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PEER REVIEW:

ORGANISATIONAL LEARNING FOR NURSES

A thesis presented in partial fulfilment of the requirements for the degree of Master of Arts in
Nursing at Massey University

Brigid Halmai Te Kahui McRae
1998

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Abstract

Organisational learning as it relates to the development of a peer review system within a clinical area of nursing practice is the focus of this study. Sixteen Public Health Nurses, with the manager of their service, and three key managers from the employing Crown Health Enterprise in provincial New Zealand, took part with the researcher in this praxis-oriented participatory action research process. A framework of the learning organisation was created to direct the research inquiry and evaluate data in relation to the developing peer review system.

Through the use of critically reflexive discussions in an ongoing spiral of planning, implementing, observing, and assessing, this study illuminates the growth of the learning organisation and the building of a peer review system, within a cost-conscious healthcare service delivery environment. The account of the research process includes factors facilitative of, and critical to, the learning organisation. Use of many direct quotes from participants creates a context against which to visualise problems and constraints faced by the research group, and offers the reader a decision trail with which to resolve issues of credibility.

Use of the peer process, it is suggested, will generate vital information about organisational performance, which will enable nurses to assume legitimate control of clinical nursing workplaces. Conclusions derived from this study suggest that peer review and the learning organisation are important tools for both assuring the quality of clinical nursing performance and securing organisational goals.

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CHAPTER ONE

Background to the study

Introduction

With the most recent restructuring of the clinical workplaces of nurses in New Zealand, has come a commercially focused, quality-conscious environment and the need to 'work smarter' (Troughton, 1993, p. 1). The need for efficient and effective health service delivery has created a new awareness of performance management, with a spotlight on performance appraisal for health professionals. Performance appraisal practices for nurses in this country are seen to meet neither organisational need, nor the needs of the nurses who work for these organisations (McRae & Ramsey, 1992). The challenge for nurses, faced with inadequate performance appraisal tools, has been to design profession-specific, context-sensitive performance appraisal systems that will recognise specific competencies of particular nursing roles.

A group of Public Health Nurses and their manager, employees of a regional Crown Health Enterprise (CHE) in New Zealand, have elected to develop a peer review appraisal system. These nurses, working with the researcher, together with three top level managers employed by the same CHE make up the research group.

In this chapter, the links between performance appraisal and performance management are established, and these human resource management issues are located within the organisational context of the changing New Zealand health service structures. The process by which the peer review model was developed by the research group of nurses is outlined, as is their peer review system. The point which the peer review process had reached at the beginning of the study is clearly indicated. The action research methodology and the framework for analysis, developed from an organisational learning perspective, are introduced. A guide to the presentation of this thesis concludes the chapter.

The Research Focus

This study describes the development of a peer review process for and by 16 Public Health Nurses, who are employees of a Crown Health Enterprise (CHE) in New Zealand. The research has relevance to the discourse and practice of both peer review and performance management for nurses. As well, this study is pertinent to discussions concerning professional practice and accountability for nurses.

Performance Appraisal and Performance Management

Performance appraisal practices describe aspects of the human resource management procedures that exist within an organisation and contribute to the evaluation of individual job performance. Performance appraisal practices include employee selection practices, induction and orientation practices and job descriptions. As well, explanations of performance standards and articulation of performance expectations for each individual, as well as the performance appraisal process itself are seen as integral to the practice of performance appraisal.

Career development practices exist in organisations to match the needs of employees with potential/ability for advancement, to the needs of the organisation. Training and development resources in such an organisation are tailored to ensure that both the needs of the organisation, in terms of appropriately skilled nurses, and the needs of the nurses, in terms of appropriate training and education to meet advanced career opportunities, are met.

Performance appraisal practices and career development practices play a key role in performance management cycles. Performance management is generally viewed as an integral part of the human resource management process. Existing performance appraisal and career development systems for nurses in this country have been seen as flawed, in that they neither meet the needs of nurses nor of the organisations where nurses work (McRae & Ramsey, 1992). Speculation about ways

to improve the situation leads to a consideration of the organisational context of the health services, within which performance management systems exist.

The Organisational Context

There are complex issues surrounding career development and performance appraisal for nurses in New Zealand. Not surprisingly, these issues are intimately linked with the organisational context within which nurses are employed. Tax-funded health service structures, such as the CHE that employs the Public Health Nurses of the research group, are shaped by and interdependent with, the political forces that direct social and economic policy in the wider community. As such, the health service organisations are subject to frequent restructuring to align with variations in the political climate of the day.

This has resulted in first, an array of approaches to the management of the health service delivery organisations. Secondly, the upheaval associated with each round of bureaucratic restructuring has reduced the attention and resources directed to the management needs of the various health professional groups who deliver the health care services. Management systems which would support the work of the health professionals include effective performance management systems. It is argued that the creation and use of effective performance management systems by the organisations responsible for health service delivery in this country is underdeveloped. Further, it is suggested that performance management will assume a greater priority as the current restructuring of government owned health service delivery organisations moves towards a commercial model of service delivery.

Structure of the Health Services

As with other government operated services in New Zealand, there have been several rounds of bureaucratic restructuring within the health services in the last decade, the most recent of which in 1993 saw the establishment of Crown Health Enterprises (CHEs) to replace the Area Health Boards

(AHBs) of a former period. The principal difference with the new-look health services of 1993 was a funder-provider split, whereby four Regional Health Authorities (RHAs) were created, as funding authorities, to manage the financial resources previously allocated to the 14 AHBs. The 23 CHEs, which were created following redrawing of previous AHB boundaries, would now tender to the RHA for funds with which to provide health services, formerly provided by the AHBs. There was an expectation that other non-Government agencies would compete with the CHEs to secure RHA funding for the provision of particular health services.

Present objectives for Health Services

The Government's objective in setting up the 23 CHEs in New Zealand was to provide 'as much health as possible for each dollar spent' (p. 1), said Dr Peter Troughton (1993), the man in charge of the unit set up to direct the establishment process and monitor the results. For Troughton (1993, p. 1) the deficiencies in the then current system were readily apparent:

There is little accountability, there are few incentives to make sure each dollar is spent to maximum effect, and there is no focus to encourage hospitals to work smarter. And the end result is to waste health dollars and frustrate those working in the system. Our job is to create the kind of environment that will allow people working in the public health sector to do what they have been trained for; to work together to provide top quality health services.

The emphasis in the quote above has been added to convey the relevance of this study to the fiscal and commercial pressures which shape the clinical practice environment for nurses in New Zealand. It is argued that managing performance in the public health sector in New Zealand, given these pressures, is a growth area that managers in the health industry will not be able to ignore. There is a strong suggestion that the lack of effective performance management, which appears to be a feature of health service organisations in this country, also characterises service organisations unrelated to health service delivery. It is relevant, at this point, to look at a kaleidoscope of issues

faced by service organisations in North America, in the belief that some if not all may become considerations affecting performance in nurses' workplaces in New Zealand.

Service Organisations

In attempts to improve economic performance, the focus of management planning in service industries has tended to follow a predictable path. Ulrich, von Glinow and Jick (1993) note that in the past, planning cycles within commercial organisations have tended to emphasise capital over competence, which is to say that most business planning efforts have highlighted financial requirements and their implications. Traditionally, Ulrich et al claim, there has been less planning attention to human resource management issues. The quality of the workforce, according to these authors, is said to be declining. A number of factors are seen to contribute to this scenario, such as the demographics of an ageing workforce and the smaller number of academically qualified entrants into the workforce. In addition, there is the claim from Ulrich et al (1993) that the quality of the available education has declined markedly in North America, so that as a result, real competence has become an increasingly scarce resource. This situation has created an imperative for service organisations to provide adequate training and support for all employees, and to nurture their best performers (Ulrich et al, 1993).

While it is interesting to speculate how the issues outlined in the preceding paragraph might affect nurses' work performance in New Zealand, this is an area which is presently unresearched. Certainly, consideration of such issues adds weight to the argument for supporting the present workforce with appropriate performance management practices. The current reality, as mandated by the directives from the Crown Health Establishment Unit, headed by Troughton, is that human resources and human resource management initiatives, of which performance appraisal is a vital part, are increasingly important in the health services industry in New Zealand.

Focus on Health Professional Performance

Troughton (1993) states that managers in the health service organisations should be concerned with providing the management systems that will best support the clinical work of the health practitioners employed by the CHEs, of whom nurses are by far the largest group. Hence, it is argued, managing health professionals and improving health professional performance will become an increasingly important part of this new health service delivery environment.

For historical reasons, which will be outlined in Chapter Two, management for health professionals and measuring and improving health professional performance are presently under-emphasised in the health service. Resources, as Ulrich et al (1993) suggest, tend to be directed elsewhere. Because of this, nurses have encountered difficulties in their attempts to create effective performance appraisal systems.

A dearth of research concerned with the practicalities of peer review, means that the research group of nurses, who designed and implemented the peer review system of this study, are, in many respects, pioneers. While the ground-breaking aspects of their work are included in this report, the study is primarily concerned with the developing peer appraisal system. The community-based role of the Public Health Nurse, and the independent focus for each practitioner have accentuated the need for a performance appraisal system which is sensitive to context. The work environment of the Public Health Nurse allows neither manager nor peers to have direct access to the nurse/client interaction. Assessment of performance in such a situation inevitably begins with self review of performance.

The Public Health Nurses' Role

Public Health Nurses are registered nurses employed by CHEs who work almost entirely in the community. These nurses provide public health and personal health care services to individuals, families, groups, institutions and the wider community. Each nurse, depending on experience, works

relatively autonomously, and has limited opportunities for peer consultation and on-the-job training. The work is extremely varied and requires extensive liaison and networking with other agencies, and health and social service professionals (Briascio, 1994, p.7).

The registered nurses who were members of the research group are Public Health Nurses in provincial New Zealand. Their service covers an extensive geographic region, which includes four urban areas as well as many scattered rural communities. They are managed by a registered nurse who has had considerable experience as a Public Health Nurse. The Public Health Nurse group, with their manager, began discussing performance appraisal and peer review in 1993, following increasing frustration with the generic, manager-initiated appraisal process then in use within the employing CHE.

In the manager's view, this existing appraisal system required '*considerable imagination to generate useful information for the nurse or for the manager*' (Briascio, 1994, p. 5). The manager was also critical of the generic performance appraisal tool in that it did not acknowledge the differences between the Public Health Nurses' role and that of their hospital-based colleagues. The generic nursing performance appraisal tool appeared to make no distinction between the close work environment which hospital nurses experienced with peers, and the independent community-based practice of the Public Health Nurses. The Public Health Nurses expressed an urgent need to the manager for a form of performance review which would enable them to assess and improve their clinical performance.

There were vaguely articulated expectations within the organisation at this time that, at some unspecified time in the future, a computerised generic appraisal system for all health professionals, as part of a comprehensive human resource management package, would emerge. The manager of the public health nurse group was reluctant to set up a temporary performance appraisal process for public

health nursing staff in the light of this information. However, she was concerned about the current lack of an adequate appraisal mechanism, and fearful that a future system would not enable reliable measurement of nurses' clinical performance (Briascio, 1993). It was agreed by the manager and the Public Health Nurses that a peer review process should be developed.

Development of the Peer Review Model

The manager of the Public Health Nurses approached the researcher, in her capacity as the staff development co-ordinator for the CHE, for assistance. At an initial meeting, all the Public Health Nurses, their manager and the researcher, identified objectives for peer review. These objectives were to:

- improve the quality of services delivered by Public Health Nurses
- improve personal performance
- improve effectiveness and efficiency in the use of resources
- monitor personal and team performance against measurable standards
- identify training and development needs
- motivate staff by providing positive feedback

The business of initiating peer review began with a general discussion about the development process. It was presumed that this would possibly take a year to develop (Briascio, 1993). All members of the group agreed that the process would be participatory, with the nurses, the manager, and the researcher attending monthly staff development sessions to plan the peer review process.

Over the next twelve months, a series of workshops with the nurses of the research group were facilitated by the researcher, who was then the staff development co-ordinator. The aims of these workshops were to develop:

- a workplace philosophy

- relevant and measurable nursing standards
- a peer review model

A workplace philosophy is a statement of values and beliefs generated by the group to reflect the Public Health Nurses' values and beliefs about their work. A working philosophy was required which resonated with both the organisation's mission statement and the service objectives for the group. As well as focusing the thinking of the group, the workplace philosophy would provide the link between professional aspirations and work targets. The philosophy was intended to be a living document that stated the following clearly:

- the work of this group of Public Health Nurses
- their professional beliefs about their work
- the goals of performance to which they aspired

The second objective for the participatory workshops with the Public Health Nurses was to develop relevant and measurable standards of clinical practice. While manager-initiated appraisal is more likely to use individual job descriptions, along with organisation and unit goals, to appraise performance, professional standards of practice have been identified as the most effective basis for measurement of performance by peers (Hickey, 1982, p. 69; Gordon, 1992, p. 672). Hickey contends that the reason that peer review may not be received well by some managers and nurses is the lack of proof that nursing performance can be improved with its use. However, it is suggested that it is possible to measure performance accurately when appropriate standards and outcome criteria exist. Houston and Luquire (1991, p. 205) state that performance standards are accountability statements which reflect performance expectations.

Hickey (1982) recommends that standards of clinical practice must be agreed by all parties prior to the introduction of peer review. Time and effort must be taken over the difficult task of

developing clear standards of practice and expected outcomes (Hickey, 1982, p. 71). Philp (1990, p. 18) stresses that standards must be realistic, have a real bearing on outcome, and have the commitment of the job holder. By defining standards, the objectivity of the peer appraisal process will be increased, thus allaying nurses' anxiety and validating feedback (Mio, Speros & Mayfield, 1985, p. 42A).

For a standard of clinical practice to be judged as relevant and measurable by the Public Health Nurses, it needed to accurately describe the work of the group, in outcome terms, ensuring positive outcomes for clients of the service, and meeting quality of service objectives. Thus, the links between professional aspirations and standards, and organisational and service goals, were strengthened.

The manager of the public health nurse group stated that the developing and refining of both the workplace philosophy document and the clinical standards, over an extended period, '*contributed to a sense of cohesion and common purpose within the public health nurses group*' (Briascio, 1994, p.9). In addition, discussion about the philosophy and the clinical standards was seen as '*a powerful tool to raise group consciousness as to the need for an appraisal system*' that would competently evaluate public health nurse performance.

It was decided by the research group, that for the purposes of the public health nurse peer review system, a 'peer' would be any Public Health Nurse employed by the organisation, regardless of experience or educational background. The nurses required that the manager select the peer groups. They were concerned that choosing their own group could result in a lack of balance, given the wide variation in experience and educational attainment. Groups of three to four members with varying levels of experience and skill were selected by the manager and agreed upon by the whole team.

Training in the various aspects of the peer appraisal process was also a feature of these participatory workshops with the public health nurses, their manager and the researcher. According to Hickey (1982, p. 69) nursing has poor socialisation in the area of evaluation. Training of all participants is an essential item of the implementation process (Fletcher & Howarth, 1989, p. 65). Hawthorne, Roe and Woods, (1989, p. 52) suggest that training should include topics such as evaluation principles and techniques, familiarisation with the tools and expectations of the process, and professional communication and negotiation skills. Training for successful peer review, say these authors, should also include role play and group discussion. Further, there is a recommendation that ongoing training should continue beyond the implementation phase and particularly as needs are identified by participants. Eventually, over a period of a year, a peer review process was designed and an appraisal tool was created.

Development of the appraisal tool

In 1994, working as a graduate assistant for Massey University, and by invitation from the group, the researcher continued her association with the public health nurse peer review project by working with the group to develop an appraisal tool for use with the peer review process. Pelle and Greenhalph (1987, p. 37) recommend that all participants be involved in the development of the appraisal tool, taking into account the objectives for peer review, and the service objectives for the group. The format of the appraisal score sheet, on which self appraisal scores and peer appraisal scores are recorded, is a behaviourally anchored rating scale (BARS). This BARS appraisal tool has four descriptors, indicating the level of clinical performance in each of six categories of clinical behaviour (Appendix A, p. 4). A research project based on the creation of the four-page Peer Review Model (Appendix A), and the wording and layout of the BARS tool, which was the work of the Public Health Nurses and their manager, had constituted a Special Topic in Human Resource Management at Masters level for the researcher.

In 1995 the manager of the Public Health Nurses invited the researcher to maintain ongoing association, as an independent consultant, with the Public Health Nurses' group. The role of the researcher would be to assist the group with the continuing development of the peer review system. The manager considered that this situation would enhance professional and organisational support for the development of the peer review system. In April 1995, at the beginning of the formal research process described in this thesis, the peer review system had been successfully implemented. Monthly meetings of the peer review groups had occurred for the previous four months.

The Peer Review Process

A model of the peer review process, including the appraisal tool and the documentation, designed by the research group, is presented in Appendix A. According to Lawler (1988, p. 82) achieving positive results from an appraisal scheme is a matter of good design. An effective peer review system will need to be designed and implemented differently in different settings. Peer review, according to Hawthorne et al (1989, p. 54), should be related to evaluating the outcomes of service provided by nurses. Philp (1990, p. 95) indicates that such an appraisal tool should be kept simple and brief to aid application and administration.

The peer review appraisal tool designed by the research group consists of four pages (Appendix A, p. 1-4). The first page enables the individual nurse to prepare a summary of the case or project to be discussed. The second page of the appraisal tool identifies the standards addressed in this case or project, and the third page allows for peer recommendations, and outcomes of implementing these recommendations, to be documented. The fourth page provides an opportunity for the individual nurse and the peer group to rate her performance against the standards, according to behavioural criteria. In the belief that individuals should be rated on specific job behaviour and not compared to others (Philp, 1990, p. 102), care was taken to avoid measuring personality traits, which is a common fault with rating scales (Fletcher & Howarth, 1989, p. 9). A specific time schedule was agreed as the appropriate

format for the peer review meetings, it was proposed that each presentation and associated feedback discussions should take no more than fifteen minutes. Each presentation required advance preparation on the part of each nurse, to ensure that the salient features of the case or project were presented within the time frame specified.

Peer Review Meetings

The following describes the procedure for public health nurse peer review meetings: Prior to each scheduled meeting the individual nurse will choose a case or project that she is working on or has completed. She will be encouraged to avoid always presenting her best work as the emphasis is on professional and personal performance improvement. Peer review should be viewed as an opportunity for growth. Having selected the case or project, the nurse prepares a summary of action or outcome to date on Page 1 of the appraisal tool (Appendix A, p. 1). She then identifies the standards that have been addressed during work on the case or project (Appendix A, p. 2).

Before the peer review meeting she completes a review of her own performance, using the BARS sheet (Appendix A, p. 4), and makes recommendations for improving her practice, or completing the case, if she feels she can. The self appraisal that each nurse makes of her own performance when presenting case work to the peer review meeting, ensures reflective critique of individual practice against the standards of clinical practice, which had been recently updated.

At the scheduled peer review meeting the nurse presents the summary of the case or project, along with all documentation relating to it, and the standards sheet (Appendix A, p. 2). A strict time limit for presentation is set. The peers give feedback about the individual's management of the case or project, offering recommendations, including ways to improve elements of performance, and training and development needs. This feedback is noted by the nurse being appraised on page three of the

appraisal tool (Appendix A, p. 3). Each group member rates the individual's performance on the same BARS sheet (Appendix A, p. 4) which is then signed by all members.

The individual addresses the peer recommendations during the course of her work and documents the outcomes on page three of the appraisal tool (Appendix A, p. 3). If she feels she requires more feedback to assess progress and improvement, regarding the same or a similar project, she may bring it to a future session. However, ideally, she should bring a variety of cases or projects which address different standards so that as many aspects of her practice as possible can be reviewed. All peer documentation is maintained, in a personal folder, by the individual nurse so that it can be reviewed in future performance appraisal sessions, and as a record of her progress and achievement.

Why use Peer Review?

Peer review, as internal professional review, has much to offer nursing, in relation to performance appraisal and assessing the value of nurses' work. The process of peer review is designed to foster individual as well as group accountability for the quality of professional practice and development. According to Waldo, Hogschule, Magno and Colleran (1993, p.58) it is a tool for measuring performance and enhancing communication in order to maintain the profession's self regulation and integrity.

An underlying assumption directing this inquiry is that the concept of peer review, whereby the quality of nursing practice is assessed and assured, could become an important professional tool for nurses. A central tenet of this thesis is that the appearance of the peer process is a major development in the evaluation of nursing performance and in the valuing of nurses' work by nurses, and by employing organisations. Concern exists that research reports describing peer review practices by nurses in New Zealand are scant. It is important to document the progress already made with peer

review by the Public Health Nurses of the research group. The ongoing development of the peer review process for this group of Public Health Nurses is the focus of this study.

Research Goal

This study pursues the following research goal:

To design and implement a peer review process for Public Health Nurses that accurately measures the specific competencies of the particular nursing role, in a way that facilitates and fosters organisational learning.

Methodological approach

An action research approach has been used for this study, based on a model of organisational learning. The learning organisation concept at its simplest is about marrying individual and team growth with economic performance (Garvin, 1995). Use of the learning organisation framework offers a perspective of the developing peer review system as an exercise in organisational learning, and directs and facilitates the collection and evaluation of data. The learning organisation framework also benchmarks the peer review development process for other potential users, particularly nursing groups, and builds a framework for continuous improvement into the peer review process itself.

Thesis Presentation

This thesis is presented in nine chapters. The following outline of each chapter provides an overview of the thesis:

Chapter One explores the compelling reasons for the study, notably the background of change within health care structures where nurses work which have led to a growing focus on performance management. Consideration of difficulties associated with performance measurement for nurses

suggests that context-sensitive, profession-specific appraisal systems are needed to accurately value nurses' work.

In Chapter Two a literature review of three major areas where peer review for nurses has significance is presented. These three major areas are the academic and practical views of peer review, the case for performance management in nursing, and a theoretical perspective of the restructuring of nursing workplaces.

Chapter Three discusses the learning organisation, a developing concept in the organisational growth literature which seeks to make visible and foster the links between individual and group learning and effective organisational performance. A model of the learning organisation was developed as a framework to guide the collection and evaluation of the data for this study.

The methodological choice, described in Chapter Four, was an action research design. Interviews with the nurses and managers of the research group were carried out over a period of eight months, to observe the development of the peer review process through a learning organisation framework. The praxis-oriented, participatory action research process is well suited to the pursuit of the research goal.

Chapters Five, Six, Seven and Eight chronicle the issues that were discussed in each of the three action research spirals. Chapter Five describes clearly what was done by the research group, setting out the process of the three action research spirals, and describing the events of the first spiral. The critically effective decision making process which was achieved through the creation of the review team is explored in Chapter Six. Chapter Seven documents the developments observed with the peer review system during the research process, and summarises the situation at the conclusion of

the study. Chapter Eight includes a discussion of the growth of the learning organisation, both in the research group and in the wider organisational context.

Outcomes of the research process are discussed, and implications and limitations of the study are presented in Chapter Nine. This concluding chapter is followed by a reference list, with Appendices A, B, and C completing the thesis. The referencing style used throughout this report is that documented in the *Publication Manual of the American Psychological Association* (4th ed., 1994).

Summary

The commercially focused, quality-conscious environment within the clinical workplaces of nurses in New Zealand, and the need for efficient and effective health service delivery has created a new awareness of performance management and performance appraisal for health professionals. Traditional performance appraisal practices for nurses in this country are seen to be an under-resourced under-emphasised area of health professional management. The challenge for the nurses of the research group has been to design a context-sensitive peer appraisal system that would recognise the specific competencies of the Public Health Nurse role and meet organisational requirements.

In this chapter, the links between performance appraisal and performance management and their contribution to a cost conscious health service environment have been shown within the organisational context of the changing New Zealand health service structures. The participatory process by which the peer review model was developed by the research group of nurses has been outlined, and the model of peer review in use by the nurses of the research group has been described. The development of the appraisal tool has been discussed, and the point at which the study commenced clearly indicated. The chapter concludes with an outline of the presentation of this thesis.

It has been a significant endeavour to develop a peer review system, as this group of nurses has done. While the concept of performance appraisal is generally accepted as an integral part of nurses' clinical practice, the extent to which effective peer review systems can be designed and implemented by nurses is largely unresearched.

The research objective, the continuing development of the peer process with the Public Health Nurses of the research group, requires an exploration of the literature of peer review. Accordingly, Chapter Two presents a literature survey of three major areas where peer review for nurses has significance.

CHAPTER TWO

Peer Review and Performance Management for Nurses

Introduction

The theoretical context within which this research has meaning is examined in this chapter. The definition of peer review adopted in this study is presented, followed by a discussion of peer review as internal professional review for nurses. As outlined in Chapter One, within the recently restructured health service organisations performance management systems are assuming increasing importance. With this sharpened focus on health professional performance, introduction to the organisational issues surrounding performance appraisal for nurses is made. Two such issues are the difficulty of measuring nurses' performance, and the problems generated by the replacement of a professional model with a management model for the administration of nursing workplaces. The theoretical position of peer review within the process of performance appraisal for nurses is explored. Studies which relate to the development and implementation of peer review systems are examined. Finally, the concluding elements of the chapter include the particular significance of the peer process for nurses in relation to the changing dynamics of power and control within the clinical practice setting.

Literature searches

The database searches for this literature review were carried out initially in 1994, using Medline, CINAHL, and ABIInform, looking for material from 1970-1994. These database searches were repeated in 1996. The nursing literature and that of human resource management have furnished three major areas where peer review has significance. These three areas, as outlined in the introduction, are:

- performance management for nurses
- empowerment of the nurse-as-employee
- governance of the clinical practice setting.

Each of these three aspects are explored in some depth in this chapter.

Definition of Peer Review

For the purposes of this research, peer review is understood as the process whereby a group of practising professionals of the same occupational group make retrospective survey and systematically and deliberately re-examine and critically review the work of individual members of the profession. Peer review is undertaken in order to assess the merits, identify excellences, defects and peculiarities, gain greater familiarity with, and if necessary change the directions and correct defects, of the peer performance, so that professional norms are upheld.

From such a definition it is apparent that peer review is deeply concerned with professional behaviour. It is also explicit from the foregoing definition of peer review, that the standards for professional performance (behaviour) should be written by the practising professionals. Peer review is internal professional review.

While a definition of peer review opens this discussion, it is of note that as yet 'peer review' does not appear as a single entry within dictionary sources (Funk & Wagnall, 1950; Heineman, 1989; The Oxford University Press, 1989). Definitions of 'Peer' and 'Review', can be found in Appendix B, p. 1-3.

Peer review as professional review

As different professional groups have sought to define the standards and norms of practice that safeguard the integrity of a profession, they have also identified the need for internal review of

professional practice and standards (Hart, 1990). Mullins, Colavecchio, and Tescher, writing in 1979, stated that the practice of peer review is grounded in the development of professional organisations.

Hawthorne, Roe and Woods (1989) argue that those in health service professions are granted considerable autonomy by society and by law. To retain this privilege health professionals are accountable to society to maintain trust by continually updating their knowledge and practice. Gordon (1992) asserts that such professional groups demonstrate this accountability by practising only within their level of expertise, and through being self-regulating. The identity and integrity of the profession is seen by Waldo, Hogschule, Magno and Colloran (1993) as most appropriately, though not exclusively, maintained by the peer process. These authors claim that the ability of the profession to self regulate is achieved through internal review. Such internal review, Hart (1990) claims, can only be achieved using the peer process.

The peer process, through which accountability and professional standards are maintained, can range from a formal presentation to, and appraisal by, a panel of peers, to an informal sharing of ideas and experiences by colleagues (Harwood & Olson, 1988). Peer review is also a method used to determine the scientific value and literary merit of academic or professional writing (Felton & Swanson, 1995). For the purposes of this study, it is essential to site peer review within the context of performance management for nurses. This theoretical position is provided in the next section.

Performance management in the health care industry

A background of change within the structures of the health service organisations in New Zealand, briefly profiled in Chapter One, has led to a new and growing focus on performance management and performance appraisal for health professionals. These changes have prompted managers to search for innovative ways to monitor and enhance the performance of professional staff (Briascio, 1994). Motivation and guidance are said to be key functions in the management of professionals, rather than the control exerted by the authoritarian hierarchies which previously

characterised such organisations (Charns & Schaefer, 1983, p.7; Maccoby, 1993). Related to this issue, is the difficulty associated with meaningful performance measurement for health professionals as a group and for nurses in particular. The outstanding question is where, within the cycle that constitutes performance management, the planning work should begin.

Performance management planning, according to Houston and Luquire (1991) has a focus on both team and individual performance. Within a quality-oriented work environment, both job descriptions and client expectations, in conjunction with the business plan, will form the basis for establishing the performance expectations for any employee, and also for determining the performance outputs expected of the group. Performance monitoring systems that ensure regular review of all employee performance are recommended by Marszalek, Gaucher and Coffey (1991) as a way of monitoring that organisational progress is on target and that goals relating to quality of service are met. In the present climate of cost containment and quality improvement it is important to link performance management objectives with those of the quality improvement process. Various authors suggest that in such circumstances the most appropriate and workable systems are those that are sensitive to context (Fegley, 1992; McRae & Ramsey, 1992).

It follows then, that effective performance management systems will take due cognisance of the particular work setting, and will be specific to the professional group which is to use the system. Extrapolation of this notion suggests that having the professional group that will use the system actively involved in the design and ongoing development of the system is appropriate, perhaps mandatory. This involvement by the professional group, it is argued, will better ensure that the performance monitoring system is enduring, user-friendly and able to accurately provide reliable information (Hawthorne et al, 1989).

O'Loughlin and Kaulbach (1981) have suggested that the first step in a performance management system is to identify performance expectations that the organisation has of the nurse, and

to communicate these expectations clearly to the nurse. Further, to be minimally effective, Fegley (1992) insists that performance management systems have at least an annual appraisal interview between the nurse and the manager. At this manager-nurse meeting an objective discussion of the nurse's ability to meet predetermined goals over the appraisal period is the primary concern. Schlesinger and Heskett (1990) say an effective performance management system will function as a powerful tool to improve the quality of individual and team performance, in relation to organisational objectives. In the next section, the elements of effective performance appraisal for nurses are considered.

Performance appraisal for nurses

Accurate appraisal of nurses' performance has a pivotal role in the development of an effective performance management system for nurses. Raelin (1985) and Hart (1990) have identified the central attributes determining the usefulness of performance appraisal systems for nurses. These are first, whether the appraisal system provides accurate, meaningful information for the manager and the organisation about the performance of each nurse, and secondly, whether the appraisal system provides appropriate information to enable the nurse to improve the quality of clinical performance.

Dubnicki and Williams (1992) develop this picture of the 'ideal' performance appraisal process for nurses further. They state that to be effective in an organisational environment driven by the quality improvement dynamic, an appraisal process will include personal attention of a one-to-one nature between the manager and each nurse, where detailed discussion of the job to be done and the standards to be met will occur.

Manager-initiated appraisal

In a human resource intensive industry such as the health services the health professionals are intimately involved with the delivery and the quality of service. In such a situation, the manager needs an appraisal system that will monitor individual performance and influence improvement in

performance. Whereas manager appraisal interviews have in the past been a norm in the health services, ever increasing demands on managers are acting to restrict the amount of time available to implement useful performance appraisal (Briascio, 1994). The problem may be compounded further when the manager is not of the same occupational group as the clinicians and is perceived as not having sufficient expertise to judge performance.

In such a situation, Martin and Shell (1988, p.180) suggest that peer review has potential as an effective motivational tool when managing professionals. It is strongly suggested that a direct relationship exists between effective performance appraisal and improved performance outcomes (Burke, 1982; Weitzel & Wier, 1982). When appraisal systems that meet the foregoing criteria are used to evaluate clinical nursing performance, Pavett (1983) and Hawthorne et al (1989) have stated that increased motivation and greater job satisfaction accrue for the nurses who use such systems.

Measurement of Nursing Performance

Measuring nursing performance is difficult in any circumstance. There is a claim that the nature of nurses' work implies that much that nurses do has an invisible quality when the work is performed to a predetermined standard (Cook, 1991; Lumby, 1991). From this perspective, nurses' work is most visible when it is absent, or when it is perceived as not meeting an expected standard.

When the nurse works autonomously in a community setting, as do Public Health Nurses, this problem is compounded because practice cannot easily be observed, and nursing performance is seen to further elude measurement by generic appraisal systems (Knox & McKay, 1982, p.17). While the level of output for the individual can be judged from the statistical returns and reports which she produces, the quality of her clinical practice cannot.

Peer appraisal and self appraisal

Trends revealed from a consideration of studies relevant to nursing performance appraisal show that self appraisal and peer appraisal have much to offer nurses. Self appraisal has the potential for promoting enduring improvement in nursing performance (Mann, Presti, Barton & Hirsch, 1990; McRae & Ramsey, 1992). Self appraisal is also a valuable element of the peer review process, according to Mann et al (1990, p. 12). It encourages the individual to look critically at personal performance and clinical practice. Various authors warn that self appraisal is useful only if the assessment of performance is made against clearly defined standards or targets which clarify performance expectations (Gordon, 1992; Knox & McKay, 1982; Hyde, 1985). Knox and McKay contend that self appraisal is essential for professional growth. In their view, it promotes increasingly higher levels of performance by enabling the individual to identify strengths, as well as weaknesses, through self-observation and evaluation. When self appraisal is part of the peer process, it also provides the peer group with an opportunity to see how each nurse perceives her own level of performance.

Fletcher (1985) suggests that the major advantage of self appraisal is that the individual has more opportunities to observe her performance than anyone else, and is more likely to address the weaknesses that she has perceived. Fletcher contends that self appraisal is probably no more biased than other forms of appraisal. However, Hyde (1985) argues that individuals are more likely to be over-critical of themselves and that, while a self appraisal system is designed to be self directing, the individual using this system is likely to feel unsupported. Ideally therefore, self appraisal should be used in combination with other appraisal methods. Peer appraisal is suggested as an obvious choice in this situation. Not only is peer review concerned with such intangibles as professional identity and professional integrity (Waldo et al, 1993, p.58), it also addresses the issue of performance appraisal.

Peer review is described as able to promote enduring improvement in nursing performance (Hawthorne et al, 1989). It enables individual nurses to obtain credible, more objective assessments of

clinical performance. Peer review also releases managers from a close supervisory role to pursue increasing administrative functions (Briascio, 1994; Zelauskas & Howe, 1992). In short, peer review appears to fit well with nursing objectives for performance appraisal (Morgan & Irbey, 1978). According to Mullins et al (1979) and O'Loughlin and Kaulbach (1981) a goal of the peer review process for nurses is to provide job satisfaction through peer recognition for excellent performance. As well, Morgan and Irbey (1978) have stated that peer review is an educational tool whereby peers learn through critical evaluation of performance which is compared with established standards. The importance of performance standards is discussed in the next section.

Performance standards

A quality-oriented performance appraisal system will need to establish objective standards for evaluation of performance. These standards for performance evaluation in a nursing context will be the same standards of clinical nursing practice against which professional behaviour is assured. Gordon (1992), and Hickey (1982) point out that professional standards of practice should form the basis of peer assessment of performance. Charns and Schaefer (1983) have suggested also that it is more meaningful, to both the individual and the group, that performance should be assessed in comparison with past performance rather than on a rating scale, or in competition with other individuals or groups.

The importance of feedback

Various authors (Dubnicki & Williams, 1992; Hawthorne et al, 1989) suggest that the 'environment', or organisational culture, within which the appraisal occurs will determine how effective any feedback will be in achieving performance improvements. The challenge for the organisations that employ nurses is therefore to create the 'right' kind of environment and appropriate opportunities for meaningful and effective feedback to occur. It is suggested that the right environment for effective feedback is created with the right performance appraisal system.

Morgan and Irbey (1978) have made the point more specific, saying that for individual performance improvements to be sustained there must be regular and ongoing feedback about each nurse's performance, as well as appropriate opportunities for discussions about performance, within an environment conducive to such an exchange. Performance appraisal systems, for these authors, must provide opportunities for this regular ongoing feedback, which is in fact a form of coaching, in order to sustain and direct the performance improvement of individuals and teams. Such improvement in performance represents a continuous improvement in quality, and follows the plan/do/check/act formula of the quality cycle. Hence, it is suggested that improvement in performance, in relation to quality standards, is best achieved when a performance appraisal system follows the quality cycle approach (Morgan & Irbey, 1978). Effective performance appraisal systems are thus intimately and inevitably involved with the quality improvement process. These links between performance appraisal and the quality cycle are described further in the next section of this chapter.

Feedback is critical to health professionals such as nurses, to assist them with their own learning and development needs and to provide needed recognition for achievement (Pavett, 1983). Similarly, feedback on clinical performance is essential to the group or team in order to provide a measure of how well the group is meeting service objectives and to ensure continued enhancement of organisational systems (Schlesinger & Heskett, 1990).

Feedback concerning clinical performance may come from different sources. Von Glinow (1988) suggests that feedback from the manager or team leader is a vital source with respect to the meeting of organisational targets, but that the feedback available from peers will be seen by the individual nurse as more meaningful in terms of improving the quality of clinical practice. Raelin (1985) states that professionals will generally prefer to be evaluated by their peers because a major source of conflict between managers and health professionals is the conflict between professional standards and bureaucratic expectations. According to Maccoby (1993), key clients both internal and external are perhaps the most important sources of feedback in an environment oriented towards

quality improvement. Further, Maccoby predicts that nurses, who are in the front line of the delivery of health care service, in the interests of improving the quality of their service, will have a key role in assuring that feedback from clients is available to themselves and their managers.

To draw these themes together, there is a strong recommendation that for a performance appraisal system to operate effectively in a quality-conscious environment, nurses and nursing teams will need to develop ways to review their own performance, in relation to the expectations which their clients have of the nursing service which they provide. Managers of nursing teams will be accountable for ensuring that these performance targets resonate with the business plan (Dubnicki & Williams, 1992).

Quality assurance and peer review

Within the funding contract which a Regional Health Authority (RHA) holds with a Crown Health Enterprise (CHE), there is an agreement that measures of quality improvement about the delivery of health care services will be made. Formal processes of quality assurance within the CHE will provide for the measurement of both outcomes of health care and the activities of the health caregiver. In this environment, neither the quality assurance nor the nursing practice standards nor the evaluation of nursing performance can unfold independently (Hawthorne et al, 1989). Each system is critically important to the other, in the following way.

The nurse must adhere to professional norms. It is membership of the professional group that requires the individual nurse to display competency to peers, and to the organisation, in order to remain an attractive employee and a respected member of the group. (S)He does this by meeting the obligations (job description and service objectives) that the organisation has defined for the professional role, and by giving evidence to the peer group of complying with the defined standards for clinical practice (Mann et al, 1990). At the same time, in meeting professional standards, the nurse is also meeting organisationally defined service objectives and quality targets.

The design of the performance evaluation and quality assurance systems is thus the basis for connecting the evaluation of the caregiver to the assurance of the quality of care. Both processes are essential to the delivery of effective care and only when the evaluation processes are connected to each other can the assessment of the quality of care be systematic and complete. In short, the clinical team must ensure quality outputs and this is seen to be achievable using the peer review process, whereby nurses write the nursing standards and the quality standards, and nurses determine when the performance standards are met (Porter O'Grady, 1991). It is suggested that other approaches to performance appraisal and quality assurance tend to either break this connection, or attempt to improve one at the expense of the other.

The whole issue of performance management for nurses needs to be seen against the wider debate that concerns the management of performance in the service industries. This view, which highlights the role of the peer process in the empowerment of the nurse-as-employee, is explored in the next section. This discussion represents the second theoretical area where, it is suggested, peer review has escalating significance for nurses.

Empowerment of the nurse-as-employee

There is a decidedly humanistic focus in the discourse of human resource management as it relates to developments in the service industries. In seeking to stimulate the creation of excellence in service delivery, Block (1993) places emphasis on empowerment of the service delivery front-line worker, in this case, the nurse. He states that the continuous improvement ethos will 'come to life' when the nurse becomes 'free' from bureaucratic restraints which in many situations 'act to sustain mediocrity' (Block, 1993, p. 9). This can only occur, Block says, when there is recognition that the nurse who does the work will often know how it could be done better, smarter, and perhaps with cost savings.

Maccoby (1993) supports this prediction when he states that there is an expectation that authoritarian hierarchies, such as those which have characterised health services organisations, are approaching obsolescence. In a similar vein, Block (1993, p.27) claims that much traditional performance management activity is counter-productive within a quality-driven service environment, and asks: *'Should we not be burying manager-initiated performance appraisal? Does it not have too many insurmountables?'* Block states that performance appraisals within service organisations have tended to be used as instruments for social control. *'They have been annual discussions between the manager and the individual that have been avoided more often than held and have produced little that is valuable or memorable in terms of improving performance'* (Block, 1993, p.29).

Changing the way performance appraisals are conducted within an authoritarian hierarchy is seen by Block (1993) as a purely cosmetic approach which will do little to enhance the value of the process. The appraisal interviews can be softened, and held regularly and informally, but none of this changes the basic transaction in Block's view. They are still managers evaluating clinicians with the outcome determining advancement. Block suggests the control of the process by the manager robs the appraisal of value for both the manager and the nurse.

A similar view of the mismatch of manager-controlled appraisal for nurses was expressed by Knox and McKay in 1982. Twelve years later, the inappropriateness of a manager-controlled generic performance appraisal system, was the main catalyst for beginning the development of the peer appraisal process with the Public Health Nurses of the research group (Briascio, 1994).

With the advent of management training in the health service organisations, most managers are likely to have had training in listening skills, making good eye contact, asking open-ended questions, making support statements, and identifying strengths so as to avoid becoming *'obsessed with weaknesses'* (Charns & Schaefer, 1983, p.39). However, these adjustments will have only limited value in terms of genuine improvement, because as Block says, while these changes may help to

promote better communication, none of them heal the deeply flawed premise upon which a top-down process is based. *'The entire transaction still has an element of sovereignty that will not go away'* (Block, 1993, p.48).

The underlying philosophy of this argument suggests that health services organisations are moving into an age where the systems and the relationships that previously governed ways of managing are changing. Porter-O'Grady (1991), writing in *Nursing Management*, suggests that this change is due in part to the introduction of service-oriented 'soft' technology into the health services work environment; an environment which is increasingly driven by the requirements of quality improvement programmes. There is much to indicate widespread development of this 'soft' technology-based service model which has continual improvement of the quality of health care service as its fundamental goal (Fletcher & Howarth, 1989; Health Care Hawke's Bay, 1993; Maccoby, 1993; Porter-O'Grady, 1991). An example of a 'soft' system is the shared governance model, described in the next section. This model shares decision making power equally between clinicians and managers, and relies for its success on new patterns of thinking and interacting in the workplace (Porter-O'Grady, 1991).

It is argued that a paradigm change within the discourse of health services delivery is underway. The old industrial model for health service organisations, which put the people who deliver the service last, so that nurses and other health professionals were generally at the bottom of a vast bureaucratic hierarchy, is fast being overtaken by the client-service model of the quality environment which puts the front-line workers first and designs the business systems round them (Barker, 1992).

Thus, there is a suggestion that 'soft'-systems management technology is developing in the health services organisations. These 'soft' systems are arguably able to provide better support for the efforts of the front-line workers, who, in more than fifty percent of cases in the health care industry, are nurses. Schlesinger and Heskett (1990) suggest that by using this new model, health service

organisations are placing as much value on their investments in health professionals as on their investments in machines.

Health services organisations are beginning to do as Troughton (1993) predicted they would. CHEs are creating the management systems methodology, such as the peer process that is the focus of this research, that provides support for the work of nurses and other health professional groups. Viewed from this perspective, the peer review process, created and implemented by the Public Health Nurses of the research group, is a performance management initiative, to meet the expressed needs of this group of nurses for an appraisal system. Many questions remain, however, as to the structure and process of an effective peer appraisal system. As well, there are outstanding questions as to the nature of organisational support which will best enhance the development of the peer appraisal process. This question is pursued in the next section, with an examination of the shared governance model.

Governance of the clinical practice setting

This is the third area where it is suggested peer review has growing significance for nurses. The appearance of the shared governance model for the clinical practice settings of nurses, represents an alternative to the authoritarian hierarchies which Block (1993) suggests control many of the service organisations of today. The control of such areas is generally held by a management team. The key concept within the shared governance model is the devolution of power from the management team and the equivalent empowering of the clinical team, so that a participative sharing of control of the clinical setting between clinicians and managers is achieved (Porter-O'Grady, 1991).

The shared governance model predicts flattened structures within the multiservice and multidiscipline settings where nurses work. Management teams and clinical teams share decision-making and control at a unit level, and work together under an organisation-wide system that shares decision-making equally between the clinicians and the managers throughout the organisation (Porter-O'Grady, 1991). This shared governance, by balancing the needs of both groups allows an

egalitarian structure to develop. Within such a structure, Porter-O'Grady (1991) claims, fluid, non-hierarchical, power-sharing relationships develop throughout the organisation which are able to engage all participants to work for the best solutions available. Consequently, an organisational environment is created which supports the ethos of quality improvements in the nurses' clinical workplace (Porter-O'Grady, 1991).

Within the shared governance model, as Porter-O'Grady describes it, the role of the manager becomes one of co-ordinator, integrator and facilitator of the nursing system within which client care is offered. In this environment, the clinical nursing team will write the professional standards for clinical practice, to ensure that high quality nursing service is delivered. The clinical team will also create the performance appraisal system, to measure nurses' performance and ensure that the clinical standards are maintained and improved. Nursing performance is compared to these unit-generated clinical performance standards, using the peer review process. Because clinicians use the peer review process to create and maintain high standards of health professional performance, and high standards of care delivery, the peer process is the key to the ongoing development of the shared governance model. The peer review process drives both the assurance of quality of care, and the assessment of the caregiver. The manager, as co-ordinator and facilitator, ensures that the system works.

The theoretical benefits of optimally effective performance management systems have been outlined, and much that has value in creating meaningful appraisal systems for nurses has been included. However, creating an effective performance appraisal system, incorporating the theoretical wisdom of the preceding paragraphs, is problematic. Firstly, when considering this possibility, it is quickly apparent that there is a dearth of reliable studies to determine the practical value of existing appraisal systems for nurses. Further, the comparative lack of prescriptive studies to indicate how effective appraisal systems may be developed within the clinical practice setting represents an even more obvious gap in the nursing literature. Two studies concerning the implementation of the peer process are discussed in the next section.

Implementation of peer review

An examination of the literature of peer review for nurses shows that nursing journals, mainly American, have published numerous articles on the topic and its potential value for the nursing profession. There is, however, scant information in terms of operational details. Hickey, writing in 1982, stated: *'In support of peer review the nursing literature gives little evidence of any implementation of peer review in the clinical nursing setting.'* (p.69).

Hawthorne et al (1989, p.49) expressed the same concern seven years later, in their paper which outlined the development of a peer review system for nurses in a tertiary care institution. Since then, Mann et al (1990) have studied the development and implementation of peer review, also in a hospital setting for staff nurses in an acute facility, and Waldo et al (1993) report the use of peer review for measuring the performance of nurse managers.

Two studies from 1989 which have used group involvement of managers and practising clinicians to develop peer review systems and have evaluated their results favourably are those of Hawthorne et al (1989), and Zelauskas and Howe (1992). Hawthorne et al view peer review as part of the professional self-regulatory cycle, and in the context of their research, as one element of a professional practice climate. Peer review, for these authors, is interrelated with primary nursing, evaluation of patient outcomes, quality assurance and self-governance. The goals of peer review for this group of nurses were said to relate to professional accountability for nursing. A peer review system was needed, Hawthorne et al (1989) concluded, that would resonate with the unit-based philosophy of primary nursing and standards of clinical practice.

This peer review system was developed and operationalised through the collaborative efforts of clinicians and administrators (Hawthorne et al, 1989). The group of nurses who developed this system worked in an Intensive Care Unit in an 800 bed teaching hospital in North America. Completed peer

review audits were shared by peers (appraisers and appraisee) in a 'conference' setting. These conferences were planned as opportunities to refine communication skills, and to give appropriate feedback, as well as being opportunities for written goal setting. The study was evaluated by participants as successful, in terms of the personal and professional benefits of peer review, and satisfaction with the process. There was an expectation that the group of nurses would refine the system, to meet their performance appraisal needs in the future (Hawthorne et al, 1989).

In the second paper, Zelauskas and Howe (1992) have written about the implementation of a Professional Practice Model (PPM) and described peer review as an integral part of this model. A PPM is a unit governance system for clinical practice, claimed by Zelauskas and Howe to provide nurses with greater control over the environment in which they deliver care.

The underlying assumptions within this paper relate to devolution of power from an hierarchically defined management structure to the nurses who work in the unit (Zelauskas & Howe, 1992). As in the previous study by Hawthorne et al (1989), the basic propositions reflect the need for both increased accountability and autonomy for primary nurses. Peer review is defined somewhat differently in this model, and the process by which peer review is achieved has a noticeably different emphasis than that described by Hawthorne et al (1989). The judgement made in the peer review process, it is claimed, is about ongoing quality of care. However, it is argued that the process whereby peer assessments are made, and feedback given, falls short of the optimal system described earlier in this chapter.

The major problem with this system is that all evaluation processes use a hospital-wide performance appraisal tool. A generic appraisal tool, it is argued, may not reflect specific competencies of a particular nurse's role. Further, in the absence of group or unit involvement to develop the process of appraisal, it is an imposed appraisal system. A top-down generic appraisal seems at odds with the ideas suggested by self governance in the Professional Practice Model,

described by Zelauskas and Howe (1992). In short, despite the day-to-day self governance said to exist, it would appear that the hierarchical infrastructure of the organisation is unchanged. It would also appear that self-governance, at least of performance appraisal systems, for the nurses in the unit described by Zelauskas and Howe (1992), is not yet a practice reality.

A further problem is the way the peer process reported by Zelauskas and Howe (1992) generates feedback from the peer group. It is argued that achieving a consensus in a peer review group prior to the meeting with the appraisee may 'wash out' the objectivity of the individual peer appraisal, and diminish the value such peer suggestions and feedback have for the appraisee. It is also argued, from the opposite view, that individual peer appraisals allow for a range of subjective perceptions from peers, without acknowledgement of personal bias. While the process, as it stands, may act to 'cancel-out' apparent individual bias, it is equally conceivable that the peer process, described by Zelauskas and Howe (1992), could serve to accentuate biased judgements of performance. Hence, given the apparent lack of unit-devised evaluation tools and standards, and the absence of opportunities for the appraisee to 'negotiate' appraisal results with the peer group, the claim that the assessment of performance is centred on quality of care becomes difficult to sustain.

By comparison, the model described by Hawthorne et al (1989), where the completed peer review audits are shared by appraisers and appraisee in a 'conference' setting, provides a forum for the exchange of ideas and information. This peer conference is also viewed as an opportunity to refine communication skills, by giving appropriate verbal feedback, as well as opportunities for written goal setting (Hawthorne et al, 1989). In this process, there appears to be an emphasis on nurturing, and a valuing of the self-perceptions of the appraisee, which is not apparent in the process described by Zelauskas and Howe (1992).

These problems combine to diminish the usefulness of the report from Zelauskas and Howe (1992) as a guide for developing a truly consultative and participative peer process for other groups of

nurses. However, the first research report from Hawthorne et al (1989) is, in many respects, state-of-the-art for the development of peer review, and as such is extremely valuable for this research project.

Summary

New Zealand's Government-owned health services organisations have recently made the transition from a professional model to a management model in the administration of clinical workplaces for the majority of nurses in this country. With the changes in workplace administration have come difficulties in evaluating the performance of the professional employees within the health services workforce.

This problem has relevance for nurses who together make up more than half of the health service professionals employed in New Zealand. Managing nurses as health professionals and measuring their performance accurately requires appraisal systems that are context-sensitive and are specifically designed for and by the professional group that will use them. Difficulties relating to performance appraisal for nurses include the credibility of a non-nurse manager, who is perceived as 'not being expert enough to know'. It is claimed that accurate measurement of nursing performance is difficult in any circumstance. The problem is compounded when the nurse works alone in the community, as do the Public Health Nurses.

Peer review is regarded as a 'hallmark' of professional behaviour. The use of peer review articulates the expectation that nurses will seek self-regulation and professional accountability through peer feedback. Using peer review there are increased opportunities for clearly focused communication about performance and practice issues which allow nurses to improve their clinical performance. The use of peer review is said to have positive effects on morale and patterns of interaction within a work group. When peers are required to evaluate each other's performance on the basis of established standards of clinical practice, which reflect professional goals and the goals of the organisation, the evaluation of the caregiver becomes linked to the assurance of the quality of care. In

this way the peer process sustains the connection between professional aspirations and the quality of service aspirations of the organisation.

The employee-empowering ideas espoused by Maccoby (1993) and Block (1993), when applied to the issue of appraisal for nurses, show peer feedback to be a powerful mechanism for achieving critical performance improvements. Peer feedback which is regular and ongoing is important to sustain such performance improvements. From this view, the peer review system which the Public Health Nurses of the research group have developed offers an optimal performance improvement situation of regular, ongoing peer feedback. Finally, the shared governance model suggests that the peer process could prove to be a useful tool whereby nurses are able to assume decision making power in their clinical workplaces.

In Chapter Three, the learning organisation, a developing concept in the organisational growth literature, is discussed. The learning organisation seeks to make visible and foster the links between individual and group learning and effective organisational performance. A model of the learning organisation was developed to guide the data collection and analysis for this study. It was seen as appropriate for use in this research project in ways which are described in the next chapter.

CHAPTER THREE

Organisational Learning and Peer Review

Introduction

The theoretical background linking conventional theories of organisational learning with the development of the peer review system is presented in this chapter, where the central theme is the description of the organisational learning framework constructed to guide the research process. The learning organisation framework directed the research inquiry and the collection and analysis of data. It also became a tool to measure organisational learning as the peer review process developed.

Peer review as organisational learning

In the preceding chapter a performance appraisal process designed to meet the needs of nurses and employing health service organisations was outlined. An underlying assumption in the design and implementation of such an appraisal system which will meet organisational and professional needs is that the people who will use the system should design it and take responsibility for making it work. This position, recommending involvement of the professional group in effective performance appraisal design, has close links with an array of factors identified as seminal to the successful initiation of the 'learning organisation' (Nevis, diBella & Gould, 1995; Senge, 1990). The learning organisation is a developing concept in the literature of organisational growth, and is the basis of the framework which directs this research inquiry.

The Learning Organisation

Basic assumptions

At its simplest, the concept of the learning organisation is about marrying improved personal and team performance with economic performance. While debate continues about many aspects of learning organisations, Ulrich, von Glinow and Jick (1993) outline three basic assumptions which

have become widely accepted as part of a new organisational learning paradigm. These assumptions are as follows:

- the concept of the learning organisation is grounded in diverse streams of management history
- organisational learning matters to the success of the organisation
- effective organisational learning follows a pattern, a progression

The first assumption is that the concept of organisational learning has arisen from various influences within the history of management. The first person to study organisations as learning systems was Frederick Taylor in the early 1900s (Garvin, 1993). Taylor's premise, in his development of scientific management, was that as management 'truths' were articulated they could be transferred to other employees in the organisation and thus improve the efficiency of the organisation. In the late 1950s and 1960s, Herbert Simon and his colleagues at Carnegie Mellon contributed to the study of organisational learning with their work on models of decision-making in organisational settings (Garvin, 1993).

In the intervening decades, many authors have used and developed ideas generated by inquiry into the characteristics of the learning organisation and have created models proposing to describe the phenomenon of organisational learning. Some of these models will be explored here, and different aspects of organisational learning suggested by various theorists are included in the learning organisation framework used in this study, and described in this chapter.

Credit for first articulating the concept of the learning organisation belongs to Karl Wicke (1979) in *The Social Psychology of Organising*. Wicke stated that to be successful in their efforts to change an organisation into an effective commercial or social enterprise, those who would create the changes must first be aware of the characteristics of learning as it occurs in the organisational context.

A further contribution to the field of organisational learning comes from the work of Chris Argyris and Donald Schon of Harvard University in the 1970s (Argyris & Schon, 1978). Of particular significance is the distinction which these authors have made between first and second order learning. First order or 'single loop' learning involves improving the organisation's ability to achieve a known objective. It is often associated with routine and behavioural learning of a problem-solving nature. First order learning is learning without significant change in the assumptions that underlie the organisational culture. Second order, or 'double loop' learning, involves changing the organisation's culture (Argyris, 1977, p115-124).

Double loop learning, says Argyris (1977), is learning how to learn because it re-evaluates the nature of objectives and the values and beliefs which underlie them. This learning-how-to-learn is seminal to the concept of the learning organisation. It is closely linked, say Ulrich et al (1993), to the second 'widely accepted' assumption about organisational learning, which is that learning matters.

Schein (1992) argues that companies that demonstrate an understanding of how much learning matters use various strategies to focus thinking, encourage dialogue, and make tacit, instinctively understood ideas explicit. This suggestion highlights the value, when initiating organisational learning, of bringing to light the 'theories-in-action' which nurse theorists, such as Meerabeau (1992), claim underpin the practice of the expert nurse. Implicit within this idea, about the importance of tacit theories, is both recognition of expertise in nursing practice, and the importance of this expertise in developing a learning organisation within a structure such as the CHE where the research group of nurses are employed.

Recent work on learning in the organisational context comes from Peter Senge and his colleagues at the Massachusetts Institute of Technology. By applying systems theory to the observable process of learning, Kofman and Senge (1993) have been able to plot the progression of organisational learning. Hence, the third assumption said to underlie the learning paradigm is that

successful organisational learning follows a pattern, a predictable progression (Ulrich et al, 1993). Of importance to Nevis, diBella and Gould (1995) is the consideration of identifiable stages of the organisational learning process. These authors have proposed a three stage model of the growth of organisational learning, which will be explored in this chapter.

As this overview suggests, the study of organisational learning is not new. What is new is the upsurge of interest in how the concept of the learning organisation can help managers improve personal and team performance and link this to economic success. A question that hangs in the balance is whether the Learning Organisation is a true alternative to the authoritarian hierarchy, as its supporters claim. A further, perhaps more pressing question, is whether it is possible to identify and foster the conditions essential to the growth of committed co-operative activity said to be central to the idea of the learning organisation (Senge, 1994).

What is the learning organisation?

There is an elusive quality to descriptions of the learning organisation and prescriptive formulae are even harder to acquire. Senge (1990), who popularised learning organisations, describes them as places *'where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning how to learn together'* (Senge, 1990, p.24).

Senge has suggested the use of five 'component technologies' as a way to understand and create the learning organisation. These are:

- systems thinking
- personal mastery
- mental models
- shared vision

- team learning

These component technologies of personal and group interaction should be nurtured if an organisation is to learn effectively (Senge, 1990). In a similar vein, Schein (1992) characterised knowledge creating companies as places where *'inventing new knowledge is not a specialised activity...it is a way of behaving, indeed a way of being, in which everyone is a knowledge worker'* (Schein, 1992, p. 97).

Most scholars view organisational learning as a process that unfolds over time (Huber, 1991; Levitt & March, 1988; Stata, 1989) and link it with knowledge acquisition and improved performance (Argyris, 1977; Finl & Lyles, 1985). However, they differ on other important aspects. For some theorists behavioural change is required for learning to take place (McGill & Slocum, 1993); for others, new ways of thinking are said to be sufficient to show that learning has occurred (Meen & Keough, 1992). Some, such as Huber (1991), cite information processing as the mechanism through which learning occurs, others insist shared insights, organisational routines and memory have a key role (Nevis et al, 1995). Some express the belief that organisational learning is a norm (Kofman & Senge, 1993), while others believe that flawed self-serving interpretations are more likely to occur (Ulrich et al, 1993).

Theoretical speculation continues as to what it is that constitutes the organisational learning experience. Garvin (1993, p.80) suggests that effective utilisation of learning involves reflective changes in organisational behaviour and states that *'a learning organisation is skilled at creating, acquiring, and transferring knowledge, and modifying behaviour to reflect new knowledge and insights'*.

This description has merit for the purposes of this research framework. New ideas are indeed essential if learning is to take place. Sometimes they are created *de novo*, as Garvin suggests, through

flashes of insight or creativity. At other times they arrive from outside the organisation via a consultant, or as in this study, a researcher. New ideas may also be suggested or communicated by knowledgeable insiders, the expert practitioners, who in this study are the Public Health Nurses of the research group. Whatever the source, new ideas may trigger organisational improvement. However, while new ideas are a necessary condition for learning, without accompanying changes in the way the work gets done they represent only the potential for improvement.

For Senge (1990), learning concerns the enhancement of the ability to create and inevitably it starts with a vision, a picture of what might be. Real learning, says Senge, occurs when people are trying to do something that they want to do. Learning is always related to doing something (Meen & Keough, 1992). As with Garvin's description, there is a further necessary ingredient in Senge's vision, and this is the idea of expanding the capacity to create. The organisation, having acquired the new idea, uses it, puts it to work, translates the new idea into action.

In the practical arena, there is yet another dimension to a definition of organisational learning for, as Senge (1990) says, there must be some assessment of progress. This assessment, Kofman (1993) suggests, should be made by the peer group: *'Learning is the enhancement of or increase in knowledge, and knowledge is the capacity for effective action in a domain where effective action is assessed by a community of fellow practitioners'* (Kofman & Senge, 1993, p.48). This claim, which places the activity of the peer group centrally with respect to the assessment of organisational learning, is a vital link between the study of the developing peer process, and the use of the learning organisation as a research framework.

To draw these themes together, it is apparent that the learning organisation has a cognitive dimension, and an action dimension, which are intricately entwined. The work of building the learning organisation, however, as the discussion in the next section shows, is largely speculative at this point.

How is the learning organisation to be built?

There is a lack of research in this 'operational middle ground', for, while theorising about the learning organisation portrays it as eminently desirable, it does not provide a framework for action. It has a philosophical rather than a practical focus and, in the context of this study, leaves unanswered the following questions: If a health services organisation, such as the CHE which employs the nurses involved in this research, is to become a learning organisation...

- what concrete changes in behaviour are required?
- what policies and programmes must be in place?
- what changes in the organisational culture will be required to sustain the growth of the learning organisation?

Senge's (1994) model of the learning organisation

In order to discover possible solutions to these pressing questions it is instructive to look first at a model of organisational learning developed by Senge (1994) in *The Fifth Discipline Field Book*. In Senge's model, organisational learning is shown as beginning within the deepest levels of behaviour, in an area which Senge calls the deep learning cycle. It is here, in this domain of enduring change, where attitudes and beliefs are changed by the experience of learning. Skills and capabilities are shown to change as development of attitudes and beliefs occurs. Eventually, the way the work is performed will change. This represents a change in the wider organisational architecture, the domain of action (Senge, 1994). Other changes in the organisational architecture follow the growth of organisational learning as it progresses through the deep learning cycle and spreads, ripple like, through the infrastructure of the organisation. Changes are seen to occur in the ideas that guide the planning of the work, and the methods and tools which ensure that the work gets done. Organisational infrastructure adapts to accommodate and support organisational learning. The effect of these changes is to create an environment that supports further growth throughout the deep learning cycle, and the domain of action.

Senge's (1994) model of the learning organisation as proposed in *The Fifth Discipline Field Book*, is included here as a basis for the discussion of the research model:

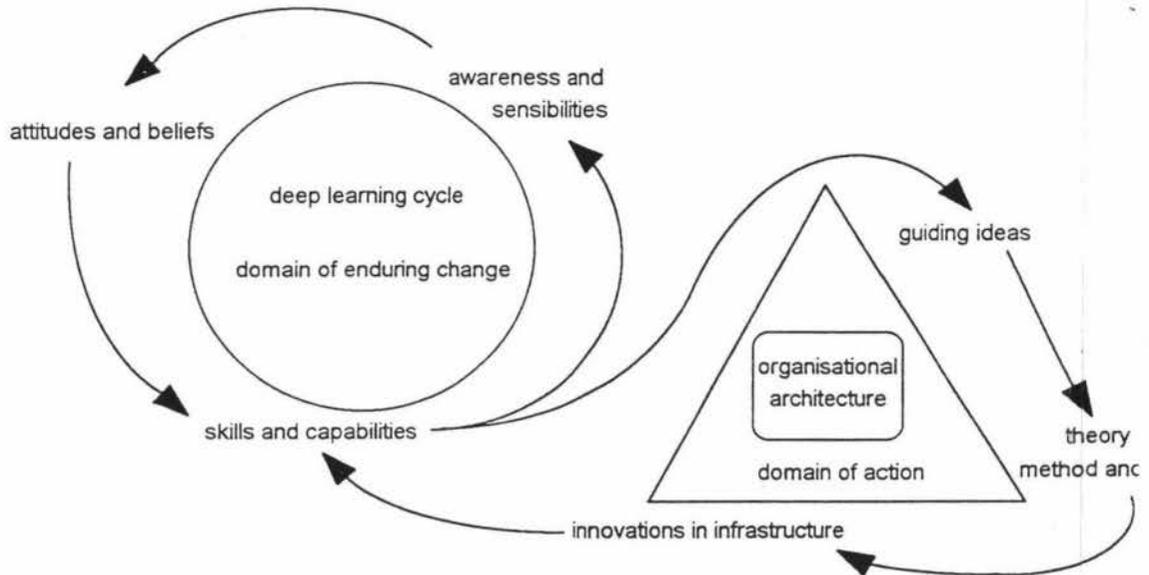


Fig. 1. The Architecture of Learning Organisations

adapted from *The Fifth Discipline Field Book* (Senge, 1994, p. 45)

Senge (1994) suggests reflection on the deepest nature of the project to be undertaken, and the central challenges it presents, as a prerequisite to successful and enduring organisational change.

Such reflection, says Senge, involves a consideration of the deep learning cycle of the people and groups within the organisation. The deep learning cycle, which Senge (1994) also called the domain of enduring change, is the process whereby people are changed, often profoundly, by the experience of what they can do and understand. As new capabilities develop so too do new awarenesses. New beliefs and assumptions begin to form which enable further development of skills and capabilities. For Senge (1994), the deep learning cycle constitutes the essence of a learning organisation, and is the development of fundamental shifts of mind both individually and collectively. Using this learning organisation framework for research would predicate a search for changes in the patterns of thinking and interacting within the research group. It would be expected, says Senge, that, over time, as new skills and capabilities develop within this group, the world as it is "seen" would literally shift. Different relationships would be expected to emerge and the way the group interrelates with the wider organisation and health services culture might also become predictably different as the learning organisation takes root.

The work of building learning organisations, Senge claims, is effected by activation of the deep learning cycle, and is the province of all who engage in the ongoing practice of the learning discipline. The growth of the learning organisation takes place within a "shell", an architecture of guiding ideas in organisational infrastructure. There will be changes also in the theories, methods and tools which are used to sustain the work of the organisation. Senge calls this shell the domain of action, and says that positive changes here reinforce and sustain changes in the deep learning cycle as organisational learning develops.

Despite the descriptive rhetoric found in much of the foregoing, important prescriptive questions have not yet been answered. The focus is still philosophy rather than the gritty details of practice. Clearly, a model of organisational learning, incorporating the more tangible aspects of such inspired theorising was required for this study. Hence, a learning organisation framework, which draws together many of these ideas, was created.

The research framework

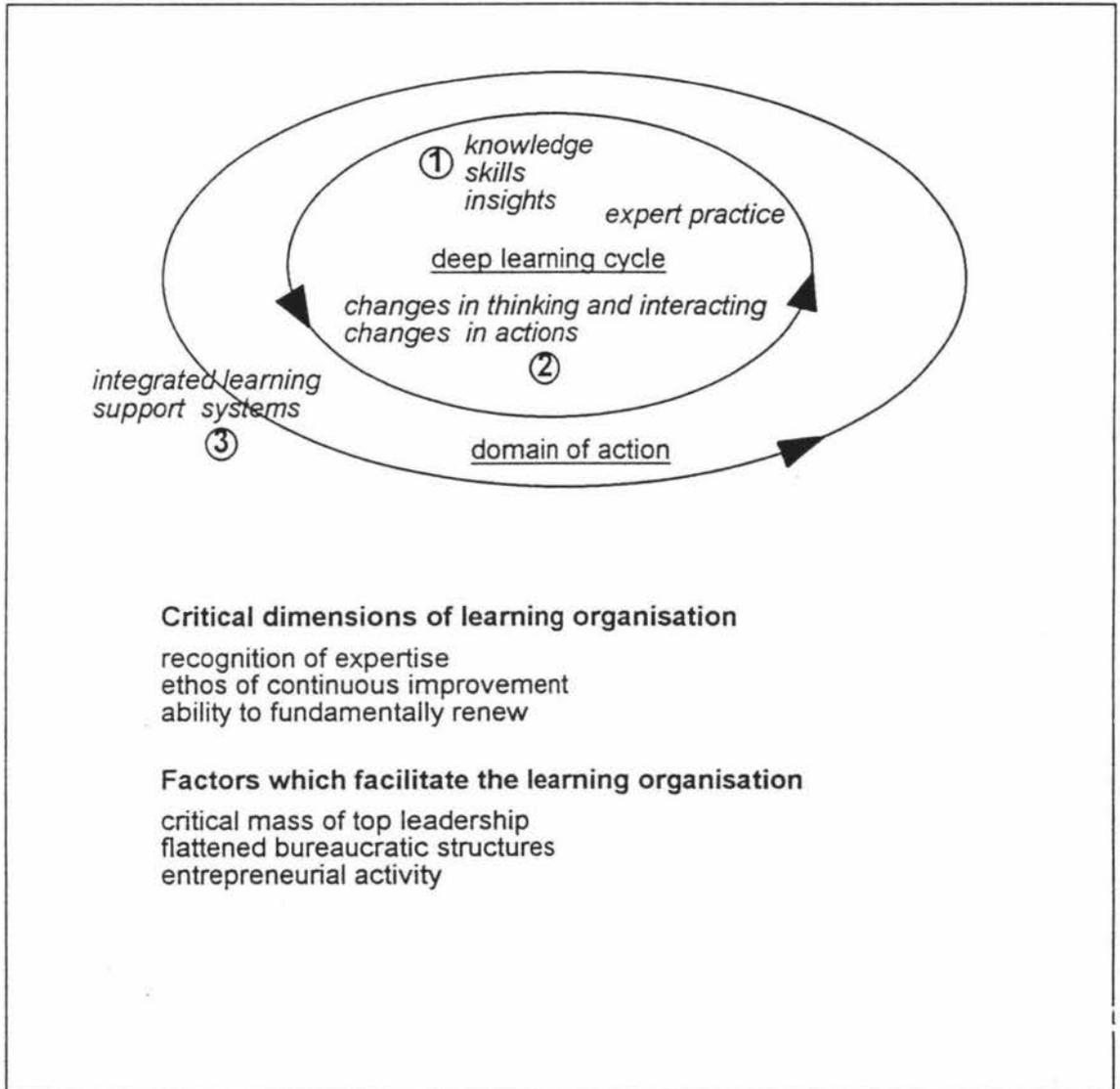


Fig. 2. The Learning Organisation: A framework for peer review research project

(McRae, 1995)

This research framework of the learning organisation incorporates attributes of the deep learning cycle and the domain of action as Senge (1994) envisioned them. These areas are suggested to be more intimately associated than Senge's model shows, with the deep learning cycle now surrounded by the domain of action. In addition, the research model shows three stages of organisational learning, which begin within the deep learning cycle and spread outward, ripple-like, through the domain of action.

Three-stage model of organisational learning

A three-stage model of organisational learning is proposed by Nevis et al (1995), who consider identifiable stages of the organisational learning process to exist. These three stages include:

- knowledge acquisition, where skills, insights and relationships are developed
- knowledge sharing, which occurs with the dissemination of what has been learned
- knowledge utilisation where integration and generalisation into new situations occurs.

The first stage of organisational learning, it is suggested, is the acquisition of new knowledge, skills and insights. These lead eventually to the development of expertise, and the recognition of expert practice, by individuals and the peer group. This stage occurs within the deep learning cycle, the domain of enduring change. The second stage of organisational learning, indicated by the research framework, also takes place within the deep learning cycle of the research group of nurses. It occurs when changes in patterns of thinking and interaction within the group indicate that group learning has occurred, knowledge has been shared and transferred into action. The third stage of organisational learning identified by the research framework is the presence within the domain of action of integrated systems which support organisational learning. These systems act to support and reinforce individual and group learning. Such systems also disseminate and generalise the learning of the group to create enduring changes throughout the organisation.

Critical dimensions of the learning organisation

Critical dimensions of organisational learning are thought to be those practices, attitudes and ideas which are present, and generally accepted, within the organisational culture, without which the learning organisation may not flourish. According to Nevis et al (1995), these are:

- a set of well-developed core competencies
- an attitude that supports continuous improvement
- the ability to fundamentally renew or revitalise

The first critical dimension is a set of well-developed core competencies reflecting the expertise of the workers, who in this study are the nurses of the research group. Well-honed core competencies, say Nevis et al (1995), serve as launch points for new services and products. These competencies also support the creation of a variety of notably different products and services. A further aspect of this critical dimension of organisational learning is the recognition of expertise, a valuing of the knowledge of the expert practitioner, which begins in the deep learning cycle of the group.

The second critical dimension for the success of the learning organisation, as identified by Nevis et al (1995), is an attitude that supports continuous improvement in the value-added chain of production and service. On-going development and assessment is cited as an example of this attitude. An inquiring organisational mindset where innovation is rewarded, and a climate of openness where it is acceptable to make mistakes and mandatory to learn from an analysis of mistakes, is at the heart of the learning ethos for these authors.

The third critical dimension, described by Nevis et al (1995) as a feature of successful organisational learning, is the ability to fundamentally renew or revitalise. Organisations that have

this ability to renew, periodically exit old products and services and enter new ones to retain their position as market leaders.

These three critical dimensions are assumed to be important both within the deep learning sphere as well as within the domain of action. It is suggested that these critical dimensions of organisational learning can be shown to occur, or not, using the theoretical perspective created with this framework.

Factors which facilitate the learning organisation

Three factors are suggested as having important facilitative clout in the building of the learning organisation (Mapes, 1993; Meen & Keough, 1992; Ulrich et al, 1993). These are:

- a critical mass of top leadership
- flattened bureaucratic structures
- entrepreneurial activity which crosses hierarchical boundaries

Not surprisingly, it is suggested that the development of the learning organisation will occur most readily where there are advocates of the learning process at all levels of the organisational structure. This multi-level sponsorship of learning and change is offered as a facilitating factor by several authors. Meen and Keough (1992) cite a critical mass of top level leadership as an essential component of the learning organisation. As well, these authors predict that organisational learning will develop most easily in organisations that have flattened bureaucratic structures, rather than in those which preserve rigid authoritarian hierarchies. Freedom to pursue interactive entrepreneurial learning interests throughout an organisation, particularly across hierarchical boundaries, is an important facilitating factor identified by Mapes (1993). All of these factors, in concert with local operating group activity, where a group is 'licensed' to simultaneously challenge both strategic assumptions and operational processes, will provide dramatic results say Ulrich et al (1993). The

learning power of the group is said to be enhanced where there is an ability to both generate and generalise ideas with impact at all levels in the organisation.

Effective learning organisations such as those studied by Nevis et al (1995) 'diligently pursue' a constantly expanding knowledge base. They assimilate and use knowledge and have some kind of integrated learning system to support such 'actionable learning'. Continuous education for employees about the organisation, its performance and goals are seen as factors that facilitate organisational learning (McGill & Slocum, 1993). Further, an organisation's ability to survive and grow is said, by Nevis et al (1995), to be grounded in advantages that accrue from well developed core competencies. It is these specific core competencies, which together with the presence of other 'facilitating factors' represent collective or organisational learning. As a corollary to this claim, Nevis et al assert that the creation of a learning culture and the socialisation of employees into the culture of the organisation relies on the learning process to ensure an 'institutionalised reality' that is shared by all employees.

Hence, these are the factors shown by the research model to facilitate organisational learning. It is suggested that evaluation of organisational learning during the research process can be mapped using this learning organisation framework.

The learning organisation as a system

According to Nevis et al (1995), organisational learning is a systems level phenomenon because it stays within the organisation even if the people change. Inevitably, a systems perspective is touted as a basic ingredient in the view of almost every theorist on the subject of how to facilitate organisational learning. Systems thinking encompasses taking cognisance of the whole, identifying key factors and seeing what needs to be done (Kofman & Senge, 1993). Senge (1990) describes this capability of developing mental models, which can reflect workplace reality and illuminate both the complexity and the essentials of what is required, as being 'organisational wisdom'.

Guided by the research framework, the entire observation and study of the developing peer review system takes place within the two concentric spheres of first the deep learning cycle of the public health nurse group, and then spreads to the domain of action, the organisational architecture of the CHE. Most importantly, the use of this framework makes evaluation of the progress of learning in the organisational context possible. In this study the landmarks of progress were identified and assessed by the peer group.

Notable benefits arising from the use of the learning organisation framework relate to creating a systems perspective of the CHE within which the public health nurse group is located. The peer process development activities of the research group are thus viewed within the context of the nurses' clinical practice, which in turn is seen within the wider setting of the employing organisation. The planning for the data collection, the analysis of data, and the action and reflection phases of the research process which will be described in successive chapters are likewise directed by a systems view.

The learning organisation is possible because, it is argued, deep down we are all learners, it is our nature to learn and we love to learn (Senge, 1994). The learning organisation framework assumes connections with the deepest learning processes within the individual and the group to the dynamic organisational architecture of the whole. Using this research framework, there is an expectation that learning within the public health nurse group may be transfused throughout the organisation to improve the quality of health services delivery.

Summary

The learning organisation has been presented in this chapter as a framework of organisational growth with which to study the process of the developing peer review system. As outlined in Chapter Two, there is a trend in the health service organisations towards creating structures that recognise and

value basic human interactions. The understanding of what such organisations are capable of achieving is perhaps the most salient and compelling reasons for building a learning organisation.

A framework to study the growth of learning, which connects the deepest learning processes of the individual and the group with the dynamic organisational architecture of the whole is conceptualised. The learning organisation framework assumes that there are generalisable aspects of group learning which will enhance the economic performance of the organisation. Further, there is a belief that the learning organisation acts to support the learning of individuals in groups, and to translate this learning into practical strategies to improve group performance. Such an adapted framework is described in this chapter as directing the research inquiry. The learning organisation framework directs the collection and evaluation of data, and is a tool to measure organisational learning as the peer review process develops.

In Chapter Four the methodological approach adopted in this study is outlined. Links between the theoretical framework outlined in this chapter and action research methodology are explored in Chapter Four.

CHAPTER FOUR

Action Research

Introduction

This chapter provides an overview of the research process followed in this study. An action research approach, based on the learning organisation framework described in the previous chapter, is outlined. The rationale for a praxis-oriented participatory action research methodology, derived from the critical paradigm, as an alternative to naturalistic or humanistic science, is explained in this chapter. The slightly different foci of participatory methodologies and co-operative enquiry are presented, then the participatory action research process as used here is described. The research participants and setting are sketched, and issues pertaining to data collection, which was chiefly through interviews, are discussed. Finally, in this chapter, ethical considerations, and issues of reliability and validity are considered.

Methodology

The rationale for selection of the research approach was driven by the question: "What sort of research process will deliver the results we want?" It has been suggested by Parker, Gortner, and Brannon (1992) that the success of a research project such as this depends on the selection of a research approach which facilitates involvement of the entire research group. The right research method in this instance would engage the researcher, all the Public Health Nurses, the manager of their service, the Chief Executive Officer (CEO), the Human Resources Manager (HR manager), and the Nurse Advisor, and would support participation by all these people through all phases of the project. Further, there was a belief, that the research process, in supporting the development of the peer review system, should also help the research group to secure their goals in relation to their appraisal system. Hence, it was seen as important that the research approach for this study should foster group ownership of the entire peer review process, in order to create a peer review system which

would endure, and which would engender supportive changes in the organisational architecture (Senge, 1994).

Parker et al (1992) state that, in a practical nursing context, the right research process will help the definition of goals and the evaluation of outcomes. With the right research process, responsibility for the success of the project tends to devolve equally amongst participants, say Parker et al. This suggests that participants will take responsibility for achieving the goals of the research, if the research process is appropriate (Parker et al, 1992). Extrapolation of this possibility suggests that a research process that would ensure this level of commitment and responsibility, will also ensure ownership of the results of the research. Ownership of the peer review system is thus theoretically assured with the use of an appropriate research methodology.

Modified participation for the three managers not directly involved with the Public Health Nurses was perceived as a useful goal. The level of participation for these managers was seen as modified because, while they would be informed as to the issues and outcomes for the developing peer review system, they would not be actively involved in the peer process. However, there was an undertaking that concerns voiced by these managers would be addressed as the study progressed.

A further capability that the research process for this study was seen to need was that of enabling a sharing and respecting of values within the research group. Ideally, the entire research group of managers, researcher, and Public Health Nurses, were to be involved to a greater or lesser degree in a committed co-operative effort as co-researchers working toward a common goal. It is suggested that such a sharing and respecting of values is eminently desirable, if for no other reason than to allow the project to progress smoothly (Parker et al, 1992).

Naturalistic and Humanistic science

The prevailing paradigm in nursing research, especially within the Anglo-American tradition, has until quite recently, been that of the natural sciences (Gortner, 1990; Schultz, 1987; Silva & Rothbart, 1984; Stevenson & Wood, 1986). An argument against the adequacy of the naturalistic paradigm for nursing research is that the foundation of nursing science within the paradigm of the natural sciences does not correspond well enough with the nature of knowledge needed for nursing practice. The humanistic sciences are seen by Holmes (1990) and Stevenson & Wood (1986) as a viable alternative to the current over-emphasis on the natural sciences. Hall (1985) states that action research incorporates both humanistic and naturalistic scientific methods and was designed specifically for bridging the gap between theory, practice and research. Given this context, an action research method was a highly compelling choice for this study.

What happens in Action Research?

Action research is derived from critical social theory which has as a fundamental premise that all people are oppressed and would behave differently if they were aware of the nature of their oppression (Habermas, 1974, p.48). Given this ideological derivation, Fleming (1991) states that action research offers a powerful basis for critique of the *status quo*. An action research approach, it is argued, provides a firm methodological footing for the emancipatory problem solving such as that required by the public health nurse group. Using this theoretical perspective, participants in an action research project, such as this, are invited to critically examine their practice environment. The action research process directs participants to consider possible solutions to problems, and then to try out possible solutions in practice. Finally, in subsequent planning phases of the research process, participants are asked to evaluate the effects of their actions. It is argued by Fleming (1991) that the action research process has empowering and emancipating effects, so that participants, in a study such as this, are potentially enabled to revisualise and redesign their social and practical settings.

Prior to the beginning of the data collection period, the nurses of the research group had already taken responsibility for designing and developing their own performance appraisal system.

This was seen as a noteworthy feat in a work environment where the traditional response had previously been a generic manager-initiated performance appraisal. An action research approach, it was anticipated, would support development of the peer process and facilitate organisational learning.

The methodological choice for this study was a praxis-oriented participatory action research process which involved a series of interviews with the research group over a period of eight months, and was concerned with the resolution of problems with the peer process and observation of the growth of the learning organisation.

What is Action Research?

Action research as a concept does not easily lend itself to definition. The variety of approaches, methods, uses and names that have emerged since Lewin's original work in the 1940s has created much debate within the social and behavioural sciences (Whyte, 1991; Kalleberg, 1990). While a kind of confusion persists over which methodology is which, there are four characteristics central to action research (Holter & Schwartz-Barcott, 1993). These are:

- to create a change in practice
- to develop and refine existing theory
- a focus on practical problems
- involvement and collaboration of researcher and practitioners in planning acting and assessing

Participatory Action Research Methodology and Co-operative Enquiry

In his classic work, *Action Research and Minority Problems*, Lewin (1946) described action research as a collaborative effort between members of organisations and behavioural scientists to study situations which were of interest to both groups. Today most researchers recognise the limitations of Lewin's work, such as the taken-for-granted assumption that research/intervention is 'better' for the

research group than no research/intervention. However the important characteristics that persist are that participatory research methods:

- are participatory in nature
- follow a democratic impulse
- make a significant contribution to social science and social change

Ellen (1990) states participatory research methods modelled on action research were developed by researchers to identify community needs in developing countries and engage community members in problem-solving dialogue and planning activities. The results of the studies were then used to help the communities change in some way. A generic goal of participatory action research processes is said by Hall (1985, p.9) to be "the liberation of human creative potential and mobilisation of human resources for the solution of social problems".

In general, participatory action research methods include both the researcher(s) and the people who are being researched. The norms of participatory action research, according to Ellen (1990, p.47), include:

- participation of the entire group in discussion, investigation and analysis of practical problems
- planned interventions
- implementation of new activities to resolve the practical problem
- evaluation, assessment and further planning is a norm of participatory action research

All of these characteristics emphasise the congruence of the relationship between action research and the organisational learning framework described in the previous chapter.

Elden (1983) suggests that participatory research could be applied to commercial organisations and the results could be expected to lead to employee-managed inquiry and change in the workplace.

Sims (1992) reiterates this position in relation to nurses' workplaces. She states that research methods subsumed by action research and based on values consistent with those of nursing work groups have the potential to contribute to the successful integration of administration and management changes into a clinical practice area.

A methodological approach closely allied to action research is co-operative enquiry. Co-operative enquiry emerged from the realities of conducting research into various aspects of human life and from the ongoing philosophical discussions about the nature of human study (Reason, 1988). This form of inquiry emphasises the involvement of research 'subjects' in the total process, by treating them as co-researchers. Information is gathered from them and, as Reason (1988) describes it, is then used to reach conclusions, develop theory and suggest changes and courses of action for the future. Reason (1988, p.3) adds, whatever the terms used to describe the new methods, such as participatory research, action research or co-operative inquiry, the commonality in all methods is "that they are all working openly, directly and collaboratively with the primary actors in their various fields of interest."

An orientation towards praxis

Participatory action research, within a nursing context such as that of the Public Health Nurses' peer review project, is described by Fleming (1991) as emphasising the role of the nurse as practitioner, and thereby introducing the idea of praxis. Praxis implies reflexive relationships between theory and practice in which each builds on the other (Carr & Kemmis, 1983).

Fleming (1991) suggests that nursing action is informed by practical theory, the 'theory-in-action', which may in turn inform the theory which informed it. Praxis thus has its roots in the commitment of the practitioner to wise and prudent action in the practice setting, as well as an ability to reflect upon this action and modify subsequent nursing action on the basis of this reflection. There is, therefore, a reflexive property in the exercise of praxis, which suggests a cyclic aspect as praxis develops over time.

When the topic under study is nursing practice, the nurse as practitioner is central to the action research process. Meerabeau (1992) sees the nurse practitioner as central because only the practitioner has access to the commitments and practical theories that inform praxis. Thus in a praxis-oriented participatory action research study, where the aim of the study relates to social, political, and, as in this case, administrative changes, the practitioner is central and the rest of the research group, that is, the managers and the researcher, act to support this centrality. As well, the research group is committed to ensuring that organisational and research goals are met.

Hence, the shared goal of the research process is to improve the quality of nursing practice. The aim of praxis-oriented action research is always to improve practice through a critique of practice; to improve understanding by a critique of understanding; and to improve practitioners' situation on the basis of a critique of the situation (Carr & Kemmis, 1983, p.168).

Friere (1972) states that praxis-oriented research highlights the key concepts of action and reflection. It is perceived that this focus on praxis through action and reflection within this study reinforces the selection of the organisational learning framework, with its key concepts of learning and action, with which to plan and implement the research process and to collect and evaluate data.

The Research Process

Lewin's framework for conducting action research consists of a 'cycle of steps' (Lewin, 1946, p.38). Each cycle of steps is composed of a circle of planning action and fact-finding about the result of action. It is a cycle, says Lewin, because action research is ongoing and the research strategy is repeated and reformulated with each circle.

A somewhat more recent description of action research, by Susman and Everard (1978), proposed a cyclical process similar to Lewin's and included the steps of diagnosis, planning, taking

action, and evaluation. Most recently, Tripp (1990) has introduced the idea of a 'spiral' as best describing action research in the belief that this better conveys the open-ended movement of the action research process rather than the closed system conveyed by the term 'cycle'.

Fleming (1991) suggests that there are 'moments' rather than discrete 'steps', of diagnosis, planning, action, and evaluation which occur continuously during the spirals of the action research process. For a nurse researcher, a particularly attractive feature of the action research process is the non-intrusive quality of the spiralling research process, which, as Fleming (1991) argues, facilitates access to the field for the researcher and is eminently acceptable to nurses working in a clinical practice area. As Fleming (1991, p.69) says, *'it is the naturalness of the spiral of 'moments' that leads nurses to see action research as something done by practitioners rather than the artificial imposition of a 'scientific' research structure'*.

The situation at the beginning of the study

The formal research period, for this study began in April 1995. The developments which occurred during the study are outlined in this section. First, however, the status quo of the developing peer review process, at the beginning of the formal research period, was as follows:

The peer review process began four years ago, as was outlined in Chapter One, when the manager of the Public Health Nurses approached the researcher, who was then the staff development co-ordinator for the employing CHE, for assistance in her search for ways to evaluate public health nurse performance. Peer review was selected as an appropriate alternative to the generic, manager-initiated nurse appraisal system then in use. The Peer Review Model developed by the Public Health Nurses of the research group (Appendix A) consists of monthly meetings, of each smaller peer group of three or four nurses, where each nurse presents a case to her peers and in return, receives from each peer constructive critique, an appraisal score, and recommendations to improve her practice. At the time the formal research process began in April 1995 the peer review system had been successfully implemented. Monthly meetings of the peer review groups had occurred for the previous four months.

A significant event to note at this point, immediately prior to the beginning of the data collection period, was the creation of a review team which was to critique the developing peer process and recommend changes. The review team, consisted of the manager of the public health nurse group and two Public Health Nurses who had been selected by the research group of nurses. This review team, which was to meet immediately after the second round of data collection in June 1995, was set up to consider the various issues arising from the first six months of peer review meetings. The brief for this review team, as set out by the group of Public Health Nurses and their manager, was as follows:

- to discuss the peer review development process
- to analyse any reported difficulties
- to formulate possible solutions for problem areas
- to bring recommendations for change back to the public health nurse group

The review team, membership of which would be rotated through the public health nurse group, was scheduled to meet quarterly. Clearly, the review team was perceived by the research group of nurses as providing a decision making forum, in the event that it should prove difficult to resolve development issues with the peer review system. As well as the assessment and evaluation of progress afforded by the review team, ongoing critique of the entire peer review process continued within the larger public health nurse group. Issues pertinent to all facets of the peer review process were being debated here, before being referred to the review team.

Data collection

The research process, which involved a series of interviews with the research group over a period of eight months, to observe the growth of organisational learning in relation to the development of the peer process, began in April 1995. Interviews with the public health nurse group were scheduled for April, mid-June and September, 1995. The manager of the public health nurse

group would also be interviewed on the same day as the larger group of nurses. Interviews with the CHE managers, the CEO, the HR manager, and the Nurse Advisor, were sought at the beginning of the study, in April, and again at the end of the study, in September.

The data collection was characterised by interviews with all participants. These interviews were held in formal groups, as with the entire public health nurse group, and in formal one-to-one meetings as with the manager of the public health nurse group, and the CEO, HR manager and the Nurse Advisor. Less formal data-collection interviews also occurred with a group of three Public Health Nurses, and as one-to-one conversations with four individual nurses. The data collection was a major part of the action research spiral, with planning, action, observation and evaluation occurring, inevitably but not exclusively, within the interview settings.

Evaluation of data, which is described in detail in Chapters Five, Six, Seven and Eight, was retrospective; looking back at problems and constraints made visible through planned purposeful strategic action. Themes and issues identified during evaluation of data were returned to the research group in successive rounds for discussion, planning, implementing and assessing. It is this combination of the prospective and retrospective steps of action research that distinguishes an action research project such as this from problem-solving or everyday planning in the organisational context.

The planning and evaluation steps of the action research spiral acted to promote discourse among participants, while the action and observation steps continually reiterated and re-established the link with praxis. Each of the four phases of the action research spiral was not isolated but rather seen as essential to the entire action research process. This action research process, as Fleming (1991) has acknowledged, is intrinsically critical in that the declared aim of the research was to bring about changes at an individual and a group level, as well as engender change in the wider organisation, through reflective critique of the current environment in order to improve nursing practice.

Research participants and setting

The research participants for this study, with the exception of the researcher, were all employees of a particular CHE. They were:

- sixteen registered nurses who were Public Health Nurses
- the manager of their service who was also a registered nurse
- the Chief Executive Officer of the CHE
- the Human Resources Manager
- the Nurse Advisor who was also a registered nurse
- the researcher

As outlined in Chapter One, I had worked with the research group earlier when as the staff development officer for the CHE, I facilitated much of the group work leading to the development of peer review. Later, as a Masters student at Massey University, I had worked with the Public Health Nurses for a year in 1994 developing the model of peer review, the peer review appraisal tool and the BARS tool.

Prior to any planning of the research process, the manager of the Public Health Nurses had enlisted support for the research project with the CHE managers, as well as securing their agreement to participate in interviews with the researcher. These activities by the manager had the effect of minimising problems with entry to the research field, thereby bearing out Fleming's (1991) assertion that action research projects are particularly attractive for nurses in terms of entry to the field.

Setting the scene

Prior to commencing the planning phase of the first action spiral, a workshop was held with the Public Health Nurses, the manager of their service and the researcher. At this workshop some of the characteristics of participatory research were outlined, particularly the relationship between the researcher and the participants. As a researcher, my position was that of an 'outsider' in that I no

longer worked for the CHE. However, over the preceding years, when I had been an employee of the CHE, I had come to know the group through our association in the earlier stages of planning for peer review. It was this association which was perceived by the group and myself as a desirable ingredient in the undertaking of collaborative research and led to the manager inviting my continued involvement.

From the perspective of knowledge of organisational systems, knowledge of the participants and an understanding of the practice setting I may have been initially considered an 'insider'. The geographical distance which separated me from the group and the constraints of working for a different organisation made it inevitable, however, that over the course of the eight months of the data collection period I was eventually considered as an 'outsider'. I do not believe being seen as an 'outsider' would necessarily have prejudiced the nature of the data or the data collection methods, although it is possible to speculate that had I been a true 'insider' for the Public Health Nurse participants a more concentrated mass of data may have been accumulated.

For example, it could be argued that had I been considered a true 'insider' the nurses may have been more willing to discuss particular clinical aspects of cases they were presenting to illustrate difficulties with the BARS appraisal tool. Discussing such clinical information with an 'outsider', would perhaps be incongruent with the provisions of the Privacy Act (1993), and perhaps for this reason, I did not become privy to such discussions.

In the final analysis, however, I believe that as an 'insider', that is, as the staff development officer, my position would have been seen differently by the managers of the CHE. I would have had diminished access to these CHE managers and therefore the data collected from these sources may have been less dense. Further, as an independent consultant and therefore as an 'outsider' I believe I may have been awarded greater credibility with this latter group and, were this so, it might be argued

that greater weight would accrue to the project in terms of securing continuing organisational support for the peer process.

Following this preliminary workshop to plan the research process a level of reciprocity was achieved, where expressed problems were addressed and the key needs of each participant in relation to the research process were assumed to have been met. Such a situation meets the key concepts of reciprocity outlined by Tripp (1990). Tripp states that a shared commitment to the necessity of the research, and a research agenda which is of mutual concern are central to discussions of the reciprocity which ought to exist in participatory research design (Tripp, 1990, p.20). To ensure reciprocal gains as well as fairness and justice for all concerned, Tripp advises control of the research process must be equally shared, with some guarantee that outcomes be of equal value to all participants in professional terms.

It is argued that these key conditions of reciprocity have been addressed with the design of the peer review research project. While it could be argued that the degree of importance of the research for each of the participants must vary, there was an understanding that the research proposal was meaningful to all participants, and that the planned interactive research approach was an appropriate way to involve all concerned in the implementation and development of the peer review system.

Ethical considerations in relation to the ownership and usage of data were outlined at this preliminary workshop. Permission to collect and use data was sought from all involved prior to the commencement of the study. It was emphasised that the process and the data remained the property of the CHE. However, the thesis which would result from the research project would be copyrighted to the researcher. Verbal consent to participate was obtained from all potential participants; which was later followed by written consent to participate and accept the use of a tape recorder to record interviews (Appendix C, p. 2). It was emphasised that this consent was not a binding contract, rather

that it was for the protection of all parties and withdrawal from the study without penalty was possible at any stage of the research process.

Interviews

In addition to the preliminary meeting already described, three meetings with the public health nurse group, and three meetings with the manager of their service made up the larger part of the data collection. Two meetings with the Nurse Advisor, one at the beginning and one at the end of the data collection period, and one meeting with each of the CHE managers, the CEO and the HR manager, at the end of the data collection period, were a smaller part of the data. An additional four informal meetings with four different Public Health Nurses, and one informal meeting with a group of three Public Health Nurses were the final sources of data. Recordings were made of all interviews and the transcripts of each interview returned to participants for agreement with, and permission to use, the material. These interviews and other accumulated data represent the planning, observing and evaluating moments of the action research spiral, with action occurring continually over this period. Since the research was a collaborative venture, the planning moments of the action research spirals occurred mainly in the form of group interviews with all participants having the opportunity to be present, as well as opportunities to meet informally with the researcher. Group sessions lasted approximately one hour with all participants contributing to the discussion. While some participants were more vocal than others all had valuable contributions to make to the project.

Observation and evaluation also formed part of the group interviews. However, after the initial interview with the Public Health Nurses, part of which was specifically about the planning phase of the first spiral, it often became difficult to distinguish between the three other phases of the action research spiral. With planning and observation in the research group setting came evaluation, and evaluation of one action, as Fleming (1991) has observed, was frequently the planning of the next.

All interviews were unstructured though focused and lasted from thirty minutes to two hours. Participants were invariably keen to offer opinions on progress. Individual interviews focused predominantly on the observation and analysis phases of the research spiral. Individual interviews were audio-taped allowing comments to be placed in context more accurately. The group interview sessions were also audio-taped, although there were occasions of short duration where more than one conversation occurred, or laughter obscured some comments. However, in the majority of data collection interviews the audio-tape recording proved satisfactory. Amendments to transcripts were not required in any cases.

The key points of each interview were noted by the researcher and, once vetting of transcripts by the particular participants had occurred, these points became part of the agenda for discussion at the next meeting. Participants were also reminded to note issues as they arose in peer review sessions so that these concerns were discussed at the next meeting. The data obtained from these sources mainly relate to the observation and analysis moments of the research spiral, and serves as a direct link between the interviews and the action.

Ethical considerations

There is a need in any research for the researcher to undertake certain steps to maintain ethical standards. Accordingly, before the commencement of this study, the research proposal was approved by members of the Massey University Human Ethics Committee. Approval was not sought from the ethics committee of the participating CHE as no client contact was required, and also because the managers involved, including the CEO, had all given verbal approval that the study could proceed.

The collaborative nature of participatory research should not obscure the rights of each participant. Because action research, with its goals of understanding and empowerment is overtly interventionist, the researcher is obliged to take reasonable care to protect the rights of autonomy and self direction for each participant. It is important to ensure that the participants understand as fully as

possible the nature of the research process and the intended outcomes of the study, in order that they may freely choose to participate or not.

Informed understanding was initiated prior to the beginning of the study with all participants receiving a copy of the information sheet, with a verbal explanation to clarify issues as required. The relationship of the researcher and participants was described as being one of collaborative partnership. Assurances were given that the aim of the research was to assist the development of a peer review system for the Public Health Nurses, using the technology of the Learning Organisation. The discussion of progress, it was pointed out, would be a feature of all interviews so that as the study progressed all participants remained fully informed.

Participants were reminded at the commencement of each taped interview session that they were free to withdraw from the study at any time, and also that should they request it, the audio tape recorder would be switched off. Further there was a reminder that transcripts for each interview would be returned for editing and approval and would not be used without the express consent of all concerned. It was emphasised that tapes would not be available to any one other than the researcher and two supervisors, and that upon successful completion of the resultant Masters thesis the tapes would be destroyed.

Issues of reliability and validity

Lather (1986) states that efforts to produce social knowledge, that will solve practical problems, advance the interests of participants and provide accurate parameters within which the knowledge has meaning for readers, must pursue both rigour and relevance. Past efforts to remove all elements of subjective knowledge from the research process have been shown to be a contradiction in terms (Cronbach 1980). However, the acknowledgement of subjectivity and personal bias should mean that participatory researchers consider carefully the reliability and validity of the methods with which they seek to advance theory.

It is argued that for results to be considered valid and reliable in the critical paradigm there is a need for considerable re conceptualisation of the ideas that underpin 'reliability' and 'validity' and what it is they describe when moving from a traditional research stance. Fleming (1991) suggests that 'reliability' and 'validity' in the new paradigm will require that researchers develop techniques and concepts for obtaining and defining trustworthy data, such that there is a transparency as to the process, which will thus allow critical consideration of the tensions and contradictions inherent in the research design. This self-reflexivity of design and method will lead to a paradigm where issues of bias are no longer "canonised methods of establishing scientific knowledge" (Lather, 1988, p. 576).

Reliability and validity in the critical paradigm, it is argued, rest in the replicability of the process described in this study, to generate similar understandings and processes in other settings. There is acknowledgement that the process rather than the outcome is emphasised in this paradigm, and that the validity of the research process will be determined through ongoing reflexive critique. Trustworthiness of data and transparency of process in relation to this study will be briefly discussed under the following headings:

- replicability
- surrogate experience
- face validity
- construct validity
- catalytic validity

It is argued that if these factors are adequately addressed, the design and method used in this study is valid and reliable.

Replicability

The reflexivity of the participatory method described for this study, involving dialogue between participants and researcher implies a distinctiveness about each situation which is therefore not

replicable; replicability in the strictest sense may be perceived as somewhat incongruent within this method. However, the research report provides an account and a critique of the way in which shared subjective understandings of the practice world of the research group are developed into strategies both to improve the assessment of the group's performance as nurses and the quality of their nursing practice. This experience may certainly prove replicable for other groups. Hence it is suggested that the research process as described here is in many respects a blueprint for a similar experience to be created in a different setting. To this end, the research report offers a process which, it is argued, is replicable in other settings.

Surrogate experience

Fleming (1991) has argued that participatory research in a practical nursing context may be seen as a continually evolving process with constant potential for action. Further, this illumination of the practical and theoretical issues and outcomes for one group provides new possibilities for action for other groups. A 'surrogate experience' is offered to readers who may identify similarities and differences with their own practice world thereby enhancing the potential for effective action. While Hickson (1988) confirms that the validity of participatory research methods and the action theories produced within them are testable only in action, it is argued that the surrogate experience is an encounter with the possible which broadens the problem solving potential for other groups in other settings.

Face validity

Lather (1986) has suggested that a re conceptualisation of validity as it is perceived in relation to action research involves looking first at extended methods of triangulation beyond the traditional definition of multiple measures, to include multiple data sources, methods and theoretical schemes. In this study, data from the research group and from individuals was discussed by the entire group during subsequent data collection interviews. This situation, it is argued, demands that all data be

constantly viewed against previous understanding, thereby creating an extended and ongoing triangulation effect. Negotiation amongst the Public Health Nurse participants concerning the meaning of problems and propositions at all stages of the research meant that the conditions of face validity as described by Lather (1986) were met. Most importantly, it is argued that continuing participation by the public health nurse group in the planning and refining of the issues through all phases of the three action research spirals strongly suggests that the process was viewed by the research group as having face validity.

Construct validity

Only self reflexive critique by the participants will reveal how the practice environment and the theory which informs it has been changed by the research (Lather, 1986). For construct validity to be seen as operative in this study there is an expectation that the practice environment of the public health nurses will be changed by the development and implementation of the peer review system described within this research report. Self reflexive critique by the research group of nurses will reveal how their practice and theory have changed. It is expected that the enhanced understanding which participants develop in relation to the peer process will bear out the validity of the constructs underpinning this study.

Catalytic validity

The degree to which a research process re-orient, re-focuses and re-energises participants towards knowing their practice world, so that they are able to transform it, is a measure of catalytic validity that has been suggested by Lather (1986, p.18). For catalytic validity to develop as a result of this study, there is an expectation that changes wrought with the implementation of the peer process would be sustained. Evidence of enhanced understanding of interpersonal and group dynamics within the public health nurse group, and the ways in which this understanding contributes to the successful peer process, would be seen as meeting this criterion. However, as with construct validity, it is

expected that these effects are not immediately visible, but may be expected to become so with the passage of time.

Summary

Participatory planning and action by the research group of nurses was essential to ensure group and organisational support for the developing peer review system. The use of a participatory action research process with a focus on learning and action theoretically assured such commitment. An action research approach, based on the framework of the learning organisation described in Chapter Three, directed the study. Methodological justification for the use of an action research approach is included in this chapter together with a description of the key features of this research approach. Derived as it is from critical social theory, action research lends a theoretical perspective for this research which sustains a critical focus on praxis, where the nurse practitioner is central, and the shared goal of the research is to improve the quality of clinical nursing practice. Finally, a detailed description of the entire research process, has provided a clear picture of what was done by the research group.

The following Chapters Five, Six, Seven and Eight provide a discussion of the data, while the concluding chapter discusses implications for nursing practice education and research, and outlines the limitations of this study.

CHAPTER FIVE

Peer Review as Organisational Learning

The First Spiral

Introduction

This chapter opens with an outline of the entire research inquiry. There is a focus on the developing peer review system as seen through the research framework of organisational learning outlined in Chapter Three. The research occurred over eight months, mostly as interviews with the Public Health Nurses, the manager of their service, and three of the CHE managers. The study took place when the peer review system was in the first months of being used in the clinical environment of the nurses involved. Data collection and evaluation occurred in three action research spirals, each of which is discussed in detail. The planning, action, observation and evaluation for the first spiral are covered in this chapter. Chapter Six deals with the second spiral and the impact of a review team, while Chapters Seven and Eight discuss the third spiral and provide a summary of all findings and evaluation respectively.

The learning organisation framework created a dual focus for discussion and evaluation of data. First, there was a concern with the developing peer process, and second, there was a concern to observe learning in the organisational context. The research process as described in Chapter Four was focused on the developing peer process as an ongoing problematic situation to be resolved. Discussion of the data as the basis of evaluation thus relates to the resolution of problems with the peer process, and to observing changes indicative of the growth of organisational learning.

Three spirals of the planning, action, observation and evaluation phases characteristic of an action research design complete the research process of this study. The four phases of the first spiral are described in this chapter with considerable emphasis on the discussion and evaluation phase. In

this chapter, as in Chapters Six, Seven and Eight, data are presented and discussed in a way which contextualises information, leaving the reader with a clear picture of the participants' views in regard to the peer review system, and their involvement in the development of the peer review process.

Planning and Action in the First Spiral

The planning, action and observation phases for the first action research spiral were concerned with establishing participants feelings about the peer review process, and working to resolve problems with the peer review system. While these three phases were all crucial steps of the research process, it is the discussion and evaluation phases which occurred throughout the spirals that drew together the themes and issues in each spiral. In this way, informed judgements were made to improve the peer process and initiate the next loop of the research spiral. It is readily acknowledged that for much of the time there was no clear delineation of boundaries between each phase of the research spiral.

The first round of data collection interviews was planned by the researcher, following consultation with the research group in the preliminary workshop described in Chapter Four. The data collection began with a group interview with the public health nurse group, followed by an interview with the manager of this group, and concluding with an interview with the Nurse Advisor. While it was originally intended to interview other CHE managers at this time, the Human Resources Manager (HR manager) had not been appointed at this stage and the Chief Executive officer (CEO) was unavailable.

In the data collection interviews, the Public Health Nurse participants were asked to:

- identify and discuss gains, issues and problems encountered with the peer review system
- suggest possible changes to the peer process to resolve perceived problems
- comment on any changes arising in clinical practice and any changes in their own attitudes

and beliefs about their practice, noted since the advent of the peer review system.

The focus of the interview with the manager of the group was slightly different as she was invited to comment on any interesting gains, issues and problems that she perceived arising with the peer review system, as well as possible solutions.

Observation

The data gathering discussions with the research group of nurses and their manager centred around the following issues:

- the positive aspects of the peer review system
- problems with the peer review system
- possible solutions to problems
- organisational learning.

Positive aspects of peer review

The positive aspects of the peer review system were reported to be considerable. There were a number of comments about improvements in clinical practice since peer review was initiated. The perceived gains were largely to do with recommendations from peers, for as one nurse said:

It's so good to see that a high level of skill [expert practice] is acknowledged in peers' comments and feedback, and to get written comment as to how well one is working and how to improve...As well contact with others in the group to discuss work is wonderful, and you go away thinking 'I must do that', and try what was suggested where before, without this [peer review process] we didn't really have the opportunity to improve clinically.

For another nurse, there was the conviction that since using the peer review system, she could see improvement in her own practice. Further, issues of group practice and group accountability were becoming visible in a way that she had not previously noted:

My clinical practice skills, including documentation skills have definitely improved...it has been a general growth really, and I believe that peer review has improved the practice of the entire group...Well, issues that come up in the peer review meetings now tend to be aired with the whole group [of Public Health Nurses] so that we have an opportunity to think about the issues and how we practice, as a group exercise...and I am starting to see that we do practice as a group. Obviously, if a group is using peer review then that group is eventually looking at its

practice as a group, and at the design of the service at the same time, things which are so obvious now but were not actually visible, or available to us before.

For some nurses, gains were apparent in their use of the recently revitalised clinical nursing practice standards. The standards were perceived as relevant and measurable and nurses reported that they were now assessing their work and that of their peers against the clinical standards.

Accountability issues have become more accessible, given our [clinical practice] standards...and now, by using the standards the way we do, I can see exactly what I am required to do..Yyou think about the work, you think 'what are the issues here' and then we talk about it in the group, so it certainly has implications for group accountability, and it makes us more articulate about our work in the community.

Issues of professionalism were beginning to be examined, as another nurse reported when discussing her feelings about her practice:

[I am] aware of huge growth in the way I work, in the way that I practice as a nurse, a feeling of what professionalism is and of what nursing is, the job has led me to do this, as well as the peer review. Peer review is just one of the changes, we have looked at the whole issue of what we do and how we do it, peer review is part of a big development, part of the climate, and it has really fitted into the climate. Peer review is definitely the way to go.

Problems with the peer review system

The accumulated issues identified in this first round of data collection largely related to five areas, which were the:

- BARS appraisal tool
- time constraints
- recognition of expertise
- giving and receiving of feedback
- selection and presentation of cases

The BARS tool

The most hotly debated area was the use of the BARS tool, the behaviourally anchored rating scale against which performance was appraised. The problems were said to stem from two foci.

Firstly, the language of the BARS tool appeared unable to recognise expert performance so that an expertly handled case almost invariably led to a mediocre, or 'OK' rating from peers. The following quotes outline the problems with the language of the BARS tool:

It doesn't recognise expert performance.

An expertly handled case can lead to a mediocre or 'OK' rating.

The language of the tool doesn't fit.

Second, the BARS tool appeared to have little practical value in terms of helping practitioners to improve clinical performance, as the following quotes indicate:

It [the BARS tool] is not contributing to my personal performance at all.

If it [the BARS tool] is supposed to change the way you practice, well I don't even read it, so it is not useful.

I'm not happy with it [the BARS tool], I'm not getting anything back from it.

The credibility of the [BARS] tool is a problem, it is seen as the manager's tool.

The perceived value of the BARS tool at this stage was as a record of performance for the annual manager appraisal interview. However even as a 'manager's tool' the BARS tool was seen as flawed in that it was unlikely to give an appropriate picture of nursing performance. The following quote traverses all these issues, including the spectre of the annual performance review:

I did a presentation and I know it was expertly done, but when I took it to the peer review meeting, even though there is nothing to add, no suggestions about how I could have improved I wind up getting a mediocre rating, so I have a real problem with that. When I go to an appraisal meeting with my manager I will be able to negotiate those issues with her, but in the meantime it's a credibility problem with the rating page. It exists for the manager's use but I don't believe it contributes to my personal performance and I actually brought it up with the larger group and suggested we take it right out. We don't need it, we have the comments page and the standards, which are measurable and relevant, and we assess our work against the standards so why ask that our work be rated against a scale that doesn't recognise expertise?

While this statement suggests that the nurse concerned would indeed argue her case effectively on the issue of a mediocre performance rating from an inappropriately worded appraisal tool, the

point is made. In practice, the language of the BARS tool does not allow for recognition of expert performance, and use of the BARS tool gives little or no direction for improvement of performance.

Time constraints

Endorsement of the peer review system was coupled with some apprehension about the time constraints within the peer review meetings, and the need for the nurses to accommodate the process in their already busy work schedules, as the following quote shows:

There is supposed to be a fairly rigid time limit for presentations [of each case or situation] so we all get a turn to present a case at each meeting, and sometimes it is reasonably difficult to adequately describe a case in a couple of minutes. It takes quite a while to prepare the presentation, so I find I am doing this at home, which I resent having to do, but there just isn't time at work.

For another nurse there was frustration that the agreed-upon time limits for the presentation, discussion and scoring of each case were not being adhered to within the peer review meetings:

Staying with it can get difficult; an issue can come up [at the peer review meeting] that just drowns the [peer review] process, like our use of the process is a learning experience right now and having someone in the group who is orienting [to the job] detracts from the process somehow, and it can turn into an orientation for the new person, which is fine for them, but a big fat waste of time for the rest of us.

A second comment about the 'sabotage of the peer review process' in relation to having 'new' nurses in the peer review meetings also indicated considerable impatience with this disregard of previously agreed time limits:

Having a new practitioner join the group means that the [peer review] process is shot to bits by all the interruptions to explain the [peer review] process. It would be acceptable [for the new practitioner] to just ask questions that are pertinent to becoming a Public Health Nurse, I believe, and not have other people go into lengthy justifications and explanations. Occasionally there might be something that would not necessarily come up in any other context for them [the new practitioners], but mostly I think it is entirely inappropriate, given the time frames we have agreed on to use the peer review meetings as an orientation session for new people.

The expertise question

A further issue that developed at this point was also to do with the presence of staff nurses 'new' to the Public Health Nurse role, and related to the competence of these nurses to assess the case work of their more experienced peers:

I wonder how you would feel being reviewed by such a person, a new practitioner? I agree there is a level of experience and commitment and skills that you haven't got until you have been in the job for a certain number of years, and that has to be taken into account. I want to be able to take my review problem away and say 'M. said I should try this, and I'm going to try it' but if she is a new practitioner I'm not going to be doing that because her knowledge base...while she may have a very good grasp of all sorts of things, she hasn't got the experience of the job that will help me perform better.

This raises the question of assessment of expert practice, which was also an issue in relation to the use of the BARS tool, as the quotes in the previous section showed. Experience, as Benner (1984) suggests, is a requisite of expertise. The recognition and description of expertise is a problematic aspect of performance measurement, and as such will be explored in some depth in the discussion of these findings.

Giving and receiving of feedback

There was considerable concern arising from the need to give honest and objective feedback to peers. This was coupled with fears as to the effect that such evaluative judgements might conceivably have on the group dynamics within each peer review group of three or four nurses. The question here was how to objectively appraise a colleague's performance without diminishing the easy flow of information and the relaxed and trusting atmosphere of the small group.

Linked to this issue about feedback was the concern, raised by the manager of the public health nurses group, that in some situations the peer review meetings might be viewed or used as a supervision session, thereby creating a hostile environment that would detract from learning. On other occasions, as already identified by the nurses, there was a concern that the peer review sessions might

become an orientation tool for practitioners new to the job. Neither of these situations, in the view of the manager, constituted appropriate use of the peer process:

The orientation process should not be 'parasitic' on the peer review process, it [the peer review process] is a learning tool but to use it this way [as an orientation tool] 'sabotages' the value of the peer review process for other people, and means that it is at risk of becoming an arduous task.

Selection and presentation of cases

The issue of which cases, the expertly managed cases or the problem situations, to take to the peer review meetings was nominated as an item to be explored further in the discussions relating to the next research spiral.

Evaluation

Discussion and evaluation in this section relate to firstly the peer review process, and second to the growth of the learning organisation, and is presented under those headings.

The peer review process

These initial interviews with the sixteen Public Health Nurses and their manager showed a group of nurses embarked on the process of fine-tuning their peer review system. The highest priority in all discussions at this first round of interviews was the BARS tool and the difficulties which it posed.

Pressing problems in relation to the use of the BARS tool were to do with the credibility, appropriateness and usefulness of the tool, particularly in terms of its language which, it was claimed, did not resonate with the way the nurses perceived their performance. Further, the tool was criticised for leading to 'mediocre' ratings of what was claimed to be expert practice. Consequently, the tool was seen as not contributing to improved performance, and in fact, to continue to use the tool, said its

detractors, would be to '*downgrade our work as independent practitioners*', and to perpetrate a '*gross disservice*' against the group.

Reports about the positive aspects of peer review showed that using the clinical practice standards greatly facilitated the task of assessing the work of the Public Health Nurses. The recently revitalised nursing standards had become a '*living document*' and as nurses and peers assessed their improved performance against these relevant, measurable standards, the need to use a rating scale which did not acknowledge expertise, and did not '*resonate with the language of the nursing standards*' was increasingly frustrating.

The outstanding practical issue at this point was whether the BARS appraisal tool was appropriate as an indicator of performance and whether to modify the language of the BARS tool, and/or the way in which it was being used. Alternatively, as had been suggested several times, there was an option to take the BARS tool out of the peer appraisal process altogether.

Thus, the problem with the BARS tool had two faces. It did not 'fit' with the way the Public Health Nurses described their work, even though they had actively ratified its inclusion into their peer review model in 1994. The language of the tool was proving to be '*not right*'. The descriptors of performance contained within the BARS tool did not consistently, if at all, allow for a performance which all concerned might recognise was an expert performance to be so scored by the peer review meeting. As a group, the Public Health Nurses stated that the BARS tool was detracting from the smooth flow of the peer review development, and that to continue to use it would be doing the group a disservice. The manager was equally clear that the problem was in need of a solution: '*As a principle, it is not in our interests to ignore the fact that no-one is happy with it*'.

The other facet of the problem with the BARS tool was that none of the Public Health Nurses were deriving any performance benefits from using the tool. It had been noted that considerable

performance improvements related to the advice available from the comments of peers which the appraisee recorded on the recommendation sheet but that no such benefits were forthcoming from the use of the rating tool. It was viewed as a *'manager's tool'* which would generate a record of past performance that a non-nurse manager might use in an annual performance appraisal review. As a *'manager's tool'* the BARS tool thus posed considerable threat to many of the Public Health Nurses, because of the fear that poor peer appraisal scores, recorded on the BARS sheet, could constitute a misleading or perhaps unflattering record of performance, which might be used against them.

Suggestions to improve the situation centred on taking the BARS tool out of the peer appraisal process entirely. There was a lesser amount of support for the idea that a more objective view of the value of the BARS tool might be forthcoming if it was left unchanged for a six month trial. The group acknowledged that the BARS tool had been primarily developed by the manager, with help from the group. The manager was perceived to be *'quite protective'* of the BARS tool, and, it was assumed that she would therefore be *'reluctant to can it'*. The decision-making in the larger research group of nurses, as to the fate of the BARS tool, was adjourned pending consideration by the review team.

It was interesting to note at this point the ease with which the group moved the decision-making responsibility from this forum to that of the review team. Equally interesting was the recognition that eventually decisions and recommendations made by the review team, to be effective, must be ratified by the larger public health nurse group.

Issues of professional behaviour and accountability were nominated as areas of clinical practice which had been illuminated by the creation of the peer review system. It appeared that particular problematic aspects of the Public Health Nurses' professional role had benefitted from the clarity achieved with updated standards and the opportunity afforded by peer review to discuss concerns with peers. While these aspects are in large part the *'intangibles'* of health professional behaviour, there were other more immediately apparent clinical benefits arising with the use of the peer review

process. Many of the positive aspects of peer review reported by participants related to the peers' recommendations page (Appendix A, p. 3). This was providing excellent opportunities for discussion of practical strategies to improve practice, and also allowing peers to 'critique the way we work, not just outcomes' (PB R1). This remark suggests a more reflective approach to some of the broader issues of the nurses' work, in particular *the way* the work is done. It is argued that this shows a new attitude to work, and the effect of the change in attitude is to create an easier forum for discussion, which offers further opportunities for learning about, and improving clinical practice. This is exactly the kind of development which, using the learning organisation research framework for evaluation, is suggestive of the growth of organisational learning.

A concern expressed by the manager of the Public Health Nurses during the first data collection round was the need which she perceived for the group to establish 'ownership' of the peer review process:

I'm not sure that they (the Public Health Nurses) would keep it going if I stopped pushing it.

Yet what was also apparent from the first data collection round was the level of commitment from the public health nurse group to the process of peer review. There appeared to be an implicit 'acceptability' about the peer review process. At no stage did any of the participants suggest that the peer review process should stop. However, while there were clear indications that peer review was viewed positively, equally apparent was the individual variation in levels of enthusiasm for the system. For some people peer review was a '*definite bonus, definitely the way to go*'. For others of the group it was '*OK, a bit of an effort, but yes, I think its worthwhile*'.

The growth of the learning organisation

Importantly, from this first round of data collection, came an emerging outline of changing attitudes, values, skills, knowledge, and valuing of knowledge within the public health nurse group which signified the learning organisation at work.

Reflection on the deepest nature of the undertaking and the central challenges it presented was suggested by Senge (1994) as a prerequisite to successful and enduring change. Such reflection involved a consideration of the deep learning cycle of the research participants within the domain of action of their employing organisation. The learning organisation framework predicted that as new capabilities developed in the public health nurse group so too would new awarenesses. Further, there was an expectation that as these changes were becoming visible in the deep learning cycle there would also be accompanying changes in the organisational architecture, the domain of action, so that the way the work was done would also change accordingly. Finally, the use of the research framework of organisational learning predicts the development of structural changes in the domain of action, arising as a consequence of the need to support and protect the learning experience, and the need to integrate group learning so as to benefit the entire organisation.

The comments included from the Public Health Nurses suggest that such a scenario was becoming a reality for the research group. With peer recognition of high levels of skill (expert practice) came the acknowledgement of 'general growth' of understanding for individuals and for the group, and a belief that peer review had improved the practice of the entire group. New beliefs and assumptions about accountability and professionalism had begun to emerge which in turn enabled further skills and knowledge development, such as the recently perceived ability for the group to critique not only peer performance but group performance, and to look critically at the effectiveness of their service.

It was acknowledged within the research group of the Public Health Nurses and their manager that increased understanding of the links between professional goals for nurses and group performance in relation to meeting service (organisational) objectives had enabled the group to effectively 'redesign' aspects of their service. It was suggested that an undertaking of this nature *'could not have eventuated prior to the advent of peer review'*.

Further, an undertaking of this scope, seen through the research framework of organisational learning, looks significantly like the changes in the patterns of thinking and interacting which indicate activation of the deep learning cycle. The deep learning cycle, which Senge (1994) calls the domain of enduring change, is where we begin to integrate the effects of our learning and to change aspects of our interactions within the work group. Changes wrought here, says Senge, will profoundly affect the experience of what can be done and understood. It would appear that for this group to be able to redesign aspects of their service, there had been a considerable shift in the way they understand their work in relation to both professional goals and service objectives.

As well as the changes described, there was confidence that the process was positive, *'on track'*, *'definitely the way to go'*, and that problems would be resolved. There were also clear indications, despite misgivings on the part of the manager of the public health nurse group, about *'whose process it was'*, as there was a reiterated suggestion from the nurses that the peer review process had acquired a *'life of its own'* and therefore was at least partly *'owned'* by the public health nurse group.

Changes in action, that arguably represented a significant growth of organisational learning, were indicated. There were clear ideas forthcoming from the group as to how to sustain the valuable learning opportunities now recognisable within the peer process. Developing and exploring fully the comments and recommendations to improve practice, was seen as an opportunity for the growth of learning. Improving learning opportunities through adhering to the time limits for presentation and discussion of cases in the peer review meetings was recommended. This would give each nurse the chance to present her case and create personal and group learning opportunities using the peer review system.

The suggestions from peers about how to improve practice, the peer recommendations, constituted '*valuable learning experiences*' which were cited by the group as the primary benefits of peer review. It is this realisation, both of the value of the learning exchange, and of the movement toward the group goal of improving the quality of clinical practice, that illustrates the ethos of continuous improvement which underlies the learning experience. This ethos of improvement, described by the research framework as a critical dimension of organisational learning, without which significant and enduring organisational learning will not occur, was observed to be a part of the research group's experience in the first spiral.

As a move to further protect the time frame within the peer review group meetings, the manager suggested that an orientation package be developed and be available for nurses new to the job, which would include an introduction to the peer review system and familiarisation with the various skills involved, particularly of presentation and giving/receiving feedback, in the peer review meetings. This arguably suggests a change in the organisational architecture, whereby a structural development, the orientation package, was proposed to both improve orientation procedures for new practitioners, and support/protect the highly valued learning opportunities of peer learning present in the peer review system. This could be seen as an initiative both to create and integrate learning support systems to sustain the growth of the peer process, as is consistent with the use of the learning organisation research framework.

The evaluation phase of the first research spiral, which involved identification of problems, consideration of possible changes and evidence for the activation of organisational learning, became the basis for the planning of the next action research spiral. From the evaluation phase, a plan emerged to guide the next data collection meetings with the research group. This plan is applied in spiral two of the action research process and is discussed in detail in Chapter Six

Summary

The outstanding issues in spiral one of the research process were problems to do with feedback and scoring of peer performance. The BARS tool was seen as a central problem. It would need further discussion in the second spiral of the research process.

Considerable growth activity was observed and reported in relation to organisational learning. Notably, demonstrable changes in knowledge and understanding, as with the redesign of services, and marked changes in patterns of interacting, as with the accountability and professional behaviour issues, were noted. Such changes, the learning organisation framework suggests, are characteristic of activation of the deep learning cycle.

Finally, all of the factors identified by the research framework as critical dimensions of organisational learning were shown to be present in the first spiral. The ethos of continuous improvement of clinical practice through the peer process shown by the research group was noted. The recognition of expertise, the expert practice acknowledged by the peer group but unrecognised by the language of the BARS tool, was a feature of discussions at this point. There was also the clear suggestion that by renewing their clinical practice standards at a point prior to the initiation of the peer process, the group had demonstrated that they did indeed possess the third critical factor for the development of the learning organisation, the ability to fundamentally renew.

The problems with the peer review process to be pursued further in the second spiral of the research process and described in the next chapter were firstly, those related to peer feedback and second, the selection of cases for presentation. Time constraints, and the ownership of the peer review process would also be considered further.

CHAPTER SIX

Problem Solving and the Review Team

The Second Spiral

Introduction

The four phases of spiral two of the action research approach are described in this chapter, with considerable emphasis on the evaluation phase of the second spiral. An outline of the review team's activity and an indication of the importance of this team to the peer review development process is included with the discussion of data in spiral two. In this chapter, as in Chapters Seven and Eight which deal with the third spiral, data are presented and discussed in a way which contextualises the information so that the practitioner's views in relation to their clinical practice environment, and the developing peer review system, are heard.

Planning and Action in the Second Spiral

The focus for the second round of data collection centred on the issues related to the giving and receiving of feedback. The most pressing concern was still the BARS appraisal tool, its credibility, usefulness and appropriateness, as well as its status as a true indicator of performance. The selection of cases to take to peer review was also to be discussed as were the issues of support for, and ownership of, the peer review system.

Discussion about the creation of an annual performance appraisal system, based on the peer review process, was to be given some priority during the second spiral, as the concern had been expressed, both from within the public health nurse group and by their manager, that the peer review system needed a larger framework within which to be viewed if benefits to the organisation and the group were to be sustained. As one of the Public Health Nurses said:

What happens to our (peer) assessment of our own performance if we don't yet have a formal system of annual appraisal which recognises peer review?

This statement shows an appreciation of the potential value of the developing peer review system, both to the research group and the employing organisation. Such an appreciation is an excellent example of the learning organisation at work. Where appraisal of performance had previously been seen as a negative experience, there was now an understanding and valuing of the importance of performance management.

For the research group, there was at this point an understanding of the suitability of the peer review process to critique peer performance and improve the quality of clinical performance. As well, there was an expressed belief that the performance of the entire group had been enhanced with the use of peer review. With this heightened awareness generated by the use of peer review, it was apparent to the nurses of the research group that the gains for their service were more likely to be sustainable within a performance management cycle.

Evidence to support further activation of the learning organisation, in particular the deep learning cycle of the public health nurse group was sought in this second round of interviews. Nurses of the research group were again invited to reflect on their clinical practice skills and attitudes to their work and performance since the advent of the peer process.

Circulation of interview transcripts to participants prior to the second meeting provided publication of and readership for nurses' own views expressed in the first round of data collection interviews, about problems and gains since the advent of peer review. It was intended that circulation of transcripts, as well as securing permission to use the information in this research report, would serve to remind participants about the issues.

The review team, whose structure and function will be discussed at length in this chapter, was to meet for the first time immediately after the second data collection round. The review team was to provide a decision-making forum for changes to the peer review system. It was considered crucial to resolve outstanding questions with, in particular, the BARS tool and the many problematic aspects of peer feedback. It was deemed essential that, having discussed the issues at length, the group must take positive steps to maintain the credibility and integrity of the peer review system.

Observation

The data gathering discussions with the research group of nurses and their manager centred around the following issues:

- ownership of the peer review system
- selection of cases for peer review
- an annual performance appraisal process
- the BARS tool

Ownership of the peer review system

Discussion about issues of ownership in relation to peer review was perfunctory.

The following quote, from one of those nurses initially least enthusiastic about peer review, suggests that the peer review process was now becoming something of a norm, almost a part of the way the Public Health Nurses work:

Yes, well I am starting to feel really pleased about it, whereas I think six months ago I would have preferred that we not do it...I don't think there's any doubt that it actually enhances practice, so I would like to go on with it...I would certainly like to think that it would keep going.

It was suggested by a second nurse that the question of ownership of the peer review system may only have been of concern for the manager of the public health nurse group. And further, it was suggested that for ownership of the peer review system to be an issue at all might arguably be

perceived as an artefact of the research approach. The ownership issue will be explored and discussed further in the third spiral.

Selection of cases for peer review

Discussion concerning the cases which should be taken to peer review, the expertly performed cases or the problems, settled for a while on the solution of practical problems as being a *raison d'être* for peer review:

It's the problems that get taken...the thing I want to know is what do I do here? I don't feel like talking about something that went all right, unless I feel that it could have been better and I needed help, then I would bring it.

In situations where we don't know what to do, there is value in having the group consider the case, and review the whole thing.

However, it was suggested from several quarters that interesting and excellent cases also demanded a hearing, and the suggestion was made that to exclude exemplary cases or problems from the peer review process was not in the group's best interests. Hence a definitive solution was not forthcoming from the public health nurse group. Rather, the short term solution was that the review team should consider the whole question. As one of the nurses said:

Let's get the review team to look at that one too.

Annual performance appraisal

The question of developing an annual performance appraisal process stirred little comment. There was an expressed opinion that the manager would manage this problem:

That's what manager's do...

The BARS tool

The majority of the group discussion centred on the feedback issues. The giving and receiving of feedback about performance in the peer review meetings was seen as critical to the acceptability of

the peer review system. The difficulties reported with feedback were seen to be closely related to the escalating problems with the BARS tool. A primary problem in this area was inevitably linked with the inability to reconcile the language of the BARS tool with a mental perception of an expert performance, and the inability of the BARS tool to generate a score that fitted the performance, as was shown by the following comment:

I don't have a problem discussing the case that has been presented, and suggesting how it could have been done better, or asking questions and finding out about something I don't know, but its very hard to feel that someone has done well and tell someone that their work is good then find out that you can only rate them as average, or in fact if you have picked up on a couple of things that they haven't done, you wind up having to give them a poor score, yet in your heart you know that they have done well. I don't see that helping anyone, because if you know that the score isn't appropriate and won't help them at all, then it makes it a nonsense to be doing it.

The problem with the BARS tool proved too overwhelming for the group to realistically contemplate finding a solution. Instead, the whole feedback question was referred without opposition to the review team, which, as the next section shows, proved to be an intensely interesting development in terms of the peer review system and the learning organisation.

The Review Team

The review team was composed of the manager and two nurses, both of whom were known to strongly favour the continued development of the peer review system. It is suggested that decision-making to resolve group issues is dealt with very appropriately in this manner, in that the review team were well exposed to the views of the group and yet were mindful that they must propose solutions, which would both solve problems and support the peer review system.

The review team met in the week following the second round of data collection interviews and, following due consideration of recommendations from this meeting, the public health nurse group approved several important changes to the peer review process.

The first change saw the BARS tool (Appendix A, p.4) omitted. The controversial peer scoring of each nurses' performance on the specifically created rating scale would no longer be a part of the peer appraisal. The comments page which contained the recommendations from peers (Appendix A, p.3) was to be reworded to give it more prominence in the appraisal tool, as it had been noted that these recommendations and suggestions from peers were considered the most valuable learning opportunities in terms of improving clinical performance.

The review team also recommended that the peer review system not be a part of any formal annual performance appraisal. The reasons for this suggestion related to the level of anxiety perceived by the review team to surround the whole issue of performance rating, whether by peers or by a manager. It was deemed an appropriate developmental step both to protect the informal nature of the peer review meetings and support the potential within these meetings for collegial exchange and learning. It was acknowledged that, at a later stage it could become appropriate to reconsider using material generated in the peer review meetings in an annual performance appraisal cycle, but that this would only happen after group deliberation of the issues at some time in the future.

Further recommendations for change concerned the membership of the peer review groups, which would now number no less than four and up to a maximum of five nurses. As well, the membership of each group would remain the same for six month intervals rather than being rotated three-monthly as was originally intended. There was to be an attempt to 'match' peer group members according to their scores on a recent Myers-Briggs personality inventory questionnaire, so that conflicts and tensions within the peer review groups, particularly in relation to the giving and receiving of feedback, could be minimised.

Finally, under the structural changes to the peer review system recommended by the review team, each nurse was now required to present a maximum of five cases a year to the peer review group, rather than the ten case presentations which had previously been envisaged for each nurse.

Following this restructuring, the review team predicted, time constraints on individuals would be eased. Further, it was suggested by the review team, the time limits on presentations and discussions within the peer group meeting could now be relaxed as there would be a maximum of two cases for review at any peer group meeting.

Evaluation

As in Chapter Five, the discussion and evaluation in this section relates to firstly the peer review system, and second to the growth of the learning organisation, and is presented under those headings.

The peer review system

While opinions may have been expressed more forcefully during the second data collection round in relation to the inadequacies of the BARS tool, there was no intention within the public health nurse group to act to resolve the problems prior to the review team's decision. As it was, the review team meeting was able to deal with the BARS tool as described above.

It seemed appropriate that the BARS tool be discarded. Despite misgivings that it might still prove useful following modification of the language of the descriptors of performance, and that it may have had an insufficient trial, the mounting antagonism expressed in round two of the data collection interviews seemed to show that it was a threat to the integrity of the process. Using the wrong rating tool was deemed worse than no rating tool.

Without the BARS tool the documentation of the peer review process, while continuing to support performance improvement within the group, was seen to be relatively inaccessible to a non-nurse manager. Therefore, for the reasons outlined below, to the public health nurse group it seemed logical to remove the proposed link between the peer review process and annual performance appraisal.

Removing the peer review process from the proposed annual performance appraisal cycle defused the threat posed by the possibility of a manager having access to poor peer reports. As well, the threat to inter-group relationships, implied and articulated by the difficulty of needing to rate a peer performance critically and score it, perhaps less well than one would like, was also removed. It is suggested that given the inter-group resistance to evaluative peer judgements at this stage it was entirely appropriate to remove this threat, thought to be outstanding within the peer review process, to the developing learning exchange. For, as Block (1993) has suggested, if the concern of the appraisal is evaluation and judgement, the opportunities for learning are inevitably diminished and the inter-group dynamics will suffer.

The review team suggested that these changes would have the cumulative effect of creating more relaxed and open attitudes to the whole question of peer review. The review team further suggested, having acknowledged that the constraints imposed by rigid time frames were proving oppressive, that now five rather than ten presentations to the peer review group were required by each nurse over a twelve month period. The expectation was also aired that, by virtue of the considerably more relaxed time frames for presentation now indicated, presenters would be freed from much of the pressure of time constraints. Such a series of moves, it was suggested, by acting to secure a more user-friendly profile for the peer review system, would relieve many of the tensions outstanding within the peer review meetings.

The review team expressed the hope that, by developing the recommendations page and thus nurturing collegial exchange between the members of the peer review group, the peer review meetings would continue to develop as a learning exchange and as a forum for the management of clinical issues. There was also the hope that these newly introduced changes would foster the reflexive considerations of practice that ensure the group is focused on performance improvement.

The growth of the learning organisation

The review group was called into being by the manager with full consent from the public health nurses group to assist in the ongoing decision-making which the manager perceived must accompany the growth of the peer review process. The two Public Health Nurses in the group were known to be articulate in their support of the peer review process, and there was an assumption that, through their efforts and those of the manager, the 'right' decisions would be made. These decisions would then be more acceptable to the group, than a top-down directive from the manager, and would be likely to be ratified and 'owned' by the group, thus ensuring the peer review system would continue.

The research framework of organisational learning suggests that a factor facilitative of both the peer review process and the learning organisation is at play here. The work of the review team was in many respects outside the public health nurses group. It was a team which functioned in a managerial advisory capacity and could be said, by virtue of its membership of one manager and two nurses, to cross bureaucratic boundaries. The review team could also be said to function entrepreneurially to facilitate organisational learning, in that while there were no blue-prints for this kind of activity within the organisation, this team was set up solely to review and resolve problems with the peer review process.

Summary

The prominent issues in spiral one and two of the research process were problems to do with feedback and scoring of peer performance. The BARS tool was seen as a central problem area, and following reflexive discussion in the public health nurses group, decision making was referred to the review team which was able to act decisively to remove the BARS tool from the peer review system.

The review team recommended that peer review be viewed as separate from annual performance appraisal issues. This proposal, combined with several other less dramatic adjustments to presentation requirements and time frames, recommended by the review team and ratified without

further discussion by the entire public health nurse group, created a more user-friendly, less intimidating and less constraining profile for the peer review process.

Considerable growth activity was observed in relation to the learning organisation. Notably, enhanced understanding of the connections between professional and organisational requirements, shown in this spiral by the concern with annual appraisal and performance management, both for the research group and in the wider organisation, was apparent. A heightened awareness of the professional and organisational interface, which manifested as a group concern with the redesign of the service, was also noted in the first spiral. Changes in patterns of interacting within peer review groups were noted, and the overall effect was suggestive of a more relaxed, confident approach to the process of peer review. Such developments, the learning organisation research framework suggests, are characteristic of continuing activation of the deep learning cycle.

Creation of an entrepreneurial structure such as the review team, which was able to defy bureaucratic boundaries, is an example of a factor facilitating the growth of organisational learning, as identified by the research framework. The review team functioned to integrate and support the learning opportunities for the group, in particular through its ability to fine-tune decision making in relation to the peer review system. This structural change to support the development of peer review showed that the organisational learning changes extended outside the deep learning cycle of the public health nurses group and into the domain of action.

The changes in actions and inter-relationships proposed by the review team were able to be initiated because of the accumulating knowledge and insights now available to the review team as a result of their experience with peer review. That the review team was able to act decisively given the mandate to secure the smooth continuation of the peer review process implies the development of skills and abilities which the research group did not previously have. These organisational learning

gains indicate a high probability that an important goal for the public health nurse group, that of ongoing improvement in clinical practice through the peer review system, was secure.

The final data collection interviews which pursued outstanding issues with the peer review process, the selection of cases for presentation, ongoing feedback issues, and the question of ownership, as well as the interviews with the CHE managers, are described in Chapter Seven and Chapter Eight.

CHAPTER SEVEN

A Workshop aids Decision Making

The Third Spiral

Introduction

This chapter follows the research process through the four phases of the third and final action research spiral. Included in this chapter is an account of a workshop which Phil Ramsey from Massey University conducted with the nurses of the research group during this period. Discussion and evaluation of data in the third spiral pursues the further resolution of problems with the peer review system, and describes indications for the continuing growth of the learning organisation.

Planning and Action in the Third Spiral

As in the two preceding spirals, problems at the beginning of the third spiral were dominated by difficulties with feedback in the peer review meetings. Guidelines for the selection of cases for presentation at the peer review meetings were to be considered in this third spiral, and there would also be further discussions to elucidate the question of ownership of the peer process. The changes wrought by implementation of the review team's recommendations were in need of exploration in this final research spiral, and ultimately, evidence suggestive of continuing organisational learning would be sought.

Selection of cases

The questions in relation to the selection of cases for presentation and discussion at the peer review meetings centred on which cases were the most appropriate, the problems or the 'expert' cases. Was the peer review meeting to become exclusively a problem-solving session? Should there be an opportunity to discuss expert performance? What about the interesting and the 'one-off' cases? Could it be that all options had value? Finally, how were decisions with respect to this issue to be made?

Feedback problems

The giving and receiving of constructive feedback was perceived as an increasingly sensitive area, where it was now readily acknowledged that group decision making was required. Comments made in previous interviews acknowledged that it was:

...not necessarily an easy task to open one's work to the scrutiny of colleagues without feeling defensive and vulnerable.

It had been suggested in the second round of interviews that the ability to give and receive constructive critique in a peer review setting was a learned skill. This idea generated the notional possibility of a seminar or workshop with an appropriate consultant to facilitate group learning of these skills.

Hence, in relation to both the problem of constructive feedback, and the problem already described with the selection of cases for presentation, it was agreed that a participatory workshop to discuss these matters, facilitated by an independent consultant, would inevitably create a more informed climate for decision making. Accordingly, a three hour session to explore these topics was arranged with Phil Ramsey, from Massey University's Human Resource Management Department. Phil has a particular interest in organisational learning, and acted as a second supervisor for this study. The workshop with Phil and the Public Health Nurses was scheduled to take place two weeks prior to the third and final round of interviews. There was an expectation that enhanced understanding of both issues, namely, those of feedback and case selection, which could result from this session would empower the group to experiment confidently with potential solutions.

Ownership of the peer review process

Aspects of the idea of ownership of peer review remained obscure. The questions relating to ownership and support for the peer review process had first arisen following the manager's assertion

in the first round of interviews that unless she continued to 'push' peer review, the process would stop. Her enduring concern, outlined in Chapter One, was that a non-nurse manager of this service would be unable to accurately assess the performance of the Public Health Nurses. The manager perceived the level of ownership accorded to the peer review process by the research group of nurses as critical. She reiterated that while currently she saw herself providing the major support for ongoing development of the peer review system, the ideal situation was where the Public Health Nurses themselves would provide the initiative and determination to sustain it. Unless the nurses were prepared to do this, the manager predicted, the peer review system would collapse.

The belief had grown within the research group that, through the use of peer review as a form of appraisal, by which the nurses themselves assessed performance, quality of practice could be assured. The manager believed that peer appraisal of nurses' performance would generate important information about individual and group performance which could eventually be accessible to a non-nurse manager. However, the recommendations made by the review team meant that, for the time being at least, this information would not be available to the manager of the service for use in a performance appraisal cycle. While both the nurses and the manager appeared to have vested interests in sustaining the peer review system, at this point the issue of whose process it was, the manager's or the nurses', remained unclear.

Signs of the learning organisation

Information was sought in the final round of data collection as to what research participants would say and what could be observed, about their learning as individuals and as a team since they had begun to use the peer review system. Finally in the third spiral of the action research process, there was a probe, in the form of interviews with two corporate managers and the Nurse Advisor, to see what could be discovered about changes in the wider organisational context, in relation to the Public Health Nurses' experience with peer review. These interviews, the opinions expressed, and potential or implied effects for the peer review process and organisational learning are discussed in

Chapter Eight. The results of the entire research process in terms of organisational learning are also described in Chapter Eight

Observation

The final data-generating discussions with the research group of nurses and their manager centred around the following issues:

- changes noted since the implementation of the review team's recommendations
- feedback about performance
- selection of cases for peer review
- ownership of the peer review system

Changes noted since review team's recommendations implemented

There had now been two peer review meetings following the changes suggested by the review team and participants were keen to talk about the consequences of these changes. Altering the time limits within the peer review meetings appeared to have resolved the problems with time constraints. Now, with the more relaxed attitudes reported in the peer review meetings since the removal of restrictive presentation and discussion schedules, it was proving to be:

...really interesting to go into things in more depth and see what is really happening and what level of service we are providing.

Comments about the effects of removing the BARS tool indicated that this was also viewed as a positive step.

It was quite good not to have that sheet [the BARS tool] at all.

We had really helpful discussions and you didn't have to worry about scoring because it used to be, if there was a lot to talk about, it must mean there was a lot of improvement required and that you would be giving them a low score.

Lots more comments are being made and recorded at [peer review] meetings, and that's why we need to develop the recommendation sheet further, so we can get hold of this side of things and use it to improve practice.

It was decided that developing the recommendation sheet (Appendix A, p. 3) to better capture the peer comments and recommendations was to be managed by a sub-group of three nurses, who self-selected for this task following the discussion.

Other effects of the structural and procedural changes to the peer review meetings were also viewed positively. Some nurses reported gains following the removal of the link between the peer review process and the annual performance appraisal. That the manager would no longer have access to poor peer assessments had reduced the threat that peer evaluation held for some participants. Further, the demise of the BARS tool appeared to have lowered anxiety levels with respect to the giving and receiving of feedback in the peer review meetings. There were clearly still problems for some nurses with the need to make evaluative judgements about a colleague's work, and for other nurses a level of discomfort, evoked by the threat of evaluative judgement about their work, was seen to persist.

The format of each peer review group, in particular the blend of personalities within each group, was a factor that was seen to affect the giving and receiving of feedback, as the following remark suggests:

I think it [feedback] is an ongoing thing, that we will probably get better with, which is pretty much what Phil [Ramsey]'s session suggested too. I think it will improve to a certain degree with the rating page[BARS tool] gone, and I think that while some nurses are a bit threatened by criticism they also feel uncomfortable in a certain group. Which comes back to who is in the group and how they interact. I've been in three groups now and I can see that the blend of the group is really important, and that if criticism is offered in a positive way and a non-threatening way it is good and most of us are then looking forward to the next meeting to say what happened and what we did with the peer recommendations.

It was resolved at this point that the blend of personalities in each peer group needed attention, as the situation with respect to giving and receiving feedback was notably improved in the groups where the manager had placed people according to their scores on a Myers-Briggs personality inventory.

In some quarters enthusiasm for the peer process was seen to be growing in direct relation to the removal of the BARS tool.

I couldn't really see the benefits [of peer review] when we started, but the last two meetings got really good, and it was great to go into some depth with the problems and the comments...and without the rating thing [BARS tool], if you have not done well with a case, you can take it back to the next meeting and say 'See what I've done using the recommendations', and feel good about it, which you probably wouldn't have had the courage to do before because the rating stuff was pretty disheartening. So it really does seem to be working a whole lot better.

Feedback about Performance

A possible solution to the feedback problem, proposed during the workshop with Phil Ramsey, was for the group to develop a feedback model, whereby constructive critique of performance by peers would replace evaluative peer judgements. For example, the feedback model mooted at the workshop suggests that constructive feedback is given most appropriately if first a positive comment about things well done is made. The positive comment is then followed by a comment identifying an area of performance which could be improved, together with suggestions/ possible solutions for whatever the problem might be. The group elected to develop this idea, perhaps at a second workshop, using role-play to gain needed practice with the feedback model. In the meantime, there would be an effort to ensure that feedback to peers be proffered in the format prescribed by the feedback model.

Selection of Cases for Peer Review

At the workshop with Phil Ramsey ideas about managing the polarities that exist in social situations had been aired in relation to the selection of cases for peer review. Polarities are described as the positive and negative weighting that various options may have for a group, and about which group members' opinions will polarise when making decisions. In the selection of cases issue, the research group had polarised in favour of *either* the expert case, *or* the problem case, with an understanding that it was proving difficult to create clear guidelines about which cases should be presented, so that the best learning opportunities were preserved.

A broader view of the situation provided by the consideration of polarities suggested that there were excellent learning opportunities for the group if *both* polarities, the expert *and* the problem cases, were perceived as important learning situations. Management of polarities for this issue involved seeing the inherent tension between the poles as a strength, validating the varying points of view within a group, and using the tension to move the group forward, rather than seeking to resolve the conflict. Hence, this view suggests that effective decision making behaviour in this situation arises through managing the tensions of the poles, and this behaviour is valued over decision making which would act to remove the underlying polar tensions.

In seeking to enlighten the 'which cases' dilemma, the possibilities of polarity management showed group members that preserving all options for presentation had a distinctive value. Hence, it was accepted that all possible types of cases, those expertly performed, those which were problems, and those which were interesting cases would all have a place in peer review. It was suggested that the skill to be developed by the nurse when selecting cases for presentation at the peer review meetings, would be the ability to balance personal learning needs with learning opportunities for the group.

In practical terms, this implied that the nurse presenting a case was at liberty to present any aspect of her work that she chose, so long as in so doing, and over the course of a twelve month period, she used a variety of problem cases, and interesting and expert cases, both to give a comprehensive account of her performance to her peers, and to create the learning opportunities that would allow her to improve her practice.

Ownership of the peer review process

As an idea, 'ownership' appeared more accessible to group discussion as the research progressed so that during this third round of interviews, and following the rapid acceptance of the review team's recommendations, the question of ownership appeared to resolve credibly, if a little circuitously. A factor promoting group identification with the peer review process was the

improvement noted in various aspects of the group's work since using the peer review system. As one nurse said, the benefits of the process were now readily apparent:

It [the issue of ownership] needs looking at, it used to be that it [peer review] was driven by C. [the manager] and the keen nurses, and there are others who used to look at it as something they would rather not be doing, but I think that has changed and as peer appraisal has developed people can see that it has made quite a big improvement to all sorts of aspects of the work.

Her comments were succinctly reiterated, by one of her peers:

The ownership thing is clearer now because I think now people can see that they are a part of it, and are happy to take part in it, and be a part of it [the peer review system].

For at least one nurse, ownership was initially seen as an artefact of the researcher's activity:

It [the ownership issue] is very interesting although I didn't think about it till I read the stuff you [the researcher] sent.

This refers to the transcripts of the previous interviews, which were circulated by the researcher prior to the final round of interviews. In the most recent transcript, the manager had described the issue of ownership as one critical to sustaining the peer review process, which had as yet received little attention from the group.

Other comments from the group indicated a clear level of comfort with the idea that the peer process was 'theirs', as well as a group acceptance of responsibility for the continuing development of the peer review system. Eventually, the ownership issue was acknowledged as important by the same nurse who had previously expressed surprise that it was an issue at all, as the following quote shows:

Ownership is a big thing, because with any change you get heaps of information but often then you don't hear what else has happened, or if it is still the 'flavour of the month', and no-one asks you how you feel about it. But with this I feel that while part of it has been excellent management of change, a big part of it has been with the group actually taking it on too, taking responsibility for it, and making it work, so yes, that's ownership.

The point was made here, and endorsed by the research group, that the peer review system had been in use for eight months, following a two and a half year participatory development process.

There appeared to be overwhelming support for the idea that the public health nurse group had in fact taken responsibility for the peer review process, and for making it work. The peer review process was theirs.

Evaluation

As in Chapters Five and Six, the discussion and evaluation in this section relates to firstly the peer review process, and second to the growth of the learning organisation, and is presented under those headings.

The peer review process

The recommendations from the review group to improve the situation with respect to the feedback question were both profound and subtle. The feedback situation was changed in major ways through modifying the appraisal tool, notably the removal of the BARS tool and the development of the peer recommendations' page. Changing the size and stability of the peer review groups, and ensuring that each group was adjusted in terms of 'matching personalities' to provide an atmosphere where each nurse might find support as well as develop skills in relation to giving and receiving feedback, were all seen as having less dramatic, and rather more indirect effects, on the feedback situation.

All of these changes, coupled with changes in ways of thinking about feedback, plus the move to adopt a feedback model that occurred as the research spiral progressed, were seen as further evidence of sustained growth of organisational learning, particularly within the deep learning cycle of the nurses of the research group. These changes within the developing peer review system, indicative of the growth of the learning organisation, are explored further in the next section.

Ideas about ownership of the peer review system within the public health nurses group had developed considerably by the final round of interviews. Ownership had been initially perceived as a

problem only by the manager, and to some extent had appeared to be an artefact of the research approach. That is, asking questions about a 'non-issue,' or something that was only an issue for the manager, was perhaps turning it into an issue. However, at this stage of observing the developing peer review process it became apparent that it had indeed, as was suggested previously, acquired a life of its own, and was set to enter the 'culture' of the public health nurses group. Thus, in answer to the question 'Whose process is it?' a very clear reply emerged:

The peer review system was developed within this group over a three year period and therefore belongs to the public health nurse group. Initially it was the manager's project, she had displayed '*outstanding leadership*' through her initiation and support of the peer process. Her continuing promotion of and support for peer review provided the opportunity for the peer review process to become a norm within the culture of the public health nurse group. In particular, having enlisted outspoken nurses in the review team and having insisted that this review team take responsibility for the ongoing 'fine-tuning' required to modify the process, the manager further ensured that peer review did indeed belong to the group. Peer review had been guided through all the initial problems and development stages by the manager and if at any point in this start-up period the manager had withdrawn her support it might have ceased to be. Equally, without the ownership and support which had gradually developed from within the group, and about which the group was now able to be articulate, it might have ceased to be.

It is suggested that as the Public Health Nurses recognised the increased opportunities for autonomy in the workplace provided for them by the peer review process, coupled with gains in learning and performance which they were able to link with the peer review system, there was an inevitable transition, whereby this process became valued and owned by the group. The results of the ownership inquiry thus indicated that the peer review system had become part of the identity of the public health nurse group.

The growth of the learning organisation

The learning organisation research framework provides support for the idea that through the use of peer review, where performance is assessed against recently updated clinical standards, the Public Health Nurses of the research group had considerably broadened both their understanding of their practice and of the value of their work. This broadening of understanding within the research group, made visible through the research framework, is indicative of activation of the deep learning cycle, the core of the organisational learning experience depicted in the research framework.

Factors strongly suggestive of continuing activation of the deep learning cycle include recognition of peer expertise, as well as an awareness of the difficulties associated with the definition and measurement of expertise, as the feedback issue has shown. These factors, coupled with the research group's preparedness for further fine-tuning to improve the peer review system, show formal and informal changes in ways of thinking and doing since beginning to use peer review indicative of the organisation of learning within the group. In turn, as the learning organisation framework predicts, this growth of learning and understanding in the deep learning cycle of the research group has generated further developments in the wider CHE organisation, representative of structural and procedural changes in the domain of action.

The formation of the review team, and the development of an orientation package, are changes which show how the organisational architecture has responded to integrate and support the organisational learning gains of the public health nurses group. Operating as it was able to, within the domain of action, the review team acted to ensure that the necessary fine-tuning occurred so that the peer review system remained viable and user-friendly. The development of an orientation package, by preventing the 'sabotage' of the peer process by new practitioners seeking an orientation tool, is further evidence of change in the domain of action, indicating growth of the learning organisation into the wider culture of the employing CHE.

The learning organisation research framework helps to create the mindset that sees the strong underlying support within the group, which it is assumed, approximates with ownership, as an expression and measure of the success of the peer process. The inner logic of this idea is clear; the 'better' (that is, more user-friendly and beneficial) the peer review process became, the more the Public Health Nurses liked it. The more they liked it, the more they were prepared to make it work and the more they valued and 'owned' it. Similarly, use of the learning organisation research framework suggests that the proliferation of expressions of ownership could be loosely approximated with the growth of organisational learning. Such an association leads to the idea that ownership of the peer review process at the group level was linked with, perhaps a requisite for, the development of a peer review system as an exercise in effective organisational learning.

Demonstrable growth of understanding within the public health nurse group in terms of what could be done in group decision making, particularly in relation to both the selection of cases, and the giving and receiving of constructive feedback were clear examples of the activation of the deep learning cycle. Both of these issues had been problematic from the outset, and since the changes wrought by the review team's recommendations, the situation had also changed significantly with respect to both issues.

With the growth of understanding that occurred as familiarity with the process developed, and following the workshop discussion, the 'which cases' dilemma was seen as best 'unresolved' for the meantime. This was seen as a meta decision, for essentially, within the loosely defining injunction to the nurses to present cases for peer review that represented learning opportunities, the group elected to let the process unfold further before making additional changes.

Continuing consideration of feedback issues, by contrast, suggested an escalating acuity which demanded immediate intervention. Hence a decision was made to adopt a feedback model, a formula

for giving peer feedback, so that evaluative judgements were softened and focused and became instead constructive critique.

Decision-making about both issues was notably relaxed. The understanding was clearly expressed that at various points in the future small amounts of fine adjustment would inevitably be needed as the peer review system developed, and as the nurses became more practised and confident in both the selection of cases for presentation, and the giving and receiving of peer feedback. The maturity of understanding associated with this long term planning, which included an anticipated future development of skill, incontrovertibly illustrates both the activation of the deep learning cycle and the growth of learning, as described in the research framework of the learning organisation.

The learning organisation framework also points to the development of the review team, with its incisive decision making ability, as a structural and procedural change in the organisational architecture. Creating a review team to review progress with the peer review system, changed the way things were getting done, in order to support the existence of the peer review system, and integrate it into the practice environment. The way the review team dealt with the whole issue of feedback as well as the other constraints impeding the smooth flow of the peer review process shows an advance of inter group understanding about how to refine the process and make it work better, than was available to the group at an earlier date. This shows organisational learning at its most effective: The developing peer process needed fine-tuning, and while the group could not decide how to supply the needed intervention, a review team was created which could.

The review team is important for another reason. In terms of organisational structure, it exists as an entrepreneurial body, in that it is licensed to engage in highly unusual activity, within a barely structured sector of the bureaucracy, solely for the purposes of sustaining the peer review system. Described in this way, the creation of the review team thus provides illustration of two of the factors

which the research framework identifies as facilitative of the learning organisation, that of entrepreneurial activity, and the capability to cross bureaucratic boundaries.

The notably enhanced inter-group dynamics portrayed in the leap of understanding that led eventually to the review team's effective decision making, is offered as an example of catalytic validity as it was described in Chapter Four. There it was stated that research propositions and concepts could be said to have catalytic validity to the extent that they catalysed group activity and enhanced group interactions (Lather, 1986). For the research group, this enhanced ability to manage the development of the peer review system, produced the organisational changes within the domain of action which would sustain their peer review system.

Finally, while concern with creation of an annual performance appraisal system marked a further initiative to secure integrated support for the developing learning peer review system, so that learning gains for the Public Health Nurses would be sustained and valued, the resolution of this problem remained outside the scope of this research project.

Summary

The outstanding issues at the beginning of the third spiral were to do with the selection of cases, the giving and receiving of feedback, the question of ownership, and an exploration of the effects of the changes made to the peer process.

A workshop facilitated by an outside consultant empowered the group to make important gains with the selection of cases and the feedback issues. The selection of cases for presentation at peer review was able to be discretionary, loosely defined by the need for each nurse to show improvement in her practice. Adoption of a closely formatted feedback model, by contrast was expected to ensure that, with practice, the peer feedback process would become one of constructive critique.

Ownership of the peer review system was acknowledged to be critical to the growth of organisational learning. The group and their manager were clear that the process was 'theirs'. Using the peer review system had produced gains in individual and group performance, had allowed the group to redesign aspects of their service to better meet service objectives, and had rendered issues of professional behaviour and accountability more accessible. Coupled with these benefits, the time constraints had been minimised with the revision of the structure of peer review, and the process was seen to be considerably more user-friendly following the implementation of the review team's suggestions.

In Chapter Eight, data from the interviews with the CHE managers and the Nurse Advisor is presented, and evaluation of this material against the research framework of organisational learning is made. This is both a pursuit of the growth of the learning organisation into the wider organisational setting and a look at the effect of the organisational bureaucracy on the development of the peer review system. Finally, a summary of all the issues, actions, and findings from the entire research process is presented as a prelude to the final chapter.

CHAPTER EIGHT

Interviews with CHE Managers

Summary of Research Findings

Introduction

In this penultimate chapter, data from the interviews with the CHE managers and the Nurse Advisor are presented and discussed in relation to the research framework of organisational learning. Consideration of data in this final phase of the third research spiral pursues the growth of the learning organisation into the wider organisational setting. Of particular interest is the effect the level of support from the CHE leaders, perceived as a critical dimension by the research framework, may have had on the peer review system. Finally, a summary of the findings from the entire research process in relation to the research framework of organisational learning is presented.

Signs of the learning organisation

As was described in the previous chapter, information was sought in the final round of data collection as to what research participants were able to say and what was able to be observed, about their learning as individuals and as a team since they had begun to use the peer review system. Interestingly, each of the dimensions of the learning organisation identified as critical by the research framework had become visible within the deep learning cycle of the nurses of the research group during the first research spiral.

During the second research spiral, the incisive decision-making and entrepreneurial activity of the review team, perceived through the research framework of organisational learning, was noted to be an example of a structural development, generated within the domain of action to integrate and support the learning of the research group. In these final interviews of the third research spiral, the influence and effects of factors suggested by the research framework as facilitative of organisational

learning were sought. Specifically, there was interest as to the nature of support for peer review amongst the CHE leaders, as well as a speculative assessment of the influence of bureaucratic structure on the development of the peer review system.

The organisational learning research framework predicted that continued growth of the peer review system would be facilitated by recognition and support from all levels of the organisation. In particular, a critical mass of top leadership was recognised as vital. For example, without corporate acceptance and approval that the peer review system was providing gains that could be viewed positively from an organisational perspective, it would cease to be.

It became apparent at this point in the research process that the Human Resource (HR) manager's role represented, by default, aspects of the second factor, that of a lean bureaucratic structure, shown by the research framework as facilitative of organisational learning. Prior to a new appointment three months ago, the HR manager role had been vacant for more than two years, which arguably suggests a very low profile within the (then) AHB for concerns relating to performance management. At the time the manager of the Public Health Nurses was making enquiries within the corporate structure as to the suitability of her ideas about peer review, there was no HR manager with whom to deal. There was an outgoing Chief Executive of the Area Health Board who was presumed to have other concerns more pressing than the place of peer review in performance management. Following creation of the CHE in July 1993, the newly appointed CEO was also for some time presumed to be pre-occupied with more pressing fiscal and political concerns.

Effectively, the bureaucratic structure at the time the peer review project was mooted consisted of the Public Health Nurses, their manager and the CEO. Hence, it is suggested that the organisational upheaval engendered by political restructuring of the health services bureaucracy caused a dearth of bureaucratic interest in issues of performance management. This situation enabled

the Public Health Nurses and their manager to progress with the development of the peer review system, with a minimum of bureaucratic interference.

The research group had thus become licensed by this absence of functional bureaucracy to generate the initiatives that they needed to improve the quality of their professional performance. Further, it had been tacitly assumed by the entire research group, including the researcher, that initiatives to improve performance quality could be generated at a hands-on, front-line level. The Public Health Nurses were in need of a performance appraisal system, and with minimal bureaucratic input or support, they had created one using knowledge of previous research and the practical and theoretical wisdom available to them.

Given the apparent flux in the organisational architecture, and relative lack of management scrutiny during the peer review system development period, the Public Health Nurses, it could be argued, free from bureaucratic constraints, engaged in a productive action research project. At this stage in the research project it was apparent that these nurses had forged the link between performance appraisal and performance improvement; they had identified areas of cost containment within their service, and had redesigned aspects of their service to better meet the organisation's objectives. Further, their efforts to sustain the learning opportunities they had created for their own group, led to the formation of other structures and processes in the organisational architecture which served to support their learning and publicise the gains arising from their peer review system throughout the CHE. Their activity had produced a potentially viable and valuable peer review system and represented an important exercise in organisational learning.

The interviews with the CEO, HR manager and the Nurse Advisor were a probe to see what could be discovered about changes in the organisational context, in relation to the public health nurse group's experience with peer review. The interviews with the CHE managers are described in the

following two sections, while the results of the research process in terms of organisational learning are summarised in the concluding section.

Approval of material by CHE managers

The managers had agreed to be interviewed by the researcher, on the understanding that transcripts of the interviews would be returned to them for approval, prior to the use of the material in this research report. No changes to transcripts were required in all cases. The interviews with the Nurse Advisor, the CEO and the HR manager were thus the ultimate information gathering exercise in the third spiral of the research process.

Interviews with the CHE managers

Interviews with the CHE managers provided considerable variation as to the views held by these people in relation to the value of peer review. In the first interview with the Nurse Advisor at the beginning of the research process, she had been asked what thoughts about peer review were current in the organisation, and whether there was familiarity at corporate level with the peer review process created by the Public Health Nurses. Also sought was her personal view of how peer review might prove useful for other groups, both nursing and non-nursing, within the CHE.

The Nurse Advisor was eloquent in her support of the perceived theoretical value of peer review for nursing. She saw peer review as part of belonging to a profession:

Nurses do performance appraisal reasonably well, but we don't talk about peer review and we don't do peer review. Peer review is a vital ingredient that is currently missing, it means being able to make your work open to scrutiny from your colleagues, and being able to discuss it and positively evaluate and critique it. We are growing up as a profession, we are beginning to recognise these things, and to realise that there is a long way to go.

In her discussion of the role that peer review might conceivably come to have in the organisational architecture of the employing CHE, the Nurse Advisor stated that the Public Health Nurses were '*out in front*' in their use of peer review:

They are autonomous practitioners and this is likely to be a factor in their development of peer review, this is unfortunately not the case for hospital nurses, and there is not the same opportunity at this stage to make independent decisions within the hospital setting.

Leadership within the public health nurse group was described by the Nurse Advisor as outstanding, and was credited as being an important factor in the Public Health Nurses' success with peer review. By contrast, as the Nurse Advisor perceived it, neither the hospital nursing leadership nor the hospital staff nurses were ready for peer review. The need, the Nurse Advisor stated, was for staff nurses to have opportunities, not presently available within the hospital culture for independent decision making and autonomous practice, in order to have the right environment where peer review could be established.

We need to have the culture and the attitude for peer review and be able to open our work to scrutiny, or it [peer review] will fail, and the hospital environment is just not ready for that yet.

It was predicted by the Nurse Advisor that the next three to six month period would see the creation of an environment within the hospital setting that would support the peer process. In this period the implementation of a clinical practice structure for nurses and the appointment of nursing leaders who would be a part of this new culture would be happening. This proposed clinical practice structure, and the new nursing leader appointees '*would have to create and strengthen the culture that will support peer review*'.

However, many other major changes, for example, the restructuring of the base hospital and the reduction of services at some sites, were also predicted to occur over the same period, and these changes, the Nurse Advisor suggested, would inevitably take priority over the implementation of the clinical practice structure. Nevertheless, the expectation expressed by the Nurse Advisor was that the soon-to-be-appointed nurse managers and clinical advisors would have key functions in establishing an organisational architecture which would support peer review. As she said:

It would be a valuable challenge for these people to create the professional environment where we do have that culture, and the attitudes to support professional growth and the development of peer review.

Once the proposed clinical practice structure was in place, the Nurse Advisor explained, a form of peer review would be the mechanism through which nurses advanced to higher levels of practice:

What the Public Health Nurses are doing is 'true' peer review, we will also be looking to do some modified forms of peer review with the career pathway, where, for example, for a nurse to move to a new level of practice s/he will have to argue their case before a panel of their peers, so it is another way of being evaluated by peers.

Because of the emphasis presently required on performance management in the health service industry, as was described in Chapter One, and the consequently fundamental role which performance appraisal plays in performance improvement, the researcher sought to establish the perceived importance of performance management and performance appraisal within the culture of the CHE. When asked to explain the CHE management position in respect to performance appraisal, the Nurse Advisor suggested that there was not a defined position. Performance appraisal was a funding requirement in the contract which the CHE held with the RHA, she said. As such, performance appraisal within the CHE was driven by that requirement, rather than as a way to improve performance. The issues relating to performance appraisal, she conceded, were not seen to have high priority for the management team, and, in her view, even less attention was given to other issues surrounding the management of health professionals:

Although a lot of managers carry out performance appraisals on the various professional groups within the CHE, I don't think many of them understand what it is to be a health professional in such an organisation at such a time, nor what the requirements of the professionals in their service are.

In the interviews with the CHE managers and the Nurse Advisor at the end of the research process, the focus was on obtaining and providing information about the Public Health Nurses' peer review project. Also to be explored were the implications, as each manager perceived them, which the project might have for impending or projected changes within the wider organisational architecture. A summary of the development, issues and actions with the peer review system had been sent to each manager prior to interview.

During the final interview with the Nurse Advisor she expressed special interest in the ownership issue in relation to the development of the peer review system:

You have specifically identified in this process the difficulty with performance appraisal if the manager hasn't got the knowledge to tell if people are working well or not, so the ownership thing comes in when the manager is looking at the service needs. The bottom line is that the manager is responsible for the performance and the service, and probably for developing a peer review process, such as the manager of the Public Health Nurses has done. Because otherwise, unless the manager takes it and pushes it how does a peer process happen, and without it how does the manager get the information she needs?

Her interest in this issue was primarily in the value which the peer review process could have in the traditional organisational view of performance appraisal, where, as was subsequently reiterated by both the CEO and the HR manager, the manager is responsible for, and therefore needs to know, how the service is working. The implications of the Public Health Nurses activity with peer review was such to suggest that questions of cost containment and quality improvement within a nursing service could realistically be managed using information and knowledge generated by the peer review process.

I guess we have to kind of develop managers who can see the value in this. Ultimately the manager of the area does need to buy into this and 'own' the process to get it going, and I believe that will happen....and perhaps there is an awareness of this because of the Public Health Nurses' peer review, not as much as there could be obviously, but at least it is a beginning.

The Nurse Advisor was able to describe the growth of interest in peer review throughout the organisation. There were several clinical nursing services that had expressed interest in peer review since the first round of data collection. The paediatric unit was keen to use peer support meetings for their community-based nurses, and hospital midwives were also looking at the beginning stages of setting up peer review meetings, based on the system the Public Health Nurses had created.

As well, the manager of the Public Health Nurses had been awarded a prize from the CHE management for outstanding leadership in nursing because of her work with the Public Health Nurses' peer review project. As the Nurse Advisor pointed out, *'this is exactly the kind of positive publicity that peer review needs.'*

The Nurse Advisor was able to disclose that enquiries about using peer review had also been voiced from non-nursing groups. The medical social workers had shown interest in using peer review, as had the mental health team, some of whom were nurses.

The clinical practice structure for nurses working within the CHE was developing, the Nurse Advisor reported, with the senior nursing positions currently being advertised. The inclusion of a modified peer process, a panel of peers to which nurses would have to apply for advancement to a higher practice level, would be a feature of the new clinical practice structure:

It is not happening yet, but the process is being laid down, so the organisation is moving toward peer review. I think there is a growing general realisation that we should be able to evaluate our colleagues. The developing clinical practice structure will drive that whole thing, where a peer process will determine eligibility to progress to a higher level.

The Nurse Advisor saw this panel of peers, an integral part of the developing clinical practice structure for nurses in the CHE, as playing a critical role in the integrity of the proposed clinical practice structure:

The maturity, well really the communication maturity, of this group [the panel of peers who would determine advancement to a higher practice level] is a critical factor in the success of the entire clinical practice structure.

The after hours resource co-ordination positions, described by the Nurse Advisor as 'difficult and lonely' jobs, with one nurse filling two potentially conflicting roles, managing resources and providing clinical support, were the 'ideal candidates for peer review.' These senior nurses would need support and opportunities to meet and talk about work and problems, as, in the Nurse Advisor's opinion, much of their work would involve managing crisis or near-crisis situations which by definition would be 'one-off' situations and would therefore require on-the-spot decision making with few opportunities to consult. It was a situation which:

...could be expected to lead to 'burn-out' very quickly unless there is strong organisational and peer support available for these people, and in terms of learning and improving their practice, peer review seems the obvious choice.

While the Nurse Advisor was unequivocal in her support for the peer review system, the next interviewee was the newly appointed Human Resource manager, who had a very different perspective on the value of peer review. When asked about the importance of performance management, The HR manager gave as a first requirement that performance appraisal systems should provide managers with easily accessible information about the service being managed:

As a basic, managers need a streamlined process whereby they can access the information they need when reviewing the team. It ['the streamlined process'] should take the guess work out of it for me and make it easier for you if you are a member of my team.

Performance appraisal interviews were 'most importantly' information gathering opportunities for the line manager, said the HR manager:

If you are the manager and you don't know what the problems are then you are not doing the job properly. When you are not clear about how the service is looking, or how well people are working, then you have got a problem.

Direct supervision was part of the management answer to the challenge of meaningful performance appraisal, according to the HR manager:

I would like to see that a manager would take every opportunity to work alongside staff, to see how they work and to see what their client contact skills are like, how effective they are, whether or not they achieve their work targets...And if you are able to do this on a quarterly basis then you would have a good idea of how things are looking for the service.

In the HR manager's view, including peer review reports in an organisational performance appraisal cycle would introduce potential conflict:

Peer review is based on bias, by virtue of the professional's view of the right course of action, and within the professional group this view may be different from the goals of the organisation.

The HR manager went on to explain further that while performance appraisal was a combination of many things and was ultimately the manager's responsibility, in his opinion peer review was not the best way to conduct performance appraisal and in fact had limited organisational value for the CHE.

By contrast, the Chief Executive Officer (CEO) professed considerable interest in the Public Health Nurses' peer review system, and cited the same projected new roles for senior nurses, already noted by the Nurse Advisor, which, in his view, would ideally benefit from the gains which the Public Health Nurses had pioneered with peer review. The CEO's preference, he pointed out, was for manager-initiated performance appraisal interviews, which he invariably found 'absorbing and informative, although time consuming'. He discussed the difficulties associated with the gathering of appraisal information when the professionals being appraised were engaged in work to which he as a non-health professional had no access:

I'd like to pop into the emergency department and see what their admission book looks like for last night, I would like to go and watch the use of the CAT scanner, I'd like to see what goes on in theatre, but under the terms of the Privacy Act, I can't, and the managers can't, so the traditional avenues for observing staff at work, or even asking clients to discuss their experiences are not there. Because of this, we need to be looking at all sources of information, not just in performance appraisal but in terms of the quality of health care that we are providing.

An interesting instance where the CEO hypothesised that the peer process could benefit the organisation was at the corporate executive team level:

The management team could use this kind of exercise. It [the executive team] is potentially an isolating level of working where the organisational demands often appear to take first call on time and energy, and very often there is little in the way of support or discussion with many of the decisions that are made within a service.

In summary, the attitudes of these three top CHE managers towards the peer review project were perceived to range from extremely positive and actively supportive on the part of the Nurse Advisor, through to relative disinterest, verging on hostility, on the part of the HR manager. The CEO viewed it positively, aware of the barriers to traditional performance appraisal, and aware of the potential for peer review to prove a useful tool in securing organisational goals. Theoretically, the CEO had endorsed the potential of the peer review process to provide information vital for an improvement in performance for both the Public Health Nurses and their service. It remained to be seen whether the HR manager would be willing to accept the potential value to the organisation of the peer review system developed by this group.

As the CEO had noted, the requirements of confidentiality and privacy mean service managers within health service organisations may not approach clients directly to see how well the nurse is working. Traditional avenues of information and supervision are therefore not available to the managers of today's health professionals. The Nurse Advisor had reiterated the over-riding concern, already voiced by the manager of the Public Health Nurses, which had precipitated the entire project initially, to do with the inaccessibility of public health nurse performance to managers, and especially to managers who may not be nurses. In short, there was a recognition amongst the CHE managers, with the exception of the HR manager, that the peer review system generated key management information for the manager of the service, as well as providing the development opportunities which are integral to an effective performance appraisal cycle. Arguably these characteristics should preclude the exclusion of a peer review system from an annual appraisal cycle.

Accordingly, in the interview with the HR manager, whose role is central in the creation of performance management policy within the CHE, this idea was progressed. It was suggested that, in the presence of a peer review process, a manager who needed to find out about the group and the way it was working would have access, where possible, to the traditional avenues of information, *as well as* that generated by the peer review process. Such triangulation could potentially enrich the manager's perception of the service, enabling more accurate decision making. The HR manager agreed with this view:

OK well it is reassurance that you are getting the right messages. OK well I can see that would have value. And its providing development opportunities, that is important, we tend to forget how important it is and concentrate on the big issues like cost containment and providing the quality of service, which you say is possible with what these people have done. OK well you are convincing me...and well now that peer review is happening, perhaps performance appraisal needs to be more or less in the traditional mode but with this kind of thing as well. OK, I can see that growing...

This conversation is included to show that opinions held by the HR manager were proving open to suggestion, to the extent where he could be said to have conceded the value of peer review. However, his active support for the peer review process was perceived to be some way in the future,

and unlikely to have been forthcoming had the peer review system not been a fait accompli. Initially, the HR manager's ideas about performance appraisal had been seen as a potential obstacle to the development of the learning organisation, capable of preventing gains achieved by the Public Health Nurses from being generalised throughout the CHE. However, it was interesting to see how readily the HR manager recognised the value of peer review when a 'fit' with his own previously held ideas about performance appraisal was offered.

The lack of an annual performance appraisal process for the Public Health Nurses still loomed as an unsolved problem at the end of the formal research period. As the nurses of the research group had identified, the peer review process was capable of generating important information about their service that was not available through other avenues. This, it is argued, is the very factor which should preclude the exclusion of the peer review process from annual appraisal, particularly in view of the comments reported from interviews with both the HR manager and the CEO which stress the value to the manager of information about the service from all sources. Hence, the decision to make the peer review system independent of an annual performance appraisal process, it is suggested, could prove to be in need of further consideration. The continuing dilemma however is that linking the peer review process with the annual appraisal process may mean that the vital organisational improvement information ceases to exist.

Within the public health nurse group, it had previously been suggested that a self appraisal, supported by material selected from the peer review records, presented by the nurse at an appraisal interview with the manager would be a reasonable scenario for an annual performance appraisal. While this idea was seen as having merit it was agreed that the question of annual appraisal needs considerably more attention than the scope of this project has allowed. Concern with the creation of an annual performance appraisal system, in terms of the research framework of organisational learning, marked a further initiative on the part of the Public Health Nurses to secure integrated organisational support for the developing learning organisation.

Summary of all Data Evaluation

This section presents a summary of all data evaluation in relation to the problems with the peer review process, and shows what was discovered about organisational learning as a result of the research process. In the foreground of interest in the research inquiry was the way the peer review system was developing. At a deeper level, it was the growth of the learning organisation that was noted, to see the way this experience of peer review was changing and improving the clinical practice of the Public Health Nurses. In the three spirals of the action research process, documentation of each of the planning, acting, observing, and evaluating phases has shown how the reflexive (reflection on action) nature of the research process provided opportunities for the group to improve their peer review process and secure organisational support for their learning gains.

Problems with the Peer Review System

The issues at the beginning of the data collection period were to do with peer feedback, the selection of cases, and time constraints. Overshadowing these issues was the problem posed by the BARS tool, where the questions were related to the tool's ability to accurately measure expert, or indeed any level, of clinical nursing practice. Following the second round of data collection, where the additional questions of ownership, and an annual performance appraisal process were first considered, the activity of the review group changed the process and the structure of the peer review system. A more user friendly system resulted from the removal of time constraints, the axing of the BARS tool, and the changing of the composition and duration of each peer review group. Finally, the decision to sever the connection, for the time being, between an annual performance appraisal system and the results of the peer review meetings defused the threat that poor peer appraisal would have had for some of the nurses.

In the third and final round of data collection the issues under consideration were still to do with the giving and receiving of constructive feedback, selection of cases for presentation at peer review, and the question of ownership, as well as an examination of the effects of the changes made to

peer review. A workshop with an outside consultant facilitated group decision making with respect to both the feedback issue, and the selection of cases issue. It was appreciated that further 'fine-tuning' of both issues would be required at a later date. The question of an annual performance appraisal, and the relationship it would have to the peer review system remained outstanding at the completion of this research project.

The Learning Organisation

By the completion of the final round of data analysis, it was apparent that significant growth in organisational learning could be observed both within the public health nurse group, and spreading through the wider organisation. Within the group of nurses engaged in this process, there had been a valuing of knowledge and expert skills, and a recognition not only of expertise but of the importance of the expert practitioner to the quality of practice available to the group. The changes in thinking and action that had occurred during the research period were indicative of activation of the deep learning cycle, as described by the research framework. All of the factors identified in the research framework as critical to the learning organisation were noted to be present. The ethos of continuous improvement was apparent in the drive to improve performance, and the updating of standards of clinical practice to resonate with service goals and meet professional requirements was a sign of the ability to fundamentally renew.

All of the factors predicted to facilitate organisational learning within the organisational bureaucracy were seen to operate to some extent in the development of the peer review system. The development of an integrated system to support learning was noted to occur in relation to the review team's activity, indicating a change in the organisational architecture, the domain of action, to support changes in the deep learning cycle. The composition of the review team, which crossed hierarchical boundaries, and the entrepreneurial nature of the review team's activity, correspond well with factors identified by the research framework as facilitative of the growth of organisational learning. In addition, other facilitative factors seen by the research framework to have a role in the development of

the peer review system, included both the lack of bureaucratic scrutiny, and the quality of leadership shown by the manager. Similarly, a level of support from the top management, also facilitative of organisational learning, was found to exist, and in the case of the Nurse Advisor, had contributed to a wide appreciation of the Public Health Nurses' experience. In addition, the expressions of interest from other nursing services within the CHE were arguably examples of the changes which the framework of the learning organisation predicts will spread 'ripple-like' throughout the wider organisation.

An interesting result of this study was the illumination of the question of ownership of the peer review process by the public health nurse group. Findings strongly suggest that developing group ownership of this project was a factor critical to the growth of organisational learning. It is suggested, as a corollary, that in the absence of a sense of group ownership, organisational learning will not occur.

The research process, it is argued, created a background against which to view the developing peer review system. To the extent that reflective discussion of factors seminal to the learning organisation, which might otherwise have failed to achieve prominence in the busy practice world of the Public Health Nurses, was intrinsic to the research approach, it is suggested that the growth of the learning organisation was enhanced by the research process.

In the final chapter, a discussion of these results is followed by an outline of perceived limitations of the study. Implications for these findings in relation to clinical practice, nurse education, and nursing research concludes this report.

CHAPTER NINE

Discussion, Recommendations and Limitations

Introduction

This research report has created a commentary of an organisational learning experience based around the development of a peer review system by a group of registered nurses. While it is emphasised that the participants in this study were not a sample representative of a larger population, this study nevertheless has implications for clinical nursing practice, as well as nursing education and nursing research. In this concluding chapter, these aspects are discussed and recommendations for change in nursing practice, education and research are made. Finally, limitations of the study are identified and discussed.

Discussion: Recapitulation of research findings

During the research process, discussion of both the resolution of problems with the peer review system and the growth of the learning organisation showed that the group of nurses were able to use the gains from their learning experience since developing peer review to confidently redirect and reshape their peer appraisal system to meet group and organisational needs. The way the group was able to manage continual development challenges, and the way necessary organisational support for the peer review system was created suggested activation of the deep learning processes of the group. Connections with the dynamic organisational architecture, the domain of action, were quickly established. As a tangible example of this connection, integrated learning support systems were created within the practice setting of the nurses' domain of action to ensure that benefits to the group from using the peer process were sustained.

The learning organisation framework suggests that effectively flattened bureaucracy and minimal bureaucratic intervention allowed the manager and the nurses to work entrepreneurially to

develop their peer review system. A critical mass of top leadership within the CHE was found to provide the necessary support and dissemination of gains, factors shown by the research framework to be essential for organisational learning.

All three dimensions of organisational learning, indicated as critical in the research framework, were identified during the course of the study. The first critical aspects, recognition of expertise and the valuing of expert knowledge, were initially highlighted by the ineptitude of the BARS tool in rating expert, or indeed any, nursing performance with accuracy.

The ethos of continuous improvement, also identified as critical to the learning organisation, was apparent throughout the research process. In the first data collection round the nurses were able to identify valuable learning opportunities to improve clinical practice available to them since using the peer review system. The learning opportunities were able to be nurtured and developed, largely through the informed decision making of the specifically created review team, so that eventually peer review came to be described as an attractive and rewarding exercise for participants.

The organisational learning framework predicted that to be successful, the peer review process must be shown to improve the group's situation, which it arguably had done by contributing to the achievement of group and organisational goals. Following this realisation, it would be expected that the group would choose to own and run the peer review system. It is worth noting that this is very close to the initial considerations of ownership by the manager. She had noted that it seemed to be critical to the long-term success of the project that feelings of ownership be generated within the group. If it was the group's project, she reasoned, they would ensure the peer process continued to develop as a tool to improve the quality of practice of the group.

By the end of the data collection period, the group of nurses were aware that the peer review appraisal process was incontrovertibly theirs, that considerable improvement in quality of service had

occurred since their use of the peer review process, and that they were responsible for, and capable of making, the finer adjustments that would ensure the peer review process remained viable and useful.

The ability to fundamentally renew, described by the research framework as a further dimension critical to the establishment of the learning organisation, was apparent within the group from before the commencement of the data collection period. It is argued that the creation of the workplace philosophy and the rewriting of the standards of clinical practice by the group of nurses demonstrates this urge to reinvigorate, said to be characteristic of organisational learning.

It is also suggested that the ability to revitalise was apparent in the decision making ability that saw the review team recommend that the BARS tool be discarded. This was seen as a reversal of previous thinking, particularly as the entire research group had been actively involved in the creation of the BARS tool in the preceding year, and also because the manager, who was seen to be 'protective' towards the BARS tool, chaired the review group.

In addition, many of the factors which will continue to influence the development of the peer review process, and the opportunities for learning it presents, within the particular practice world of these nurses, have been discussed. These are factors to do with the structure and stability of the peer review groups, the group learning expected to occur about the selection of cases for presentation, and the whole spectra of feedback issues, which are central to appraisal, and critical to improvement of performance. All of these matters are, to some extent, anticipated as the next candidates for consideration by the review team. There is thus a mechanism for review and fine-tuning of the peer review system. This is the feedback loop that will keep the process focused appropriately on professional and organisational goals for the nurses of the research group.

Evaluation

In the research process used throughout this study, discussion and evaluation have produced the following important considerations:

Peer review is an important tool for nurses

The peer review system designed by the Public Health Nurses of the research group (Appendix A), provides for peer appraisal of clinical nursing practice. The system has been shown to create a forum for peer learning for the improvement of professional behaviour. It is claimed to be capable of assuring improvement in the quality of clinical practice. It was stated by nurses of the research group that issues of accountability and professional behaviour for nurses became accessible using peer review.

Peer review is an important organisational tool

The use of peer review enabled this group of nurses to critique their service on the dual bases of cost containment and organisational service objectives, as well as that of professional practice. It is argued that as part of an annual performance appraisal cycle, peer review has the ability to provide the service manager, who may not be a nurse, with vital information concerning individual and group performance. It is suggested, as an important result of this study, that peer review has the potential to become the cornerstone of effective performance management for nurses within the health service organisations of this country.

Ownership is important for organisational learning

An important result from the organisational learning perspective was the strongly highlighted ownership issue. It was apparent that a sense of ownership developed as the group began to see benefits from the peer review system. With an appreciation of the value of peer review, they quickly assumed responsibility for 'making it work'. This involved correcting the faults of the organisational learning project which in this study was the peer review system. Making the system 'work' also required the securing of organisational support. It thus became 'everyone's project'.

Organisational learning is possible in the health service

The study has shown the growth of organisational learning in a health service bureaucracy like those which employ most of the nurses in this country. The critical dimensions of the learning organisation research framework were shown to be factors in the deep learning cycle of the research group of nurses. All of the related aspects which the research framework identified as facilitating the development of learning within the wider organisational structure were noted to be important in this study. The process was possible because of the critical mass of leadership, first and most importantly, from the manager, and secondly, from the Nursing Advisor, and, largely by default, from the CHE management.

Conclusions

Peer review is an important tool for nurses

Peer review is an important organisational tool

Ownership is important for organisational learning

Organisational learning is possible in the health service

Finally, while peer review is 'learn-able' and 'do-able', it is under-utilised by nurses

Peer review is effective performance appraisal for nurses. It benefits nurses and the organisations that employ nurses. Traditional approaches to performance appraisal contain elements that cause it to fail. Peer review avoids these elements. To develop an effective peer review system requires group ownership of the project, and at least tacit approval from the organisational bureaucracy of the employing health service structure

The research group was able to develop the critically important feelings of ownership to sustain their organisational learning project. The success of this project was due in some part to the lack of scrutiny by CHE management, which was presumed to be in a state of flux following the most recent round of bureaucratic restructuring. Ownership of the organisational learning project further

implied a need for acceptance of the project at all levels of the bureaucracy, and the nurses of this research group were able to secure this important management support through their own initiatives.

It is suggested that with the description of the research process for this study, a blueprint has been created that will benefit nurses and other health professional groups who want to achieve effective performance monitoring systems. It is also suggested that the organisations where nurses are employed, when confronted with the need to manage health professional performance will be willing to consider the use of peer review as an important component of performance appraisal for nurses. It is finally suggested, given the political and fiscal pressures which will inevitably inform the agenda for CHE managers, performance management for nurses may remain undeveloped unless nurses take it upon themselves to develop their own peer review systems, as the nurses of this research group have done.

Implications for nursing practice

The implications for practice of the results of this study are considerable, given that peer review, understood as internal professional review which is deeply concerned with professional behaviour, has been shown in this study to generate information critical to effective organisational performance. It is suggested that using the soft systems methodology of organisational learning as a framework to develop a peer review process will have attractive features for other nursing groups and other health service organisations. Clearly, at its most basic level, the learning organisation is about marrying the performance of the individual and the group with improved economic performance of the organisation.

As was discussed in Chapter One, performance management systems traditionally employed in the health service are seen as flawed. The experience of introducing peer review into the practice setting of the nurses of the research group suggests that peer review could become the basis of quality-

oriented, context-sensitive professional appraisal systems, able to recognise competencies critical to a specific nursing role and to furnish performance information vital to the employing organisation.

To establish a peer review system requires that the standards for professional behaviour are written by the practising professionals. The experience of this research group would indicate that the professional standards of clinical practice must resonate with the organisational goals. In this way, congruence is created between professional and organisational goals, ensuring that the work of the professional group meets service objectives as defined in the organisation's business plan. In this way peer review, as well as providing the quality framework for continuous improvement of clinical practice, exists to monitor and improve organisational performance.

Peer review is potentially of great significance for nursing practice in relation to the governance of clinical workplaces. As outlined in Chapter Two, the restructuring occurring in clinical nursing areas seems inevitably to lead to a devolution of power and a shifting locus of control within the traditionally bureaucratic hierarchies where nurses work. It is strongly suggested that, as power has shifted from the professional model to the management model within the health service, there has developed an awareness of the need for a less bureaucratic, more democratic approach to the administration of nursing services.

In some organisations this has meant that nurses are assuming responsibility for both the delivery and quality of nursing services, as is exemplified by the activity of the group of nurses involved in this study. The ability to enhance performance and confidently meet service objectives, which familiarity with a rigorous peer review system would confer, considerably strengthens nurses' legitimate claim to the governance of clinical workplaces. The assurance of quality healthcare service to the people who use the health services must, after all, be a primary concern in any healthcare organisation.

New roles for senior nurses, like those envisioned and discussed by the Nurse Advisor of this study, are being created in many health service organisations. In order to take up such roles with confidence, the nurse managers and the clinical advisors engaged in developing such clinical workplaces will need familiarity with the peer process. As was identified by the Nurse Advisor, these nurses will be responsible for creating the culture that will support autonomous practice and also with creating the environment where nurses will be able to confidently open their work to peer scrutiny.

Nurse leaders of tomorrow, it is suggested, as well as facing the challenge of creating the culture that will sustain internal professional review within a hospital setting, are themselves in need of peer support. These senior nurses, who will operate in roles which cross the traditional boundaries between clinical and management roles, will of necessity be breaking new ground in many of the issues that they face. It is strongly suggested that opportunities to learn about and improve their clinical and management skills are unlikely to be available except through peer review.

Implications for nursing education

Peer review relies on praxis, reflection on action by practising professionals, to generate appraisal. Praxis is inevitably about improving performance and therefore about quality improvement. Peer review also generates information about the efficacy of group outputs in relation to organisational goals. Structural changes proposed for the health services by the present Government may create a climate, such as that described in the preceding section, which favours shifting the locus of power in clinical areas into nurses' hands.

If nurses are to realise the opportunities created by this predicted 'fluidity' in workplace management, it is suggested that acute awareness of the issues relating to effective management of the nursing resource is needed. It is argued that mastery of such issues, in particular, those that relate to planning and implementing quality assurance cycles, and which also relate to planning and

implementing performance management cycles, will enable nurses to understand and confidently manage clinical workplaces within a cost-conscious, quality-driven health service environment.

Education programmes for nurses well prepared for this challenge will include familiarity with the concept of praxis, as a way to improve clinical practice, and familiarity with the peer process as a way to secure improvement in the professional performance of the group. Post basic nurse education programmes will thus be providing practising professionals with the tools with which to critically value their work, assure quality outputs within the nursing workplace, and direct nursing skills at meeting organisational goals. In the light of the conclusions of this study, it would be appropriate to see the complex issues of performance appraisal and performance management for nurses occupying a very high profile in the management courses available to nursing graduates in this country.

In addition, understanding how organisations learn, and knowing how to use this process to advantage, is seen to have considerable promise for graduate nurses. The organisational learning framework used in this research, which suggests enlightenment and emancipation as learning outcomes for participants, has empowered nurses of the research group to change their work environment so that the system whereby their work was appraised, was designed, implemented and critiqued by them. Such wisdom in relation to organisational learning for nurses could profitably be included in tertiary level courses relating to change management. It is strongly recommended that nurses be able to use with confidence the principles of the learning organisation to secure organisational support for nursing initiatives.

Implications for nursing research

The research process for this study, directed by the framework of organisational learning, provides a useful benchmark for the further study of both the peer review process and the development of the learning organisation within the health service. The use of a learning organisation framework facilitated the planning, action, observing and evaluation phases of the action research process. It has

also benchmarked the peer review development process for other potential users, particularly nursing groups, and builds a framework for continuous improvement into the peer review process itself.

In this praxis-oriented participatory action research study, where the goal of the study related to improved performance management practices, the practitioner was central. The rest of the research group, that is, the managers and the researcher, acted to support this centrality, as well as to ensure that organisational and research goals were met. The shared goal of the research process was to improve the quality of nursing practice. To ensure that potential gains identified during this study are transferred and generalised throughout the clinical practice world of nurses in this country requires a practical strategy. A straight forward approach to research utilisation in nursing, precipitated by the growing focus on evaluation of performance and quality assurance, is suggested.

It is argued that it is appropriate to talk of significant clinical 'facts' which are indicative of good practice. This approach demystifies the use of research by presenting it as a servant to practice. In cases where practice is informed by research, such as for the group of nurses in this study, it is likely that the nurses view what they do as simply good practice rather than research-based practice. In such cases, the research-based findings have become re-classified as professional knowledge.

Hence, suggestions for marketing the 'product' of this study involves a conceptualisation of the problem of research utilisation within the confines of change theory. This is a focus which is beginning to be apparent in the nursing literature with respect to the implementation of organisational change using methods such as have been outlined in Chapter Four, which are loosely subsumed by the term 'action research'.

Typically, an action research approach may generate a focus on evaluation or development. In the situation described in this study, emphasis was placed on the process of development and thus, it is argued, the process had the look and feel of action learning. In this way the linkage of research to

development is created with a focus, in this study, on a 'benchmark' for the creation of a peer review appraisal system. Thereby, it is suggested, does the research product, or in this case, the research process, become the 'best practice', and research generated knowledge is reclassified as professional knowledge. An important implication arising from this study is the recommendation that it would be unwise for other groups to adopt the finished 'peer review' product, which has become a piece of the organisational architecture of the employing CHE. Rather, it is suggested, other groups could adopt the process outlined in this report, so that deep learning and organisational architecture develop together.

Suggested areas for further research

In the practical arena, there is yet another dimension to effective performance management learning for nurses for, as Senge (1990) says, there must be some assessment of progress. This assessment of learning, Kofman (1993) suggests, should be made by the peer group:

Learning is the enhancement of or increase in knowledge, and knowledge is the capacity for effective action in a domain where effective action is assessed by a community of fellow practitioners (Kofman & Senge, 1993, p.48).

In this study, measurement or assessment of the outcomes of organisational learning was the function of the research group itself, the Public Health Nurses assessed their learning. Similarly, the manager of the public health nurse group and the managers of the employing CHE assessed the impact of this group learning on the wider organisation. The outstanding question here is on what did they base their assessment of group and organisational learning?

Many of the most important results of organisational learning, it is suggested, are not quantifiable; things like openness, innovativeness, courage, confidence, genuine caring for clients, for one another, and for the shared aspirations of what it is hoped will be created. Despite the non-quantifiable nature of such results they are not unknowable. There are many ways in which people can come to agreement about assessment of progress in achieving such results. Ultimately, learning is

judged by results. The difference will be noted between what is possible now that was not possible before the learning began. The problem here is knowing how and when to measure important results, and as such this represents an important area for further study.

There is considerable potential also for further studies with praxis-oriented intent to be carried out in the clinical practice world of nursing, to reinforce the value of peer review. One such study would be to track the future development of this peer review process, already begun with the research group, in order to outline further the effects of the peer review process, and an eventual (predicted) relationship with an annual appraisal cycle. It would also be a valuable exercise in promoting peer review to undertake the development of a peer review system with another group of nurses, using the framework developed for this study.

Limitations of this study

While this study has identified the benefits of a peer review process for improving the quality of clinical nursing practice, as well as illuminating important features of organisational learning which facilitate the development of peer review. it has the following limitations:

Boundaries imposed by the research process

The major limitations of this work are the artificial temporal boundaries. The nurses who participated in this study began with the desire to create an appraisal system which would accurately value their nursing performance and provide development opportunities for improvement of clinical performance. Throughout the period of the study, despite reiteration of this goal, which seemed to reflect the need to fix the peer review system within an annual performance appraisal cycle, the full implications of this relationship had not been realised at the conclusion of the study. Limited progress towards this development had therefore been made. In mitigation of this idea of limited progress however, it is suggested that it is the process which the research engendered, rather than the specific

outcomes of the research project, which will determine the usefulness of the research both to the research group, and within the wider nursing context.

In the discussion of action research in Chapter Four, it was acknowledged that the reflexive spiral of the research process mapped easily onto the praxis-centred peer review process. This relationship suggests that the reflexive process which shaped the development of the peer review system is ongoing within the peer review meetings, and in the continuing activity of the review team, and will thus continue to guide and shape the development of the peer review process for the research group.

As a corollary to this suggestion, the idea is offered that there is no appropriate terminus which may be reached, with all goals achieved, for, as was shown in this study, the peer review process which was created is dynamic and responsive to the changing needs of the user group. In the development of this process, the potential for its continuation exists, not only in the practice world of the nurses involved, but also in the practice world of other nurses who may hear about it.

Interestingly, evaluation of the data showed that several of the problem issues surrounding the peer review process persisted in some form at the conclusion of the data collection period. Arguably, these issues were considerably illuminated by the research process, in particular by the insights which developed from the use of the learning organisation framework.

Evaluation of Data

A further limitation of the study concerns the interpretation of data. The issues identified and the discussion and evaluation provided are not the only possible interpretations of data to be made. However, it is emphasised that this study was carried out in a rigorously participatory manner, with all data being returned to the group for reconsideration in each research spiral. Issues were continually brought back to participants for discussion and challenge, as was shown by the

exploration of the ownership question. There was no predetermined view of how issues should be pursued, nor of what the outcomes would be. It is readily acknowledged for example, that using a different research framework would inevitably produce a different view of the research process and a different view of the outcomes of this study. Face validity of the research approach, as explained in Chapter Four, is said to have been achieved given the research group's acceptance and explicit validation of the accumulating data.

Concluding statement

There is a key understanding that both the research and the researcher will profoundly influence and be influenced by the research process. Experience of this research process has reinforced the perceived value of the action learning approach, for as outlined in the preceding section, the 'process' and the 'product' of the research, the peer process and the learning gains, are now a given of the practice world of the nurses who were involved in the study. Research knowledge has been reclassified as professional knowledge.

Presenting the research process in a way that has shown the various facilitative factors and critical dimensions of the learning organisation at work within a clinical nursing area, created a context within which to view the problems and constraints experienced with developing the peer review process. This aspect of the research process has significance in that an understanding of the learning organisation appears to have facilitated both problem solving skills, the single loop learning, as well as the double loop learning, the transformative insight which recognises the adaptive mechanism that is required and takes action to create the appropriate changes.

Many direct observations reported in the participants' words ensure that individual voices are heard rather than obscured by the research process. This also leaves a clearly documented decision trail whereby the reader can resolve issues of rigour relating to the credence and credibility which attaches to this praxis-oriented participatory action research study.

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APPENDIX A

Peer Review Model

**PUBLIC HEALTH NURSE
PEER REVIEW PRESENTATION RECORD**

SUMMARY OF CASE/PROJECT

NAME: _____

DATE: _____

CASE/PROJECT: _____

NURSING DIAGNOSIS/PROBLEM: _____

BACKGROUND/HISTORY: _____

SUMMARY OF NURSING ACTION:

OUTCOME TO DATE: _____

**PUBLIC HEALTH NURSE
PEER REVIEW PRESENTATION RECORD**

STANDARDS

NAME: _____

DATE: _____

STANDARDS

Circle the standards address in course of work with this case/project

The Community
Standard 1 2 3

Individual and Family Health
Standard 1 2 3 4 5

Educational Institutions
Standard 1 2 3 4 5 6

Disease Prevention and Control
Standard 1 2 3

Professional and Personal Development
Standard 1 2

Administration
Standard 1 2

PUBLIC HEALTH NURSE PEER RATING

1. **JOB KNOWLEDGE** = Familiarity of work knowledge and skill gained through theoretical and experiential learning.

Exceptional job knowledge used outstandingly for activity being reviewed	Very good job knowledge used well to meet the challenge of activity being reviewed	Job knowledge adequate to meet the challenge of activity being reviewed	Knowledge appropriate of a beginning practitioner. Inadequate to address the activity being reviewed.
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2. **ABILITY TO GET THINGS DONE** = Ability to use resources effectively and efficiently to achieve optimum results.

Achieves difficult objectives and tight deadlines with an exceptional degree of professional competence and efficiency. Always completes. Sustains enthusiasm.	Always meets objectives within anticipated timeframe with high degree of competence and efficiency. Enthusiastic and interested.	Generally achieves objectives within timeframe. Competent practitioner.	Sets unrealistic objectives and/or timeframes which are not fully met.
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3. **INITIATIVE** = Ability to initiate activity within the scope of the PHN role

Anticipates need to initiate action and takes prompt action independently and with originality/resourcefulness/enterprise.	Able to plan ahead to meet potential difficulties. Can act independently in most situations.	In uncomplicated situations takes early action without prompting from others. Seeks assistance when appropriate.	Takes initiative appropriate for a beginning practitioner. Does not seek early assistance when uncertain about situation
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4. **DECISION MAKING** = Ability to make sound judgement on best alternative course of action

Outstanding ability to make well-founded judgement between alternatives within a restricted timeframe.	Very good ability to make timely, sound decisions based on consideration of all options.	Able to make appropriate decisions between alternative courses of action. Seeks peer assistance in difficult situations.	Decision making skills appropriate to beginning practitioner or has difficulty selecting an option between alternatives. slow to seek peer assistance.
--	--	--	--

5. **PROBLEM SOLVING** = Ability to find solution to given situation or task

Uses creative and innovative thinking to analyse complex and challenging situation/task. Selects the most optimal solution.	Analyses situation/task creatively and finds an acceptable solution to the problem	Capable of thinking through a situation/task and finding a solution to it.	Problem solving skills appropriate to a beginning practitioner. Has difficulty thinking through a situation/task clearly.
---	--	--	---

6. **PLANNING AND ORGANISING** = Ability to develop a rational way of proceeding with activity.

Accurately identifies needs/requirements in complicated situations and establishes realistic objectives and priorities. Initiates action within appropriate timeframe and achieves excellent results	Accurately identifies needs/requirements and develops objectives which realistically addresses them. Prioritises. Results achieved as a consequence of action exceed expectations.	Identifies needs/requirements and sets objectives which address them. Prioritises. Evaluates results.	Appears to lack adequate planning skills. Has difficulty identifying needs/requirements or setting appropriate objectives. Does not evaluate.
--	--	---	---

Peers signatures: _____

Date: _____

APPENDIX B

Definition of Peer Review

Definitions

'Peer' as a noun has the following meanings: An equal, especially in natural gifts, social characteristics, social rank, or personal condition as another. It also implies a person who is of the same civil rank as another, and an equal before the law (Funk & Wagnall, 1950, p.1025; Heineman, 1989, p.829). The Oxford University Press (1989, p.913) includes 'a person who is the same age as another'.

'Review' as a verb means to recall to thought in memory; especially, to go over in recollection, to survey; to look back upon; to view again with scrutiny. To review is to go over again critically and deliberately in order to make needed changes and directions; to revise, to go over in order to note the excellences, defects or peculiarities of that which is reviewed; to write or print a critical review of (a book, film, etc.) for publication; to make a critical, formal, official or ceremonial inspection as of a body of troops. There is a further implication in that to review may also mean to go over, to reconsider, retrace, repeat to fix in memory, to examine again (work already learned) in preparation for an exam; to revise.

As a noun, a **review** is a second repeated or new view of past events or a subject; a retrospective survey; to go over anything again in order to acquire greater familiarity with it; a summary of several preceding events; a lesson studied or recited again. A review is an act of re-examination or reconsideration. A review is also a critical study or examination. It may be an article or essay containing a critical discussion, or notice of and comments upon the characteristics of some work. A review may be a critique, or a published report that assesses the merits of a book, film, etc.,

and it may be a formal or official inspection, or a judicial revision (Funk & Wagnall, 1950; Heineman, 1989, p.974; Oxford University Press, 1989, p.1085).

The definitions of 'peer' and 'review' seem to have changed little in the years between 1950 and 1989, and although a comparison amongst different authors would not be valid there is room to speculate that the meanings of both words have narrowed rather than developed; they have become more precise rather than having the nuances of ambiguity which were previously possible.

In summary, 'Peer' describes a person who is of the same rank, age, ability, status or merit as another. A peer is an equal. 'To review' means to recall to thought, to go over in memory; to recollect and reflect with deliberate and careful scrutiny; it is a new look or a second look, a retrospective survey which looks critically, noting excellences, defects or peculiarities, in order to gain greater familiarity with that which is reviewed.

APPENDIX C

Information sheet

PEER REVIEW FOR PUBLIC HEALTH NURSES

My name is Brigid McRae, I am a registered nurse with seventeen years of clinical experience, two years as a staff development officer and two years in nursing education. I have a BA in Social Science (Nursing) from Massey and am proposing to write my master's thesis this year based on the Peer Review system presently being developed by the Public Health Nurses.

My supervisor is Valerie Fleming PhD, a Senior Lecturer in the Nursing and Midwifery Department, Massey University; my advisor in the Human Resource Management Department at Massey University is Phil Ramsey MBS. Both Valerie and Phil are available to answer your queries if required.

What is the study about?

The purpose of my research is to describe the development of the peer review system recently initiated by the Public Health Nurses. I will use an action research approach in interviews with the entire public health nurse group, and with Crown Health Enterprise management to investigate the organisational learning process as it is occurring.

Participation in this study is entirely voluntary, and you have the right to refuse to participate, and to withdraw without penalty at any stage. Prior to starting the study I will undertake to negotiate with you in person, and, following your written consent, will record all interviews and transcribe them personally. These transcripts will be returned to you for vetoing; any recorded statements considered unusable for any reason by you or by any participant will be deleted at this point. The resulting data

from this process will be explored for developmental implications and returned to the group/manager concerned for further discussion at successive interviews.

These interviews will be repeated three times (twice for the managers) over eight months and the same process to determine usability of data will be followed with all transcripts. The final research report will be an evaluation of the development of the Peer Review system in terms of an organisational learning framework.

Each Public Health Nurse participant can expect to take part in three meetings with the researcher and the entire Public Health Nurse group (approximately 40 minutes). These meetings will be audio-taped. Completed transcripts when judged to be acceptable by all participants will be retained by me for the purpose of completing this research project, and I will undertake to destroy all transcripts and erase all tapes following acceptance of my thesis.

Following successful completion of the research project, it is my intention to submit for publication a research report that will outline the Peer Review process within the learning organisation which is generated during this research process. Prior to submission of this report, written consent for publication will be sought from all participants

What can you as a participant expect from me?

You can expect that at the beginning of each interview I will remind all participants that any one of you may refuse to agree to taping all or any part of the interviews and that your wishes in this will be respected, you may therefore stop the tape at any time, and you may also expect that without the consensus of the whole group, taping will not occur.

You can expect that at the beginning of each session I will also remind you that participation is entirely voluntary and that you are free to withdraw at any time.

You can expect to be continuously informed as to the progress of the study. I have a commitment to legitimately supply available information to you to make good any knowledge gaps that you may experience as a result of participating in this project.

If you take part in this study you have the right to:

- ask any particular question and to withdraw from the study at any time
- ask any further questions about the study that occur to you during your participation
- provide information on the understanding that it is completely confidential to me

All information is collected anonymously and it will not be possible to identify you in any of the reports that are prepared from this study

- be given access to a summary of the findings from the study when it is concluded.

Thank you for your help.

Brigid H McRae

CONSENT FORM

PEER REVIEW FOR PUBLIC HEALTH NURSES

I have read the information sheet for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction and I understand that I may ask further questions at any time.

I also understand that I have the right to withdraw from the study at any time, or to decline to answer any particular questions in the study. I agree to provide information to the researcher on the understanding that it is completely confidential.

I understand that I will be given a summary of findings from the study when it is concluded.

I give my consent to my interviews to be taped / I do not consent to my interviews being taped
(cross out which ever does not apply)

I wish to participate in the study under the conditions set on out on the Information Sheet.

Signed

Name

Date