as the merits and values associated with the project aims.

Although opportunities to become familiar with action research methodology were made available to the key stakeholders of each project – these were not fully availed of, often due to time constraints. Consequently the ethos of action research approach was not fully understood by all, and as a result there were some misguided expectations from key participants in terms of immediate actions, and the practice of consensus and collaboration was not always acted on [9].

While there have been a small number of action research cycles that were unsuccessful these have provided opportunities for learning and proved as a catalyst for more meaningful action research cycles that are continuing to bring about the desired goal of introducing palliative care interventions within disease management frameworks.

Conclusion

Bridging the theory – practice gap by using action research has been hugely beneficial in these projects, and this method of research is being used increasingly in health care settings [10]. It has allowed for the realities of the acute hospital setting to dictate the implementation of action research cycles. The downside of this is that most of the work happens in this theory - practice 'gap'. An ongoing challenge for the project officers is moving between these two worlds, whilst also creating their own virtual space without undue isolation.

These projects have provided the opportunity for staff to work together to identify issues, agree and implement solutions within an evaluative framework. They enable a communicative space for health care staff to introduce change in a real working environment with the support of the key players and the skills of an action research project officer.

In addition they are providing a unique opportunity to compare and contrast the impact of using action research as a methodology in three health care settings.

Most importantly they have also presented a platform for challenging the myths in relation to palliative care, and assisted in changing attitudes and beliefs that palliative care is appropriate and necessary for all people with life limiting diseases and can be delivered within disease management frameworks [1].

References:

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